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Session 53PD
Prescription Drug Update

Track: Health

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Panel: BRIDGET EBER†
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Summary: Pharmacy costs continue to provide headaches for health plan actuaries and consultants. If it's not utilization, it's price; if it's not price, it's utilization. For most, it's both at the same time. Panelists with close ties to prescription drug programs provide information such as factors that continue to drive pharmacy cost increases, strategies in use to combat rising utilization, benefit designs being employed to hold rates down and the value of mail-order drug programs.

MS. KARA CLARK: Good morning, everyone. My name is Kara Clark and I'll be moderating the session this morning. I'm an actuary on staff at the SOA, supporting the health practice area.

This session is entitled "Prescription Drug Update," and the front page of yesterday's *Wall Street Journal* included a number of stories related to prescription drug issues. For example, AstraZeneca agreed to pay $355 million to settle charges that it falsely induced doctors to bill government health programs. The Food and Drug Administration (FDA) approved the sale without prescription of AstraZeneca's Prilosec heartburn drug. The FDA is revising procedures to encourage their reviewers to process new drug applications more rapidly; drug companies are jockeying for advantage as the Medicare Bill advances in Congress. The Senate again voted to make it easier to import drugs from Canada, but implementation is unlikely. These are front-page issues of concern to employers, to health plans, to

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pharmaceutical benefit companies, to consumers and to policymakers. Some of our panelists this morning will be able to speak to some of those perspectives, and I'd like to introduce them to you now.

Bridget Eber is a pharmacist by background, and she leads the Hewitt Associates pharmacy practice in their Lincolnshire, Ill., office. Bridget and her team work with large employers, assisting them in managing the pharmacy benefits they offer to employees. Her work focuses on evaluating utilization experience to develop plan designs and cost management strategies into pharmacy benefit management partnerships. Bridget received her bachelor's degree in pharmacy and her doctorate in -pharmacy from the University of Illinois.

Also with us this morning is Rob Ecker. Rob joined CIGNA Healthcare as vice president and chief financial officer for CIGNA Pharmacy Management in April 2001. He oversees all financial and pharmaceutical manufacturer relations to CIGNA Pharmacy Management, including CIGNA Teldrug, CIGNA's mail order pharmacy. Rob has 18 years of varied industry and financial management experience. Prior to joining CIGNA, Rob has held chief financial officer, controller and financial planning positions, and worked in financial services in consumer product industries. Prior to that, he spent seven years with KPMG. Rob earned a bachelor's degree in business administration with honors from Bryant College, Smithfield, R.I., and a master's degree in business administration from Ohio State University. He is a CPA and a member of the American Institute of Certified Public Accountants.

Margaret Wear is a health care actuary, most recently working as an actuary for Advance PCS, the nation's largest pharmacy benefit manager (PBM), on risk and benefit design issues related to pharmacy benefits. Her experience also includes work at a health plan and in consulting. She is a member of the Health Practice Council of the American Academy of Actuaries and vice chair of the Academy's Prescription Drug Work Group.

Let me give you a general sense of how we decided to structure this session. Rather than having each panelist come up and make a presentation, we decided to structure things a little bit differently. I will present a question based on a general theme as outlined in the session description to the panel. One or more of the panel members will then answer that question based on their personal perspectives.

Starting with the business environment, what environmental influence do you see as being the most significant for the current pharmaceutical benefit market?

MS. BRIDGET EBER: There's quite a bit going on in the area of pharmacy management, which really speaks to the attendance we have this morning. There have been so many changes, so many questions that employers and consultants and all of the stakeholders have been asking that we're looking at what's changing in the environment today. We're also looking at what people are learning today, because there really are so many details about pharmacy price issues, cost issues,

drug mix issues, and who's doing what. It's been a little overwhelming for a lot of people to manage, and we're beginning to unbundle who's doing what. That leads us to some more pointed directions as we help our clients move forward in developing strategies. First and foremost, we're seeing that there is a bit of a black box in terms of managing pharmacy benefits. PBMs really are engaged in three different lines of business. I think that unless we all understand what those lines of business are, we might find ourselves becoming a little bit confused with some of the semantics as we talk through solutions and strategies. My schematic helps you understand which way we're going from a strategy perspective.

When PBMs engage in a relationship with employers or a plan sponsor, it primarily is to manage those pharmacy benefits to make sure that the claims are administered the way they should be, through the price terms or the benefit design terms: a pretty straightforward assignment. I think for a long time employers and plan sponsors looked at that as the sole line of business that was substantiating their relationship, not realizing that there is a lot of other activity behind the scenes. As you move clockwise through the schematic, there is the retail pharmacy and the mail order pharmacy bubble, if you will. A lot of employers and plan sponsors are starting to realize that PBMs actually purchase prescriptions from those retail pharmacies and mail order pharmacies. They essentially sell them back to employers or plan sponsors, so the benefit itself is a matter of buying prescriptions that are provided by pharmacies and selling them at a discount to employers. This is a pretty linear transaction, and it really represents the bread and butter of much of the work that we've done that focuses on the discount of average wholesale price and the dispensing fees. This has been very much focused on the price of that transaction, and that has been the real bread and butter of strategy for a long time for many employers, just that linear price management component.

From the PBM's perspective, owning and operating that mail order pharmacy certainly generates a significant amount of revenue and profit, and represents a lot of opportunity to manage cost but, in general, when we look at network management, we're really looking at supporting those transactions.

The other component of the PBM line of business really is represented in two bubbles: the pharmaceutical manager and the data buyers. The PBMs of 20 years ago recognized that there was a lot of opportunity to essentially broker formulary space with manufacturers of brand name drugs. That translated to utilization management or cost management in their business model. The purpose of our discussion here is to help you understand the moving parts as we and as employers see them. We're certainly not making judgments or assessments as to right or wrong or compliance. But the fact is that PBMs have enjoyed a very profitable space in managing utilization or influencing market share of primarily brand name drugs, and for a long time (probably five years in terms of our discussion) that translated to cost management. There's a definition of cost management that PBMs provided to their customers. The biggest change that we're seeing, in terms of the business environment in 2003, compared to 1997 through 1998, is the recognition

that there's much more to cost management and utilization management than buying and selling formulary space. And there's much more than managing the price components of buying a prescription from a pharmacy and selling it back to an employer. What we see is much more global appreciation that it's the medical conditions that drive utilization, and that drug mix is a matter of the right drug, but also making low-cost drugs or affordable drugs more accessible to members and to payers. Taking advantage of the lessons learned and the moving parts that really put forth this complex structure and moving it to the next level says that there's much more to it than what we've been dealing with in the past.

Hewitt Associates did a survey in the fall in which it asked employers essentially what they thought about their partnership with their PBM. Essentially employers were saying that they weren't really sure if PBMs are demonstrating that they were managing their costs. We haven't thought too much about the price component, but essentially employers are saying, in these survey results, that they're ready to look at a different model in terms of managing pharmacy benefits, so that's the direction that we'll take as we go forward with unbundling some of these other strategies.

Probably most interesting is this conflict of interest. Ninety percent of employers told us that they felt PBMs were in partnership or in tighter partnership with pharmaceutical manufacturers than employers, so that 90 percent of partnership with pharmaceutical manufacturers versus the 34 percent partnership with employers essentially tells us from a consultant perspective that there's a big gap. There's a big opportunity to help PBMs better demonstrate how they can add value from a cost management perspective. At the same time, from an employer's perspective (and I think this is an area where all of you can really help), there are better questions that they should ask in terms of developing a better service model.

MR. ROBERT ECKER: To follow Bridget's comments regarding perception, obviously it's very real and adding to that are the legal concerns that we read about in the newspapers. Practically every week something new is going on. One area that's been under investigation by the Justice Department for nearly five years is the relationship between PBMs and drug manufacturers, and what type of influence drug manufacturers may have over PBMs' selection of drugs for their formulary. My understanding in everything I've read is that no tangible results have yet come out of this, but it has created the additional perception that there's something going on there that may not be appropriate from the employer's perspective. We see that in the survey results. I don't know which preceded which, but they obviously go together. From the PBM's perspective, this creates a significant amount of difficulty in the marketplace, and more importantly, it creates an environment where pricing transparency is becoming more prevalent. While every component feeding into that box is integral in the economic model of the PBM, it's now more important to the employers that we break that out and that they understand each component. Then they can try to make determinations and selections based on that knowledge. The PBMs price by combining those components and try to deliver a competitive market value to employers, but now that's becoming more transparent. You'll have

employers saying, "I understand you're getting all of this money from the manufacturers. I'd like to see more of that money coming to us." Their thinking is that, if they can move some of that down to them as opposed to the PBM retaining that, it's going to be better for them. What you find is that it creates a situation in the market like squeezing a balloon. You're squeezing in one area, and it's going to come out in another area. Many PBMs will price this mix of items, including rebates, to create a margin for themselves. If we take that away, we're going to see it in the form of administrative fees or some other form, so we would really be moving the pieces around. We are seeing margins continue to get compressed as a result of this, so this creates a significant challenge for the industry.

MS. MARGARET WOOD WEAR: I looked at it from a little different perspective than Bridget and Rob. In thinking about the pharmaceutical benefits in the marketplace, one of the things I feel impacted a lot of different factors in the benefits that are currently offered has to do with pharmaceutical marketing. It started about five years ago and was coupled with a drive for consumerism within the general health care market. When you look at today's pharmaceutical marketing and you see all the advertisements for Allegra and Nexium, etc., it has truly impacted the utilization of those products. People go in and specifically request those products from their physicians. I think a lot of that has driven changes in the way benefits are designed. When you look at three- and four-tier benefit design, coupled with the fact that the member can get most products they would request, it's just a matter of how much they're going to have to pay for them. I think it has had significant impact on the drug choice and on what the health plans are looking at putting in for utilization management controls. For example, you can look at the proton-pump inhibitors, and we were talking earlier about Prilosec about to go over the counter. You look at how many people are taking actual products, and are these really the best products for every single person that has a little heartburn? Probably not, and the products are very expensive. I think that type of pharmaceutical marketing is driving members to request those higher-priced products that are meant to treat a significant disease. They're using them to treat something that's much less; then that drives the health plan to set in limits and controls on those kinds of products being used by people who don't have the higher level of disease that that product was put in place for.

MS. CLARK: We will now move on to benefit design. What benefit design strategies are being used in the marketplace to manage pharmacy benefits? Margaret, let's start with you.

MS. WEAR: From my experience, most plans are looking at incentive co-pay designs now. Most plans are using three-tier designs, but other plans are looking at going into four-tier, and some are even looking at five-tier designs. You see the four-tier designs in a couple of different categories. Some of them are basically a three-tier design, and then the fourth tier is added to cover drugs that might not otherwise have been covered. It might have even been covered at 100 percent co-pay, but where the member then gets the benefit of the pricing discounts that

Bridget was talking about earlier. I've seen some other plans that tier all their products into different tiers, with the four tiers being price-driven, so that you might have some high-cost generics falling into the second tier. Then you bucket your drugs into tiers differently.

Some plans look at what are considered to be lifestyle drugs, and some plans consider lifestyle drugs to include things like non-sedating antihistamines. They feel that if consumers can get an antihistamine over the counter, the more expensive non-sedating antihistamines might be considered lifestyle drugs and might fall into that fourth tier. The fourth tier might have a very high co-pay or even a 50 percent coinsurance. It clearly gives members the incentive to choose the products that they want to choose. They can get lower-cost generics and preferred brands at a less expensive cost to the member.

When you look at formularies, they work in conjunction with the plan design designating which drugs fall into which co-pay tier. We also have seen a number of employers considering coinsurance design, which automatically indexes the amount the member has to pay to the cost of the drug and keeps it up –to date on the yearly renewal.

Most plans have a MAC (maximum allowable cost) program component to them. It's widely used for generics and usually represents savings back to the employer or the health plan. These kind of MAC programs can be used in a number of ways and at the most (although I'm not sure the word "extremist" makes sense), the best use for the plan is when there is a generic available and the member still takes the brand drug. You can set it such that the member has to pay the full difference in cost.

Reference pricing is sometimes looked at, where you have a reference price in a therapeutic class. I believe that you can get a similar result by looking at tier co-pay designs and setting the co-pays for the tiers at the appropriate level. For example, you have a reference price in a class that you want to be at $40, so that for any drug that's more than $40, the member has to pay the difference. An easier plan design would be to look at drugs in that class and set the co-pays such that those differences are for the most part made up, when you look at your average price for your preferred versus your non-preferred.

MS. EBER: As you might imagine, we're seeing quite a variety of approaches to design changes. If I were to encapsulate the guiding principle that I see across most employers, it is recognizing again that there are a lot of conditions that require utilization of drugs and also recognize that the prices for those treatments range from pennies per day to dollars per day. That in and of itself is a complex challenge. Employers are trying to develop strategies that can be communicated relatively simply. All of the moving parts are too complex to pull apart, so we try to help them identify the key drivers or the key opportunities and develop designs that can be as simply communicated as possible.

Whenever we work with a population, actuaries have taught me that that the first step is to profile the utilization. Again, this is just an example of the distribution, but they must get an idea of how much utilization there is among that population. You're always going to have some percentage of the population that doesn't use drugs at all, and you're going to have a peak at some relatively manageable cost, and then you'll have a small amount of the population in the extremes. One of the key questions is to see how you can best develop a cost-management strategy so that you target the people who consume a majority of the resources, but not penalize the people with catastrophic illnesses who really need a benefit to cover them. Profiling that population is really important because, again, you don't want to develop a strategy that creates some unhappy people.

I just went to a seminar a couple of weeks ago that was sponsored by Express Scripts, another large PBM. They shared some statistics with us that you might be interested in. They said that across their book of business, 10 percent of the licensed physicians in the country were responsible for writing 63 percent of the scripts. Their population includes 72,000 physicians, so a little more than 7,000 physicians were writing 63 percent of the scripts. Then they looked at utilization counts across the membership, and 10 percent of the members accounted for 70 percent of the cost across their book of business, and a little less than 60 percent of the membership accounted for 100 percent of their cost, so this was a little bit in contrast to the data we had of 15 percent of the population not using any drug. In terms of Express Scripts, they had about 40 percent of members across the board not using anything. Again, the importance of knowing where that utilization lies is very important.

As we look at some of these strategies, I'm not going to walk through the definitions of all of these. Some of them are going to be pretty familiar to you. The right strategy for an employer is really a function of the conditions that are driving utilization for that population. We look at that overall population, but then break it down by the top conditions, to recognize that, for example, stomach and ulcer conditions represent about 8 to 9 percent of an employer's drug spend, generally speaking. Cholesterol-reducing drugs also account for about 9 percent of spend, in general. Breaking down these conditions to know who is using the drugs and within those conditions how the drugs are being used helped to unbundle that drug net component that I was talking about. The "silver-bullet strategy" that a lot of employers are considering now says that the majority of their utilization is targeted at certain conditions. We also know that there are treatment guidelines that support the utilization of much more affordable drugs than our utilization is telling us right now. High-cost drugs are over-utilized compared to low-cost drugs, so let's unbundle those distributions based on the conditions, look at the treatment guidelines, and then develop design strategies that target the most cost-effective utilizations within those conditions. This is a way of bringing those concepts of disease management or condition management a little bit closer to pharmacy

management because, again, managing all of that in a vacuum really gets you nowhere.

The strategy that we've implemented with a number of employers falls along this continuum. If it makes sense, we've used certain strategies to manage certain conditions, and then used a global universal strategy to go with that. What does that mean? Essentially, if you look at the bottom of the triangle, the bottom left, with a three-tier design, we use that as our reference design. It was phenomenal to me that four or five years ago some of the employers just adopted that differential between formulary and non-formulary drugs. That taught us that consumers really did drive utilization if they had the right financial compressor. For the right reason, members would talk to their doctors about their drugs. One of the other reasons that we're seeing now is direct-to-consumer advertising. Members perceive that there's a good reason for them to talk to their doctors about that drug. Financial incentives and the right communication materials put in the hands of members impacts utilization, so does that give us an opportunity to build strategy in a constructive way so as not to meddle in the physician space, but again to manage demand for those low-cost drugs? That's really the key.

We thought about removing that transparency. It makes sense for a member to know if he's asking for a high-cost or low-cost drug. Coinsurance is one way that employers are doing that. To walk you up this hypotenuse a little bit, retail pharmacy alliances are not necessarily a design strategy, but a management strategy that we're seeing interest employers more. What that means is to recognize that those pharmacists, or the PBM, or your health plan pharmacy department really has the strongest access to knowing what those treatment guidelines are and what the cost of those drugs are. An alliance with the pharmacy, whether it's a pharmacy or a PBM to promote knowledge of those low-cost drugs, seems to be well received by a lot of employers, so leveraging the role of that pharmacist seems to be emerging.

Consumer-enabled tools and choices, the concept we were just talking about, means making sure people know what's in it for them, to increase the demand for most low-cost drugs. Health risk appraisal (HRA) for drug benefits only is something that we're modeling for employers and employers are looking at it. Originally, the HRA designs were promoted as integrating medical and prescription drugs. We're hearing employers say that it feels like that decision was too hard for members to make in terms of deciding which doctors and which hospital to use. But some employers are sitting back and saying there is more objective evidence-based medicine, more knowledge and more concrete information available to members that might help them to be smarter, better consumers with regard to prescription drugs. The idea is to manage a relatively fixed budget or a fixed allowance for a while; the thought is that interest in utilization of low-cost drugs will go up.

A couple of other options that we talked about include the therapeutic MAC, an option that Margaret talked about. We have some employers who are saying,

because there is price disparity between low-cost drugs and high-cost drugs that really produce the same outcome, does it make sense from an employer's perspective, when some employers have a fixed budget, to pay for all these high-cost drugs? This year I've put in quite a few of these therapeutic MAC options for treating certain conditions, such as high cholesterol and ulcer — those seem to be the more common ones — but the point is that employers will offer a fixed amount toward prescriptions for treating that condition. Anything above that would be the responsibility of the member. This is a very draconian strategy, but certainly an option in terms of managing cost for those employers. At least in my experience, they really didn't have much of a choice. They had to reduce expense and took that approach.

MS. CLARK: Let's move on to clinical strategies. How can drugs then be integrated with total health care, to better understand and manage health care costs, utilization and outcomes?

MS. EBER: That really goes back to what I was talking about a little bit earlier with the designs, and that is to recognize that we have those conversations because people have conditions that require prescription drugs for management. Recognizing that there is an inherent interdependence between condition management and pharmacy management is key. Some of the highest opportunities for managing drugs then are listed in there. I've listed a few, and the rest are in my notes. I told you that the gastrointestinal drugs and the cholesterol-reducing drugs account for about 9 percent in general of what employers spend. Other opportunities are the antidepressants; those usually account for about 8 percent of what employers spend. If you look at the cost of antidepressants, you're comparing 30 cents a day to more than $3 a day. Again, this is a big opportunity to reduce that 8 percent.

Non-steroidal anti-inflammatory drugs include the pain medicines and the cyclo-oxygenase-2 inhibitors, Vioxx and Celebrex. Those account for about 5 percent of spend, as well as diabetes drugs that are about 5 percent of spend. Looking at the conditions that are driving drug spending and identifying those as the target for the strategy seems to be a reasonable place to start, as opposed to a shotgun strategy that says we need to raise our co-pays 30 percent.

Because the direct-to-consumer advertising and other forms of promotion of brand-name drugs have been so effective, we really see that the prices of many of those drugs are what the market will bear. From a cost-management perspective and certainly from an analysis perceptive, I think you have to recognize that the price of the drugs isn't directly related to the effectiveness of that drug.

I have an example of the various price tags that are associated with treating a certain kind of ulcer condition. Pulling that information into a design or a cost-management strategy seems to make a lot of sense for employers. For the same outcome, you could spend $70 for a course all the way up to $250 for a course. The

purpose of this presentation really is not to make a statement as to the correctness or incorrectness of the prescribing patterns, but to point out that there is some real weight of knowledge behind condition management, so taking advantage of that knowledge might make some sense.

I would like to give you a sense of some of the prices that you find on the cholesterol-reducing drugs. Again, the point is that if people have high cholesterol and want to reduce their risk of heart disease, we're not saying it's a bad idea to take drugs that reduce cholesterol. We're saying that there are some additional facts behind that drug utilization that can allow better cost management. For example, for the same general degree of lowering of your cholesterol, there are some treatment options that can cost more than $4 a day, and there are other treatment options that can cost $2 per day. Again, that price disparity might become intuitive to a lot of people. If we were just looking at a drug tape, that utilization is counterintuitive to the data that we see here, so finding a way to correct that utilization back toward the more affordable drugs seems to be a way to go.

MR. ECKER: I can pick up where Bridget left off. She's mentioned the difference in the cost of treatment on the medication side, which is very important, and an opportunity to manage that cost exists there. I want to give you a quick example of how we're trying at CIGNA to extend that to not just the drug cost, but the drug-related medical cost or what we like to refer to as the integrated benefit. It's an example from us, but I believe that many other companies are obviously moving in this direction also, with continued pressure to not just manage drug spend, but overall medical spend. Within CIGNA pharmacy, 99.9 percent of the time our clients have not just our pharmacy benefit, but they have the medical benefit, so there's an enormous opportunity to try to manage both of them at the same time.

Here, we're taking the medical data, the lab data on our patients, and trying to identify members who are at risk for heart attack or chronic heart disease and whether their cholesterol levels, the lipid levels, the low-density lipoprotein, are higher than normal or an acceptable level. We are trying to find who these individuals are, reach out to them through our health facilitation centers, and ensure that they understand their situation and that the proper medications are being prescribed and utilized. We also reach out to the physicians as well. The goal here is to reduce the recurrent cardiovascular events in people with chronic heart disease receiving cholesterol-lowering drugs. It's an outreach effort, but it's an area where we feel there's a lot of promise and opportunity.

The cost per episode of a heart attack or an acute myocardial infarction is obviously significantly higher than the cost of treating hyperlipidemia. The goal obviously is to manage at the right side of that curve as opposed to waiting until we get to the acute myocardial infarction side. The cost from the drug cost side is considerably lower at that end of the curve, but the point is that if we can be more preventive

and manage on the right side of the curve, then we're doing our clients the appropriate service.

I have an example where we looked at our population in a certain geographic market. We had the lab data for about 30 percent of our members who were on lipid-lowering medications. That doesn't sound like an overly impressive number, but it's something that we, as well as others, continue to work on to make sure that that integration exists. About 9 percent of those have lipid levels twice where they should be, so there's an opportunity for us to target that membership, focus in on their treatments, and ensure that they're reaching their target goals.

We can take a segment of our population and see that, for the approximately 34 percent of members with chronic heart disease for whom we have the lab data, that there's about a 54 percent opportunity within that group to treat them down to their appropriate levels. Once again, just to highlight the size of the opportunity, the benefit of going to an integrated model allows you the opportunity not just to manage the drug cost, but also the drug-related medical cost.

The flow of how that process would work is pretty straightforward. I'll let you read that on your own.

MS. CLARK: What's the value of the mail order benefit? Rob, can you speak to that?

MR. ECKER: We have a win-win-win situation with mail order. If we were to think about the industry in a macro sense, then the losers in this — because to a certain extent we are playing a zero-sum game — are the retail pharmacies. The margin that the pharmacies make on selling drugs now moves to the PBM, who operates the mail order, but in doing so we're able to pass on lower cost to the member and lower cost to the employer.

I have a simple example of the math associated with mail versus retail. When we talk about filling prescriptions in mail, we're talking about chronic maintenance medications, typically 90-day fills, and in doing so you see the average wholesale price is three times that of retail, so you're getting three fills in one. There's an inherent cost savings there, because instead of one dispensing fee per 30-day fill, you're having one dispensing fee per 90-day fill. There also are lower discounts that we have in mail order versus retail, and the numbers I have here for illustrative purposes could vary 2 percent in either direction for retail or mail order. That could change the economics significantly if you play with a simple model.

Member co-pay is another area that works as a lever in this model. We see in selling mail order, we sometimes offer two times co-pay for three fills. Sometimes it will be three times 30-day co-pay minus a percentage to create a financial incentive for the member to use mail order. The goal obviously is to create that economic

benefit for the member and for the employer to drive prescriptions into the mail centers for the PBM.

In addition to the economics associated with mail, what we've seen in various surveys is that patients are very satisfied with their mail order experience. I've summarized one of these surveys here. Convenience and price obviously are driving those numbers.

I wanted to quickly point out the value of mail order to the PBMs. I thought the simplest way to do that was to take a look at the three largest publicly traded PBMs — Advance PCS, Express Scripts and Caremark — and show a correlation between their EBITDA (earnings before interest, taxes, depreciation, and amortization) per adjusted claim. So that would include both mail order and retail claims, and correlate that to the amount of mail order penetration that each of them have. Caremark has a significantly higher penetration and correspondingly a significantly higher margin.

Mail order is a significant opportunity for the PBMs going forward, and with the pressure around "commoditizing" the retail network offering. This is where we'll see the PBMs focus their efforts to continue to grow their businesses. We'll also see opportunities here to use with mail order operations for specialty distributions such as self-injectables, home infusion drugs and the like. I would expect to see more of that being pushed through mail order operations as well.

MS. CLARK: Looking ahead to future developments and trends in the marketplace, I'd like to hear from each of you on what you see as the future of the pharmacy benefit marketplace.

MS. WEAR: I pulled out two items that are going to be significant in the future of the pharmacy benefit marketplace. One is Medicare prescription drug coverage, with a lot going on with that in the last two to four weeks. A lot has been going on for the last two to four years, but I think that when we find out what the final benefit could be, it could have significant impact on many different players in this marketplace. Just as a thought, how is this going to affect other prescription drug coverages? In some of the other discussions I've had, there's a lot of concern that once the federal government is providing this benefit to Medicare eligibles, how is that going to impact what you normally will be offering as a retiree health benefit? Will employers look at doing wraparounds? Even broader than that, if the plan in effect begins to regulate the kind of drug prices that are being offered in the marketplace for these particular products because they're governmental plans, then how will that impact the prices that the pharmaceutical manufacturers charge across the board? What kind of impact is that going to have on the manufacturer and the kind of prices the manufacturer is going to have to the retail pharmacist? What is the retail pharmacist then going to offer to regular commercial plans compared to what they might offer on the Medicare side? I think there are many

different pieces of this that are going to be impacted in different ways depending on how this finally plays out in Washington, D.C.

Bridget brought up the other item I wanted to bring up. It's basically the same as HRAs. How does this look when you look at prescription drug coverage separately under a consumer-driven health care plan? Bridget brought up the fact that a lot of different employers are looking at this as a good way to get your toe wet in this kind of marketplace, as well as the fact that the members probably are better equipped to make choices on the prescription drug side. My concern as an actuary is how is this really going to price out? Is it truly going to save money for the employer? I agree that there are clear benefits to the member. How are the members driven to make their choices in the way that they actually look at their own health care and begin to take some responsibility for the kind of choices that they make? I'm not convinced at the end of the day that the employer is going to have a lower cost in their pharmacy benefit plan. Maybe that's not necessarily the driver around this, but it's a broad question I'm throwing out. Will this work, and will it work from every specific angle?

Those were the two things I saw as being more significant coming up this year and probably next year.

MR. ECKER: A lot of what's been said today covers future developments, as well as the current situation, but beyond benefit design strategies. It is truly a strategy where the member is brought into it, and the employer has to be very active in selecting the right benefit design. That has opportunities still in it, but I believe that even that will be limited in terms of its opportunities. I think the underlying economics of the pharmaceutical industry will continue to drive cost, and as long as there is a desire for brand-name medications in the marketplace, we're going to see drug inflation. As we see consolidation of generic manufacturers, we're going to see drug inflation. We're going to be able to manage cost in traditional means, but it won't be to the extent that I think everybody is hoping. We're still going to see trend, we're going to see inflation, and I think that's apparent to most when we sit down and really think about how the economics of the industry work. Traditional revenue streams, I think, are threatened. I think we've talked about that here. As for the idea of rebates and the amount of attention that receives, I don't believe that the PBM industry can rely on that entirely as it has historically. From my perspective, I think the opportunity for the future, and what I think will drive the development in the future, is on this integrated benefit concept. That consists of looking for ways not just to manage the drug cost, but the drug-related medical cost. Whether it's with a managed care organization or an independent PBM, some collaboration is needed to make sure that data is available. The key for this is to be able to have that data available and integrate the two. In doing so, I think the marketplace is going to require that we guarantee the results of these outcomes. I know that a number of companies, including ours, have made steps in that direction with our offerings for pharmacy benefit services or with guarantee outcomes in our clinical programs.

As I mentioned, data management and reporting are going to be key. In addition to access to the data, we're going to have to be able to show our clients these outcomes as well as guarantee them. These are things that have been talked about for several years, if not more, within the industry, and I know the consultant and broker community looks to us and asks, when are we going to have this? It's a nice story, but can you deliver on it? Likewise, we'll talk to the brokers, and we'll ask them to emphasize this more. We're in the middle right now, but I think this is really where both segments of the industry would like to see us go. Ultimately, the employers are going to benefit from it as well as the members.

MS. EBER: What I've summarized here really are some of the tactics that we're seeing and things that we're going to be seeing relatively soon. One is to rethink the current strategy of chasing rebates, if you will. What we've learned right now is that the high-cost drugs generate rebates, but they also increase employers' costs, so let's dim the spotlight on that strategy and focus a little bit more on redirecting that drug niche to increasing the utilization of low-cost drugs. That can have a significant impact on cost. There's a lot of opportunity there.

The second concept is in terms of what's out. Let's stop looking at clinical rules or clinical strategies as punitive penalties. I think that's the trap that a lot of us have fallen into. You can't have more than a certain number of working days of high-dose Prilosec because it feels too punitive. What we really want to say is, evidence-based medicine and treatment guidelines show that optimal therapy is something else. We should focus more on what the evidence tells us, than on how it feels if it's punitive. One thing that I have learned very dramatically during the six years I've been consulting is that, when we talk about pharmacy strategies, whether we look at an employer, a business manager or a union group, people tend to personalize that conversation. When you talk about management strategies, you have to first get over that hump of what will this strategy mean to me? Can I get my drug or not? This happens before you have an opportunity to talk about population management or even business management. People tend to personalize all of these conversations first and then get into the business aspect.

The third component that I mentioned in terms of what's moving out is the pharmacist as an innocent bystander. We've been taking the pharmacist and the PBM as innocent bystanders in terms of supporting the transaction, but we really haven't called those pharmacists to action to help us learn a little bit more about the evidence and increase the utilization of low-cost drugs. I see an opportunity for pharmacists to become empowerment coaches, or whatever the term might be. I think there's a great opportunity for pharmacy practice.

Mandatory mail order is not a good strategy for some employers from a cost-management perspective. Usually the benefit level between those retail prices and the mail order prices is not that favorable, so some employers still think about mandatory mail order as a way to manage the price of those maintenance drugs.

It's not always the case. You have to do the homework and identify where that benefit level might be. We have seen some PBMs offer mail order discounts. We don't want to pull this business away from CIGNA or those organizations, but for PBMs, who have been able to promote 90-day fills at retail while delivering those lower discounts, this really shifts utilization to the retail pharmacies, increases access to members and creates a great convenience. That might be something that we'll see more of frequently.

The other comment is about Canadian drugs. The reason that drugs are less expensive in Canada primarily is because the purchaser of those drugs is the Canadian government. They exercise tremendous leverage with regards to price management. They also exercise tremendous leverage in terms of managing utilization, by identifying certain conditions under which certain drugs are covered. In the United States we don't do that; payers don't do that. The silver bullet doesn't really lie in the border across which you pass to buy your drugs. The bullet lies in how you manage your procurement and utilization management. I tell employers that if they want to rent a bus to go to Canada that might work, or maybe not. Maybe that wouldn't be your first strategy.

Lastly, I want to comment on procurement options. We really didn't bring that up today. We've seen a number of employers look at pharmacy benefits and say, this is only about discounts and dispensing fees, isn't it? Does it make sense to go through a huge research and development process, micromanaging, microanalyzing, formularies, utilization management programs and customer services? Some organizations essentially have made part of their money supporting these online procurement options that focused solely on the procurement price of the prescription. We see that happen, we've seen some results, and we've seen some clients come back to us very disappointed in the results because it is not a commodity. The analysis and the procurement exercise is not as straightforward as some might think. I just point this out because it might be something that you've been exposed to. Those procurement options look good and look straightforward at the outset, but they can lead to some real messy and undefined procurement terms at the end of the day.

I have a comment about some of these more draconian designs. I mention this to acknowledge that some employers might decide to go with a more draconian strategy such as therapeutic management of drugs. We have some employers who will put it in as a full replacement; others will offer it as an option alongside their legacy plan. However, there are issues like adverse selection and other migration tendencies. The point is that you should take a look at the options you're offering, identify their value, assign different contributions and monthly payroll deductions, and price accordingly so that if an employer identifies a plan as the desired plan or preferred plan over which to migrate people, than they can do it through contributions and price tags as well.

MS. CLARK: Are there any questions at this point?

MR. DOUGLAS MCCANN: I'm Doug McCann from Highmark. I wanted to fit in a couple of quick questions here. In one of the other sessions they were talking about underwriting and using the data from the PBMs on an individual level to do underwriting. I didn't notice that on your box structure of the different moving parts, and I was wondering if that was becoming a common thing or if that was still a little bit in the future, to purchase the individual claims data from the PBMs.

MS. WEAR: I don't have the answer to the question, but I can tell you what he's talking about. A couple of companies now have relationships with PBMs, and if you're an insurance company, especially a smaller one, you can go to that company with the employee's signature on the form, get his drug history and use that to do underwriting to determine if you want that group or don't want that group. It's based on their drug plan.

MS. EBER: Is that on an individual basis?

MR. MCCANN: Individual and small group.

MS. EBER: I wouldn't advocate that on an individual level. I think you're talking about risk stratification based on drug claims, and drug claims can be a precise measure of health risk or health need. Therefore, the concept or the study of doing that, both filling the health needs of a population for purposes of identifying risk and underwriting, I think, has an advantage.

MR. MCCANN: But you haven't seen that commonly in the setup of the PBMs in terms of the different services that they provide.

MS. WEAR: The PBMs don't provide that service, as far as I know. It's these other intermediary companies.

MS. EBER: We are aware of one PBM that has software that they'll license to do some level of this stratification. The application of that can vary, because they have a tool that helps to stratify that risk, but I don't see that as a line of business that PBMs are moving into now.

MR. DALE RAYMAN: Dale Rayman of Towers Perrin. I have a question for Bridget. You showed the cholesterol-lowering drugs, and the cost per day of therapy. You said that utilization was counter to what you would expect, given the cost per day of therapy. I think the lowest was something like Lescol down to Zocor. You mentioned that what you try to do with the plan design, then, is try to steer members to lower-cost drugs. In that case, then, how would you handle the challenge that the member is not going to be looking at the plan design when he or she needs to go to the doctor? You're going to be bombarded with direct-to-consumer advertising so that when they go in, they're not thinking about their net cost or their out-of-pocket cost. They're thinking about what they saw in the latest

advertising. It's not until they get to the pharmacy, when they're actually at the doctor's office that they're going to know what the out-of-pocket cost is.

MS. EBER: I think there's a delicate balance between making a consumer educated in terms of managing a budget for drugs and encroaching on the practice of medicine or on areas where you essentially don't belong. There are a lot of factors that enter into this. My point in demonstrating those potencies and the prices for the cholesterol-reducing drugs is that price is not necessarily associated with potency of that product. How do you best manage a population's behavior so that you maximize utilization of the low-cost drugs? We could probably argue all day about the best way to go about it. We've seen it played out in probably three different ways. One is through a reference-based pricing approach. For the design that we've modeled, we've essentially identified the median specification for that category. We're not necessarily saying it's the most efficient spend. We're just saying that *x* percent of utilization is here, and so the communication to the members is that the company will cover up to $30 for a month's supply of your cholesterol-reducing drug. We can help to identify other therapies that will cost you less, and so on and so forth. There's a component in design and the communication that goes with it. I think we have a long way to go on that. Again, I don't know what the secret to the message is, but I think that there needs to be some level of responsibility that price cannot be passed along right now to the employer.

MS. WEAR: I think some of the other strategies that are being looked at today include physician connectivity in the things that are beginning to happen. It's very slowly moving into the marketplace. One of the other ones, and Bridget had this in her presentation, includes some of the consumer tools that are being made available to the member, especially online information. That member can go online and look at what he's going to have to pay for different kinds of products. Who knows whether it's really been played out, but we believe that members are beginning to use that information more so that before they go to the physician they are going to have some idea of which drugs fall into which category.

MS. EBER: I was going to comment also on the other statistic that I put out there in terms of the percentage of physicians who are responsible for the bulk of the prescribing and also the opportunity for pharmacies. Again, we're looking at targeted strategies here. Where are the strongest opportunities? Maybe they lie within certain physician groups; maybe they lie within certain geographic areas. There would be a targeted community effort to look at treatment guidelines. They also play out.

MR. RAYMAN: You mentioned that with the 90-day supply at retail, mandatory mail doesn't work for a lot of employers because the better pricing at mail doesn't offset the co-pay losses. In the 90-day supply, you're talking that the member still pays three co-pays, because if they were paying less than three co-pays at the 90-day supply at retail, then you have the same issues that you have that mail order didn't work and you have higher dispensing fees at retail.

MS. EBER: That's a good question. In these scenarios where we've played it out, we've made it cost-neutral, so that the benefit level is the same as it would be under mail. It doesn't necessarily translate to three times the co-pays. This is an example of stepping back to the past to predict the future. In health plans before mail order pharmaceuticals became widely popular, health plans offered maintenance drug lists, for example, 100-unit quantities at retail. It's similar to that concept from the structure perspective.

MR. RAYMAN: If the math doesn't work at mail, how can it suddenly work at retail? Enough members pay higher co-pay.

MS. EBER: There are a lot of moving parts. It has a lot to do with the basis of the cost for the mail order. Some mail order pharmacies don't actually use the package size that's used for dispensing to apply the discount. In retail pharmacies, that's a universal rule. In mail order pharmacies, it's not necessarily the rule, so the strongest opportunity, which is 90-day fill at retail, has more to do with what is the real deal that you're getting at mail and comparing that to the real deal that you would get at retail. There could be some gaps there.

MR. DAVID DUNCAN: My name is Dave Duncan, Great West Life. My question actually has to do with page 18 of the handout, for those of you following at home. My question is for Rob, but anyone could answer. What was the value to PBM? I also want to ask if you could elaborate on the rationale for that discount spread. Clearly that was the big driver for the savings to the employer.

MR. ECKER: We're moving the spread, which we call sell spread in the industry, from the retail to the PBM. It creates a significant economic opportunity for the PBM to extend in that way. The opportunity on the discounts in mail order appear to be greater than what we can negotiate on the employer's behalf through retail pharmacy, and it has to do with pack sizes in a number of items, but if we're buying drugs in larger quantities at mail order facilities, we can spread that savings across the 90-day fills that we dispense, and it creates greater opportunity. That and the co-pay are the key drivers in the economics behind mail versus retail. Both of you have experience, and I don't know if either of you want to add to that.

MR. DUNCAN: You expect those spreads to narrow, as there's some kind of a push or drive to 90-day fills at pharmacies, then.

MR. ECKER: I haven't seen that. Not to dispute what Bridget's saying, I just haven't seen that, but she's closer to it. I see CIGNA, and today I don't see that spread narrowing. I see the spread going in the favor of mail order in the other direction largely from competitive pressures. We're seeing mail order discounts for brand drugs. AWP minus 21 to 22. I saw one bid for a large employer at AWP minus 25. I see the opportunity to the employer actually improving for mail order.

MS. EBER: My only comment is that there's really a lot of fine print when you unbundle the deals, and so CIGNA's pricing model isn't necessarily representative of the pricing model for other PBMs. We want to look at the package size, and what does that discount really apply to? Is average wholesale price? There are a lot of different ways that the numbers can be manipulated. I'm not saying CIGNA has a poor model at all.

MR. ECKER: I'm curious how the others are manipulating. Maybe we should talk afterwards because we don't do that. It's AWP, so maybe we're leaving money on the table.

MS. EBER: I see a few people nod, indicating that you have read some of that fine print. You have had some frank price discussions with the underwriters on proposals. That's a good use of your time.

MR. COREY BERGER: Cory Berger from Reden and Anders for Bridget. You mentioned that Express Scripts did some study that 10 percent of physicians prescribe 67 percent or something like that. That doesn't make any sense. Do you have any idea how they were counting physicians versus their prescribing patterns?

MS. EBER: I don't have all the details of their methodology, but you can pull that study down from the Web site. Essentially, this was presented in the context of a massive utilization study, and they looked at individual prescriber numbers. The same way you need member identification for utilization counts and whatnot, they counted individual physicians and they compared that again to their universal physicians, which represent all of the licensed physicians in the country. We know that only a portion of all the licensed physicians in the country actually practice, and so it is a dramatic number. The point in my representing even the thought, and I'm glad that you paid attention to it, is that shotgun approaches don't work. Maybe it's not 10 percent who write 63 percent of the prescriptions; maybe it's 20 percent of the physicians who write 80 percent, or whatever the number is. It makes sense to look at what's driving the dynamics and unbundle from there.

MR. ECKER: My interpretation, if I heard that number, would be that they have concentrations of members in certain areas and then a scattershot across the rest of the nation of physicians who prescribe one, and they counted them in the denominator. A better approach would be to look at fills per member or something along that line, so you're capturing physicians who see 100 members, and this one prescribed 200, whereas this one prescribed 100. That gives you a better profile of the physicians.

MS. EBER: That's certainly a function of geographic centers, and you could unbundle the numbers. There are a number of areas where you could identify concentrations of sick people and concentrations of physicians, then concentrations of specialties, and then the rest of the world. All of those things factor into that.

MR. MARTIN STAEHLIN: Marty Staehlin, from PriceWaterhouseCoopers. I'd like to move to public policy for a second. Somewhere the goal has to be that prescription drug trend is less than the CPI, so that it doesn't consume the whole economy. You use phrases like "encroaching on the practice of medicine" and "managing behavior." I'm not sure you can manage these people's behavior. You also used "draconian design" and "a shotgun approach." I'm assuming that the alternative is a laser approach where you actually make it right for a specific employer. If you do that, you said that people are going to evaluate this based on the drugs that they consume, and what does it mean to me. Assuming people are going to do that, do you foresee that individual employers might have to sign a statement that our drug policy is a corporate policy so you can't sue us and you can't argue with us? Because the way we're going to get our drug spend down is to do some of these things that theoretically might be interpreted as encroachment on the practice of medicine?

MS. EBER: We've found that employers seem to find it easiest to manage administrative roles that are built on clinical policies, clinical research, practice of medicine and the observations of the utilization. When it comes to my opinion on public policy or to employers who identify that they're offering a benefit at this level and that it will roll out this way in terms of the components, you design it and communicate it in an administrative way because this is the benefit that we are offering. It sounds sterile, but it's a relatively linear communication. From an employer's perspective, they tell us it's easiest for them to administer and that keeps them out of arguments that say, you're telling my doctor what to prescribe and so on and so forth. When we look at prescription drug utilization and managing prescription drug costs as a specialty discipline, we're looking at who pays for a consumer good. Among the payers, who pays how much? It's not simple, but it's an economic problem and it boils down to how much you're going to pay for a product that costs this much. In general, strategies tend to play out most successfully when they are payment rules or levels of benefit rules that don't open the argument for clinical classes this way or that way.

MR. STAEHLIN: Somebody was talking about different pricing for clinical classes. Wouldn't one solution be to draw a line and, if you spend more than that, the payment is yours, so to that extent you would have a different price mark for each clinical class, and haven't you made those decisions? People might argue this.

MS. EBER: I'm familiar with that strategy. I would not endorse that strategy. It's a strategy that says if you're in this clinical bucket, then your benefit is here. If you're in that clinical bucket, then your benefit is there. Again, based on the feedback and dynamics of working with employers, right now it feels prohibitively cumbersome to administer. I can understand why. I think from an educational and academic perspective it's certainly defensible, but it's just too difficult.

MR. STAEHLIN: In addition to the administrative issues, it accelerates that consumer dissatisfier that the employers don't even want to be involved with.

Maybe now with the economy slowing, you have fewer people moving around to different jobs. However, to go from a situation where you potentially have a $20 co-payment for your Lipitor prescription, to be told next year that that's going to change; we're only going to pay the first $*x* and everything over that is yours, all of a sudden the member cost has doubled or more depending on which drug they use. I don't think employers are ready to take that leap to exploit all other opportunities.

FROM THE FLOOR: I came from the State Teacher's Retirement System of Ohio. I was surprised no one mentioned anything about the Office of the Inspector General guidelines that came out recently and how those are going to impact the market and how they may affect the relationships between PBMs and pharma going forward. Can anybody speak to that? I think that's going to have far more impact than a number of other things we discussed today.

MS. WEAR: Of course, Advance PCS feels like there's nothing within those guidelines that isn't met by the practices they already employ.

FROM THE FLOOR: That's not what I'm hearing from my consultants. I've been told that they will dramatically impact how PBMs do business going forward as far as a relationship with pharma. Any comment?

MR. ECKER: I can only speak for CIGNA, but we feel similar to Advance PCS. There may be PBMs out there that have a significant revenue stream outside of rebates for market share and utilization on formulary drugs that may be challenged as a result of this going forward. I would say the bulk of the manufacturer revenue still comes from that component. These other pieces, these other revenues, whether they are intervention programs or compliance programs, are still a relatively small component of the revenue stream, so I don't know how significant the impact will actually be.

FROM THE FLOOR: Isn't it part of the black box theory that you were talking about earlier?

MS. EBER: Yes, what I would say, from an employer's perspective, is that they know that there is revenue from pharma companies that's labeled as rebates to pass along to employers and there's other revenue. They recognize that there are other buckets of dollars there that are all keyed into net cost and as revenue streams for the PBMs, particularly the commercial PBMs. Employers know that. That is part of the black box, and so what we're seeing in terms of a vendor management issue is a number of employers pushing these conversations to understand the net cost, the unbundled formulary and nonformulary cost, so that we know where the offset of the rebate is, where the offset is coming over their dollars. However, I see that right now each PBM is taking an individual customer approach to those conversations. I understand the report and I understand that there could be an opportunity to change that business model, but right now I'm seeing a "don't ask/don't tell" approach. If an employer is wise enough to ask those

questions and to know that there are those revenues, then to ask about disclosure will push that conversation, but if they don't, I don't see any automatic change right now, not at the moment.

Editor's Note: The Express Scripts Web site offers a useful report on drug utilization trends, which can be found at the following link: http://www.express-scripts.com/other/news_views/2002drugtrend/drug_trend_report.pdf (as of the time this session was edited).