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# Generic Dispensing Rates: Silver Bullet No More?

by Troy Filipek

**G**eneric prescription drugs emerged years ago with major patent expirations and have been a focus of cost containment efforts for insurers and employers in managing overall medical costs. By offering to share the savings with patients through cost sharing decreases, the value proposition makes sense to both the payer and the patient. For example, if a patient can switch from a \$100 brand prescription to a \$30 generic prescription and reduce their copayment by \$10 or \$20, both the plan and the patient save money. This has led to an increase in generic dispensing rates (GDR) over time.

In particular, GDRs increased significantly over the past several years, helping to mitigate drug trends to their lowest levels in recent years. While overall utilization and drug prices increased, the mix of drugs shifted dramatically toward more generics to offset these utilization and price increases. Excluding specialty drugs makes the trend picture even more favorable for generics. Table 1 contains a summary of recent drug trend reports from the three major pharmacy benefit managers (PBMs).

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The logical questions arising from these figures include:

- What is the upper bound for the GDR?
- What does the pipeline for new drugs and expiring patents look like?
- When the GDR increase slows, will prescription drug trend return to the high single digits or even double digits?

Let's review some background on the recent GDR increases and the resulting implications to help assess what may happen in the future.

## Drivers of GDR Increases

The GDR increase over the past several years has been fueled by big-name patent expirations in some major therapeutic classes, as well as other efforts from PBMs, employers, and health plans. All of these entities pushed for increased generic use to mitigate costs through benefit plan design, formulary design, utilization management programs, and other programs. The following have been major drivers of the GDR increase:

- **Big-Name Patent Expirations in Recent Years:** Patents recently expired on a number of heavily prescribed medications and are now available as generics, including:
  - 2009: Topamax, Prevacid, Adderall, Valtrex
  - 2008: Nexium, Fosamax, Risperdal, Lamictal, Imitrex, Altace, Depakote
  - 2007: Norvasc, Ambien, Lotrel, Toprol XL, Protonix, Coreg
  - 2006: Plavix, Flonase, Pravachol, Zocor, Zolof
- **Strong Plan Design and Formulary Incentives:** Temporary waivers of generic copays, multi-source brand penalties, wider copay differentials, step therapy/prior authorization programs, closed formularies, and coinsurance-based cost sharing are a few examples of benefit and formulary design creating financial incentives for members to choose less-expensive generics.
- **Increased Public Acceptance:** Increased marketing of the generic cost savings, therapeutic

**Table 1  
Pharmacy Trends Mitigated Through GDR Increases**

PBM	Total 2008/2009 Trend *			Generic Dispensing Rate *		
	All Drugs	Non-Specialty Drugs	Specialty Drugs	2006	2007	2008
Medco	3.3%	1.3%	15.8%	55.2%	59.7%	64.1%
CVS Caremark	3.9%	2.8%	13.5%	55.7%	59.9%	65.1%
Express Scripts	3.0%	1.5%	15.4%	N/A	60.5%	64.8%

\* Note that the covered populations underlying the PBM trend and GDR figures may vary (PBM book of business versus overall industry, Medicare versus Commercial, etc.). Used most recent report from each PBM (2009 for Medco and Caremark, 2008 for Express Scripts).

equivalence, and comparable safety relative to brands has led to wider public acceptance and utilization of generics.

- **“Wal-Mart” Programs:** Retail outlets encourage generic drug use by using aggressive marketing for select generics (\$4/\$10 copays for 30/90 days). These programs were piloted by Wal-Mart several years ago and most retailers now offer comparable programs, with the intent of generating more in-store traffic and sales of higher-markup ancillary items.

## Impact of Population Differences

The GDR is significantly higher under the Medicare Part D program, relative to commercial plans. Table 2 compares the GDR changes for the two populations.

Population	2006 GDR	2007 GDR	2008 GDR
Medicare Part D *	60.3%	64.1%	69.4%
Commercial **	49.7%	53.1%	59.2%

\* As published by CMS; program began in 2006.

\*\* From Takeda Prescription Drug Benefit Cost and Plan Design Report

Why the significant GDR gap between commercial and Medicare? Several likely reasons are:

- The Part D benefit design encourages more consumerism to avoid reaching the Medicare Part D coverage gap (i.e., the “donut hole”) where the member pays 100 percent of the costs.
- Drug mix differences, where seniors likely use prescription drugs more heavily in categories where generics are available.
- The budget-conscious nature of the senior population relative to younger generations.

The Part D program has benefited significantly from this uptick in GDR, as reflected by the Part D national averages by year in Table 3.

Table 3  
Medicare Part D National Average Values Per Member Per Month

	2006 *	2007	2008	2009	2010	Change 2006- 2010
National Average Bid Amount	\$92.30	\$80.43	\$80.52	\$84.33	\$88.33	-4.3%
National Average Member Premium	\$32.20	\$27.35	\$27.93	\$30.36	\$31.94	-0.8%
National Average Direct Subsidy	\$60.10	\$53.08	\$52.59	\$53.97	\$56.39	-6.2%

\* Straight average weighting methodology for determining national averages. Subsequent years reflect some or all member weighting.

Other factors certainly contributed to this decline (e.g., change in the national average calculation methodology, changing carrier pricing strategies, competitiveness of the program, the use of experience in pricing, etc.), but GDR increases were one main contributor. Further, the Part D program has come in under budget relative to early projections for the program, quite unusual for a government program.



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## What Will the Future Hold?

The immediate future still holds promise for further increasing the GDR. The following are future drug patent expirations likely to have a big impact:

- **2010:** Flomax, Effexor, Cozaar
- **2011:** Lipitor, Actos, Zyprexa, Levaquin, Aricept

Beyond this timeframe, though, the generic upside could be fairly limited. There is also a limited pipeline of new traditional non-specialty drugs in the pipeline. What might we see beyond the immediate future?

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- **GDR reaching a saturation point:** Industry-wide in the 70-80 percent range, with the highest achieving plans in the 80-90 percent range. Also, expect to see commercial and Medicare GDRs converge slowly over time.
- **The rising influence of specialty drugs:** Escalating trends in the specialty market over the past several years become a bigger issue in the future, with new blockbuster specialty releases and new indications far exceeding non-specialty new development, and slowing GDR increases no longer masking the trend.
- **Overall trends emerging higher:** Likely in the high single digits or low double digits.

No one can safely predict what to expect in the pharmaceutical space with all of the uncertainty in health care recently. Government regulation looms as a big concern, but an aging population likely continues to mean higher use of prescription drugs in this country. As things stand currently, one can expect the trend-mitigating force of an increasing GDR to fade. Unfortunately, the low trends we are currently experiencing likely will become pleasant history, and finding the next silver bullet for reducing health care trends won't be as easy. ■

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