



SOCIETY OF ACTUARIES

**Projected Cost Analysis of Potential  
Medicare Pharmacy Plan Designs**

**For The Society of Actuaries**

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# I. Executive Summary

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One of the most significant current public policy issues in health care is the lack of coverage for prescription drugs under the Medicare program. The United States Congress is in the process of evaluating several different proposals. As part of this evaluation process, it is critical for Congress and the public to understand the cost implications of the proposals, both in the current year and in the long-term.

The Health Section and Health Practice Areas of the Society of Actuaries (SOA) approved and funded a research project to study the costs of a wide range of pharmacy plan designs for the Medicare population for the benefit and use of the SOA and their members. Reden & Anders, Ltd. (R&A) was retained to provide this analysis.

This report contains three types of cost estimates:

- Net benefit cost estimates per member per month (PMPM) for 28 benefit plan designs. These cost estimates, expressed for calendar year 2003, range from \$36 PMPM to \$114 PMPM. Half of the plans fall in the range of \$60 to \$90 PMPM. For comparison purposes, the current Medicare supplement pharmacy plan design estimates are \$50 PMPM for Plans H and I and \$62 PMPM for Plan J. (Please refer to Exhibits A and B.)
- Continuance table data. This information provides insight into the distribution of an individuals' annual pharmacy cost and of pharmacy usage by the cost of the prescription. This data can be used to estimate costs of additional plan designs beyond those studied in this report. (Please refer to Exhibits C and D.) For example, 20% of the members account for 56% of the total claims, and 50% of the members account for 90% of the total claims. 11% of the members have no prescription drug claims.
- Projected annual costs to the government over 10 years for two selected plan designs. (Please refer to Exhibits E and F.)
  - The total cost of drug benefits without member cost sharing or premium payment is estimated to be \$151 PMPM in 2003. The projected cost over the 10 years is \$1.8 trillion.
  - The first plan is Scenario 12, which has commercial type copayments (see Exhibit A for a detailed description). The 2003 PMPM net cost is estimated to be \$80. The net projected cost over the 10 years is almost \$1.0 trillion, assuming 17.4% annual trend, with the government bearing 54% of the total cost.
  - The second plan is a plan submitted by House Democrats as House Bill 1199, with coverage reflecting a \$100 deductible, 20% coinsurance, and a \$2,000 OOP maximum. The 2003 PMPM net cost is estimated to be \$114. The net projected cost over the 10 years is \$1.35 trillion, net of the proposed \$25 member premium, or \$1.47 trillion gross the \$25 member premium, assuming 17.4% annual trend. The government bears 68% of the total cost.

## Executive Summary (cont'd)

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- Different cost scenarios can be extrapolated from the results in this report by assuming different trend factors, rebate adjustments, or a different mix between brand and generic prescriptions. For more information on these extrapolations, please refer to the Results Section of this report.

The remainder of this report describes the data and models used in our analysis, as well as the underlying assumptions and results. We have also provided a summary of the limitations of our report. One of the key limitations of the analysis is that we have not adjusted any of the results to reflect potential behavioral effects on prescription drug utilization due to varying member cost sharing provisions or other benefit design features. We highly recommend that readers of this report review the Limitations of the Analysis Section of this report to understand more completely the analysis and conclusions.

This report has been requested and funded by the Health Section and Health Practice Areas of the SOA and is available to all SOA members. Readers are cautioned to review the underlying modeling methodology and any limitations of the analysis as outlined in this report.

## II. Data and Methodology

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We employed the R&A Prescription Drug Pricing Model to perform this analysis. The detailed database in this model was built from prescription drug claims data provided by Medicare managed care contributors and contains experience for over 50,000 Medicare+Choice (M+C) members. It only includes data for members with unlimited pharmacy benefits in order to reflect the utilization of prescription drugs which would be expected under plans with no annual benefit maximums. However, it should be noted that member cost sharing could vary quite widely in the unlimited benefit plans included. No explicit adjustment has been made for the impact of member cost sharing on utilization levels, either in the underlying data or for the various benefit plans priced.

We did adjust this data, where necessary, by reviewing aggregate comparative statistics compiled from public and proprietary sources and other data sources such as various published studies and other general information maintained by the R&A Research Services unit. For prescription drug cost data, the model relies on the most up-to-date Average Wholesale Price (AWP) information from First Databank.

To estimate the cost of a particular benefit plan, the R&A Prescription Drug Pricing Model readjudicates historical claims at the National Drug Code (NDC) and member level. This method tracks each prescription and determines how much the member pays for it versus how much the plan pays for it. This pricing approach more accurately estimates the impact of deductibles, annual maximums, catastrophic benefits and cost sharing that exceeds the cost of a particular prescription, versus sole reliance on summarized continuance table data. The 50,000 M+C claims data described above was loaded into the R&A Prescription Drug Pricing Model for purposes of pricing the benefit plans for this study.

Brand name drugs are assigned into two tiers by reviewing the underlying data. "Brand Tier 2" drugs are designated as those where the vast majority of the prescriptions of a particular NDC code were designated as non-formulary. Exhibit J summarizes the top 50 drugs by allowed cost that were designated as Brand Tier 2. This list comprises over 80% of the total allowed costs in this category. We recognize that any formulary that may be included as part of a Medicare prescription drug benefit may not reflect the formulary included here. However, in order to show the impact of including a formulary in a Medicare prescription drug benefit, we believed it was appropriate to base projections on the formulary embedded in the data.

The historical database is for calendar year 2001. A utilization trend of 7% per annum was used to project calendar year 2003. The most recent AWP data was for January 2003. This AWP data was increased by 3.5% to project calendar year 2003 AWP prices.

While we believe the data, modeling and baseline assumptions used to project costs for the prescription drug plan designs are reasonable, there are limitations warranting consideration by users of this information. These limitations are summarized in the Limitations of the Analysis Section of this report.

### III. Assumptions

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Exhibit A outlines the benefit plans analyzed. The scenarios were jointly decided upon by the SOA and R&A. We also added one plan proposal proposed by House Democrats and submitted as House Bill 1199. To develop the cost estimates for these plans, we needed to make multiple assumptions about the plans and prescription drug costs in general. The rest of this section describes those assumptions.

One key assumption is the time frame for which the pricing applies. It is unlikely that any new pharmacy coverage could be added to the Medicare program in 2003, but the SOA requested that the cost estimates apply for calendar year 2003.

Another key assumption is the pharmacy fee schedule that will apply. We assumed that the government (or private companies offering the government benefit) will buy prescription drugs on the same basis currently employed in the private market (i.e., discounts from AWP plus dispensing fees). We selected the discounts and dispensing fee assumptions based on a survey we previously performed on pharmacy contracts for eight managed care organizations. This pricing basis is referred to as allowed cost.

Demographic distribution by age and gender does not have as significant an impact on the cost of pharmacy services as for medical services for the Medicare population. In fact, the prescription drug cost for all of the age/gender cohorts under Medicare is fairly consistent. Regardless of this homogeneity among the cohorts, we also re-weighted the data in our model's database to adjust the member distribution from the underlying managed care distribution to a Medicare eligible population. No other adjustment was made for any potential difference between managed care and fee-for-service (FFS) experience.

A summary of the pricing assumptions follows:

- Effective Date: January 1, 2003 with a midpoint of July 1, 2003.
- Retail versus Mail Order: We have assumed all prescriptions that have less than a 90 day supply are Retail and all prescriptions with a days supply of greater than or equal to 90 days are Mail Order.
- AWP Discounts:

<b>Prescription Category</b>	<b>Retail</b>	<b>Mail Order</b>
Generic	45%	50%
Brand Tier 1	14%	18%
Brand Tier 2	14%	18%

## Assumptions (cont'd)

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- Dispensing Fees:

Prescription Category	Retail	Mail Order
Generic	\$2.00	\$0.00
Brand Tier 1	\$2.00	\$0.00
Brand Tier 2	\$2.00	\$0.00

- For the copayment plan designs, mail order copayments equal two times retail copayments.
- Coinsurance is applied to the allowed cost (i.e., after discount and dispensing fee).
- PBM administrative fee: We did not include any administrative fee in our estimates. If these exist, it would be an additional cost to the plan sponsor.
- Rebates: We did not include any rebates in our estimates. Any rebates received would be a reduction in costs to the plan sponsor.
- Demographic distribution: Based on Medicare eligible beneficiaries with Medicare Part B coverage in 2000.

Age Range	Gender	Percent of Members <sup>[1]</sup>
<65	F	5.83%
65-69	F	11.78%
70-74	F	12.43%
75-79	F	11.28%
80-84	F	8.18%
85+	F	8.38%
<65	M	7.66%
65-69	M	9.73%
70-74	M	9.46%
75-79	M	7.55%
80-84	M	4.59%
85+	M	3.13%
Total	All	100.0%

[1] Medicare eligible distribution is from Part B Eligible counts for 2000.

## Assumptions (cont'd)

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- The 10 year projections in Exhibits E, F.1, and F.2 use a 7% annual trend rate for utilization and a 10% annual trend rate for average cost per prescription. The 10 year projection in Exhibit F.3 uses a 4% annual trend rate for utilization and a 6% annual trend rate for average cost per prescription.

## IV. Limitations of the Analysis

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We based the estimates of prescription drug costs for calendar year 2003 for the various prescription drug plan designs included in this report on reasonable data sources available at the time of this analysis. We also developed the 10 year projections for certain plan designs using assumptions considered reasonable at the time these projections were made. Information obtained after we developed these estimates or which we may obtain in the future has not been incorporated in this analysis and may have significant impacts on its results and conclusions.

Interpretation of the results of this analysis for comparisons to other studies or for other users should be done with caution due to the limitations inherent in this analysis and the underlying data. Some of the key limitations of this analysis that we are currently aware of are as follows:

- **Data Source:** The baseline data, which reflects prescription drug experience for unlimited benefits offered primarily under employer-sponsored M+C plans, has been adjusted to reflect the demographic mix of all Medicare eligibles. However, this may not completely account for potential differences in prescription drug utilization for all Medicare eligibles versus those enrolled in Medicare M+C programs offered by HMOs, especially for current Medicare eligibles who have no prescription drug benefits. While we would expect the benefit relativities summarized in Exhibit B would remain fairly consistent for all Medicare eligibles who would enroll in a government sponsored prescription drug benefit, we cannot definitively state that this would indeed be true.
- **Behavioral Effects:** The relative and absolute cost differentials of the various prescription drug plans only reflect differences in the plan design, such as differences and the presence or absence of deductibles, copayments, coinsurance, plan annual benefit maximums, and catastrophic coverage thresholds. The cost differentials do not reflect any assumptions regarding the potential behavioral effects on utilization due to higher member cost sharing in one plan design versus another or the benefit design and the ability to maximize the benefit by a member by having knowledge of his or her expected utilization.
- **Supplemental Coverage:** We did not adjust utilization to reflect the potential presence of supplemental coverage through private insurance or employer coverage of member cost sharing not covered by the government plan. If cost sharing is reimbursed through private supplemental insurance with little or no cost liability for the individual, utilization could increase and the cost above the catastrophic coverage threshold may be significantly higher.
- **Administrative Costs and Rebates:** We did not include any assumptions regarding the additional cost of any pharmacy administrative charges or the savings from any rebate program that might be implemented.

## Limitations of the Analysis (cont'd)

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- **Member Premium:** We did not reflect the reduction in cost due to any premium assessment in Exhibit B. The proposed premium in House Bill 1199 (Scenario 28) is used to reduce the total costs in the 10 year cost projection in Exhibit F.
- **Pent Up Demand:** Sometimes services that are newly eligible for insurance coverage have unusually high utilization in the first year coverage is available. We have not assumed any first-year “pent up demand” impact in our cost estimates.
- **No Changes in Pricing Assumption for Projections:** The 10 year projections of program costs in Exhibits E and F assume no change in trend rates, generic/brand mix, or discounts/dispensing fees from year to year.
- **Sensitivity Modeling:** No sensitivity modeling of assumptions, such as variable utilization and cost trends, shifts in generic versus brand name prescriptions, the indexing of deductibles, copayments or catastrophic coverage limits or behavioral effects on utilization was performed at a detailed level. The myriad of scenarios that could be performed over the 10 year projection period is beyond the scope and intent of these projections to provide reasonable cost estimates of potential prescription drug benefit plans offered to Medicare eligibles. However, some general comments are provided below to quantify the directional changes in costs as a result of modified assumptions.
  - A decrease in trend assumptions would result in a decrease in projected costs, while an increase in trend assumptions would most likely result in an increase in projected costs.
  - A possible behavioral effect would be reduced utilization and therefore reduced costs on prescription drug plans having higher member deductibles, copayments and coinsurance.
  - A higher percentage of generic versus brand name prescriptions filled would most likely result in a decrease in projected costs.
- **New Brand Name Drugs:** No consideration was given to the potential impact that new, more expensive brand name drugs could have on projected 10 year costs.
- **Patent Expiration:** No consideration was given to the impact of current brand name drugs coming off of patent and generics becoming available, which would likely decrease costs.
- **Mandatory Versus Voluntary Enrollment:** No consideration of selection bias was made under the assumption that the Medicare program would be on a mandatory coverage basis versus on a voluntary basis. Coverage on a voluntary basis would likely lead to adverse selection in the program resulting in an increased cost per member to the program from that projected in this analysis.

## **Limitations of the Analysis (cont'd)**

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The aforementioned limitations address issues that likely have the greatest impact on the variability of the results. However, there may be other issues worth considering that have not been identified in this report.

## V. Results

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The benefit plan scenarios we analyzed are summarized in Exhibit A. The estimated cost PMPM for each of these scenarios in calendar year 2003 is presented in Exhibit B. Exhibits C.1, C.2, D.1, and D.2 provide continuance table data that can be used to estimate the impact of variation on the plan designs already analyzed. Exhibit D.1a provides an example of how to use the continuance table data in Exhibit D.1. Exhibits E, F.1, F.2, and F.3 provide 10 year projections of total annual costs, while Exhibits G, H, and I illustrate how to use the report to estimate costs under different assumptions. Exhibit J lists the top 50 drugs designated as Brand Tier 2.

### **ESTIMATED COST OF SOA REQUESTED SCENARIOS – EXHIBIT B**

Exhibit B summarizes the pricing results for calendar year 2003 of the 28 different plan designs. We iterate that behavioral effects on utilization due to member cost sharing, has been ignored in developing the projected costs of the plan designs. Also, it is assumed that coverage will be on a mandatory basis.

We have provided several breakdowns to help the reader understand the impact each cost sharing component has on the government-covered utilization and PMPM cost. The utilization and PMPM data is categorized as follows:

- Total gross utilization/allowed cost
- Eliminated due to deductible
- Eliminated due to copayments
- Eliminated due to coinsurance (PMPM only)
- Eliminated due to annual maximum
- Covered due to catastrophic coverage threshold
- Net utilization/cost covered by the plan

Utilization is only eliminated when the member pays the entire cost of the prescription. For example, the 6,448 elimination due to deductible for Scenario 1 indicates that 6,448 prescriptions per thousand members per year would be paid by the member in full since they would be utilized before the member has reached the \$250 deductible. Similarly, 5,681 prescriptions per thousand members per year would be paid by the member in full since they would be utilized after the member has reached the plan annual maximum. Prescriptions eliminated due to copayments represent prescriptions where the allowed cost is less than the copayment, so the member pays for the full cost of the prescription (e.g., a generic prescription that costs \$8 when the generic copayment is \$10).

## Results (cont'd)

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PMPM cost reductions are based on similar logic, except that the member may pay a part of the cost of the prescription. Using Scenario 10 as an example, 8,394 prescriptions per thousand members are eliminated due to copayments. However, a number of prescriptions will also have the full copayment applied to them. The \$48.91 PMPM includes both prescriptions where the member pays the entire cost (since the entire cost is less than the copayment) and the prescriptions where the member pays the value of the copayment since the cost of the prescription is greater than the copayment.

Note that the cost elimination due to deductible for plans with a \$100 deductible is \$8.73 PMPM, or \$104.76 on an annual basis. The annualized amount is greater than \$100 because members are not enrolled for the entire calendar year. During the year, members enter the Medicare program as they become eligible and leave the Medicare program as they die. Hence, the average number of member months per member is something less than 12. Upon reviewing our analysis and data, we are comfortable that the average cost PMPM paid by a member for the first \$100 of coverage may very well be in excess of an annualized \$100 due to this constant change in membership.

Overall, the highest cost plan is the plan based on House Bill 1199 (Scenario 28) at \$113.87 PMPM (before reduction for proposed member premium), and the lowest cost plan is Scenario 8, Variation on Breaux/Frist #3 at \$36.02 PMPM. We estimate that half of the plans would cost between \$60 and \$90 PMPM. For comparison purposes, the current Medicare supplement pharmacy plan designs are estimated at \$50.60 PMPM for Plans H and I, and \$62.36 PMPM for Plan J.

### **CONTINUANCE TABLE BY MEMBER – EXHIBITS C.1 AND C.2**

We used the database in our model to develop continuance table data by member, as presented in Exhibits C.1 and C.2. These tables reflect the cost distribution by member for calendar year 2003. Exhibit C.1 shows the breakdown by allowed cost, which is the total cost incurred after reflecting discounts from AWP and dispensing fees. Exhibit C.2 shows the breakdown by unadjusted AWP, which is the total cost that would be incurred by the member if there were no discounts from AWP (or dispensing fees).

These exhibits summarize the number of members, number of prescriptions, and costs (either allowed or unadjusted AWP) by member by the defined claim ranges. The total costs for the members are split by generic, Brand Tier 1, and Brand Tier 2. Finally, the percentage of members and dollars in excess of each of the dollar thresholds is shown. Not surprisingly, 20% of the members account for 56% of the total claims, and 50% of the members account for almost 90% of the total claims. Roughly 11% of the members have no prescription drug claims in a year.

## Results (cont'd)

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### CONTINUANCE TABLE BY PRESCRIPTION COST – EXHIBITS D.1, D.1A, AND D.2

Exhibits D.1 and D.2 also present continuance table data. These exhibits show the number of prescriptions and average cost per prescription by range of cost per prescription. In Exhibit D.1, the average cost is based on the allowed amount per prescription (discounted AWP plus dispensing fee). In Exhibit D.2, the average cost is based on the undiscounted AWP. The data is shown in the following categories so that the reader can evaluate a benefit plan that varies benefits by type of prescription:

- Retail Generic
- Retail Brand Tier 1
- Retail Brand Tier 2
- Mail Order Generic
- Mail Order Brand Tier 1
- Mail Order Brand Tier 2

This table shows that only 20% of generic utilization is for prescriptions that have an allowed cost of more than \$30 per prescription after taking into account AWP discounts and dispensing fees. Conversely, about 78% to 86% of brand utilization is for prescriptions that have an allowed cost of more than \$30 per prescription after taking into account AWP discounts and dispensing fees. If the cost is based on full AWP, 43% of generic prescriptions and 80% to 87% of brand name prescriptions exceed \$30.

Exhibit D.1a provides an illustration of how to use the data displayed in Exhibit D.1. We have assumed a generic copayment of \$10 and have illustrated how the average cost of a prescription above \$10 is higher than the average cost of all generic prescriptions. To determine the average cost of generic prescriptions above \$10, we calculate the total cost for all generic prescriptions above \$10 (\$14,276,697) and then divide by the number of generic prescriptions above \$10 (514,998). The result is an average cost of \$27.72. The average payment by the plan for a generic prescription would therefore be \$17.72 (\$27.72 - \$10.00).

In addition, we have calculated the percent of generic prescriptions that the plan would cover (69.05%) in excess of the \$10 generic copayment. Hence, if the plan knew what their utilization for generic prescriptions was, they could use this data to calculate a PMPM cost for generic prescriptions by taking their overall generic utilization, multiplying it by 69.05% to determine the number of prescriptions on which they would make a payment, multiplying that product by \$17.72 to get an average cost per member per year, and then dividing by 12 to get a PMPM plan cost for generic prescriptions. A similar analysis could be used for brand prescriptions.

## Results (cont'd)

### PROJECTIONS OF SCENARIO 12 AND THE HOUSE BILL 1199 – EXHIBITS E, F.1, F.2, AND F.3

We have developed projections from 2003 through 2012 for two different plan designs: Scenario 12 and House Bill 1199. We choose Scenario 12 as a representative copayment plan and House Bill 1199 since it was the most recent Congressional proposal when the report was being developed. These are shown in Exhibits E and F. Our projections make the following assumptions:

- All Medicare Part A eligibles will be in the proposed pharmacy program. We relied upon published CMS data for the number of Medicare eligibles in each year from 2003 to 2012. These projections include Medicare eligibles under age 65. We did not modify the underlying distribution by age and gender in our cost projections. However, we tested the impact of varying the distribution by age/gender (using CMS data) and found the results only changed by 0.1% to 0.5% in any given year.
- All Medicare Part A eligibles will be provided the prescription drug benefit, either directly from CMS or through an additional payment to M+C plans from CMS to cover the cost of the prescription drug benefit.
- The trend assumptions do not change during the projection period. Likewise, the mix of generic/brand or pricing parameters for discounts and dispensing fees do not change during the projection period.

Table 4 summarizes the plan designs for the two projections:

<b>TABLE 4 SUMMARY OF PLAN DESIGNS</b>		
	<b>Scenario 12</b>	<b>House Bill 1199<sup>[3]</sup></b>
Deductible	NA	\$100
Coinsurance	NA	20%
Copays:		
Generic	\$10	NA
Brand Tier 1	\$25	NA
Brand Tier 2	Max of \$40/50%	NA
Annual Maximum <sup>[1]</sup>	\$2,500	NA
Catastrophic Coverage Threshold <sup>[2]</sup>	\$6,000	\$2,000
Monthly Premium	TBD	\$25

[1] The annual benefit maximum is a corridor maximum benefit payable by the plan until the insured's total OOP reaches the catastrophic coverage threshold.

[2] Total insured's OOP cost limit, including deductible, copayments, and coinsurance.

[3] R&A's projections ignore indexing of cost sharing provisions.

## Results (cont'd)

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To illustrate the impact of a constant catastrophic threshold over time, we have shown the government liability separately for the portion up to the plan annual maximum and the portion above the catastrophic level. The percent of the allowed cost paid by the member in each year is also shown.

Exhibit E for Scenario 12 shows a 10 year cost of \$0.992 trillion. Also, the member's percentage of gross costs remains almost constant until 2011, when it starts to decrease.

Exhibit F.1 is the projection for the House Bill 1199 plan design (Scenario 28) using our baseline trend assumption. The 10 year cost projection is \$1.351 trillion. The member's percentage of gross costs declines steadily over the projection period.

In Exhibit F.2, we tested the impact of indexing the cost sharing so that the member percent of the total cost would be at 25% over the total projection period. This reduced our projected cost by 8% to \$1.248 trillion over 10 years.

Finally, in Exhibit F.3, we tested the impact on our projection of using a lower trend assumption (4% utilization and 6% average cost) without any indexing of cost sharing provisions. This reduced our projected 10 year cost of \$1.351 trillion by 36% to \$0.868 trillion.

## OTHER USES FOR THE PROJECTIONS

The scenarios provided in Exhibits E, F.1, F.2, and F.3 are only a small subset of the possible scenarios for a Medicare prescription drug benefit. However, the information in these exhibits can be used to develop other projections using reasonable interpolation methods. Below we describe three alternative scenarios.

### ***Example 1: Trend***

Readers may wish to estimate cost projections under different trend assumptions. Exhibit E uses an annual trend assumption of 17.4%. Exhibit G illustrates how this can be modified for an annual trend rate of about half this level (8.5%). The first three years only are shown. Additional years could be adjusted in a similar manner.

Exhibit G makes two adjustments to the estimates in Exhibit E. The first adjustment is to prorate the effect of cumulative trend on the allowed cost PMPM. This is done by taking the Allowed Cost from Line 1 and adjusting it by the new cumulative trend from Line 7 divided by the original cumulative trend from Line 4. The second adjustment reflects the impact that a different trend assumption has on the percent of the total cost for which the member has responsibility. The plan design in these projections (Scenario 12) has copays, an annual maximum and catastrophic coverage. A reduction in the trend assumption impacts this plan's cost as follows:

## Results (cont'd)

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- The cost per prescription increases more slowly, which keeps the impact of copays from eroding as fast as in Exhibit E. This should increase the value of member liability relative to Exhibit E. Note also that Exhibit B indicates that 39% of the allowed cost of Scenario 12 is eliminated due to copays and coinsurance.
- It takes longer for individuals below the annual maximum to reach the maximum. This reduces member liability relative to Exhibit E. Exhibit B shows that 9% of the allowed cost of Scenario 12 is eliminated due to the annual maximum.
- It takes longer for individuals below the catastrophic threshold to reach that threshold, which keeps down plan costs and increases member liability in total versus Exhibit E. Exhibit B shows the value of the catastrophic benefit as 2% of allowed costs.

When these factors are considered in aggregate, it is likely that the member liability under a lower trend assumption will increase member liability as a percentage of the allowed cost, at least initially. Furthermore, it would appear that the primary factor would be the relationship of the copay to the cost per prescription. The data in Exhibit D.1 can be used to understand the distribution of copay values. The cost per prescription can be increased at the selected trend rate and the proportion of the cost paid by the member (lesser of the full cost or the copay) can be computed and compared to the full (trended) allowed cost. Different plan designs will have different patterns of member cost sharing over time, with the interaction of the initial cost sharing (i.e., deductibles, copayment, or coinsurance) and the catastrophic coverage thresholds determining how quickly the cost of the benefit shifts between the plan and the member. Scenario 12 is actually a very well balanced plan in this regard until 2012 and 2013 when the member's share of the total cost starts to decrease.

### ***Example 2: Rebates***

As noted earlier, the cost projections presented here are before any adjustment for rebates. Most managed pharmacy programs result in fairly significant rebates. The savings to be achieved through rebates will vary greatly depending on the contractual arrangements that can be made through pharmacy benefit managers or directly with drug manufacturers and the actual usage of brand prescriptions. In Exhibit H, it is assumed that rebates equivalent to 4% of allowed costs can be achieved. Again, the first three years only are shown.

### ***Example 3: Generic/Brand Mix***

The database used by the R&A Prescription Drug Pricing Model contains experience from managed care entities. The design of a Medicare pharmacy benefit with regard to covered costs, use of formularies, mandatory generic substitution and so forth may result in a differential between this historical managed care experience and Medicare FFS experience. For example, there may be a lesser use of generic drugs, at least initially, which would increase the overall program costs from those shown in the projections here.

Exhibit I illustrates how one may use the baseline experience in Exhibit E, which has about 46% generic use, to assume it will take several years under a FFS program until this level of generic

## Results (cont'd)

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use can be achieved. The underlying average cost of generic and brand name drugs is obtained from Exhibit C.1. For simplicity, we have also assumed that the relationship of net to allowed costs overall applies equally to generics and brand name drugs. This assumption could be further analyzed using the continuance table data in Exhibit D.1 (see discussion for varying trends above) and revised if desired.

## VI. Conclusions

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While there are clearly many unknowns regarding how utilization will vary based on the plan design and coverage in the secondary market, the cost estimates presented here help to establish relativities between the various plan designs we have evaluated and provide a baseline for projecting costs over the next 10 years. Some key observations regarding the relativities between the plan designs in Exhibit B and the projections in Exhibits E and F are as follows:

- Some plan designs that have a low net plan payment PMPM in 2003 also have a low catastrophic coverage threshold. This catastrophic coverage will increase the cost to the plan very quickly if prescription drug costs continue to increase as they have in the past. For example, with a 17% annual cost trend, a \$4,000 catastrophic coverage threshold in 2003 would be equivalent to a \$2,000 catastrophic coverage threshold in 2008 and a \$1,000 catastrophic coverage threshold in 2013. Hence, even though a plan may have higher cost sharing and lower cost currently, the 10 year cost most likely would be higher than any of the plans without the catastrophic coverage benefit.
- The difference between Scenarios 3 (House Republican bill) and 4 (Tripartisan bill) is minor for 2003. Since the catastrophic thresholds are the same, a cost comparison over 10 years would likely also be similar.
- Of the Variations on Breaux/Frist plans (Scenarios 5 through 9), we would expect the cost differentials to increase significantly over time as the value of the catastrophic threshold becomes more important.
- Raising the copayments from \$10/\$25 (Scenario 11) to \$20/\$40 (Scenario 15) when there are no annual maximums reduces the net plan cost by almost 30%. This differential would shrink slightly over a 10 year projection as average cost trends would reduce the impact of the copayments.
- Scenarios 11 and 19, which are both unlimited benefits, are very close in cost even though Scenario 11 is a copayment plan and Scenario 19 is a deductible/coinsurance plan. Over time, we would expect the copayment plans to cost more than the deductible/coinsurance plans due to the leveraging impact of the copayments. The same is true of Scenarios 12 and 21, which both have the same plan annual maximum and catastrophic coverage threshold.

House Bill 1199, which is clearly the most expensive, provides the most up-front coverage. However, some of the plans that provide 100% coverage above the catastrophic coverage threshold, such as Variation on Breaux/Frist #1 (Scenario 6), may ultimately cost as much, or only slightly less, than House Bill 1199.

**Exhibit A**  
**Society of Actuaries Medicare Pharmacy Study**  
**Proposed Plan Designs**

Plan Scenario/Description	Copayments Per Prescription <sup>[1]</sup>			Deductibles			Member Coinsurance				Plan Annual Benefit Maximum <sup>[3]</sup>			Catastrophic Coverage Threshold <sup>[4]</sup>	Other Provisions
	Generic Drugs	Brand Tier 1 <sup>[2]</sup>	Brand Tier 2 <sup>[2]</sup>	Generic Only	Brand Only	Combined	Generic Drugs	Brand Tier 1 <sup>[2]</sup>	Brand Tier 2 <sup>[2]</sup>	Combined	Generic Only	Brand Only	Combined		
1. MedSupp Plans H & I						\$250				50%			\$1,250		
2. MedSupp Plan J						\$250				50%			\$3,000		
3. House Republican Passed						\$250				20%, \$251-\$1000; 50%, \$1001 to \$2000			\$1,100	\$3,700	
4. TriPartisan						\$250				50%			\$1,600	\$3,700	
5. Breaux/Frist						\$250				50%			\$800	\$6,000	
6. Variation on Breaux/Frist #1						\$500				50%			\$800	\$4,000	
7. Variation on Breaux/Frist #2						\$500				50%			\$800	\$6,000	
8. Variation on Breaux/Frist #3						\$500				50%			\$800	\$10,000	
9. Variation on Breaux/Frist #4						\$500				50%			\$1,500	\$6,000	
10. Commercial Copay	\$10	\$25	\$40/50%			\$250				0%			\$2,250	None	
11. Commercial Copay	\$10	\$25	\$40/50%			\$0				0%			Unlimited	None	
<b>12. Commercial Copay</b>	<b>\$10</b>	<b>\$25</b>	<b>\$40/50%</b>			<b>\$0</b>				<b>0%</b>			<b>\$2,500</b>	<b>\$6,000</b>	
13. Commercial Copay	\$10	\$25	\$40/50%			\$0				0%			\$1,300	\$6,000	
14. Commercial Copay	\$20	\$40	\$60/50%			\$250				0%			\$2,250	None	
15. Commercial Copay	\$20	\$40	\$60/50%			\$0				0%			Unlimited	None	
16. Commercial Coinsurance						\$100	25%	25%	50%				\$2,400	None	
17. Commercial Coinsurance						\$250	25%	25%	50%				\$2,250	None	
18. Commercial Coinsurance						\$100	25%	25%	50%				Unlimited	None	
19. Commercial Coinsurance						\$250	25%	25%	50%				Unlimited	None	
20. Commercial Coinsurance						\$100	25%	25%	50%				\$2,400	\$6,000	
21. Commercial Coinsurance						\$250	25%	25%	50%				\$2,250	\$6,000	
22. Commercial Coinsurance						\$100	25%	25%	50%				Unlimited	\$6,000	[5]
23. Commercial Coinsurance						\$250	25%	25%	50%				Unlimited	\$6,000	[5]
24. Comm Copay/Split Max	\$10	\$25	\$40/ 50%			\$0							Unlimited	\$1,000	None
25. Comm Copay/Split Max	\$10	\$25	\$40/50%			\$0							Unlimited	\$2,500	None
26. Comm Coins./Split Max						\$0	25%	25%	50%				Unlimited	\$1,000	None
27. Comm Coins./Split Max						\$0	25%	25%	50%				Unlimited	\$2,500	None
<b>28. House Bill 1199 Proposal</b>						<b>\$100</b>				<b>20%</b>			<b>\$7,600</b>	<b>\$2,000</b>	<b>[6]</b>

[1] Copays for retail purchases are shown. Mail purchases have copays equal to 2 times those shown. When two values are shown, the copayment is the greater of the two.

[2] The Tier 1 and 2 copayments reflect preferred and non-preferred brand name drugs.

[3] The Annual Benefit Maximum is a corridor maximum benefit payable by the plan until the insured's total out-of-pocket reaches the Catastrophic Coverage Threshold. After the plan pays the Annual Benefit Maximum, the member is responsible for all payments until the Catastrophic Coverage Threshold is reached. The Plan then pays 100% of the amount above the Catastrophic Coverage Threshold without limit. The sum of the Annual Benefit Maximum and the Catastrophic Coverage Threshold represents the total Allowed cost that must be reached before the 100% coverage takes effect. The Annual Benefit Maximum does NOT include the deductible.

[4] Total insured's out-of-pocket cost limit, including deductible, copayments, and coinsurance.

[5] We estimate the "attachment point" at which these 2 Scenarios would begin paying 100% are \$19,667 for Scenario 20 and \$19,167 for Scenario 21.

[6] Includes a \$25 per member per month premium

**Exhibit B**  
**Society of Actuaries Medicare Pharmacy Study**  
**Utilization Rates and Per Member Per Month Costs**  
**Calendar Year 2003**

Scenario	Utilization (Prescriptions per Thousand members)						Per Member Per Month Costs					
	Gross	Eliminated Due To:			Covered Over Catastrophic Threshold	Prescriptions Covered by Plan [1]	Allowed	Eliminated Due to Member Payments For:			Covered Over Catastrophic Threshold	Net Plan Payment [1]
		Deductible	Copays	Annual Max				Deductible [2]	Copayments/Coinsurance	Annual Max		
1.	38,336	(6,448)	0	(5,681)	0	26,207	\$150.64	(\$20.78)	(\$50.61)	(\$28.65)	\$0.00	\$50.60
2.	38,336	(6,448)	0	(724)	0	31,164	150.64	(20.78)	(62.36)	(5.14)	0.00	62.36
3.	38,336	(6,448)	0	(9,554)	1,580	23,915	150.64	(20.78)	(28.30)	(45.30)	9.66	65.92
4.	38,336	(6,448)	0	(3,591)	1,191	29,488	150.64	(20.78)	(55.30)	(19.27)	7.67	62.96
5.	38,336	(6,448)	0	(10,598)	548	21,838	150.64	(20.78)	(40.10)	(49.66)	4.15	44.25
6.	38,336	(11,559)	0	(8,915)	1,580	19,442	150.64	(38.57)	(34.73)	(42.60)	9.66	44.40
7.	38,336	(11,559)	0	(8,915)	548	18,410	150.64	(38.57)	(34.73)	(42.60)	4.15	38.89
8.	38,336	(11,559)	0	(8,915)	89	17,951	150.64	(38.57)	(34.73)	(42.60)	1.28	36.02
9.	38,336	(11,559)	0	(3,479)	386	23,684	150.64	(38.57)	(46.66)	(18.75)	3.20	49.86
10.	38,336	(6,448)	(8,394)	(2,097)	0	21,397	150.64	(20.78)	(48.91)	(15.25)	0.00	65.70
11.	38,336	0	(10,451)	0	0	27,885	150.64	0.00	(62.61)	0.00	0.00	88.03
<b>12.</b>	<b>38,336</b>	<b>0</b>	<b>(10,451)</b>	<b>(1,935)</b>	<b>241</b>	<b>26,190</b>	<b>150.64</b>	<b>0.00</b>	<b>(58.87)</b>	<b>(14.31)</b>	<b>2.31</b>	<b>79.77</b>
13.	38,336	0	(10,451)	(6,240)	426	22,071	150.64	0.00	(50.85)	(38.62)	3.44	64.61
14.	38,336	(6,448)	(14,990)	(880)	0	16,018	150.64	(20.78)	(72.42)	(9.17)	0.00	48.27
15.	38,336	0	(18,569)	0	0	19,767	150.64	0.00	(88.85)	0.00	0.00	61.79
16.	38,336	(2,814)	0	(3,431)	0	32,091	150.64	(8.73)	(36.85)	(18.54)	0.00	86.52
17.	38,336	(6,448)	0	(3,568)	0	28,321	150.64	(20.78)	(33.11)	(19.17)	0.00	77.58
18.	38,336	(2,814)	0	0	0	35,522	150.64	(8.73)	(42.18)	0.00	0.00	99.73
19.	38,336	(6,448)	0	0	0	31,889	150.64	(20.78)	(38.66)	0.00	0.00	91.20
20.	38,336	(2,814)	0	(3,431)	251	32,342	150.64	(8.73)	(36.85)	(18.54)	2.38	88.90
21.	38,336	(6,448)	0	(3,568)	269	28,590	150.64	(20.78)	(33.11)	(19.17)	2.49	80.07
22.	38,336	(2,814)	0	0	7	35,529	150.64	(8.73)	(42.18)	0.00	0.45	100.18
23.	38,336	(6,448)	0	0	8	31,897	150.64	(20.78)	(38.66)	0.00	0.47	91.67
24.	38,336	0	(10,451)	(4,136)	0	23,749	150.64	0.00	(52.04)	(35.06)	0.00	63.54
25.	38,336	0	(10,451)	(858)	0	27,027	150.64	0.00	(60.39)	(9.44)	0.00	80.81
26.	38,336	0	0	(6,399)	0	31,937	150.64	0.00	(31.37)	(43.15)	0.00	76.12
27.	38,336	0	0	(1,287)	0	37,049	150.64	0.00	(41.39)	(10.84)	0.00	98.41
<b>28.</b>	<b>38,336</b>	<b>(2,814)</b>	<b>0</b>	<b>(150)</b>	<b>150</b>	<b>35,522</b>	<b>150.64</b>	<b>(8.73)</b>	<b>(28.04)</b>	<b>(1.71)</b>	<b>1.71</b>	<b>113.87</b>

[1] Equal to Gross less Eliminated (deductible, copay, annual maximum) plus Catastrophic.

[2] May exceed the deductible amount on an annualized basis due to average exposure of less than 12 months. See Results section of report for additional discussion.

**Exhibit C.1**  
**Society of Actuaries Medicare Pharmacy Study**  
**Continuance Table by Member based on Allowed Dollars**  
**Calendar Year 2003 Claims**

Member Claims Range	Number of Members	Member Months	Number of Prescriptions				Allowed Claims [1]				% in Excess of Threshold	
			Generic	Brand Tier 1	Brand Tier 2	Total	Generic	Brand Tier 1	Brand Tier 2	Total	Members	Claims
\$0 - \$0	5,811	46,832	0	0	0	0	\$0	\$0	\$0	\$0	89%	100%
0.01 - 100	3,199	26,690	6,408	1,945	472	8,825	81,036	62,124	15,187	158,347	83%	100%
100.01 - 200	2,646	20,829	9,715	4,758	1,118	15,590	149,437	206,157	50,255	405,849	78%	99%
200.01 - 300	2,346	19,766	12,719	6,668	1,605	20,991	214,108	305,760	79,119	598,987	73%	98%
300.01 - 400	2,127	18,856	14,667	8,301	2,024	24,992	259,445	386,268	106,391	752,104	69%	98%
400.01 - 500	2,011	18,691	15,590	9,789	2,784	28,163	280,440	480,924	145,383	906,746	65%	96%
500.01 - 1,000	8,288	81,586	91,511	64,354	17,308	173,174	1,786,981	3,406,564	978,463	6,172,008	49%	88%
1,000.01 - 1,500	6,398	67,619	99,216	78,403	20,971	198,590	2,078,694	4,539,755	1,336,745	7,955,193	37%	78%
1,500.01 - 2,500	8,812	96,916	177,945	157,355	45,169	380,469	3,865,488	10,006,583	3,309,129	17,181,200	20%	56%
2,500.01 - 5,000	8,213	93,104	243,763	249,447	67,817	561,026	5,629,675	17,427,643	5,285,237	28,342,556	4%	19%
5,000.01 +	2,035	23,859	93,484	109,834	29,315	232,633	2,373,871	9,445,383	3,250,408	15,069,662	0%	0%
<b>Total</b>	<b>51,886</b>	<b>514,749</b>	<b>765,016</b>	<b>690,853</b>	<b>188,583</b>	<b>1,644,452</b>	<b>\$16,719,175</b>	<b>\$46,267,160</b>	<b>\$14,556,318</b>	<b>\$77,542,653</b>		

[1] Allowed Claims are based on AWP adjusted for Discounts and Dispensing Fees.

**Exhibit C.2**  
**Society of Actuaries Medicare Pharmacy Study**  
**Continuance Table by Member based on Unadjusted AWP**  
**Calendar Year 2003 Claims**

Member Claims Range	Number of Members	Member Months	Number of Prescriptions				Gross Unadjusted AWP Claims [1]				% in Excess of Threshold	
			Generic	Brand Tier 1	Brand Tier 2	Total	Generic	Brand Tier 1	Brand Tier 2	Total	Members	Claims
\$0 - \$0	5,811	46,832	0	0	0	0	\$0	\$0	\$0	\$0	89%	100%
0.01 - 100	2,552	21,589	4,328	1,540	375	6,243	69,242	49,714	11,971	130,928	84%	100%
100.01 - 200	2,248	17,595	6,428	3,487	840	10,756	136,569	165,161	39,839	341,568	80%	100%
200.01 - 300	1,899	15,068	7,569	4,965	1,165	13,698	180,693	246,773	60,581	488,047	76%	99%
300.01 - 400	1,768	15,029	9,043	6,207	1,503	16,753	225,206	317,672	84,739	627,618	72%	98%
400.01 - 500	1,720	15,305	10,587	7,136	1,965	19,689	278,306	383,274	112,551	774,131	69%	98%
500.01 - 1,000	7,238	68,770	63,815	47,943	12,970	124,728	1,849,828	2,762,145	800,094	5,412,067	55%	92%
1,000.01 - 1,500	5,882	60,771	74,718	59,883	15,910	150,511	2,395,473	3,808,147	1,111,744	7,315,363	44%	84%
1,500.01 - 2,500	8,681	93,988	150,355	130,279	36,967	317,602	5,202,254	9,001,886	2,892,889	17,097,029	27%	67%
2,500.01 - 5,000	10,395	116,708	276,147	259,507	71,166	606,820	10,476,900	19,959,118	6,170,142	36,606,160	7%	29%
5,000.01 +	3,692	43,094	162,025	169,904	45,721	377,650	7,053,618	15,757,077	5,303,887	28,114,582	0%	0%
<b>Total</b>	<b>51,886</b>	<b>514,749</b>	<b>765,016</b>	<b>690,853</b>	<b>188,583</b>	<b>1,644,452</b>	<b>\$27,868,088</b>	<b>\$52,450,969</b>	<b>\$16,588,437</b>	<b>\$96,907,493</b>		

[1] Gross Unadjusted AWP are based on AWP without any adjustments.

**Exhibit D.1**  
**Society of Actuaries Medicare Pharmacy Study**  
**Continuance Table by Allowed per Prescription**  
**Calendar Year 2003 Claims**

Prescription Cost Range	Number of Prescriptions							Average Allowed per Prescription [1]					
	Retail			Mail Order [2]			Total	Retail			Mail Order [2]		
	Generic	Brand Tier 1	Brand Tier 2	Generic	Brand Tier 1	Brand Tier 2		Generic	Brand Tier 1	Brand Tier 2	Generic	Brand Tier 1	Brand Tier 2
\$0 - \$5	78,703	14,012	703	882	69	6	94,375	\$3.97	\$3.98	\$3.72	\$3.16	\$3.28	\$3.89
5.00 - 10	152,102	23,514	4,239	2,155	595	11	182,616	7.44	7.32	7.87	8.27	6.48	8.57
10.01 - 20	219,416	48,745	8,413	3,036	279	50	279,939	14.80	14.00	15.73	15.13	14.82	14.86
20.01 - 30	143,215	58,567	11,823	1,706	398	42	215,752	24.74	24.88	24.30	25.44	27.10	23.92
30.01 - 40	51,699	71,971	39,429	1,930	1,210	83	166,322	34.63	34.85	33.73	35.39	33.83	34.67
40.01 - 50	48,511	66,656	23,202	1,801	399	70	140,639	44.72	43.74	45.26	45.67	45.07	44.55
50.01 - 60	31,808	57,350	12,451	1,767	532	51	103,959	54.17	55.14	55.51	54.25	55.44	53.05
60.01 - 70	7,359	97,014	11,105	863	1,416	54	117,811	64.18	64.66	65.62	66.00	66.99	64.84
70.01 - 80	3,582	69,953	13,996	1,519	330	68	89,447	73.71	76.31	77.53	74.79	75.99	72.79
80.01 - 90	3,506	24,870	6,427	381	961	909	37,054	84.64	85.22	83.45	85.40	86.47	84.75
90.01 - 100	1,827	39,647	6,784	550	431	633	49,872	94.63	94.58	96.34	96.31	94.42	92.04
100.01 - 125	2,085	40,735	20,592	1,113	1,864	637	67,026	112.31	111.36	112.79	114.31	114.21	111.24
125.01 - 150	872	36,570	11,101	837	839	516	50,736	136.68	131.48	128.60	139.17	138.85	136.08
150.01 +	1,116	19,829	11,059	674	12,098	4,127	48,902	217.13	242.53	252.40	211.90	247.97	288.01
<b>Total</b>	<b>745,804</b>	<b>669,433</b>	<b>181,325</b>	<b>19,213</b>	<b>21,420</b>	<b>7,257</b>	<b>1,644,452</b>	<b>\$21.08</b>	<b>\$63.62</b>	<b>\$72.09</b>	<b>\$51.99</b>	<b>\$171.83</b>	<b>\$204.48</b>

Prescription Cost Range	% Utilization in Excess of Threshold						
	Retail			Mail Order			Total
	Generic	Brand Tier 1	Brand Tier 2	Generic	Brand Tier 1	Brand Tier 2	
\$0 - \$5	89%	98%	100%	95%	100%	100%	94%
5.00 - 10	69%	94%	97%	84%	97%	100%	83%
10.01 - 20	40%	87%	93%	68%	96%	99%	66%
20.01 - 30	20%	78%	86%	60%	94%	98%	53%
30.01 - 40	13%	68%	64%	49%	88%	97%	43%
40.01 - 50	7%	58%	52%	40%	86%	96%	34%
50.01 - 60	3%	49%	45%	31%	84%	96%	28%
60.01 - 70	2%	35%	39%	26%	77%	95%	21%
70.01 - 80	1%	24%	31%	18%	76%	94%	15%
80.01 - 90	1%	20%	27%	17%	71%	81%	13%
90.01 - 100	1%	15%	24%	14%	69%	73%	10%
100.01 - 125	0%	8%	12%	8%	60%	64%	6%
125.01 - 150	0%	3%	6%	4%	56%	57%	3%
150.01 +	0%	0%	0%	0%	0%	0%	0%

[1] Average Allowed per Prescription is based on Allowed adjusted for Discounts and Dispensing Fees.

[2] Mail Order Number of Prescriptions and Average Allowed per Prescription represent the actual number of Mail Order prescriptions and their cost. These prescriptions have not been adjusted to a "Retail equivalent" basis. On a "Retail equivalent" basis, Mail Order would represent about 8% of total utilization.

**Exhibit D.1a**  
**Society of Actuaries Medicare Pharmacy Study**  
**Examples of How to Use the Data in Exhibit D.1**  
**Determining Average Cost of Retail Generic Prescriptions above \$10**

Prescription Cost Range	All Retail Generic Prescriptions			Only Retail Generic Prescriptions over \$10		
	Number of Prescriptions	Average Allowed per Prescription	Total Allowed	Number of Prescriptions	Average Allowed per Prescription	Total Allowed
\$0 - \$5	78,703	\$3.97	\$312,106	0	\$0.00	\$0
5.00 - 10	152,102	7.44	1,131,567	0	0.00	0
10.01 - 20	219,416	14.80	3,248,416	219,416	14.80	3,248,416
20.01 - 30	143,215	24.74	3,543,392	143,215	24.74	3,543,392
30.01 - 40	51,699	34.63	1,790,517	51,699	34.63	1,790,517
40.01 - 50	48,511	44.72	2,169,640	48,511	44.72	2,169,640
50.01 - 60	31,808	54.17	1,722,937	31,808	54.17	1,722,937
60.01 - 70	7,359	64.18	472,300	7,359	64.18	472,300
70.01 - 80	3,582	73.71	264,057	3,582	73.71	264,057
80.01 - 90	3,506	84.64	296,804	3,506	84.64	296,804
90.01 - 100	1,827	94.63	172,896	1,827	94.63	172,896
100.01 - 125	2,085	112.31	234,207	2,085	112.31	234,207
125.01 - 150	872	136.68	119,195	872	136.68	119,195
150.01 +	1,116	217.13	242,336	1,116	217.13	242,336
<b>Total</b>	<b>745,804</b>	<b>\$21.08</b>	<b>\$15,720,370</b>	<b>514,998</b>	<b>\$27.72</b>	<b>\$14,276,697</b>

Percent of Prescriptions with Coverage =  $(514,998 / 745,804) = 69.05\%$

**Exhibit D.2**  
**Society of Actuaries Medicare Pharmacy Study**  
**Continuance Table by Unadjusted AWP per Prescription**  
**Calendar Year 2003 Claims**

Prescription Cost Range	Number of Prescriptions							Average Unadjusted AWP per Prescription [1]					
	Retail			Mail Order [2]			Total	Retail			Mail Order [2]		
	Generic	Brand Tier 1	Brand Tier 2	Generic	Brand Tier 1	Brand Tier 2		Generic	Brand Tier 1	Brand Tier 2	Generic	Brand Tier 1	Brand Tier 2
\$0 - \$5	70,256	16,678	1,283	398	67	6	88,688	\$3.38	\$2.60	\$3.00	\$4.82	\$3.95	\$4.74
5.00 - 10	82,889	23,795	3,933	485	595	2	111,699	7.55	6.85	7.41	7.54	7.89	9.63
10.01 - 20	143,441	45,134	6,748	2,155	185	44	197,706	14.41	14.13	15.28	16.54	15.67	14.97
20.01 - 30	126,556	50,720	12,161	1,273	164	43	190,919	24.60	25.73	24.86	25.75	25.27	25.27
30.01 - 40	92,936	61,700	33,047	1,762	1,107	27	190,580	34.50	35.76	35.58	33.52	37.22	36.48
40.01 - 50	69,786	59,224	18,713	707	446	82	148,957	45.62	45.31	44.97	44.54	46.07	43.83
50.01 - 60	34,894	49,924	16,002	999	382	44	102,245	54.01	54.77	54.50	55.36	55.14	53.85
60.01 - 70	27,145	47,370	10,806	794	502	65	86,682	64.74	65.50	65.37	63.96	67.34	63.81
70.01 - 80	25,954	91,596	8,789	1,136	212	25	127,713	74.73	74.20	75.60	75.53	74.58	74.44
80.01 - 90	23,644	52,575	13,599	732	1,325	77	91,952	83.63	86.79	87.85	85.21	82.98	85.28
90.01 - 100	21,604	24,746	6,365	1,070	329	28	54,142	93.87	93.08	94.16	95.53	95.64	95.39
100.01 - 125	14,009	70,766	9,103	1,890	1,324	1,567	98,659	108.29	110.89	111.59	109.45	109.34	107.40
125.01 - 150	5,031	41,600	27,711	1,634	1,503	598	78,077	136.27	140.21	134.38	141.04	136.80	136.16
150.01 +	7,659	33,604	13,064	4,179	13,278	4,649	76,432	215.09	230.44	271.45	248.73	290.12	330.40
<b>Total</b>	<b>745,804</b>	<b>669,433</b>	<b>181,325</b>	<b>19,213</b>	<b>21,420</b>	<b>7,257</b>	<b>1,644,452</b>	<b>\$34.69</b>	<b>\$71.65</b>	<b>\$81.50</b>	<b>\$103.97</b>	<b>\$209.54</b>	<b>\$249.37</b>

Prescription Cost Range	% Utilization in Excess of Threshold						
	Retail			Mail Order			Total
	Generic	Brand Tier 1	Brand Tier 2	Generic	Brand Tier 1	Brand Tier 2	
\$0 - \$5	91%	98%	99%	98%	100%	100%	95%
5.00 - 10	79%	94%	97%	95%	97%	100%	88%
10.01 - 20	60%	87%	93%	84%	96%	99%	76%
20.01 - 30	43%	80%	87%	78%	95%	99%	64%
30.01 - 40	31%	70%	68%	68%	90%	98%	53%
40.01 - 50	21%	62%	58%	65%	88%	97%	44%
50.01 - 60	17%	54%	49%	60%	86%	97%	37%
60.01 - 70	13%	47%	43%	55%	84%	96%	32%
70.01 - 80	10%	33%	39%	49%	83%	95%	24%
80.01 - 90	6%	26%	31%	46%	77%	94%	19%
90.01 - 100	4%	22%	28%	40%	75%	94%	15%
100.01 - 125	2%	11%	22%	30%	69%	72%	9%
125.01 - 150	1%	5%	7%	22%	62%	64%	5%
150.01 +	0%	0%	0%	0%	0%	0%	0%

[1] Average Unadjusted AWP per Prescription is based on the AWP with no adjustment.

[2] Mail Order Number of Prescriptions and Average Allowed per Prescription represent the actual number of Mail Order prescriptions and their cost. These prescriptions have not been adjusted to a "Retail equivalent" basis. On a "Retail equivalent" basis, Mail Order would represent about 8% of total utilization.

**Exhibit E**  
**Society of Actuaries Medicare Pharmacy Study**  
**10 Year Projection for Benefit Plan Scenario 12**  
**Assumed Annual Trend of 17.4% (No Indexing)**

	10 Year Projection Period									
	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Total Medicare Eligibles [1] (in 000s)	39,937	40,457	40,983	41,586	42,339	43,245	44,164	45,042	46,112	47,521
Percentage in Rx Program [2]	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Estimated Medicare Eligibles in Rx Program	39,937	40,457	40,983	41,586	42,339	43,245	44,164	45,042	46,112	47,521
Estimated Allowed PMPM Costs: [3]										
Up to Annual Maximum	\$77.46	\$90.83	\$104.28	\$117.21	\$129.47	\$140.84	\$151.18	\$160.60	\$169.00	\$176.44
Above Catastrophic Coverage Threshold	2.31	4.13	7.34	12.68	21.51	35.47	56.49	87.45	131.81	191.91
Net Plan Payment	\$79.77	\$94.96	\$111.62	\$129.89	\$150.98	\$176.31	\$207.67	\$248.05	\$300.81	\$368.35
Member Payment	\$70.87	\$81.68	\$95.58	\$113.23	\$134.35	\$158.66	\$185.65	\$213.90	\$241.84	\$269.20
Allowed Benefit Cost	\$150.64	\$176.64	\$207.20	\$243.12	\$285.33	\$334.97	\$393.32	\$461.95	\$542.65	\$637.55
Annual Rate of Trend in: [4]										
Benefit Cost Paid by Plan		19.0%	17.5%	16.4%	16.2%	16.8%	17.8%	19.4%	21.3%	22.5%
Benefit Cost Paid by Member		15.3%	17.0%	18.5%	18.7%	18.1%	17.0%	15.2%	13.1%	11.3%
Allowed Benefit Cost		17.3%	17.3%	17.3%	17.4%	17.4%	17.4%	17.4%	17.5%	17.5%
Percent of Allowed Benefit Cost Paid by Member	47%	46%	46%	47%	47%	47%	47%	46%	45%	42%
Annual Benefit Cost Per Member	\$957	\$1,140	\$1,339	\$1,559	\$1,812	\$2,116	\$2,492	\$2,977	\$3,610	\$4,420
Annual Cost of Rx Program (in millions)	\$38,230	\$46,101	\$54,894	\$64,819	\$76,708	\$91,494	\$110,059	\$134,073	\$166,450	\$210,054
Cumulative Cost of Rx Program (in millions)	\$38,230	\$84,331	\$139,225	\$204,044	\$280,752	\$372,247	\$482,306	\$616,379	\$782,829	\$992,882

[1] Source: CMS enrollment statistics for Part A.

[2] No breakdown between Fee-for-service Medicare and M+C has been made since it is assumed that similar funding would be provided to any members in the M+C program. We have also assumed that all eligibles will enroll in the program (i.e. mandatory enrollment) and that adverse selection will not take place.

[3] Based on pricing of benefits using Reden & Ander's Prescription Drug Pricing Model. Reflect costs after discount from AWP and dispensing fees.

[4] Trend assumptions as of 2003 are projected to apply for the entire time period.

**Scenario 12 Plan Design:**

\$10 generic, \$25 Brand Tier 1, and  
greater of \$40/50% Brand Tier 2  
\$2,500 plan maximum  
\$6,000 maximum out-of-pocket

**Exhibit F.1**  
**Society of Actuaries Medicare Pharmacy Study**  
**10 Year Projection for House Bill 1199 Proposal**  
**Assumed Annual Trend of 17.4% (No Indexing)**

	10 Year Projection Period									
	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Total Medicare Eligibles [1] (in 000s)	39,937	40,457	40,983	41,586	42,339	43,245	44,164	45,042	46,112	47,521
Percentage in Rx Program [2]	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Estimated Medicare Eligibles in Rx Program	39,937	40,457	40,983	41,586	42,339	43,245	44,164	45,042	46,112	47,521
Estimated Allowed PMPM Costs: [3]										
Up to Annual Maximum	\$112.16	\$131.89	\$154.40	\$179.82	\$208.09	\$238.82	\$271.49	\$305.46	\$339.28	\$371.79
Above Catastrophic Coverage Threshold	<u>1.71</u>	<u>2.99</u>	<u>5.38</u>	<u>9.48</u>	<u>16.33</u>	<u>27.52</u>	<u>45.02</u>	<u>71.16</u>	<u>109.56</u>	<u>163.82</u>
Net Plan Payment	\$113.87	\$134.88	\$159.78	\$189.30	\$224.42	\$266.34	\$316.51	\$376.62	\$448.84	\$535.61
Member Payment	<u>\$36.77</u>	<u>\$41.76</u>	<u>\$47.42</u>	<u>\$53.82</u>	<u>\$60.91</u>	<u>\$68.63</u>	<u>\$76.81</u>	<u>\$85.33</u>	<u>\$93.81</u>	<u>\$101.94</u>
Allowed Benefit Cost	\$150.64	\$176.64	\$207.20	\$243.12	\$285.33	\$334.97	\$393.32	\$461.95	\$542.65	\$637.55
Annual Rate of Trend in: [4]										
Benefit Cost Paid by Plan		18.5%	18.5%	18.5%	18.6%	18.7%	18.8%	19.0%	19.2%	19.3%
Benefit Cost Paid by Member		13.6%	13.6%	13.5%	13.2%	12.7%	11.9%	11.1%	9.9%	8.7%
Allowed Benefit Cost		17.3%	17.3%	17.3%	17.4%	17.4%	17.4%	17.4%	17.5%	17.5%
Percent of Allowed Benefit Cost Paid by Member	24%	24%	23%	22%	21%	20%	20%	18%	17%	16%
Annual Benefit Cost Per Member	\$1,366	\$1,619	\$1,917	\$2,272	\$2,693	\$3,196	\$3,798	\$4,519	\$5,386	\$6,427
Member Annual Premium [5]	\$275	\$275	\$275	\$275	\$275	\$275	\$275	\$275	\$275	\$275
Annual Net Cost After Member Premium	\$1,091	\$1,344	\$1,642	\$1,997	\$2,418	\$2,921	\$3,523	\$4,244	\$5,111	\$6,152
Annual Cost of Rx Program (in millions)	\$43,589	\$54,356	\$67,309	\$83,030	\$102,377	\$126,322	\$155,596	\$191,179	\$235,680	\$292,366
Cumulative Cost of Rx Program (in millions)	\$43,589	\$97,945	\$165,254	\$248,284	\$350,662	\$476,984	\$632,580	\$823,759	\$1,059,439	\$1,351,806

[1] Source: CMS enrollment statistics for Part A.

[2] No breakdown between Fee-for-service Medicare and M+C has been made since it is assumed that similar funding would be provided to any members in the M+C program.

We have also assumed that all eligibles will enroll in the program (i.e. mandatory enrollment) and that adverse selection will not take place.

[3] Based on pricing of benefits using Reden & Ander's Prescription Drug Pricing Model. Reflect costs after discount from AWP and dispensing fees.

[4] Trend assumptions as of 2003 are projected to apply for the entire time period.

[5] Adjusted to reflect less than 12 months of exposure.

**House Bill 1199 Plan Design (Scenario 26):**

\$ 25 member premium  
\$100 deductible, then 20% coinsurance  
\$2,000 maximum out-of-pocket

**Exhibit F.2**  
**Society of Actuaries Medicare Pharmacy Study**  
**10 Year Projection for House Bill 1199 Proposal**  
**Assumed Annual Trend of 17.4%**

**Assumes Cost Sharing Provisions are Indexed so Percent of Allowed Benefit Cost Paid by Member is Fixed at 25%**

	10 Year Projection Period									
	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Total Medicare Eligibles [1] (in 000s)	39,937	40,457	40,983	41,586	42,339	43,245	44,164	45,042	46,112	47,521
Percentage in Rx Program [2]	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Estimated Medicare Eligibles in Rx Program	39,937	40,457	40,983	41,586	42,339	43,245	44,164	45,042	46,112	47,521
Estimated Allowed PMPM Costs: [3]										
Net Plan Payment	\$112.98	\$132.48	\$155.40	\$182.34	\$214.00	\$251.23	\$294.99	\$346.46	\$406.99	\$478.16
Member Payment	<u>37.66</u>	<u>44.16</u>	<u>51.80</u>	<u>60.78</u>	<u>71.33</u>	<u>83.74</u>	<u>98.33</u>	<u>115.49</u>	<u>135.66</u>	<u>159.39</u>
Allowed Benefit Cost	\$150.64	\$176.64	\$207.20	\$243.12	\$285.33	\$334.97	\$393.32	\$461.95	\$542.65	\$637.55
Annual Rate of Trend in: [4]										
Benefit Cost Paid by Plan		17.3%	17.3%	17.3%	17.4%	17.4%	17.4%	17.4%	17.5%	17.5%
Benefit Cost Paid by Member		17.3%	17.3%	17.3%	17.4%	17.4%	17.4%	17.4%	17.5%	17.5%
Allowed Benefit Cost		17.3%	17.3%	17.3%	17.4%	17.4%	17.4%	17.4%	17.5%	17.5%
Percent of Allowed Benefit Cost Paid by Member	25%	25%	25%	25%	25%	25%	25%	25%	25%	25%
Annual Benefit Cost Per Member	\$1,356	\$1,590	\$1,865	\$2,188	\$2,568	\$3,015	\$3,540	\$4,158	\$4,884	\$5,738
Member Annual Premium [5]	\$275	\$275	\$275	\$275	\$275	\$275	\$275	\$275	\$275	\$275
Annual Net Cost After Member Premium	\$1,081	\$1,315	\$1,590	\$1,913	\$2,293	\$2,740	\$3,265	\$3,883	\$4,609	\$5,463
Annual Cost of Rx Program (in millions)	\$43,163	\$53,191	\$65,155	\$79,557	\$97,082	\$118,480	\$144,191	\$174,879	\$212,521	\$259,607
Cumulative Cost of Rx Program (in millions)	\$43,163	\$96,354	\$161,509	\$241,065	\$338,147	\$456,627	\$600,818	\$775,697	\$988,219	\$1,247,825

[1] Source: CMS enrollment statistics for Part A.

[2] No breakdown between Fee-for-service Medicare and M+C has been made since it is assumed that similar funding would be provided to any members in the M+C program.

We have also assumed that all eligibles will enroll in the program (i.e. mandatory enrollment) and that adverse selection will not take place.

[3] Based on pricing of benefits using Reden & Ander's Prescription Drug Pricing Model. Reflect costs after discount from AWP and dispensing fees.

[4] Trend assumptions as of 2003 are projected to apply for the entire time period.

[5] Adjusted to reflect less than 12 months of exposure.

**House Bill 1199 Plan Design (Scenario 26):**

\$ 25 member premium  
\$100 deductible, then 20% coinsurance  
\$2,000 maximum out-of-pocket

**Exhibit F.3**  
**Society of Actuaries Medicare Pharmacy Study**  
**10 Year Projection for House Bill 1199 Proposal**  
**Assumed Annual Trend of 10.2% (No Indexing)**

	10 Year Projection Period									
	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Total Medicare Eligibles [1] (in 000s)	39,937	40,457	40,983	41,586	42,339	43,245	44,164	45,042	46,112	47,521
Percentage in Rx Program [2]	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Estimated Medicare Eligibles in Rx Program	39,937	40,457	40,983	41,586	42,339	43,245	44,164	45,042	46,112	47,521
Estimated Allowed PMPM Costs: [3]										
Up to Annual Maximum	\$112.16	\$123.62	\$136.08	\$149.52	\$164.00	\$179.54	\$196.11	\$213.63	\$231.99	\$251.09
Above Catastrophic Coverage Threshold	1.71	2.39	3.36	4.77	6.74	9.43	13.08	18.03	24.66	33.37
Net Plan Payment	\$113.87	\$126.01	\$139.44	\$154.29	\$170.74	\$188.97	\$209.19	\$231.66	\$256.65	\$284.46
Member Payment	\$36.77	\$39.67	\$42.81	\$46.20	\$49.84	\$53.75	\$57.91	\$62.31	\$66.91	\$71.70
Allowed Benefit Cost	\$150.64	\$165.68	\$182.25	\$200.49	\$220.58	\$242.72	\$267.10	\$293.97	\$323.56	\$356.16
Annual Rate of Trend in: [4]										
Benefit Cost Paid by Plan		10.7%	10.7%	10.6%	10.7%	10.7%	10.7%	10.7%	10.8%	10.8%
Benefit Cost Paid by Member		7.9%	7.9%	7.9%	7.9%	7.8%	7.7%	7.6%	7.4%	7.2%
Allowed Benefit Cost		10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.1%	10.1%	10.1%
Percent of Allowed Benefit Cost Paid by Member	24%	24%	23%	23%	23%	22%	22%	21%	21%	20%
Annual Benefit Cost Per Member	\$1,366	\$1,512	\$1,673	\$1,851	\$2,049	\$2,268	\$2,510	\$2,780	\$3,080	\$3,414
Member Annual Premium [5]	\$275	\$275	\$275	\$275	\$275	\$275	\$275	\$275	\$275	\$275
Annual Net Cost After Member Premium	\$1,091	\$1,237	\$1,398	\$1,576	\$1,774	\$1,993	\$2,235	\$2,505	\$2,805	\$3,139
Annual Cost of Rx Program (in millions)	\$43,589	\$50,050	\$57,306	\$65,559	\$75,104	\$86,172	\$98,720	\$112,827	\$129,334	\$149,147
Cumulative Cost of Rx Program (in millions)	\$43,589	\$93,639	\$150,945	\$216,504	\$291,608	\$377,780	\$476,500	\$589,327	\$718,661	\$867,807

[1] Source: CMS enrollment statistics for Part A.

[2] No breakdown between Fee-for-service Medicare and M+C has been made since it is assumed that similar funding would be provided to any members in the M+C program.

We have also assumed that all eligibles will enroll in the program (i.e. mandatory enrollment) and that adverse selection will not take place.

[3] Based on pricing of benefits using Reden & Ander's Prescription Drug Pricing Model. Reflect costs after discount from AWP and dispensing fees.

[4] Trend assumptions as of 2003 are projected to apply for the entire time period.

[5] Adjusted to reflect less than 12 months of exposure.

**House Bill 1199 Plan Design (Scenario 26):**

\$ 25 member premium  
\$100 deductible, then 20% coinsurance  
\$2,000 maximum out-of-pocket

**Exhibit G**  
**Society of Actuaries Medicare Pharmacy Study**  
**Example for Estimating Varying Trend**

	2003	2004	2005
Baseline Values from Exhibit E			
1. Allowed Cost PMPM	\$150.64	\$176.64	\$207.20
2. % Paid by Member	47.0%	46.2%	46.1%
3. Benefit Plan Factor (100% - 2.)	53.0%	53.8%	53.9%
4. Cumulative Trend Factor	1.000	1.173	1.375
5. Eligibles in Rx Program	39,937	40,457	40,983
Revised Assumptions			
6. Annual Trend Rate		8.5%	8.5%
7. Cumulative Trend Factor	1.000	1.085	1.177
8. Benefit Plan Factor [1]	53.0%	53.5%	53.7%
New Values			
9. Allowed Cost PMPM (1. x (7./4.))	\$150.64	\$163.44	\$177.34
10. Net Plan Payment (8. x 9.)	\$79.77	\$87.44	\$95.23
Annual Benefit Cost Per Member	\$957	\$1,049	\$1,143
Annual Cost of Rx Program (in millions)	\$38,230	\$42,452	\$46,834
Cumulative Cost of Rx Program (in millions)	\$38,230	\$80,681	\$127,515

[1] This is a somewhat subjective adjustment. A plan design like this one (based on copays) indicates that the factor should increase over time; however, the Catastrophic Coverage threshold caps the member's total cost. Base on Exhibit E, these two opposing effects result in a steady relationship between the plan's and member's costs until 2012 and 2013, so a lower trend would prolong that steady relationship into additional years.

**Exhibit H**  
**Society of Actuaries Medicare Pharmacy Study**  
**Example for Estimating Rebate Value**

	2003	2004	2005
Baseline Values from Exhibit E			
1. Allowed Cost PMPM	\$150.64	\$176.64	\$207.20
2. Net Plan Payment	\$79.77	\$94.96	\$111.62
3. Eligibles in Rx Program	39,937	40,457	40,983
Estimated Value of Rebates			
4. As % of Allowed Cost PMPM	4.0%	4.0%	4.0%
5. Cost Reduction via Rebates	\$6.03	\$7.07	\$8.29
New Values			
6. Net Plan Payment (2. - 5.)	\$73.74	\$87.89	\$103.33
Annual Benefit Cost Per Member	\$885	\$1,055	\$1,240
Annual Cost of Rx Program (in millions)	\$35,342	\$42,671	\$50,818
Cumulative Cost of Rx Program (in millions)	\$35,342	\$78,013	\$128,831

Note: Refer to report for discussion of assumptions/limitations.

6/11/2003

**Exhibit I**  
**Society of Actuaries Medicare Pharmacy Study**  
**Example for Estimating Varying Generic Usage**

	2003	2004	2005
Baseline Values from Exhibit E [1]			
1. Allowed Cost PMPM	\$150.64	\$176.64	\$207.20
2. Net Plan Payment	\$79.77	\$94.96	\$111.62
3. Eligibles in Rx Program	39,937	40,457	40,983
Alternate Generic/Brand Distribution [2]			
4. Utilization/1,000	38,338	41,022	43,893
5a. Generic Mix	30%	35%	40%
5b. Brand Mix	70%	65%	60%
6a. Generic Allowed \$/Script	\$21.85	\$24.04	\$26.44
6b. Brand Allowed \$/Script	\$69.16	\$76.08	\$83.68
New Values [3]			
7. Allowed PMPM (4. x 5a. x 6a. + 4. x 5b. x 6b.)/12000)	\$175.61	\$197.80	\$222.34
8. Benefit Plan Factor (2. / 1.)	0.530	0.538	0.539
9. Net Plan Payment (7. x 8.)	\$92.99	\$106.33	\$119.78
Annual Benefit Cost Per Member	\$1,116	\$1,276	\$1,437
Annual Cost of Rx Program (in millions)	\$44,567	\$51,624	\$58,905
Cumulative Cost of Rx Program (in millions)	\$44,567	\$96,190	\$155,095

- [1] The baseline projection has total utilization of 38,338 for an unlimited benefit, and a generic/brand mix of 46.5%/53.5% (derived per Exhibit C.1).
- [2] Allowed cost per script figures are derived from Exhibit C.1. Utilization and cost trends use the baseline assumptions (7% and 10%, respectively). The only change from baseline is the relative mix of generic and brand name.
- [3] Assumes the Generic and Brand Allowed \$/Script are the same for both the baseline projection and the revised generic/brand name projection.

**Exhibit J**  
**Society of Actuaries Medicare Pharmacy Study**  
**List of Top 50 Brand Tier 2 Drugs by Allowed Amount**

Drug Name	Percent of Brand Tier 2 Utilization	Percent of Brand Tier 2 Allowed
ZOCOR	10.4%	15.7%
CELEBREX	9.8%	13.8%
PRILOSEC	5.9%	9.7%
PRINIVIL	16.4%	6.2%
OXANDRIN	0.0%	2.5%
COZAAR	3.5%	1.9%
PROCRIT	0.2%	1.9%
ULTRAM	1.8%	1.8%
CASODEX	0.4%	1.6%
MEGACE	0.4%	1.6%
PEPCID	0.9%	1.5%
DITROPAN XL	1.3%	1.5%
TAMOXIFEN CITRATE	1.9%	1.4%
HYZAAR	2.3%	1.2%
PRINZIDE	2.7%	1.1%
RELAFEN	0.8%	1.1%
PLENDIL	2.5%	1.1%
PLETAL	1.0%	1.1%
OCUFLOX	0.8%	1.0%
AXID	0.4%	0.8%
SEROQUEL	0.5%	0.8%
MIRAPEX	0.4%	0.8%
DEMADEX	1.4%	0.7%
ELOCON	0.7%	0.7%
LESCOL	1.5%	0.7%

Drug Name	Percent of Brand Tier 2 Utilization	Percent of Brand Tier 2 Allowed
FAMVIR	0.2%	0.7%
TIAZAC	1.1%	0.6%
AZMACORT	0.6%	0.6%
TRUSOPT	1.0%	0.6%
EPOGEN	0.0%	0.5%
DOVONEX	0.2%	0.5%
DIPROLENE AF	0.3%	0.5%
NASACORT AQ	0.4%	0.4%
AGRYLIN	0.1%	0.4%
ARTHROTEC 75	0.3%	0.4%
REQUIP	0.3%	0.4%
SINEMET CR	0.2%	0.4%
NITRO-DUR	0.5%	0.4%
NULYTELY	0.4%	0.3%
PERMAX	0.1%	0.3%
MEVACOR	0.3%	0.3%
ATACAND	0.7%	0.3%
EULEXIN	0.1%	0.3%
XOPENEX	0.1%	0.3%
ZANAFLEX	0.2%	0.3%
BLEPHAMIDE	0.2%	0.3%
MIRALAX	0.4%	0.2%
THEO-DUR	0.8%	0.2%
ZANTAC	0.1%	0.2%
DIPROLENE	0.1%	0.2%
Total	76.4%	81.9%

Note: Refer to report for discussion of assumptions/limitations.

6/11/2003