PRESCRIPTION DRUGS FOR SENIORS:
What You Need to Know

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PRESCRIPTION DRUGS FOR SENIORS: What You Need to Know

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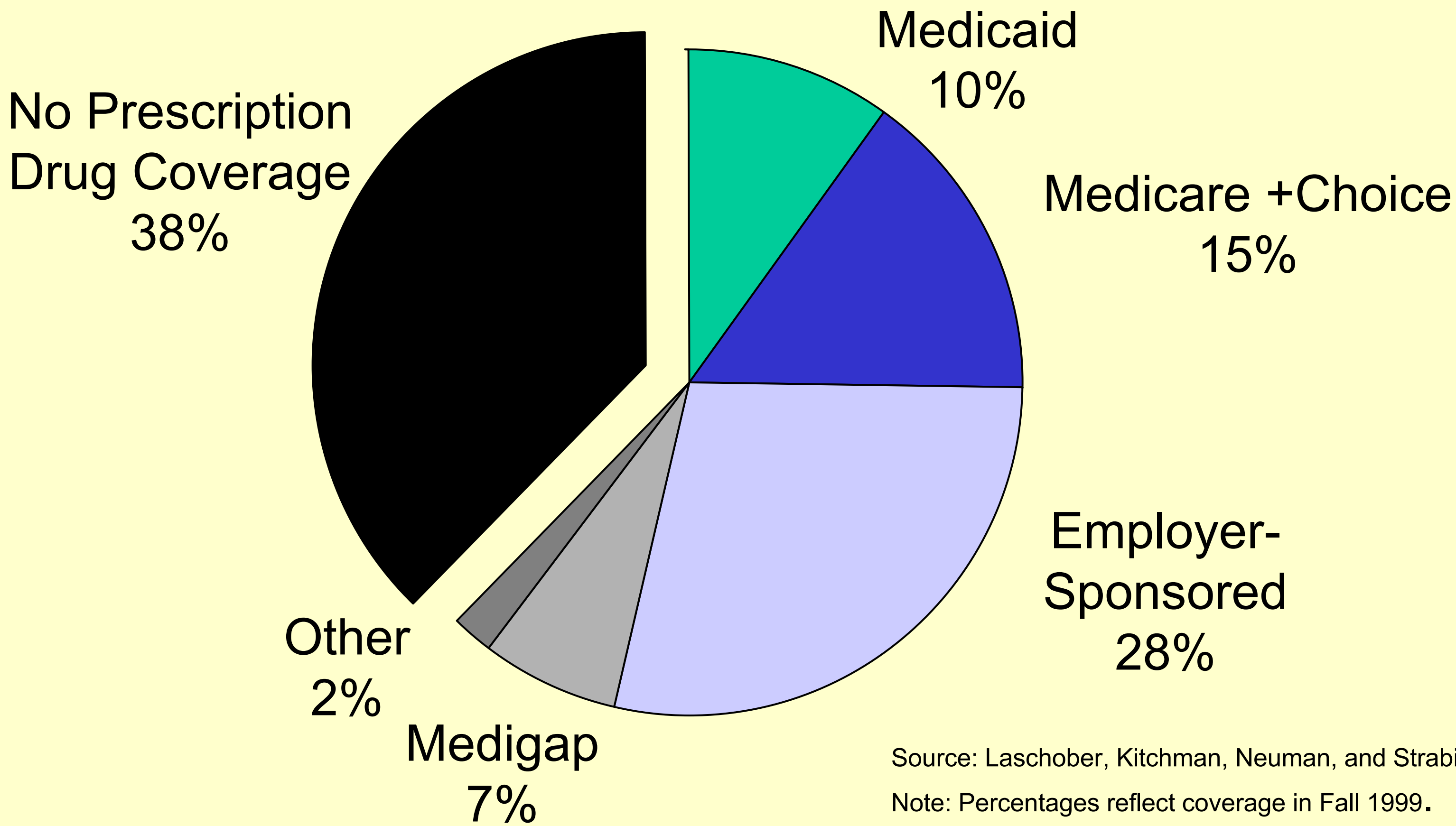
38% of Medicare Beneficiaries Have No Rx Coverage at a Point in Time



Source: Laschober, Kitchman, Neuman, and Strabic (2002)

Note: Percentages reflect coverage in Fall 1999.

Rx Spending Will Outpace Medicare Spending

	2003	2012	Annual Growth
Rx Spending per Enrollee			
Mean	2,440	5,820	10.1%
Median	1,460	3,490	10.2%
Medicare Spending per Enrollee			
Mean	6,585	10,631	5.5%

Source: CBO (2002)

Note: Rx spending per enrollee excludes costs covered by Medicare

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Discussion Topics

- Drug utilization management mechanisms
- Formularies/rebates
- Network access
- Consumer card

Drug Utilization Management Mechanisms

- Online DUR
- Prior authorization
- Managed drug limitations
- Step therapies
- Academic detailing
- Pharmacy case management

Drug Utilization Management Mechanisms

- Online service
  - Basic/concurrent DUR
  - Refill too soon
  - Eligibility
  - Drug/drug interaction
  - Performed electronically at point of sale (at the pharmacy)
  - Systematic edits
  - Can save up to 4% of drug spend

Drug Utilization Management Mechanisms

- Prior authorization
  - Generally reserved for expensive drugs that have potential for excessive use or misuse.
  - Must have clinical criteria available to determine appropriateness of therapy.
  - Physician must call or fax to get authorization for patient to receive prescription based on clinical criteria.
  - Depending on which drugs PA is implemented, savings could be from 1 - 2%.

Drug Utilization Management Mechanisms

- Managed drug limitations
  - Restricts quantity of drug received across time or per fill.
  - Appropriate for therapy where potential for excessive use exists that can effect either cost or clinical outcomes.
  - Rationale must exist for quantity restrictions.
  - Example 1: FDA guidelines may be for therapy to last 120 days, so quantity is limited to 120 days of therapy.
  - Example 2: Guidelines may be for 30 or 60 tabs in one month, so quantity is limited to appropriate number for monthly fill.
  - Depending on which drugs MDL is implemented, savings could be from 1 - 2%.

Drug Utilization Management Mechanisms

- Step therapy
  - Requires use of drug A before drug B.
  - Manages cost perspective when traditional therapy is significantly more cost-effective than newer therapies AND new therapies offer minimal to no additional clinical benefit.
  - Depending on which classes are implemented, savings could be from 1 - 3%.

Drug Utilization Management Mechanisms

- Academic detailing
  - Need to focus on key opportunities
  - Up against 60,000 detailers going after 250,000 providers
- Pharmacy case management
  - Tie to disease management and medical case management
  - Poly pharmacy situations
  - Drug-specific compliance programs

Formularies/Rebates

- Formulary design
  - Open formulary - All drugs available with no incentive to choose one over the other.
  - Closed formulary - Limited list of drugs available.
  - Incentive-based formulary - Plan design or other member cost share incentive to encourage member to select either preferred brand name products or generics.

Formularies/Rebates

- Therapeutic interchange programs
  - With pharmacist assistance and patient and physician approval, switch patient to a more cost effective and as clinically effective product.
  - Can save up to 3%.

Formularies/Rebates

- Generic incentive programs
  - Through plan design
  - Through pharmacist intervention
- Rebates
  - Manufacturer pricing strategies for AWP and rebate
  - Higher rebates are driven by ability to influence market share
  - Preferred products should be based on combination of the following resulting in the lowest net cost in the therapeutic class:
    - Actual price
    - Rebates
    - Clinical efficacy
  - Usually represents approximately 1 - 5% of total drug spend.

Network Access

- Network Contracting
  - Discounts from AWP pricing
  - MAC pricing
  - Therapeutic MACs
  - Performance contracts
  - Mail order (and legislative constraints)
  - Pharmacy auditing
  - Penalties for out-of-network usage

Consumer Card

- Generally available in the marketplace to all consumers.
- Seniors are heaviest utilizers.
- NOT AN INSURANCE PLAN.
- Provides discounts at the point of sale.
- Some cards provide for sharing of manufacturer rebates.

Consumer Card

- Pharmacy discount often bundled with other discounts (vision, dental, etc.).
- Charges to consumers for enrolling in a consumer card program vary widely.
- Manufacturer-sponsored cards are patient-in-need programs for specific products.
- PBM/other cards usually provide for unlimited use.
- Savings are real and can be substantial for some patients.

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Premium and Delivery System Considerations

- Predicting premiums
  - Plan design: what is covered?
  - Adverse selection: who is covered?
  - Trend estimates: per capita costs
  - Induced demand
- Delivery system
  - Single payor model
  - Competitive model
- Other considerations

Predicting Premiums --Plan Design: What is Covered?--

- First dollar coverage or after a deductible?
- Copays or coinsurance?
- Maximum annual coverage?
- Use of “allowance” payments towards any drug purchase?
- Stop-loss out-of-pocket payment protection?
- All drugs available or only those on a formulary?
- Are there cost-sharing incentives, such as tiered copays, to use less costly drugs?

Predicting Premiums
--Adverse Selection: Who is Covered?--

- Voluntary -- how many seniors will pay a premium?
- “Near Universal” -- will nearly all seniors participate?

Predicting Premiums --Adverse Selection: Who is Covered?--

- **Key factor: Rx use by seniors is <u>very predictable</u> and only high users will join a voluntary program without a sufficient subsidy.**
  – One model shows that compared to a near universal program, premiums could be 57% higher in a voluntary program that enrolls mainly high-use beneficiaries (i.e., the three highest-use quintiles).
  – Two lowest-use quintiles average only about $150 per year in costs, while the total average is approximately $1200 (for one group of M+C seniors with full drug benefits).

Predicting Premiums
-Trend Estimates of Per Capita Costs?-

- Rx costs for under-65 members are rising at 20-25% per year and will double every 3 years. If a Rx program is in place, will a senior program see the same trend level?
- Direct-to-consumer advertising continues, but seniors are already high users. Will they consume more?

Predicting Premiums -Trend Estimates of Per Capita Costs?-

- More drugs will "go generic" in future years and the pipeline appears to have fewer "blockbuster" drugs. Will this translate into a trend reduction?
- More research on gene therapy may increase efficacy and costs. What effect will this have on trend and how soon?
- Cost per script increased for all categories (including generics) at a high rate in 2001. How long will this continue?

Predicting Premiums --Induced Demand--

- "Induced demand" is the increase in consumption that results from presence of insurance coverage.
- Although approximately 2/3 of seniors have some coverage:
  - Employers are rapidly shrinking retiree Rx benefits.
  - Medigap plans H, I and J only cover 50% of costs and only up to a maximum.
  - M+C contracts have been reducing Rx coverage in reaction to very low increases in revenue (most at 2% per year).

Predicting Premiums --Induced Demand--

- For the non-insured, some analysts use a 100% factor (i.e., drug usage will double in the presence of comprehensive coverage).
- For those who would receive improved coverage, there may be more usage and a switch to more expensive brand drugs.

Delivery System
--Single Payor Model--

- A single organization would administer the program in a defined region (e.g., a state):
  - A single formulary would need to be determined.
  - Competition could be for an annual (more likely, longer term) contract and different regions would have different administrators.
  - Less worry about adverse selection (other than for overall funding estimates).

Delivery System
--Single Payor Model--

- Payment could be "at risk" or "cost-plus" through an intermediary:
  - "At risk" contract would require the organization to fund any deficits or to retain any gains.
  - "Cost-plus" contract would likely have service performance guarantees, but the organization would not be "at risk" for funding.

Delivery System
--Competitive Model--

- In a competitive model, several organizations would win bids to provide Rx benefits:
  - No formulary decision necessary, since each organization could construct and market its own version.
  - Service and benefits might drive enrollment decisions.
  - A practical and effective risk adjustor would be required.

Delivery System --Competitive Model--

- Contracts would likely be "at risk" contracts:
  - Each organization would need to produce its own cost estimates.
  - The government would need to set a reference premium that it would be willing to pay to each organization.

Complex Premium Environment --Other Considerations--

- Too much risk might deter possible bidders:
  - A single state may have 1 million Medicare beneficiaries; with a likely premium of just $50 per month, a 10% variance (i.e., $5 per month) could cause a loss of $60 million for a contractor.
  - Recent catastrophes may have reduced reinsurance capacity across the globe.

Complex Premium Environment --Other Considerations--

- Other strategies may be available:
  - Risk corridors which share risk between a contractor and the federal government would reduce the amount of risk.
  - Cost contracts (i.e., cost-plus based contracts) at the start may provide necessary data and experience, while providing a potential reward for the most effective contractors.

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