PRESCRIPTION DRUGS FOR SENIORS: What You Need to Know

A Luncheon Briefing sponsored by
The American Academy of Actuaries
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

No Prescription Drug Coverage 38%

Medicaid 10%

Medicare +Choice 15%

Employer-Sponsored 28%

Medigap 7%

Other 2%

Note: Percentages reflect coverage in Fall 1999.
### Rx Spending Will Outpace Medicare Spending

<table>
<thead>
<tr>
<th></th>
<th>2003</th>
<th>2012</th>
<th>Annual Growth</th>
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<tbody>
<tr>
<td><strong>Rx Spending per Enrollee</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Mean</td>
<td>2,440</td>
<td>5,820</td>
<td>10.1%</td>
</tr>
<tr>
<td>Median</td>
<td>1,460</td>
<td>3,490</td>
<td>10.2%</td>
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<tr>
<td><strong>Medicare Spending per Enrollee</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Mean</td>
<td>6,585</td>
<td>10,631</td>
<td>5.5%</td>
</tr>
</tbody>
</table>

Source: CBO (2002)

Note: Rx spending per enrollee excludes costs covered by Medicare
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Margaret Wear, A.S.A., M.A.A.A
Vice President and Chief Actuary, AdvancePCS
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.
PRESCRIPTION DRUGS FOR SENIORS:
What You Need to Know

John Bertko, F.S.A., M.A.A.A
Vice President and Chief Actuary, Humana Inc.
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 very predictable 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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