

## 2003 Segal State Health Benefits Survey: Prescription Drug Coverage for Employees and Retirees

Coping with the high and rising cost of prescription coverage continues to be a challenge for all plan sponsors, including those in the public sector. This report of data from the 2003 *Segal State Health Benefits Survey*,<sup>1</sup> the second in a series,<sup>2</sup> focuses on prescription drug coverage for state employees and retirees. The map graph shows the number of employees and retirees enrolled in participating states' drug plans by region.

### PLAN DESIGN

Survey findings about plan design include the following:

- Two-thirds of all states reported the use of a three-tier copayment plan design.<sup>3</sup>
- The use of deductibles as a cost-sharing feature was relatively low, at 8 percent for active employee plans and 11 percent for retiree plans.
- Eighteen percent of state plans offered a percentage copayment plan design

(e.g., coinsurance) instead of a flat-dollar copayment structure.

- Over one-quarter of all states capped employee out-of-pocket expenses for prescription drugs.

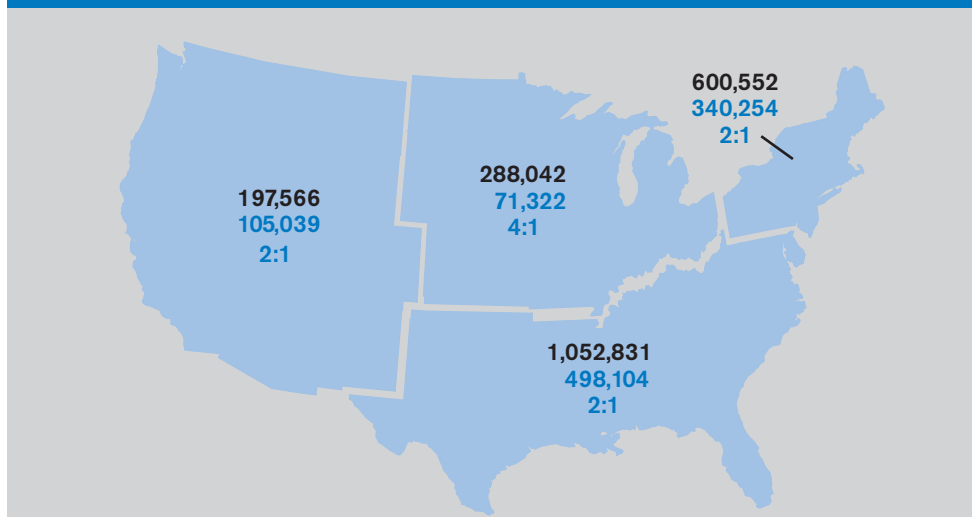
Table 1, on page 2, presents data on plan design features.

States encourage use of formulary drugs through plan design. Seventy-one percent of states participating in the survey used an incentive-based formulary, in which a participant's cost reflects whether the brand drug is included in the plan's formulary, for employees. Twenty-nine percent of the states in the survey used an open formulary. None of the states partici-



pating in the survey reported use of a closed formulary, a tightly controlled design that excludes off-formulary drugs from coverage. See Graph 2 on page 2.

Graph 1: Number of Employees and Retirees Enrolled in Participating States' Drug Plans and the Employee-to-Retiree Ratio by Region\*



Key: Numbers of employees are shown in black.  
Numbers of retirees are shown in blue.  
The employee-to-retiree ratios are also shown in blue.\*\*

<sup>1</sup> In 2003, The Segal Company surveyed all 50 states, after collecting information available on state Web sites and requesting enrollment packages from each state (steps that were taken to streamline the survey process for participating jurisdictions). Thirty-nine states provided their enrollment packages and 34 states completed all or portions of the survey questionnaire. The 2003 *Segal State Health Benefits Survey* covers more than 80 percent of total state health plan enrollment. Together, the participating states provide health benefits for more than three million employees and retirees.

<sup>2</sup> The first report in the series, 2003 *Segal State Health Benefits Survey: Medical Benefits for Employees and Retirees*, is available in PDF format on the following page of the Segal Web site: [http://www.segalco.com/publications/surveysandstudies/2003statesurvey\\_medicalbenefits.pdf](http://www.segalco.com/publications/surveysandstudies/2003statesurvey_medicalbenefits.pdf)

<sup>3</sup> Three-tiered formularies require the lowest copayment for generic drugs, a higher copayment for formulary brand name drugs and the highest copayment for off-formulary brand name drugs.

\*The regional breakdown of the survey data follows the regional breakdown used by the U.S. Census Bureau. Among states in Northeast, MA, ME, NJ, NY, PA and VT participated in the survey and provided information about prescription drug coverage. Among states in the South, AL, FL, GA, KY, MS, OK, SC, TN, TX and VA participated in the survey and provided information about prescription drug coverage. Among states in the Midwest, IA, KS, MI, MN, MO, NE, ND, OH and WI participated in the survey and provided information about prescription drug coverage. Among states in the West, AK, CA, CO, ID, NM, OR, UT and WY participated in the survey and provided information about prescription drug coverage.

\*\* The employee-to-retiree ratios reflect rounding.

Segal State Health Benefits Survey: Prescription Drug Coverage

**Table 1: Prescription Drug Plan Design Features: Deductibles, Copayments and Out-of-Pocket Maximums**

Plan Design Features	Employees		Retirees	
	Number of States Offering	Percentage of States Offering*	Number of States Offering	Percentage of States Offering*
Plans with Deductibles	3	8%	3	11%
Plans with Percentage Copayments**	7	18%	3	11%
Plans with Out-of-Pocket Maximums	10	26%	4	14%

\* This is the percentage of all participating states that provided information about prescription drug coverage.  
 \*\* Percentage copayment plans may include plans with minimum and maximum copayment levels.

**Average Copayment Amounts**

Under three-tier plans, retail copayments for employees averaged \$19 for brand drugs<sup>4</sup> and \$8 for generic drugs, as shown in Table 2. Copayments under two-tier designs were slightly lower.

Mail order copayments, adjusted to reflect a 90-day supply, approached two times the retail copayment for up to a 30-day supply on a national average basis.

<sup>4</sup> This statistic only represents brand drugs that are listed in a formulary (*i.e.*, brand name drugs not listed in a formulary are excluded).

Non-preferred prescription copayments for participants averaged \$34 at retail pharmacies and \$61 for mail order.

Average retiree copayment amounts did not dramatically differ from employee amounts.

**Regional Plan Design Data**

The use of three-tier plan designs varied dramatically by region, as illustrated in Graph 3 on page 3. States in the West had the highest prevalence (90 percent) of three-tier copayment plan designs. In contrast, Northeast states were still predominantly two-tier designs. Only 14

percent of the Northeast states offered a three-tier copayment design.

States in the West required the highest copayment amounts. Northeast states typically required the lowest copayment amounts and had the lowest differential in copayments between retail and mail order plans.

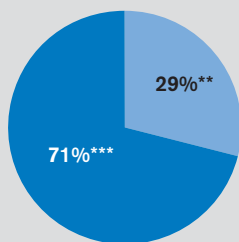
**State-Specific Plan Design Data**

Interesting state-specific findings about prescription drug plan design include the following:

- Alabama, Georgia, Idaho and North Dakota indicated that they did not offer a mail order option.<sup>5</sup>
- Pennsylvania and Virginia required participants to pay a copayment plus the differential between the cost of a brand and a generic drug when a brand drug is dispensed and a therapeutic equivalent generic drug is available.
- Three states — Alabama, Mississippi and Vermont — reported a front-end

<sup>5</sup> In some states, legislation may prevent the use of mail order drugs.

**Graph 2: Percentage of States Using Open and Incentive Formulary Types for Employees\***



Key: ■ Open Formulary ■ Incentive Formulary

\* This is the percentage of all participating states that provided information about prescription drug coverage.  
 \*\* Used by 10 states.  
 \*\*\* Used by 25 states.

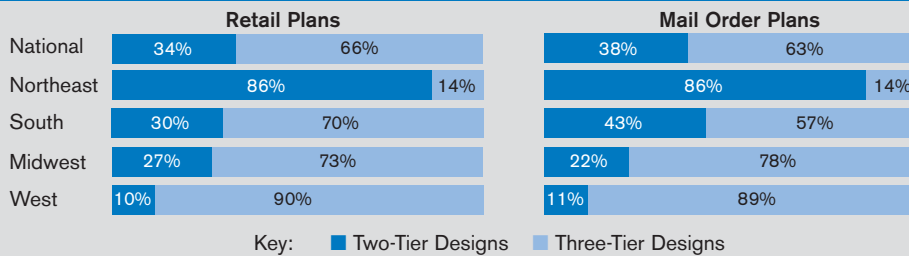
Additional notes about this survey data: Three states did not indicate which type of formulary they use for employees. The open-incentive breakdown was very similar for retirees (30 percent and 70 percent). None of the states participating in the survey reported use of a closed formulary for employees or retirees.

**Table 2: Average Copayments for Prescription Drugs for State Employees and Retirees**

	Three-Tier Design										
	Two-Tier Design				Retail			Mail Order			
	Retail		Mail Order		Generic Formulary	Non-Formulary	Generic Formulary	Non-Formulary	Generic Formulary	Non-Formulary	
	Generic	Brand	Generic	Brand							Brand
<b>Employees</b>	National	\$7	\$15	\$10	\$19	\$8	\$19	\$34	\$15	\$35	\$61
	Northeast	\$5	\$10	\$6	\$11	\$7	\$20	\$40	\$7	\$20	\$40
	South	\$7	\$17	\$13	\$33	\$7	\$19	\$33	\$15	\$38	\$63
	Midwest	\$8	\$19	\$20	\$23	\$8	\$16	\$28	\$15	\$28	\$48
	West	N/A*	N/A*	\$8	\$20	\$10	\$21	\$39	\$16	\$41	\$73
<b>Retirees</b>	National	\$8	\$16	\$12	\$20	\$8	\$17	\$33	\$13	\$29	\$50
	Northeast	\$7	\$14	\$10	\$17	\$6	\$16	\$31	\$6	\$18	\$33
	South	\$7	\$17	\$13	\$33	\$7	\$18	\$33	\$15	\$38	\$63
	Midwest	\$10	\$20	\$20	\$23	\$8	\$17	\$30	\$15	\$28	\$49
	West	\$4	\$8	0	0	\$9	\$18	\$35	\$13	\$25	\$48

\*\*N/A\* stands for not applicable. All plans in the West reported three-tier plan designs only.

**Graph 3: Prevalence of Two- and Three-Tier Designs in Retail and Mail Order Prescription Drug Plans Nationally and by Region\***



\*The retail and mail order percentages within a region may differ because some states in the region did not report offering a mail order option. Percentages may not total 100% due to rounding.

deductible provision in addition to the requirement of cost sharing through coinsurance or copayments.

- Ten states capped participant cost sharing with an out-of-pocket limit. Iowa, Minnesota, New Jersey and Wisconsin had an out-of-pocket limit of \$300 or less. Tennessee’s limit was \$720. California, Kansas, Louisiana and South Carolina had an out-of-pocket limit of \$1,000 or more.
- Of the seven states that offered a percentage copayment drug program (*i.e.*, a coinsurance plan), four plans — Alaska, Georgia, New Mexico and Vermont — included a minimum and/or maximum copayment feature.

**UTILIZATION**

On average, for the states participating in the survey, nearly 24 prescriptions were dispensed per participant in 2002.<sup>6</sup> This utilization level is six percentage points lower than Segal’s private-sector client benchmarks, adjusting for the same mix of actives and retirees.

The retail generic dispensing rate (*i.e.*, the percentage of all prescriptions filled that were for generic drugs) for 2002 averaged 39 percent for the participating states. See Table 3. This was slightly below the private sector average of 45 percent.<sup>7</sup>

<sup>6</sup> An employee-retiree breakdown is not available.

<sup>7</sup> The private sector average is from the *Medco Health 2003 Drug Trend Report*, which is cited with permission.

**State-Specific Utilization Data**

The survey found utilization differences by state. Examples include the following:

- In Ohio and Vermont, over half of total paid claims were spent on mail order drugs.
- Generic dispensing rates ranged widely, from 32 percent in New Jersey to 52 percent in Ohio.

**COSTS**

The overall average, annual, per employee/retiree cost (paid claims net of copayments) for prescription drug coverage was \$1,288 in 2002. This is approximately 6.5 percent

higher than average annual paid claims reported by several leading pharmacy benefit managers (PBMs),<sup>8</sup> adjusting for the mix of the employee (74 percent) and retiree (26 percent) populations of the states participating in the survey.

Table 4, below, presents a summary of findings on the costs of retail and mail order prescription drugs.

**Contract Terms with PBMs**

Participating states reported PBM financial terms (*i.e.*, discounts, rebates, dispensing fees) that are generally consistent with the levels provided to other large employers. However, individual states’ financial terms varied dramatically. For example, there was a three percentage-point difference in retail brand discounts between the lowest and highest reported discounts and more than a 20 percentage-point difference in the discount reported for retail generic drugs. See Table 5 on the last page.

**Cost Management Strategies**

The 2003 *Segal State Health Benefits Survey* asked states about the cost management programs currently in place. A large majority (72 percent) of participating states required prescription drug prior authorization for certain listed high-cost drugs. Almost half (47 percent) of participating states used prescription drug clinical intervention where a pharmacist contacts the

<sup>8</sup> Benchmarks include an average of data published in the following PBM surveys: *Medco Health 2003 Drug Trend Report*, *Novartis Pharmacy Benefit Report: 2003 Facts & Figures* and *Benefits Barometer 2003*, produced by AdvancePCS and *Employee Benefit News*, all of which are cited with permission.

**Table 3: Prescription Drug Utilization**

	Retail	Mail Order	Total
Average Generic Dispensing Rate	39%	29%	N/A
Average Number of Prescriptions*	20.17	2.88	23.59
Percentage of Total Prescriptions	88%	12%	100%

\* Results are based on a combination of the employee and retiree populations.

**Table 4: Prescription Drug Costs**

	Retail		Mail Order		Total
	Generic	Brand	Generic	Brand	
Average Cost Per Prescription*	\$16	\$65	\$42	\$156	\$56
Average Cost Per Employee and Retiree	\$129	\$771	\$29	\$360	\$1,289
Percentage of Total Cost	10%	60%	2%	28%	100%

\* Results are based on a combination of the employee and retiree populations.

Table 5: Contract Terms with PBMs

	Retail		Mail Order		Total
	Generic	Brand	Generic	Brand	
Median Discount from Average Wholesale Price	50%	14%	50%	21%	19%
Average Dispensing Fees Per Prescription	\$2.49	\$2.26	\$0.92	\$0.95	\$2.22
	Retail Composite		Mail Order Composite		
Average Formulary Rebate Per Prescription	\$2.05		\$2.89		\$2.12

participant and/or prescribing physician to encourage that the prescription be changed to a more cost-effective drug.

**COMMENTARY AND OUTLOOK**

High increases in the costs of prescription drug coverage are expected to continue this year. The 2004 *Segal Health Plan Cost Trend Survey* reports that retail prescription drug costs are expected to increase by 18.1 percent and mail order prescription drug costs are expected to increase by 17.4 percent in 2004 for active employees and retirees under age 65. Although the expected increase is slightly less than for 2003, at these double-digit rates of increase, the cost of prescription drug plans may be expected to double within only five years.<sup>9</sup>

The following emerging issues could contribute to escalating prescription drug costs:

- **Increased Utilization of Expensive Specialty Drugs** Plan sponsors may need to pay particular attention to managing the cost of specialty drugs, such as injectibles, which are often costly and may currently be handled outside of traditional PBM contracts (*i.e.*, covered under the medical plan).
- **Continued Spending on Direct-to-Consumer Advertisements** Continued focus on direct-to-consumer advertising by pharmaceutical

companies for their newest, often most expensive drugs is designed to create additional participant demand for the brand name drugs even in cases where therapeutically effective alternatives are available at a lower cost.

- **An Aging Workforce** As the workforce ages, utilization of and demand for prescription drugs increases.

On the other hand, different developments may help dampen prescription drug benefit cost increases. Examples include:

- **The New Medicare Prescription Drug Benefit** The new Medicare prescription drug benefit may allow employers to review their retiree prescription drug coverage and integrate retiree health benefits for current and future retirees with the new Medicare Part D coverage.
- **Federal Upper Limits (FUL) on the Pricing of Prescription Drugs** PBM contracts that are based on FUL pricing — rather than average wholesale price (AWP) or maximum allowable charge (MAC) pricing — can help to assure competitive prescription drug plans for employees and retirees.
- **Increased Competition for Market Share from Generic Drugs** Patent expirations should help generic drugs get to market quickly.

**TAKING ACTION**

State governments need to remain active in the battle to bring the cost of prescription drug benefits down

to sustainable levels. Managing to slow cost increases to single-digit levels will likely require efforts to prevent diseases, improve the management of chronic diseases, negotiate optimal pricing terms for medications and introduce plan provisions that encourage greater price competition and more rational utilization. Important elements in this effort include careful plan design, frequent program updates, competitive procurement and insightful communications.



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<sup>9</sup> See the 2004 *Segal Health Plan Cost Trend Survey*, which is available, in PDF format, on the following page of Segal's Web site: <http://www.segalco.com/publications/surveysandstudies/2004trendsurvey.pdf>