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■ ■ *PHARMACY BENEFIT GUIDE* ■
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2003

EXPRESS SCRIPTS DRUG TREND REPORT

Plan Design: A Stepwise Approach To Trend Management

Over the past 10 years, Express Scripts has conducted more than 100 research studies on how members of prescription drug plans use prescription drugs and what factors change the patterns of prescription use. This research base is used by Express Scripts to evaluate existing plans and recommend new plan designs or service offerings. From it, Express Scripts has established an evidence-based approach to manage pharmacy benefits. This section outlines both the approach recommended by Express Scripts and the research findings that underlie it.

The Big Picture

Developing a plan design that is effective at long-term drug trend management involves five key steps:

1. **Selection of a formulary.** A range of formularies is available to meet the varying needs of plan sponsors.
2. **Incorporation of guiding principles for plan design.** Quality, equity and member understanding are three important considerations in plan design.
3. **Selection of a cost-sharing structure.** Research has provided much evidence about the economic and clinical impact of various cost-sharing and plan-design options.
4. **Selection of point-of-service programs (e.g., step therapy).** Recent research provides compelling data about the value of point-of-service programs.
5. **Incorporation of the emerging strategy: Consumer-driven plan design.** Today's consumers are interested in learning about plan decisions and the logic behind them.

Step 1: Formulary Development: The Backbone of Effective Trend Management

Drug formularies form the backbone for optimizing physician prescribing and patient drug-utilization patterns. A well-designed formulary ensures that the most clinically sound and cost-effective therapy is selected for each patient. Benefit designs, such as a three-tier formulary, maximize the use of cost-effective formulary drugs. However, the selection of which drugs to promote will have the biggest impact on a plan's long-term costs.

Developing an effective formulary involves the selection of individual drugs that provide the best clinical benefit at the best cost. Using the Generic Product Identifier (GPI) codes, maintained by the Facts and Comparisons division of Wolters Kluwer Health, Inc., Express Scripts begins formulary analysis with 99 broad therapy classes, or groupings of drugs with similar chemical structures and comparable activity against specific conditions. Each of these therapy classes, such as antidepressants or antihyperlipidemics, is further divided into subclasses (e.g., statins, fibric acid derivatives, bile acid sequestrants and nicotinic acid derivatives for antihyperlipidemic drugs) and then into individual drug products. By evaluating each drug within its therapy class for safety, efficacy, toxicity, patient convenience and overall cost, Express Scripts clinicians select the most cost-effective agents for formulary inclusion.

Express Scripts uses four analytic steps to select the formulary drugs within each therapy class:

1. **Assess clinical benefit.** Through careful analysis of published literature, drugs within each therapy class are ranked according to the relative ability of each individual agent to achieve the goal of therapy. Attributes such as side-effect profiles, potential toxicities and drug interactions are used to distinguish among the agents. The Express Scripts National Pharmacy and Therapeutics (P&T) Committee, a group of practicing physicians who are not employed by Express Scripts, makes the final decision on whether each drug should be included on the formulary. P&T Committee members do not consider cost when determining clinical benefit.
2. **Consider cost.** Because agents within a therapy class usually have different average wholesale price (AWP) costs, however, accounting for cost differences allows formulary selection when drugs are equal in benefit. Lower-cost drugs are selected only when their clinical benefits have been established as equal to or better than other agents in the class for a substantial group of patients. Formulary drugs may actually be higher in cost than other drugs in the class when their clinical benefits are superior to the lower-cost drugs.
3. **Account for market share.** A drug's market share is important to consider for two reasons. Eliminating a widely-used drug (e.g., one with a high market share) from the formulary may create unacceptable levels of disruption among physicians, patients and pharmacies. In addition, market-share considerations may have a significant impact on total costs for the therapy class. For instance, if drugs with high negotiated discounts are made nonformulary in favor of potentially lower-cost agents that have little market share, costs for the therapy class may actually increase, depending on the market-share movement.
4. **Account for market dynamics over an extended timeframe.** Allowing for non-clinical drug dynamics, such as patent expirations or expected introductions of new drugs within the class over more than one year, may give formularies longer shelf lives. For example, an effective, heavily-utilized but more expensive brand-name drug that will lose patent protection within a relatively short time may remain on formulary. Not only may the eventual transition to the generic equivalent be easier, the potential for member and physician disruption may be lower. Express Scripts recommends a three-year time horizon. In the therapy class review section of this Report, we explain our predictions of trends in the top 25 therapy classes over the next five years.

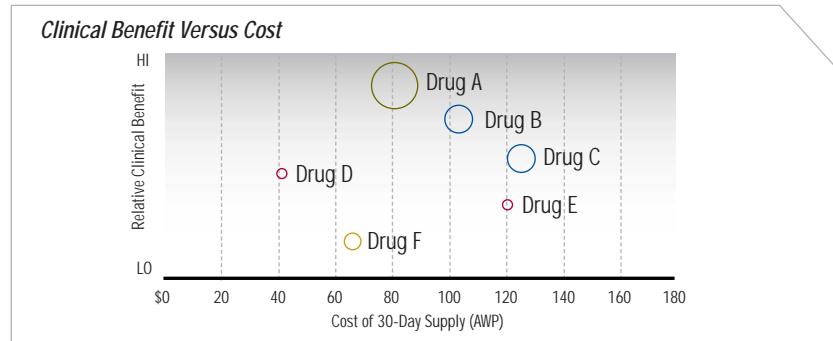
For a complete description of the Express Scripts formulary development process, please refer to: http://www.express-scripts.com/other/company/formulary_development_whitepaper_2003.pdf.

IS THERE ONLY ONE FORMULARY?

Since no one formulary can meet the needs of all plan sponsors, Express Scripts builds its formularies on a class-by-class basis — positioning each therapy class along the continuum of formulary options. Using a priority approach based on the contribution of each class to total drug spend, Express Scripts consults with each plan sponsor to analyze prescription utilization patterns for its members. The result is a cost-effective formulary that meets the needs of the plan.

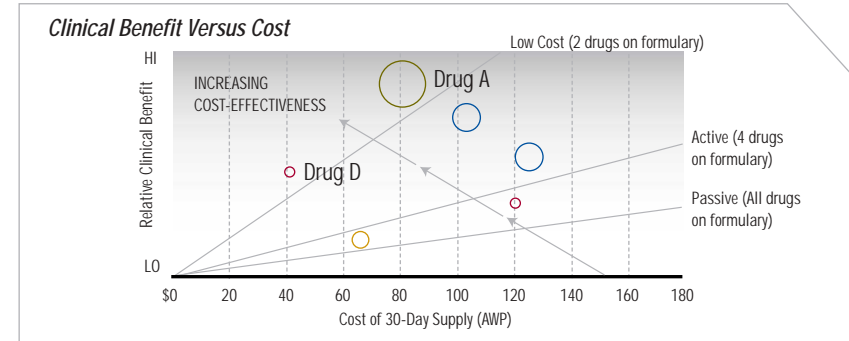
Exhibits 19a and 19b show how a plan can select a few, most or all drugs within a class to put on formulary. First, each drug is rated based on its relative clinical benefit and its cost.

Exhibit 19a



A plan can take a passive approach and include all drugs on formulary. In an active formulary approach, a plan includes many but not all drugs on the formulary. A plan that takes a low-cost approach covers the generics and lowest-cost brands that meet clinical need, which would include Drugs D and A in this example.

Exhibit 19b



Implications

- Building a rational formulary to meet the needs of a plan sponsor’s population is accomplished through a series of distinct steps. After clinical needs are met, cost is then considered, followed by analyses of market share and market dynamics.
- Express Scripts develops multiple formularies along a cost-management continuum, which allows plan sponsors to remain consistent with the twin goals of maximum cost-saving opportunities and minimal member, prescriber and dispenser disruption.
- To take full advantage of the formulary selections they have made, plan sponsors should use member and physician education programs as integral components of the benefit. Encouraging members and physicians to work together as prescriptions are written helps to optimize the use of formulary drugs.

Formulary Design Selection: **NEW LEARNINGS**

A union plan new to Express Scripts left intact its existing two-tier benefit design. During the following year, the plan experienced an almost 17% PMPM increase in drug costs. In addition, significant new enrollment growth further increased the need for greater cost management with minimal member disruption. To address these challenges, the plan selected a formulary with a performance list, implemented a three-tier copayment design, and educated both members and prescribers about the changes. Express Scripts researchers studied this plan to examine the call center and economic impacts of the benefit design change.

What Is a Performance List?

One benefit design that Express Scripts offers is a three-tiered formulary that may include a performance list. Performance lists limit or close only certain therapeutic subclasses, such as statins and proton pump inhibitors. As a result, members have additional financial incentives to use formulary drugs. Formularies with a performance-list option provide substantial cost savings yet minimize member disruption by affecting only the small percentage of members who might use drugs in the few affected classes.

Key Study Findings

- Calls to the Express Scripts Call Center increased in response to the advance notification to members, but call volume quickly subsided — returning to pre-notification levels within three months (Exhibit 20).
- Annual trend for PMPM net drug costs slowed substantially to 13.5%, well below not only the client's previous annual trend of nearly 17% but also Express Scripts 2001-2002 union benchmark of 16.8% (Exhibit 21).
- Member cost-share increased just 2 percentage points, from 12.2% to 14.2%.
- The plan's generic fill rate increased by 6 percentage points, and the use of lower-cost brands also increased, in part due to the new formulary design.

Exhibit 20

Call Center Impact After Moving to a Three-Tier Benefit

Calls Per 100,000 Lives (Three Week Moving Average)

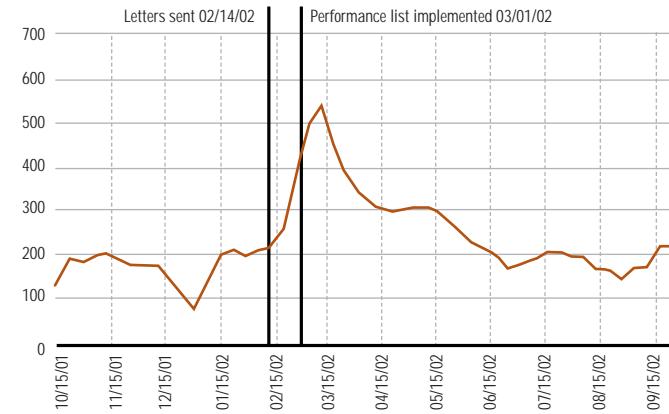
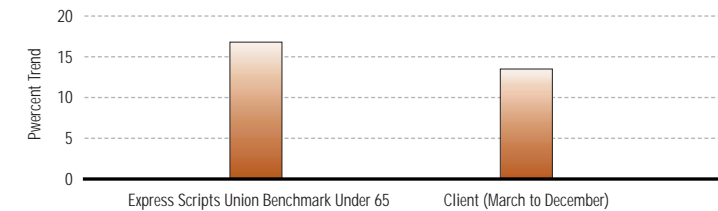


Exhibit 21

Economic Impact After Moving to a Three-Tier Benefit

Net Cost per member Trend From 2001 to 2002



Step 2: Guiding Principles for Plan Design

As discussed in the previous section, formularies are the cornerstone of pharmacy benefit design. Before discussing additional steps in plan-design development, we review the four key principles that should guide plan design:

- Manage drug trend while promoting appropriate drug use.
- Assign cost-sharing amounts that set member financial responsibility appropriately.
- Provide a member-friendly benefit in terms of communication and information accessibility.
- Develop the plan design with a three-year time horizon.

MANAGE DRUG TREND WHILE PROMOTING APPROPRIATE DRUG USE

As emphasized throughout this Report, the goal of pharmacy benefit management is not merely to control drug costs. Rather, the goal is to optimize drug expenditures, which requires a combination of drug cost management and clinical programs to encourage appropriate use of necessary medications. Express Scripts offers numerous programs (e.g., drug utilization review) that encourage appropriate drug utilization.

ASSIGN COST-SHARING AMOUNTS THAT SET MEMBER FINANCIAL RESPONSIBILITY APPROPRIATELY

Members who view prescription drugs as a nearly-free good to which they are entitled have little or no incentive for prudent consumption. By making members financially responsible for a greater part of the cost of the medications they use, plan sponsors can sensitize members to true drug costs. Express Scripts recommends that plan sponsors set the overall member financial contribution between 20% and 35%. However, clients should consider annual caps on member payments (i.e., member stop-loss) to protect the sickest patients from very high out-of-pocket spending.

PROVIDE A MEMBER-FRIENDLY BENEFIT IN TERMS OF COMMUNICATION AND INFORMATION ACCESSIBILITY

Plan designs should be structured in ways that members can understand and that allow them to use the benefit with relative ease. Good communication with members includes:

- Easy-to-understand explanation of benefits
- Cost-sharing structures that are clear to members
- Timely notification about changes in plan design
- Multiple channels for the member to contact the pharmacy benefit manager (PBM).

DEVELOP THE PLAN DESIGN WITH A THREE-YEAR TIME HORIZON

Given the rapidly changing pharmaceutical marketplace, it is important that a plan sponsor take a multi-year time horizon in plan-design development. Taking maximum advantage of new generic opportunities requires formulary and plan-design development in advance of the generic availability. In addition, a longer-term view of plan design helps member cost-sharing keep pace with rising drug costs, thereby avoiding large copayment increases that may produce negative member reaction.

Step 3: A Cost-Sharing Structure That Meets the Goals and Needs of the Plan Sponsor

One of the first steps in developing a plan design is determining what cost-sharing structure to use. Traditional options include a copayment or coinsurance design with a single tier, two tiers or three tiers. Copayments, in general, are easily understood by members. However, single-tier (flat dollar) copayments, which set the same copayment amount regardless of drug type, do not provide incentives for members to use generics. Multi-tiered copayments, which have a lower copayment amount for generics and a higher copayment amount for brands, provide members with a financial incentive to use generics.

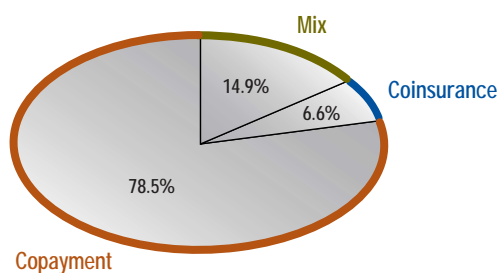
Copayments are fixed dollar amounts that members pay for each prescription. Plans can either have a single copayment regardless of the type of drug or use a tiered design that allows for different copayment amounts for different types of drugs (e.g., generics and brands).

Coinsurance, or percentage copayment, specifies the percentage of the prescription cost that the member pays for each prescription (e.g., 20%). The coinsurance percentage is often the same for all drugs, but it can vary for brands and generics.

Deductibles require a member to pay the entire prescription drug costs until a specified dollar amount has been paid out of pocket for each benefit period. After the deductible has been met, the member pays the standard copayment (or coinsurance rate) for each medication thereafter during that benefit period. Due in part to the relatively high potential for member confusion, very few plan sponsors use deductibles.

Exhibit 22

Cost-Sharing Structure: Express Scripts Clients Fourth Quarter 2003



COINSURANCE

A limitation of any fixed-dollar copayment structure is that it does not automatically keep pace with drug price increases. Thus, member cost-sharing is reduced over time. In contrast, coinsurance automatically keeps pace with rising drug prices.

A disadvantage of coinsurance is that members cannot readily determine the price of the medication before it is dispensed at the pharmacy. In other words, the member's out-of-pocket cost for each prescription is unpredictable. This uncertainty makes coinsurance less appealing to members. Express Scripts research has found less satisfaction with the pharmacy benefit among members with coinsurance.¹⁴ The study findings are discussed in detail on the following pages.

However, some have questioned whether the use of coinsurance may grow as plan sponsors search for trend-management strategies. In particular, some in the industry have asked whether coinsurance is more effective than dollar copayments at increasing the use of generics and lower-cost brands. To this end, Express Scripts examined the effectiveness of coinsurance in encouraging the use of lower-cost alternatives, such as generics, and found no difference in the likelihood of using less expensive brands or generics among coinsurance versus copayment plans.¹⁵

Given that members pay more for more expensive drugs with coinsurance, why doesn't coinsurance result in greater use of generics and less expensive brands? The answer likely stems from the realities of the prescribing process. Frequently, at the time of writing a prescription, a physician is unaware of the medication's cost. Accordingly, a patient typically does not know the cost of the medication until he or she goes to the pharmacy to have the prescription filled. Once at the pharmacy, it is unlikely that the patient will contact the doctor to ask for a less expensive medication. Thus, coinsurance's ineffectiveness in promoting greater use of less expensive brands and generics may reflect physicians' and patients' lack of awareness of medication costs.

¹⁴ Motheral B, Teitelbaum F, Frear R. *Pharmacy Benefit Guide*. First edition. Maryland Heights, MO: Express Scripts, Inc; February 2003.

¹⁵ Motheral B, Teitelbaum F, Frear R. *Pharmacy Benefit Guide*. First edition. Maryland Heights, MO: Express Scripts, Inc; February 2003.

Satisfaction With the Pharmacy Benefit: **NEW LEARNINGS**

While the pharmacy benefit is one of the most frequently used healthcare benefits, historically little has been known about member satisfaction with this benefit and how benefit-design factors affect satisfaction. To fill this gap, Express Scripts researchers surveyed a random sample of over 14,000 Express Scripts members who had a recent prescription drug claim.¹⁶

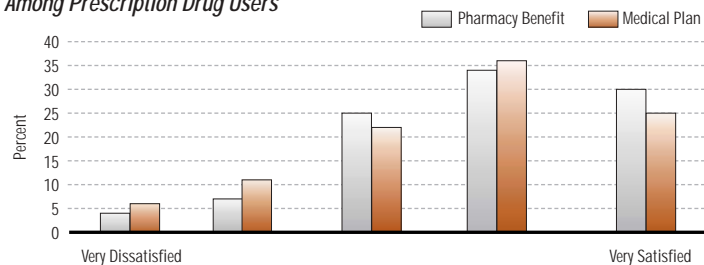
This study found that a substantial majority (64%) of the responders reported that they were satisfied with their pharmacy benefit — even more so than with their medical plans (Exhibit 23). In a statistical model that controlled for gender, age, income and member health status, neither a mandatory generic policy nor a three-tier design was found to affect satisfaction with the pharmacy benefit.

However, predictors of dissatisfaction with the pharmacy benefit were:

- Coinsurance
- Copayment increase in the past year
- Drug coverage denial in the past year
- Large health insurance premium
- Enrollment in heavy managed care

Exhibit 23

Satisfaction With the Pharmacy Benefit and the Medical Plan Among Prescription Drug Users



¹⁶ Motheral BR, Heinle SM. Predictors of satisfaction of health plan members with prescription drug benefits. *American Journal of Health-System Pharmacy*. (In Press)

Implications

- Plan sponsors can implement a generic policy without concern for member dissatisfaction, consistent with research showing that members believe generics are safe and effective.
- Coinsurance creates dissatisfaction, likely due to unpredictable out-of-pocket payments.
- Educating members about copayment increases and about alternatives when denied coverage can mitigate negative effects on satisfaction.

In summary, Express Scripts research indicates that coinsurance provides no advantage over copayment designs in terms of encouraging the use of less expensive medications. However, coinsurance ensures that member cost-sharing, as a percentage of total drug costs, automatically keeps pace with rising drug costs, making it unnecessary to adjust copayment levels every few years. Its key disadvantage is that members cannot determine their out-of-pocket cost before the medication is dispensed — a likely reason for lower member satisfaction with coinsurance.

TWO-TIER VERSUS THREE-TIER COPAYMENTS

Once the choice of a copayment or coinsurance structure has been made, the next decision is the number of tiers to employ, typically two or three. The three-tiered copayment structure provides an incentive for members to use generics and formulary brands because their out-of-pocket cost will be reduced significantly. The popularity of three-tier copayments has grown substantially in recent years because they offer comparable savings, greater member choice and ease of administration compared to closed formularies.

Exhibit 24

Formulary Structure: Express Scripts Clients Fourth Quarter 2003

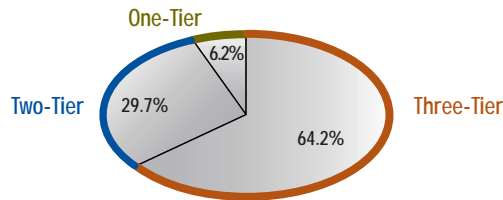


Exhibit 25

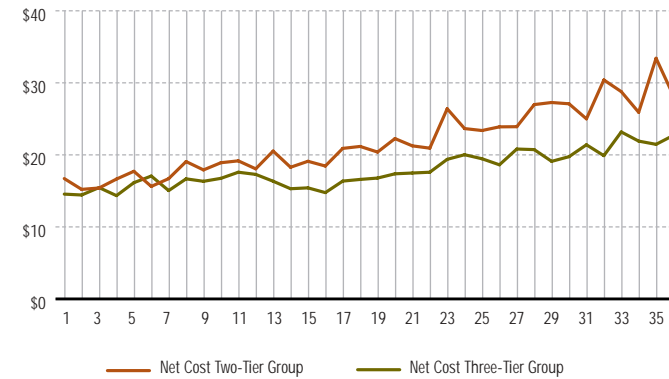
What Is a Three-Tier Copayment?

Tier 3 \$30-\$40	Nonformulary Brands
Tier 2 \$15-\$25	Formulary Brands
Tier 1 \$5-\$10	Generics

Despite its advantages, some have questioned whether a three-tier copayment structure is effective at managing trend and whether it produces unintended consequences, such as more office visits or higher medication noncompliance. To address these questions, Express Scripts examined the impact of a three-tier program on prescription utilization and expenditures, medication compliance and utilization of other medical services. As discussed in the following Three-Tier Benefit Designs: NEW LEARNINGS section, the study followed members over a three-year period, finding no negative clinical impact from moving to a three-tier plan (Exhibit 26).

Exhibit 26

Payer Cost Net of Copayment per Member



In 2003, three-tier copayments were used in a unique way by some plan sponsors as a strategy for managing the non-sedating antihistamines (NSAs). Several plan sponsors moved all NSAs to the third tier to encourage members to use OTC Claritin®. As discussed in the following text, these plan sponsors experienced a 32% decrease in drug spend for NSAs. This strategy will become increasingly common not only as other plan sponsors learn from the experience of these plans, but also as more medications become available in non-prescription forms.

In summary, the evidence indicates that three-tier copayment structures:

- Provide greater trend-management than two-tier copayments
- Achieve drug cost-savings through reduced use of tier three medications, greater cost-sharing by members and greater rebates for tier two medications
- Are both clinically and financially responsible, as research indicates that a three-tier copayment produces no unintended consequences

Three-Tier Benefit Designs: **NEW LEARNINGS**

In the Dec. 4, 2003, issue of the *New England Journal of Medicine*, researchers reported on the impact of three-tier benefit designs on prescription utilization for three therapy classes used to treat chronic illnesses. In evaluating two employer groups that implemented three-tier designs in 2000, the researchers found that after moving to a three-tier design, members in one group were more likely to discontinue use of their medications than those in the comparison group. However, in a second employer group, they found no significant differences in rates of discontinuation for any of the three therapy classes after moving to a three-tier design.¹⁷

Why the contrasting results? The difference in outcomes likely was due to the way that three-tier designs were implemented. The first employer group moved radically from a single-copayment design for brands and generics to a three-tier design, while the second employer group moved incrementally from a two-tier to a three-tier plan design. Express Scripts discourages its clients from moving directly to a three-tier design from a single-copayment design, particularly in the absence of extensive member education.

Another contributing factor for the differences could be related to the different worker profiles of the two employer groups. The first group was a large firm with mostly hourly workers, suggesting lower-income workers; while the second group, also a large firm, employed mostly salaried workers.

Furthermore, the study did not address whether implementation of a three-tier plan design affected other medical use. Examining both pharmacy and medical data, Express Scripts research found that moving gradually from a two-tier to a three-tier design not only slowed the drug cost trend but also had no unintended consequences in either use of other medical care services or rates of medication continuation. The original study, published in the journal *Medical Care* in 2001, followed members for 12 months.¹⁸ The most recently published Express Scripts study found the same results after following members for a full 30 months post-three-tier implementation.¹⁹

Implications

- Three-tier benefit designs can slow drug cost trends without unintended consequences.
- Three-tier benefit designs should be implemented after taking into consideration current plan design and member characteristics, and should be accompanied by appropriate member education.

¹⁷ Huskamp HA, Deverka PA, Epstein AM, Epstein RS, McGuigan KA, Frank RG. The Effect of Incentive-Based Formularies on Prescription-Drug Utilization and Spending. *New England Journal of Medicine*. 2003; 349(23):2224-2232.

¹⁸ Motheral BR, Fairman KA. Effect of a three-tier prescription copayment on pharmaceutical and other medical utilization. *Medical Care* 2007;39:1293-1304.

¹⁹ Fairman KA, Motheral BR, Henderson RR. Retrospective, Long-Term Follow-Up Study of the Effect of a Three-Tier Prescription Drug Copayment System on Pharmaceutical and Other Medical Utilization and Costs. *Clinical Therapeutics*. 2003;25(12):3147-3161.

OTC Claritin®: NEW LEARNINGS

When all forms and strengths of Claritin, a prescription non-sedating antihistamine (NSA), became available for sale as over-the-counter (OTC) products in December 2002, plan sponsors had a number of trend-management options available for OTC Claritin as well as for the NSA products that remained prescription-only. All benefit designs had similar increases in the rate of spend for Singulair® and Flonase®, non-NSA anti-allergy prescription drugs (Exhibit 27). However, plans that moved prescription NSAs to a third tier and excluded OTC Claritin from their benefits experienced, on average, a 17% PMPM decrease in spend for all anti-allergy drugs, while other benefit designs saw decreases of only 1% to 10%.²⁰

The study findings demonstrate:

- Moving prescription NSAs to a third tier resulted in the greatest savings for plans through greater member cost-sharing and decreased utilization.
- Plans should not cover OTC Claritin without step therapy unless OTC drugs are a standard part of the benefit.
- Irrespective of plan design choices for NSAs, step therapy should be considered for Singulair given the more than 30% increase in Singulair costs for all plans since 2002, when Singulair received an indication for allergic rhinitis.

Exhibit 27

Change in Prescription (Rx) Anti-Allergy Drug Spend and Use January to June 2002 Versus January to June 2003

Benefit Type (# Plans)	MEAN PMPM RxS CHANGE	MEAN NET PMPM \$ CHANGE			
	Rx NSA	Rx NSA	Singulair	Flonase	Total Anti-Allergy
Covered OTC Without Step Therapy (40)	-8.50%	-11.40%	30.30%	19.40%	-1.40%
Did Nothing (1732)	-22.80%	-23.70%	33.40%	21.00%	-9.60%
Placed NSAs on Third Tier (7)	-31.80%	-32.30%	33.60%	19.70%	-17.20%

²⁰ Delate T, Henderson RR, Motheral BR. Financial Impact of Benefit Design Choice for Non-Sedating Antihistamines Express Scripts, Inc. Available at: http://www.express-scripts.com/other/news_views/outcomes_research/online_pub_home.htm#. Accessed February 27, 2004.

CLOSED FORMULARIES

While three-tier copayments represent the most popular cost-sharing structure among Express Scripts clients, closing formularies represents a more aggressive type of traditional plan design that is making a comeback. With the number of generic drugs now available in the major therapy classes, closing a formulary may lead to significant savings for the client.

In a closed formulary, nonformulary drugs are not covered. Members who choose to take a nonformulary medication may receive a claim rejection at the pharmacy, or they may pay 100% of the discounted cost for the medication (i.e., the medication is dispensed at the standard network discount rate, not the higher Usual and Customary fee). However, members can always ask their doctors to request a prior authorization to receive coverage for the nonformulary drug when medically necessary.

The popularity of closed formularies has fluctuated over the years, showing considerable uptake in the early 1990s, but being supplanted by the three-tier design in more recent years. The obvious advantage of a closed formulary, as documented in an Express Scripts study published in *Inquiry* in 1999, is that it provides substantial savings for a plan sponsor.²¹ The potential disadvantage with a closed formulary, however, is that it may produce resistance from members and providers. Clients that have the ability to inform their members, physicians and pharmacies proactively about the formulary can manage much of the potential disruption. Accordingly, closed formularies are most frequently adopted by large health plans with a large market penetration and greater influence with physicians.

The most significant step a plan sponsor can take to promote the use of generics is to adopt a high-performance formulary (HPF) — a closed formulary consisting of generics and lower-cost brands. As more branded products go off patent, it is possible to increase the use of generics through formulary design. Branded products covered in the HPF are either in therapy classes without a clinically-equivalent generic or they are needed for clinical reasons.

The HPF can provide clients with immediate savings of as much as 40% off their current drug spend. Additionally, with brand-name drugs that will lose patent protection by 2008 representing over \$30 billion in drug spend, this formulary positions clients to take immediate advantage of newly-introduced generics as they are approved.

Express Scripts suggests that clients implement an aggressive, proactive communications strategy to educate members, physicians and pharmacies about the HPF and how to take advantage of it. The educational campaign should center on protecting member benefits, eliminating waste from the system without affecting health status and making stakeholders aware of equivalent medications that are covered.

²¹ Motheral BR, Henderson R. The effect of a closed formulary on prescription drug use and costs. *Inquiry*. Winter 1999/2000;36:481-491.

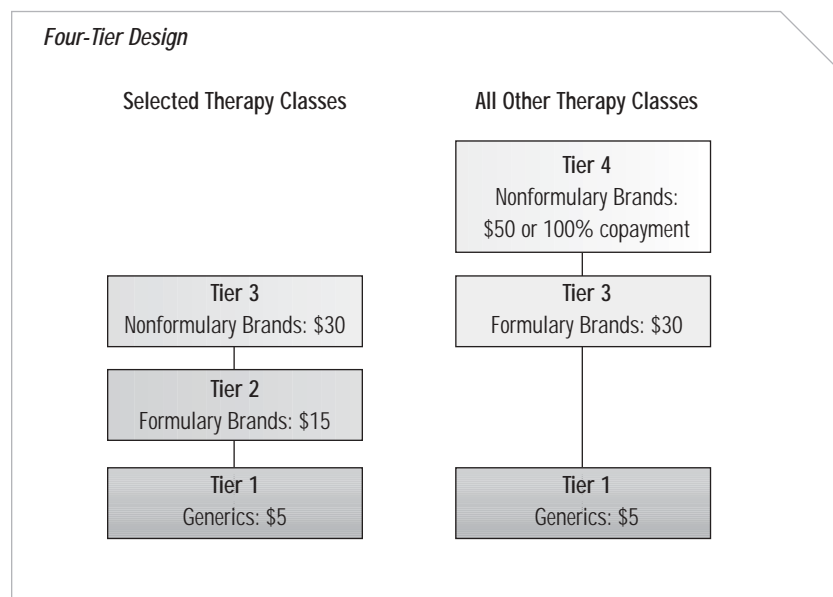
EMERGING PLAN DESIGNS

As plan sponsors continue to explore value-based solutions for managing drug trend, several plan designs are gaining increased attention. Among them are four-tier designs, reference pricing and reverse copayments.

Four-Tier Design

Four-tier plans can be structured in various ways, both in terms of which drugs are placed on the fourth tier (e.g., nonformulary or high-cost medications) and the cost-sharing structure (e.g., copayment or coinsurance). For example, in one four-tier design, members could bear a smaller financial responsibility for classes of prescription drugs that are deemed to be of greatest value for extending life (Exhibit 28). Examples of such classes include medications for diabetes (e.g., insulin), asthma (e.g., inhaled corticosteroids) and cardiovascular conditions (e.g., beta blockers and ACE inhibitors). Member confusion about copayments is the biggest disadvantage of this plan design.

Exhibit 28



Reference Pricing

Reference pricing (also known as therapeutic MAC) is a benefit strategy intended to manage a plan sponsor's pharmaceutical costs by paying only an amount equal to the lowest-priced drug of equal efficacy in the class. This technique, which began outside the United States, has demonstrated success in nationally-sponsored healthcare systems where this strategy can have a dramatic influence on the pricing behavior of pharmaceutical manufacturers, as well as on the prescribing patterns of physicians.

That said, reference pricing is not an optimal plan design for plan sponsors in the United States for several reasons:

- In some drug classes, no one drug will meet the clinical needs for all uses of drugs in the class. In these cases, a reference-based price for one drug will not work, and plan sponsors are forced to administer a duplicate benefit design for those classes, making the plan difficult to operationalize and adding complexity for the member.
- Due to the decentralization of the U.S. healthcare system, the use of reference pricing by any given plan sponsor (even large ones) is very unlikely to alter the pricing behavior of pharmaceutical manufacturers, thereby producing limited savings beyond cost-shifting to members.
- Reference-based pricing makes it difficult if not impossible for patients to know what they will pay for prescriptions. Each drug class and each drug within the class may have a different price.
- Reference pricing limits the ability to negotiate volume discounts, which lower the cost of prescriptions, on behalf of the plan sponsor.
- Without accompanying tactics for shifting market share, costs simply move to the members.
- As a significant departure from traditional plans, this design requires a substantial education campaign.

Reverse Copayment

Similar to reference pricing, a reverse copayment fixes a set contribution from the plan sponsor for each agent in a given therapy class. All agents in the class are reimbursed at the same cost to the plan, and members are responsible for the remainder of the total drug cost.

High Performance Formulary

Express Scripts believes that it is possible to get the same or even higher savings as reference pricing by using our high performance formulary (HPF). The HPF is a generic-based formulary that includes only those brand drugs clinically recommended by the Express Scripts Pharmacy and Therapeutics (P & T) Committee. When implemented as a three-tier formulary with a 100% copayment for nonformulary products or as a two-tier closed formulary, the HPF can save clients as much as 40% of their drug spend.

Unlike reference pricing or reverse copayments, the HPF allows plan sponsors to:

- Provide a traditional, easily-understood copayment structure for formulary products across all classes
- Avoid cost-shifting to members
- Continue to receive rebates (i.e., volume discounts) on branded agents that are included on the formulary
- Help members predict their costs, understand when it is important to talk with their physicians about lower-cost alternatives and understand the exact out-of-pocket savings the change will represent

Step 4: Point-of-Service Programs

Generally, point-of-service (POS) programs are the most effective and most efficient ways to optimize prescription utilization because they are based on financial incentives, they occur at the time the prescription is dispensed and they generally do not require additional resources to implement. Accordingly, plan sponsors should ensure that they have taken advantage of all POS programs before implementing retrospective programs. The following section examines key POS programs, including:

- Generic Policy
- Prior Authorization
- Step Therapy
- Quantity Limits

GENERIC POLICY

For a generic drug to receive an “A” rating from the U.S. Food and Drug Administration (FDA), it must have the same efficacy, safety and purity profile as its brand-name equivalent. Given the typical cost difference of \$47 between multi-source brands (i.e., brands with a generic equivalent available) and their generic counterparts, promoting the use of generics represents an important trend-management tool.

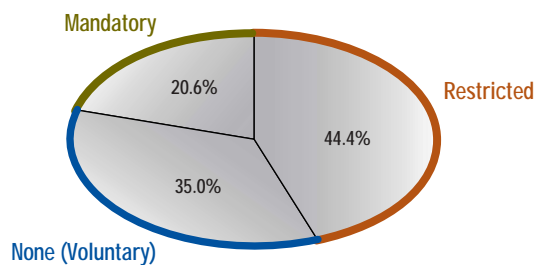
Generics Preferred is the name for Express Scripts mandatory generic policy, which requires a member to pay the difference in price between a brand and generic if the member chooses to get a brand medication when an FDA-approved generic equivalent is available. The rationale behind this approach is that the generic is an FDA-approved equivalent to the brand, and thus there is no clinical reason for the plan sponsor to pay for the more expensive brand medication. Clients can also implement a restricted generic policy (Generics Preferred – Physician’s Choice) in which the member does not have to pay the price difference between the brand and generic when the physician issues a dispense as written (DAW) order.

Will Consumers Select Generics?

A recent survey found that the majority of consumers believe that generics are just as effective as their brand counterparts.²² In addition, many consumers who do not believe generics are as good are willing to pay more for the brand. Thus, a generic policy represents an important trend tool, and research shows that it produces no member dissatisfaction. (See the previous NEW LEARNINGS section, Satisfaction With the Pharmacy Benefit, for details.)

Exhibit 29

Type of Generic Policy: Express Scripts Clients Fourth Quarter 2003



PRIOR AUTHORIZATION

With a prior authorization (PA) program, approval from the plan sponsor (or its agent) is required before the drug is covered. Typically, approval is contingent upon one of the following:

- Documentation of a specific diagnosis (e.g., hypopituitarism for growth hormone)
- Other relevant clinical characteristics (e.g., risk factors) that makes the drug medically necessary
- Participation in a wellness program (e.g., educational and exercise classes for anti-obesity medications)

PA is often used to manage the dispensing of drugs that are relatively expensive and that also may have a significant potential for inappropriate use. Simply being high-cost is not sufficient reason to place a drug on PA. However, PA can be used to limit coverage of drugs to those patients for whom there is no appropriate alternative, while disallowing coverage for patients for whom other, less expensive treatments are suitable. Clinical reasons may also affect a drug's PA status. For example, a drug that requires close monitoring because of potentially serious side effects could be placed on PA to facilitate the monitoring.

The cost-effectiveness of PA for prescription drugs has been questioned.²³ For such programs to be cost-effective, the cost of the program to the plan sponsor must be less than the resulting drug savings. Express Scripts research found that PA provides significant plan-sponsor savings amounting to about 1% of total drug spend when used for the classes of medications listed in Exhibit 30.

Exhibit 30

Drugs Commonly Placed on Prior Authorization

Alpha-1 Antitrypsin Replacement	Injectable Osteoporosis Treatment
Antifungals	Prescription Oral Smoking Cessation Products
Botulinum Toxin	Red Blood Cell Enhancers
Diabetic Foot Ulcer Medication	Topical Tretinoin & Tazarotene
Growth Hormone	
Injectable Asthma Treatment	

²² Express Scripts Consumer Survey, November 2001. Unpublished. Administered by Knowledge Networks.

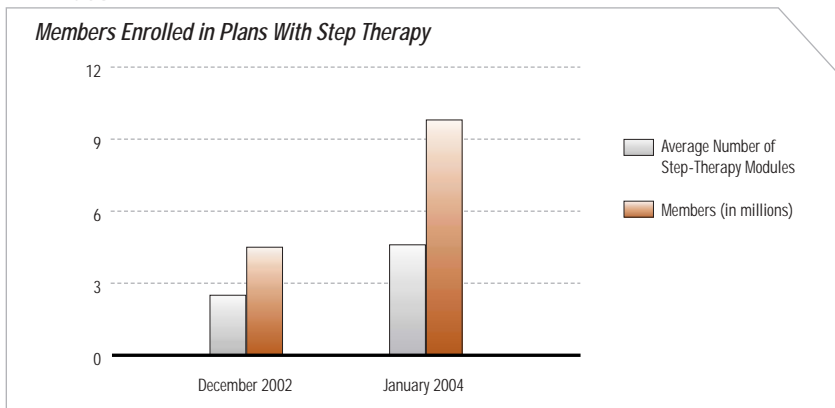
²³ Reissman D. What is the real cost of prior authorization? *Drug Benefit Trends*. 2000;12(10):22,24.

STEP THERAPY

What Is Step Therapy?

Step therapy is designed to encourage use of therapeutically-equivalent, lower-cost alternatives (first-line therapy) before stepping up to more expensive therapy (second-line therapy). In 2002, an estimated 28% of employers surveyed had implemented step therapy for one or more therapy classes.²⁴ From December 2002 to January 2004, the number of Express Scripts members enrolled in a plan with at least one step-therapy program grew from 4.5 million to 9.8 million. Additionally, the average number of step-therapy modules per client utilizing step-therapy programs increased from 2.5 to 4.6 modules (Exhibit 31).

Exhibit 31



The growth in pharmaceutical step-therapy programs is fueled by the growing number of therapeutically-equivalent treatment alternatives available for many health conditions. However, it is important to point out that having a less expensive generic product in the therapy class does not automatically make a drug category an appropriate candidate for step therapy. The first-line drug must be therapeutically equivalent to the second-line drug. Therapy classes and subclasses that are candidates for a step-therapy program are shown in Exhibit 32.

²⁴ The Prescription Drug Benefit Cost and Plan Design Survey Report: Provided by Takeda, 2003 Edition. Albuquerque, NM: Wellman Publishing, Inc; 2003.

Exhibit 32

Step-Therapy Opportunities

Drug Class	First-Line Drug	Second-Line Drug(s)
Agents for Allergic Rhinitis	Oral NSA (e.g., loratadine)	Leukotriene pathway inhibitors
Agents for ADHD	Generic stimulant (e.g., methylphenidate)	Strattera®
Aldosterone Blockers	spironolactone	Inspra™
Antiasthmatics	albuterol	Xopenex®
Antidepressants	Generic SSRI (e.g., fluoxetine)	Brand SSRIs
Antidiabetics	metformin	Glucophage XR®
Antihypertensives	Generic ACEI (e.g., lisinopril)	Brand ACEI, ARB
Anti-inflammatory Agents	Generic NSAID (e.g., ibuprofen)	Brand NSAIDs, COX-2s
Anxiolytics	Generic benzodiazepine (e.g., diazepam)	Brand benzodiazepine
Bile Acid Sequestrants	cholestyramine colestipol oral suspension and micronized tablets	Welchol™
Cholesterol-lowering Agents	statin (e.g., lovastatin)	Zetia™
Gastrointestinals	Generic H2 (e.g., cimetidine) or generic PPI (e.g., omeprazole)	Brand PPIs
Topical Immunomodulators	Generic corticosteroid (e.g., augmented betamethasone dipropionate)	Elidel® Protopic®

Abbreviations

ACEI	Angiotensin-converting enzyme inhibitor
ADHD	Attention-deficit/hyperactivity disorder
ARB	Angiotensin-2 receptor blocker
COX-2	Cyclo-oxygenase-2 inhibitor
H2	Histamine-2 receptor blocker
NSAID	Non-steroidal anti-inflammatory drug
PPI	Proton pump inhibitor
SSRI	Selective serotonin reuptake inhibitor

Clinical Evidence Supporting Step Therapy

The clinical literature often provides head-to-head comparisons of safety and efficacy for proposed first- and second-line therapies. Two examples are antidepressants and non-steroidal anti-inflammatory drugs (NSAIDs). In the case of antidepressants, a pivotal study of the selective serotonin reuptake inhibitors (SSRIs), published in the Dec. 19, 2001, issue of the *Journal of the American Medical Association*, found no difference in patient outcomes based on which SSRI the patient was initially prescribed.²⁵ Although about 20% of patients did switch SSRIs during the trial in an effort to optimize effectiveness, no significant differences were seen in clinical effectiveness or in the rate of switching across the SSRIs originally prescribed. In addition, individual patient characteristics were not reliable predictors of better or worse response to a particular SSRI. Accordingly, the study provided strong support for step-therapy programs that require a trial of fluoxetine before stepping up to the more expensive branded SSRIs.

In the NSAID class, numerous studies have shown that, at equipotent doses, COX-2 inhibitors (COX-2s) and first-line non-selective or traditional NSAIDs are equally effective in the management of acute pain and other conditions associated with pain.²⁶ While COX-2s have been shown to reduce the risk of serious gastrointestinal (GI) adverse events significantly,^{27, 28} the much higher cost of these agents does not offset the added benefit in the general population.^{29, 30} COX-2 therapy has been found cost-effective for patients at risk for NSAID-related GI problems (i.e., older patients, those using corticosteroids or warfarin concomitantly with NSAIDs, patients who have had a prior GI event).³¹ Express Scripts recently conducted research that examined the number of COX-2 users who would be candidates for a step-therapy program. The study methodology and findings are described in the following NEW LEARNINGS section.

²⁵ Kroenke K, West SL, Swindle R, et al. Similar effectiveness for paroxetine, fluoxetine, and sertraline in primary care: a randomized trial. *Journal of the American Medical Association*. 2001;286(23):2947-2955.

²⁶ Cox ER, Mothral BR, Mager D. Verification of a decision analytic model assumption using real-world practice data: implications for the cost effectiveness of cyclo-oxygenase 2 inhibitors (COX-2s). *The American Journal of Managed Care*. 2003;9(12):785-794.

²⁷ Silverstein FE, Faich G, Goldstein JL, et al. Gastrointestinal toxicity with celecoxib vs nonsteroidal anti-inflammatory drugs for osteoarthritis and rheumatoid arthritis: the CLASS study: a randomized controlled trial. *Journal of the American Medical Association* 2000;284:1247-1255.

²⁸ Bombardier C, Laine L, Reicin A, et al. Comparison of upper gastrointestinal toxicity of rofecoxib and naproxen in patients with rheumatoid arthritis. *New England Journal of Medicine*. 2000;343:1520-1528.

²⁹ Spiegel BMR, Targownik L, Dulai GS, Gralnek IM. The cost-effectiveness of cyclooxygenase-2 selective inhibitors in the management of chronic arthritis. *Annals of Internal Medicine*. 2003;138:795-806.

³⁰ Cox ER, Mothral BR, Mager D. Verification of a decision analytic model assumption using real-world practice data: implications for the cost effectiveness of cyclo-oxygenase 2 inhibitors (COX-2s). *The American Journal of Managed Care*. 2003;9(12):785-794.

³¹ Spiegel BMR, Targownik L, Dulai GS, Gralnek IM. The cost-effectiveness of cyclooxygenase-2 selective inhibitors in the management of chronic arthritis. *Annals of Internal Medicine*. 2003;138:795-806.

Step Therapy for COX-2s: NEW LEARNINGS

PROFILE OF NEW COX-2 USERS

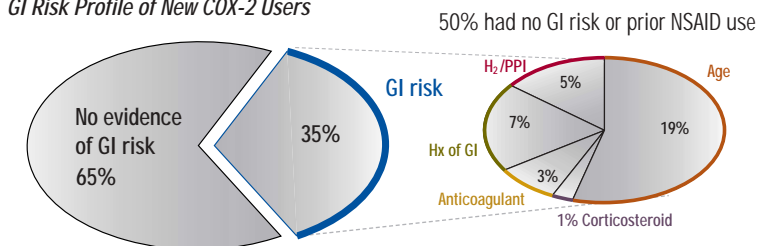
Why implement step therapy for COX-2s? Studies published by Express Scripts researchers in 2003 provide the answer.^{32,33} From 1999 to 2001, the PMPY costs for the therapy class of anti-inflammatory drugs grew by 56%. This growth was attributed to the introduction of the newer, more expensive COX-2-selective agents, whose combined market share grew to 47% in 2001.

To help clients better understand how these agents are being used in real-world practice, and to determine whether COX-2s are being reserved for members at risk for adverse GI events, medical and pharmacy claims data were studied to evaluate the use of COX-2s within a large managed care organization.

The profile of COX-2 use was predominately short-term for a variety of musculoskeletal conditions. Our results indicate that 50% of new COX-2 users were not at risk for GI events, and they had not tried a lower-cost non-selective NSAID agent prior to beginning COX-2 therapy.

Exhibit 33

GI Risk Profile of New COX-2 Users



Express Scripts research has also identified other opportunities to encourage cost-effective prescribing among patients on long-term COX-2 therapy. For example, when surveyed about their use of OTC agents, 45% of patients taking COX-2 therapy on a long-term basis also indicated they were using aspirin regularly for cardioprotection. Findings from the CLASS study³⁴ suggest that concomitant aspirin use negates the GI benefit of COX-2s, calling into question one of the fundamental rationales for prescribing this expensive therapy class — the minimization of serious GI bleeding.

³² Cox ER, Mothral BR, Mager D. Verification of a decision analytic model assumption using real-world practice data: implications for the cost effectiveness of cyclo-oxygenase 2 inhibitors (COX-2s). *The American Journal of Managed Care*. 2003;9(12):785-794.

³³ Cox ER, Mothral BR, Frisse M, Behm A, Mager D. Prescribing COX-2s for patients new to cyclo-oxygenase inhibition therapy. *The American Journal of Managed Care*. 2003;9(11):735-742. vey Report: Provided by Takeda, 2003 Edition. Albuquerque, NM: Wellman Publishing, Inc; 2003.

COX-2 cost-effectiveness studies have been conducted to compare the costs and adverse GI outcomes of COX-2s with traditional NSAID agents. Many of these studies have concluded that COX-2s are cost-effective. However, a key assumption is the extent of co-prescribing with gastroprotective agents (GPAs), such as PPIs or H2s, to reduce the risk of GI events. All COX-2 cost-effectiveness studies either assume that patients on COX-2 therapy would not require a GPA or that their rate of GPA use would be substantially lower than with traditional NSAIDs. Because cost-effectiveness results were sensitive to the GPA rate assumption and because no empirical data to support such an assumption exist, the goal of a recently published Express Scripts study was to validate the assumption using actual practice data.

Results indicate that the GPA rate for COX-2 patients is marginally higher than the rate for traditional NSAID patients. As shown in Exhibit 34, a re-estimate of cost-effectiveness models using the GPA rates from actual practice suggests that the cost per year of life saved increased from \$18,614 to over \$100,000.³⁵

Exhibit 34

COX-2 Cost-Effectiveness Model, GPA Rates and Outcomes

GPA Rate	Model	Express Scripts Data
NSAID	26%	28%
COX-2	6%	20%
Cost per Year of Life Saved	\$18,614	\$106,192

The findings from both of these studies point to the savings opportunities and provide the clinical and financial rationales for step therapy for COX-2s.

³⁴ Silverstein FE, Faich G, Goldstein JL, et al. Gastrointestinal toxicity with celecoxib vs nonsteroidal anti-inflammatory drugs for osteoarthritis and rheumatoid arthritis: the CLASS study: a randomized controlled trial. *Journal of the American Medical Association*. 2000;284:1247-1255.

³⁵ Cox ER, Motheral BR, Mager D. Verification of a decision analytic model assumption using real-world practice data: implications for the cost effectiveness of cyclo-oxygenase 2 inhibitors (COX-2s). *The American Journal of Managed Care*. 2003;9(12):785-794.

How Does Step Therapy Work?

Step therapy is administered at the pharmacy. It involves real-time checks of the member’s prescription claims history for prior use of a first-line agent, as well as for previous use of the branded agents (a practice known as grandfathering). In both of these instances, a plan automatically will provide coverage for the branded agent.

Sometimes, step therapy is combined with automated PA criteria. For example, the goal of a step-therapy program for the COX-2s is for patients to try a generic NSAID first. However, for patients with certain medical conditions, COX-2s may be preferred over traditional NSAIDs. By reviewing data in the prescription claim history, we can identify patients with some of those conditions and avoid the inconvenience associated with the PA claim rejection. For instance, patients who are valid candidates for COX-2s (e.g., older patients) can be identified and the step-therapy requirement can be eliminated automatically.

How Much Does Step Therapy Save?

Savings from step-therapy programs are significant, reaching 5% of overall drug spend. It is important to understand that the amount of grandfathering decreases over time as previous users discontinue the medication. Conversely, savings increase over time because savings result from both initial prescriptions for new users and refills for patients whose prescriptions hit the program edit in previous months. The amount of time needed to reach a steady level of savings varies by therapy class. Express Scripts has studied both the economic and clinical outcomes of step therapy. Step-therapy results from one client are shown in the following NEW LEARNINGS section.

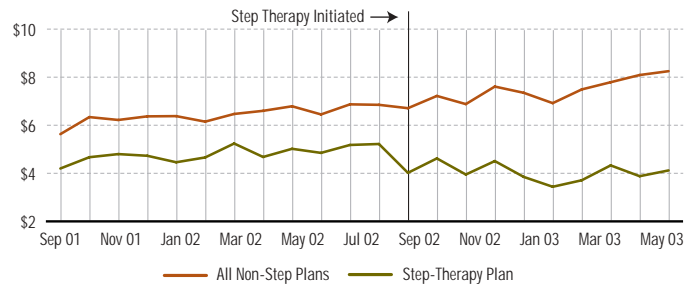
Step Therapy: NEW LEARNINGS

Given the relatively recent popularity of step therapy, little research reported the clinical and financial impact of step-therapy programs. To address this lack of information, Express Scripts researchers examined an employer plan sponsor that began step-therapy programs at the same time for PPIs, NSAIDs and SSRIs.³⁶

In the first 10 months of the programs, the plan experienced cost reductions for all three drug classes (Exhibit 35). In the month following implementation, a \$0.93 PMPM decrease was seen across all three classes. In contrast, plans without step therapy averaged a \$0.10 PMPM increase across the same three therapy classes. The step-therapy process temporarily affected customer service call volume, but call volume returned to normal levels within three months of the programs' start date.

Exhibit 35

PMPM Net Costs for PPIs/H2s, NSAIDs and SSRIs With and Without Step Therapy



A survey of the members affected by the step-therapy program (1.0% of all members) found that only three in 10,000 reported calling their human resources (HR) office, while 0.2% called Express Scripts customer service (Exhibit 36). The survey also revealed that 0.05% of these members became dissatisfied with their pharmacy benefit. On average, the plan sponsor saved \$700 for every member who called Express Scripts and \$4,600 for each member who called the HR office.

Exhibit 36

Step-Therapy Savings Offset Member Disruption

Disruption		Savings
0.05% of members become dissatisfied	MEMBER SATISFACTION	\$2,700/dissatisfied member
0.03% call HR	HR DEPARTMENT	\$4,600/HR call
0.2% call Express Scripts	EXPRESS SCRIPTS CALL CENTER	\$700/call
1.0% affected	MEMBERS AFFECTED	\$140/employee affected

³⁶ Unpublished Express Scripts Data

QUANTITY LIMITS

To minimize waste and stockpiling, prescriptions filled in retail pharmacies frequently are limited to a defined amount per dispensing or a specific days' supply, typically a 34-day supply per fill. Beyond the standard supply limits, additional quantity limits can be used to ensure that quantities supplied are consistent with both clinical dosing guidelines and the plan sponsor's benefit design. For example, quantity limits are sometimes used for inhalers and other drug delivery devices that contain specific numbers of doses. Another obvious use of quantity limits is for lifestyle products, such as drugs that treat erectile dysfunction.

Quantity limits can also be used to prevent billing errors. When the days' supply figure keyed in by the pharmacist is unreliable (e.g., for inhalers, which are sometimes charged by the gram and other times charged by device), a quantity limit on the units dispensed can be used to ensure that errors are caught.

Finally, quantity limits can be used to encourage dose consolidation. Manufacturers sometimes use a price parity structure — meaning that their products have little or no difference in price between the various strengths. For some cases, encouraging the use of a single unit of one strength in place of two units of half that strength is appropriate.

Drug classes for which quantity limits are frequently used include:

- Allergy Medications (oral and injectable)
- Erectile Dysfunction Agents
- Inhalers and Nasal Sprays
- Migraine Products
- Patches
- Vaginal Creams and Suppositories

When a quantity exceeding the plan sponsor's quantity limit is detected at the time of dispensing, a message indicating the quantity limitation is sent to the pharmacist. The pharmacist may either contact the physician to discuss a possible change in quantity that is consistent with the dosage guidelines or dispense the prescription until the physician can be reached. The physician may also request an override if the quantity limit is not applicable to the patient and the condition being treated.

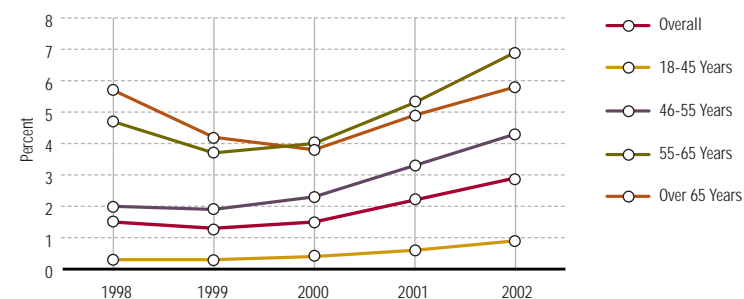
Managing Use of Erectile Dysfunction Drugs: NEW LEARNINGS

Frequently, the use of drugs to treat erectile dysfunction is managed through a quantity-limit program. The use of Viagra® increased from 1.5% of Express Scripts members in 1998 to 2.9% in 2002, an 89% increase (Exhibit 37). The fastest growing segments of users were found to be younger men, who experienced twofold to threefold increases in use. This group of potential users is the current main target of direct-to-consumer advertising. Viagra use for an identifiable underlying medical reason declined in all age groups over the five years. These factors, combined with the introduction of new erectile dysfunction products, suggest that plan sponsors can expect a considerable increase in demand for this therapy class.³⁷

Of course, plan sponsors have additional options for managing these drugs. Some plans may decide to use a PA program not only for Viagra, but also for its recently-released competitors — Cialis® and Levitra® — and for similar drugs which are expected to receive FDA approval in the next few years. Other plan sponsors may not cover them at all. Results from Express Scripts research indicate that similar savings resulted from prior authorization of Viagra and from a quantity limit of six tablets per month.³⁸

Exhibit 37

Proportion of Members (Males) Using Viagra 1998 to 2002



³⁷ Delate T, Simmons VA, Motheral BR. Patterns of use of sildenafil among commercially-insured adults in the United States: 1998-2002. *International Journal of Impotence Research*. (In Press)

³⁸ Motheral B, Teitelbaum F, Frear R. *Pharmacy Benefit Guide*. First edition. Maryland Heights, MO: Express Scripts, Inc; February 2003.

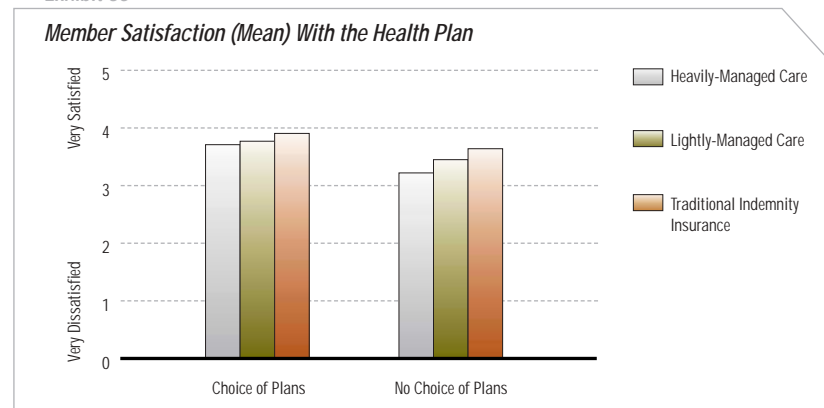
Step 5: Consumer-Driven Plan Designs

Increasingly, plan sponsors are responding to growing consumerism by offering innovative pharmacy benefits that give consumers increased accountability through more decision-making power.³⁹ Consistent with other published research, Express Scripts research has found that offering members a choice of health plans increases member satisfaction even among those who choose heavily-managed plans (Exhibit 38). This finding is the basis for Express ChoiceSM, which allows plan sponsors to offer multiple plans that let members select the one that best meets their needs. Then, throughout the plan year, members experience the effects of their own decisions regarding cost, coverage and flexibility, while the plan sponsor continues to manage drug expenditures. In other words, by providing members with options and allowing them to make personal tradeoffs, efficient use of the pharmacy benefit is encouraged, rather than imposed.

Is Express Choice a Defined-Contribution Approach?

Express Choice is similar to but not synonymous with defined contribution. The key distinction is that under defined contribution, the member bears the risk. With Express Choice, the plan sponsor bears the risk, and it is important to adjust for any selection patterns in the underwriting process. That said, the similarities between defined contribution and Express Choice include the ability for the consumer to make benefit choices, empowering the consumer through relevant information, and aligning member and plan sponsor incentives over the longer term.

Exhibit 38



Offering a consumer-centered prescription benefit plan allows members choices about coverage. The success of these options requires that consumers have some financial responsibility for their decisions and that they have enough information and confidence to make those decisions. To help members in their decision-making process, Express Choice is supported by an interactive, online tool during open enrollment. This tool presents the plan choices in a personalized way that demonstrates how each plan affects the member's out-of-pocket costs. When applicable, it also shows members how they can get the most from their benefit dollars by using generics and mail service. Plan sponsors implementing Express Choice have demonstrated consistent and very significant drug savings while retaining member satisfaction, as shown in the following section, Express Choice: NEW LEARNINGS.

³⁹ Express Scripts Consumer Survey, November 2001. Unpublished. Administered by Knowledge Networks.

Express Choice: NEW LEARNINGS

A healthcare system plan sponsor realized it could no longer afford the rich pharmacy benefit provided for its 140,000 participants. It needed to begin introducing more aggressive plan-design options to manage pharmacy expenses, but it was concerned that tighter benefit management would increase member dissatisfaction. Express Choice was chosen to accomplish the plan's goals of cost management while maintaining both quality benefits and member satisfaction.

In the first year of Express Choice (2002), the client continued offering its existing benefit, while adding two more aggressive benefits that better managed pharmacy spending trend (Exhibit 39). By coupling each plan with a member premium or a monthly payroll deduction, the plan gave members an incentive to select the more aggressive options. Over time, the client phased out the existing benefit and continued to introduce more aggressive benefits. By allowing employees to choose the benefit best suited to their individual needs, the plan kept employees involved and empowered in benefit decisions.

Exhibit 39

Pharmacy Benefits Offered Under Express Choice in the First Year

	Existing Benefit	Additional Benefit #1	Additional Benefit #2
Copayments*	\$5/\$10/\$25	\$10/\$20/\$35	\$15/\$30/\$45
Premium	\$\$	\$	None
Formulary	Broader	Broader	Narrower

*generics/formulary brands/nonformulary brands

Using Express Choice, the client was able to reduce its pharmacy expenses substantially while maintaining member satisfaction. In the first year of Express Choice, the client reduced its PMPM pharmacy cost by 20% compared to the previous year (Exhibit 40). Even with this change, member satisfaction with the pharmacy benefit continued to remain high (Exhibit 41).

Exhibit 40

PMPM Plan Cost With Pharmacy Benefit

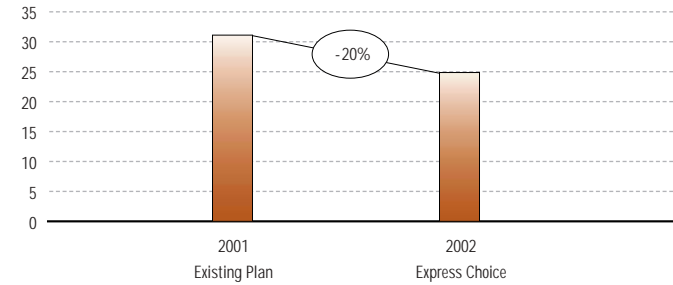
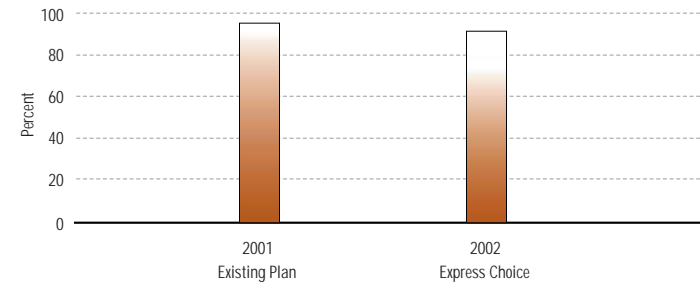


Exhibit 41

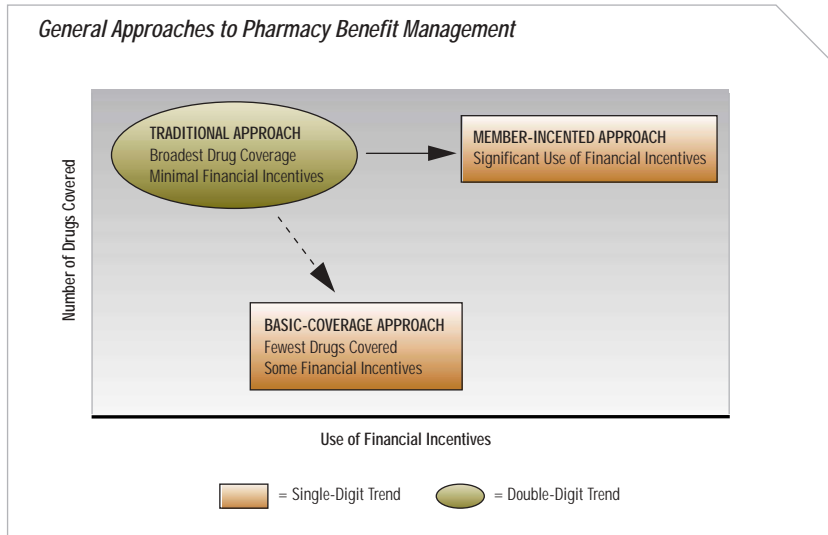
Member Satisfaction With Pharmacy Benefit



Plan Design: Developing an Action Plan

While the previous sections identified the key opportunities for trend management, any discussion of plan design involves many benefit choices beyond those already discussed. In developing a plan design, a sponsor should first assess its current goals and expectations for the pharmacy benefit. Typically, those expectations focus on two key elements: the growth in expenditures, or drug trend, and the potential for member dissatisfaction. As we have examined plan sponsor information, some distinctive pharmacy benefit approaches have emerged (Exhibit 42).

Exhibit 42



TRADITIONAL APPROACH

Plan sponsors with reservations about asking members to take responsibility for using cost-effective medications (because of employee retention or other reasons) choose plan designs that provide the broadest drug coverage. This traditional approach, used most frequently in the past, has few financial incentives to encourage optimal use.

MEMBER-INCENTED APPROACH

For plan sponsors with more interest or latitude in managing expenditures, the member-incented approach is commonly used because it combines financial incentives with information that helps members make informed choices about their prescription drug use. The economically-incented approach not only gives members a high degree of choice, it also rewards members for choices that help contain costs (e.g., use of formulary medications). Plans that adopt this approach leave the same number of drugs on the formulary but ask members to pay more for nonformulary drugs.

BASIC-COVERAGE APPROACH

Finally, plan sponsors who want to manage drug trend aggressively use what is termed the basic-coverage approach. More restrictive than the member-incented approach, the basic-coverage approach places more limits on what drugs are covered. In other words, the plan sponsor says no to coverage of nonformulary drugs instead of relying on the patient to choose, as with the member-incented approach. While fewer drugs are covered under a basic-coverage approach, the opportunity for long-term trend management is maximized.

Exhibit 43 provides more detail on the main designs for each approach.

Exhibit 43

Plan-Design Characteristics for Each Approach

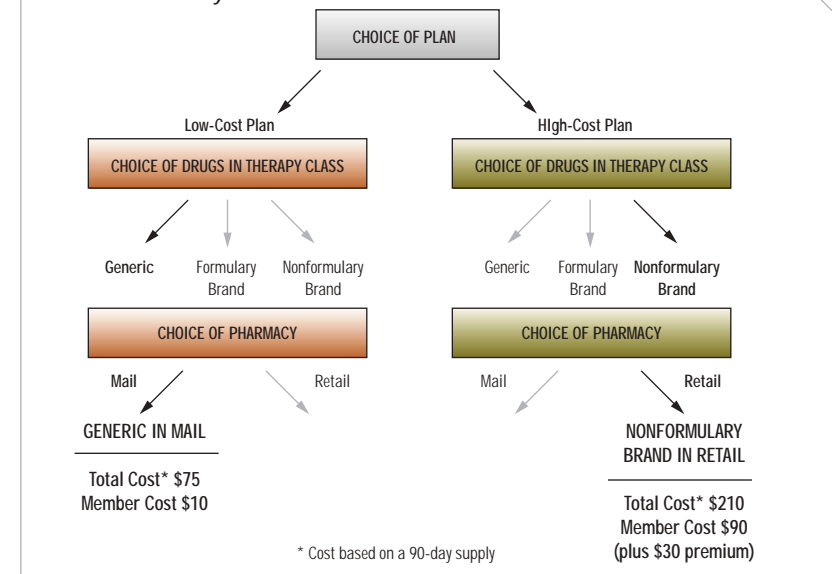
	Traditional	Member-Incented	Basic-Coverage
COST-SHARING			
Member Cost-Sharing	20%-30%	25%-35%	20%-30%
Copayment Structure	Two-Tier	Three-Tier	Two-Tier/Closed Formulary
Tier 1	Generics	Generics	Generics
Tier 2	Brands	Formulary Brands	Formulary Brands
Tier 3	N/A	Nonformulary Brands	N/A
Copayment Amounts			
Generics	\$5-\$10	\$5-\$10	\$5-\$10
Formulary Brands	\$15-\$30	\$15-\$25	\$15-\$30
Non-Formulary Brands	\$15-\$30	\$30-\$50	100% cost-share
Copayment Differences	At least \$8 between generic and formulary brand copayments	At least \$8 between generic and formulary brand copayments and at least \$15 between formulary brand and non-formulary brand copayments	At least \$8 between generic and formulary brand copayments
Generic Policy	Mandatory	Mandatory	Mandatory
DRUG COVERAGE			
Refill Restriction	Yes: 34-day supply per refill at retail	Yes: 34-day supply per refill at retail	Yes: 34-day supply per refill at retail
Quantity Limits	Basic: to safeguard against typos and fraud	Basic and Expanded: to ensure dosing within clinical guidelines	Basic and Expanded: to ensure dosing within clinical guidelines
Formulary	100% of drugs covered	80% of drugs covered at Tier 1 or Tier 2 amounts	60%-70% of drugs covered at Tier 1 or Tier 2 amounts
Prior Authorization	Administrative only (i.e., lost medication, going on vacation)	Administrative and clinical: includes drugs with significant potential for inappropriate use	Administrative and clinical: includes drugs with significant potential for inappropriate use
Step Therapy	No	Yes	Yes
Injectables	Specialty Distribution	Specialty Distribution	Specialty Distribution

For organizations moving from one general approach to another (e.g., traditional to member-incented), transitional plan designs can be used to facilitate the change. A common scenario for plan sponsors with open formularies and minimal use of POS programs is continued double-digit growth in pharmaceutical expenditures. While plan sponsors facing this scenario often desire to control drug expenditures more effectively, they may hesitate to implement changes due to concern about negative impact on employee-employer relationships. When challenged with the need to balance trend-management activities carefully with employee relationships, plan sponsors move to a member-incented approach and still maintain member satisfaction. One solution is to offer members a choice of pharmacy benefits.

Specifically, in this scenario, the plan sponsor could offer two plans: its existing benefit and an incentive-based, three-tier benefit. Monthly premiums for the existing benefit would be higher than premiums for the three-tier benefit, with the specific amount depending on the actuarial difference in cost between the two plans. Each member then chooses the plan he or she prefers. The plan sponsor will begin to experience savings as some members select the three-tier design and as manufacturer volume discounts increase on formulary brands.

Exhibit 44

Choice in Pharmacy Plans



Notes