

# STATE GOVERNMENT EMPLOYER-SPONSORED PRESCRIPTION DRUG COVERAGE

## STRATEGIES TO OPTIMIZE COST CONTROL AND USE OF PRESCRIPTION DRUGS

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# A REVIEW OF NINE STATES

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## I. Background and Overview

Since the mid-80's, spending on prescription drugs has started increasing faster than all other components of health care. The sheer increase in the drug component of employee health benefits, prompted most employers and health plans to aggressively seek cost containment and utilization solutions on how to better manage their drug benefits. This high growth in prescription drug spending raises serious concerns among states as employers as well as the state's employees, their families and state retirees. These concerns are complicated by a wide array of interrelated issues of affordability, an aging workforce, cost impact of chronic conditions, and the integral role pharmaceutical advancements and alternatives play in keeping people healthy and alive.

This paper explores the experiences of nine states by first highlighting leadership imperatives and the use of a strategic framework for making decisions and setting priorities around health policy, cost containment and design of employee drug benefits. Second, this paper examines a wide range of effective and innovative strategies to better manage drug coverage, costs and utilization while focusing greater attention on those beneficiaries with chronic conditions.

### Updated Trends in Drug Spend Paid by States and Other Payers

Demand for drugs will continue along with increases in spending, according to a revised report on U.S. health spending projections for 2004-2014<sup>1</sup>. The factors which constrained drug spending growth between 2001 and 2002 from 14.9% to 10.7 % (between 2002 and 2003), are expected to maintain their 'dampening effect' and will help brake the rate of growth according to the report analysts. What "factors" dampen the rate of growth according to this report? Increased availability and consumption of lower cost generic drugs, more people covered under tiered-copayment drug plans, shifts to over-the-counter products, and raising consumer cost-sharing.

In 2006, the same report, forecasts total prescription drug spending will grow by 11.6 % in a \$249 billion dollar industry. Medicare drug spending in 2006 is expected to reach \$69 billion, representing a \$67 billion shift in funding for approximately 38.9 million enrollees in the new Medicare Part D benefit. The shift comes from two primary payers, Medicaid and private payers. Medicaid's share of the total drug spend is expected to drop from 18.1% to 9.4% in 2006 as dual-eligibles receive drug coverage through Medicare. Private prescription drug spending is projected to account for 76% of all drug spending in 2005, falling to 59% in 2006, a "decline of \$23 billion."

Medicare Part D will provide Medicare beneficiaries with drug coverage as 1) part of a Medicare-managed care plan, 2) a drug-only private plan under traditional Medicare, or 3) through private insurance employer-sponsored retiree health plans<sup>2</sup>. *A majority of retirees with employer-sponsored drug benefits are expected to retain their private health insurance coverage.*

Prescription drug spending in the U.S. was \$179.2 billion in 2003 and approximately \$200.5 billion in 2004, nearly four times larger than the amount spent in 1993<sup>3</sup>. Even though prescription drug costs account for only 11 cents of each dollar spent on health care in this country, the drug component has grown at double digits for the past eight years<sup>4</sup>. According to the Kaiser Drug Trend report, three main factors drive increases in prescription drug spending: utilization, types of prescriptions used, and manufacturer price increases. Utilization accounted for 42% of the overall increases in drug

spending from 1997-2002. Newer/higher priced drugs replacing older, less-expensive drugs contributed 34% to the increase, and price inflation for existing drugs represented 25% of the increase.

Analysts cite multiple assumptions supporting their predictions that cost and utilization increases will slow through the year 2014. What factors underpin slowing the rate of growth, a key objective of state governments? Answer: expansion of proven, effective plan management tools such as prior authorization and step-therapy, additional increases in consumer cost sharing, and market price factors such as more drugs coming off of patent or drug products for chronic conditions such as allergies, shifting to OTC status.

### **Employers Proactive and Aggressive on Costs**

Employers (public and private) want to be proactive versus reactive when assessing options, implementing sound decisions on benefit spending and simultaneously be responsive to employee needs, such as increased workplace prevalence of chronic conditions and demand for new therapeutic trends. Employers fundamentally understand what's driving drug costs nationally, but find it difficult to nail down the specifics on their own plan spending and demographics, according to MEDSTAT analysts. They need to take action to identify the significant cost drivers, including top diseases and chronic conditions, that are costing the company the most in dollars, absenteeism, and loss of productivity.<sup>5</sup>

Public employers operate primarily in a commercial-like environment by offering a variety of "private insurance" plans (HMO, PPO), in many cases self-funded by the state. States are increasingly sophisticated in adopting private-sector cost containment strategies such as tiered formularies, utilization management, employee copayments, mail order, step therapy, and negotiating discounts from manufacturers. State governments, however, also face a number of obstacles in their attempts to make further improvements in their employees' health and drug benefits. These include legislative mandates, collective bargaining agreements, and obstacles to consolidated purchasing, performance-based contracting and vendor contract arrangements.

As employers, health plans, and other plan sponsors take aggressive and innovative steps to offer cost-effective and clinically responsible prescription drug benefits, the employee and the prescriber, who have been shielded from cost and quality information, will need education and coaching as they shoulder more responsibility for making wise and health choices.

### **What Challenges Exist? What Strategies and Tools Do State Employers Use?**

Nine states were selected for further study of effective, innovative, and emerging drug benefit management practices and tools in state employee/retiree programs and in bulk purchasing initiatives. The participating states include Georgia, Massachusetts, Mississippi, Ohio, Oregon, Pennsylvania, Rhode Island, Washington, and West Virginia.

Six of the nine states identify that their priority strategies for controlling cost and use of the employees' prescription drug benefit must be in alignment with the state and the agency's overall objectives. Five of the nine states indicate that strategies must improve care for chronic and complex

conditions and one-third of the states indicate impact in terms of savings on the drug benefit is important while also reigning in cost of medical premiums for health benefits.

## **Methods Used for this Report**

### *Selection of States' as Employers*

Following completion of a Literature Review, nine states were identified for further study on the subject of proven and innovative drug cost management tools in state employee/retiree programs and in bulk purchasing initiatives. The states featured in this report are Georgia, Massachusetts, Mississippi, Ohio, Oregon, Pennsylvania, Rhode Island, Washington, and West Virginia. These states met several criteria, in that the state stood out as an innovator or early adopter of cost and utilization management strategies, had at least two cost containment initiatives for a minimum of one year, have reported “results” in costs and/or utilization, and may have one or more specific strategies that are a focus of increased scrutiny statewide or in the country.

### *Qualitative Interviews*

Methods used for this report included an on-line Feedback Form to capture state demographics and strategic objectives of the state leadership and specific to the employee benefit program. Information captured in the Feedback Form guided direct telephone interviews with the key state officials and personnel responsible for employee health benefits and the prescription drug component. Six key topic areas provided the focus to 1) the online Feedback Form, 2) structured interviews and 3) the capture of supporting information and data. The six topic areas covered the State's top challenges, strategic framework and approach to decision-making, key attributes of cost management strategies, measurement of impact and effectiveness, emerging issues and trends, and finally, state insights on future research and technical assistance needs.

The in-depth qualitative interviews were supplemented by examination of Feedback Form submissions and secondary sources of information such as state government and agency websites.

### *Limitations of Report*

The parameters of time, resources, and reliance on respondents submissions, imposed certain limits on the scope and details contained within this report. The scope did not include conducting site visits, nor an exhaustive review of “best practices” among state government as employers. The examination of innovation, and best practices in this report is a qualified one. The author believes the participating states and various drug benefit management practices are deserving of recognition and further study. The goal here is to identify and disseminate information about cost and utilization management practices being implemented or under way to better manage spending on prescription drugs including methods states use to align drug benefit design to enhance overall health of state workers, dependents and retirees. The individual states and strategies discussed within this report, may provide the states who participated and other stakeholders with a valuable exchange of ideas, discussion on the merits of emerging strategies, and benefit design innovations needing further study.

## II. Strategic Framework

### Top Challenges Facing Employers and Employer-Sponsored Drug Benefits

Drug costs and demand are driving changes in plan benefits, but despite state and state employee agencies efforts to slow the rate of increases, the total cost—the employer and employee share--continues to rise dramatically. Costs are just one aspect state employers face in their search for solutions to the drug benefit conundrum. State policymakers are navigating a highly complex environment in their efforts to balance the state’s available financial resources with an array of interrelated challenges:

- Cost trends that jeopardize sustainability of employee and retiree benefits;
- High political stakes with unions, providers and constituents may cause states to lag behind in adopting effective private sector strategies;
- Access to drugs and coverage issues associated with changes to the drug benefit design;
- Lack of reliable and/or easy-to-retrieve cost, quality, performance information;
- “Value” impact of medicines on an aging workforce and increasing prevalence of chronic conditions;
- Buy-in barriers to cost-sharing and resistance from consumers and providers to change; and
- Conflicts in purchasing models and vendor business practices.

Benefit consultants frequently advise their employer clients that traditional cost management tactics, when applied incrementally, experience limited success in sustaining impact and control over pharmacy costs and use by consumers, and may actually have a potential downside impact on other component costs such as hospitalizations and emergency room visits. State governments are becoming more strategic in the development and implementation of a broad mix of policies and practices that can be sustained in both the short and long-term plans of the state. This is the focus of this report.

In a recent study released by Hewitt Associates, it was found among 500 major U.S. employers who cover more than six million beneficiaries, that companies believe incremental change and traditional cost containment methods are insufficient to close the gaps between inflationary increases, consumer and provider demand, and what the employer can afford.<sup>6</sup> State governments, like their private sector peers, are also recognizing the need for next-generation cost containment strategies that impact on costs, influence smarter consumer behavior, require investments in decision support tools and provide communication and education that result in better outcomes for workers, their families, and their employers.

### Case Study Snapshots

Active management control of employee pharmacy benefits can lower drug spend dramatically. Having a strategic framework that provides the backbone for decision-making and effective benefit management is receiving much more attention in the literature.<sup>7</sup> Public and private sector employers

are pinning their hopes on a combination of strategies to avoid the double-digit drug trend growth of the past five years.

For their candor and sharing of detailed program initiatives, the states are to be commended, especially for sharing critical insights on what works and what frustrated their efforts. These states, with geographic presence in all regions of this country, are cautiously optimistic about the future of employee drug benefits and the potential impact of long-range strategies not only on drug spend trends, but employee health.

Common themes in the following state examples of a strategic framework include:

*Consolidation and centralization, restructuring to create joint purchasing opportunities, rewarding high performance and cost efficiencies, building capacity and infrastructure, use of joint labor-management teams to build concessions, policy innovations with emphasis on evidence-based tools, and worker benefits' structure impact on state "fiscal fitness."*

### ***Consolidation and Centralization of Multiple Programs***

- ***Georgia's*** General Assembly authorized creation of a centralized super-agency in response to growing concerns over fragmentation of health care delivery at the state level. Their goal: To become "a national leader in innovative health planning, promotion, progress and services to improve community health." The aggregation of multiple health programs, benefit plans and three state agencies into the Department of Community Health (DCH) has provided Georgia with a lead planning agency for all health issues in the areas of health policy, purchasing and regulation.

***Georgia's*** Department of Community Health administers all state-funded pharmacy programs --Medicaid, PeachCare for Kids, Board of Regents Health Plan (BORHP) for higher-education employees and the State Health Benefit Plan (SHBP) for state employees. Given the potential advantages and related challenges, the state adopted an approach focused on proven management strategies from the private sector to control costs and utilization of prescription drugs. With realignment of agency resources, the Department of Community Health (DCH) is charged to: "serve as lead planning agency for health issues in the state; maximize the state's health care purchasing power; minimize duplication and maximize efficiencies by removing overlapping functions and streamlining uncoordinated programs; develop a health care infrastructure more responsive to consumers while improving access and coverage; and promote wellness."<sup>8</sup>

Consolidation occurred on July 1, 1999. A nine-member board provides policy direction and sets rules and regulations for the Employee Benefit Plan, which includes responsibility for plan design, member and employer contribution rates, and approving contracts for insurance, health services, and administrative services. The new Board succeeds the Board of Medical Assistance as well as subsuming authority of the State Personnel Board in matters regarding the State Health Benefit Plan. The Composite Board of Medical Examiners, the State Medical Education Board and the Health Strategies Council are also under the Department for administrative purposes.

### *Consolidation and Centralization of Multiple Programs - Cont'd*

- In January 2003, **Pennsylvania's** Governor Rendell signed an executive order creating an Office of Health Care Reform (OHCR), charged with advancing the state's health reform agenda and streamline an inefficient multi-agency system of health care. The state's Pennsylvania Employees Benefit Trust Fund (PEBTF), formed years ago through collective bargaining to manage the health benefits for active employees, participates in discussions of issues with OHCR. PEBTF Board members include seven union trustees and seven management personnel. The Commonwealth provides a collectively bargained amount to the Funds in this defined contribution plan and, the Trustees make all the decisions regarding benefits levels and eligibility.

The executive office of the governor contracts with PEBTF to administer the retirees' benefits. The executive branch retains policy and administrative authority to determine benefit level and eligibility. "There are only minor disadvantages to the structure, and major advantages of economies of scale, lower administration costs and other cost saving initiatives by piggy backing onto the active employees," according to Matt Waneck, Group Insurance Section Chief.

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### *Restructuring to Create Joint Purchasing and Resource Coordination Opportunities*

- **Washington's** legislature acknowledges through passage of SB 6088 that prescription drugs are an effective and important part of efforts to maintain and improve the health of Washington residents. However, increases in cost and utilization are severely straining resources of many state health care programs. The Health Care Authority (HCA) is charged with providing access to quality affordable health care—which extends to each of its health care programs: Basic Health (private plan coverage for low-income residents), Community Health Services (nonprofit clinics for uninsured, under insured and Tribes), the Public Employees Benefit Board (PEBB) and the newly created Prescription Drug Program.

2003 Legislation created **Washington's Prescription Drug Program** to develop a consistent evidence-based methodology for identifying preferred drugs within a therapeutic class, make drugs more affordable to Washington residents and to state health care programs, and increase public awareness of safe and cost-effective use of prescription drugs. HCA administers the program working with the Departments of Social and Health Services, Medical Assistance Administration and Labor & Industries.

Led by HCA, an "*Agency Medical Director's Group*" (consisting of eight state agencies), was created to identify new ways to improve quality of care; ensure cost-effective purchasing of health care services, and simplify administrative rules on providers participating with state's health care programs. Express Scripts is the PBM under contract with HCA and the worker's compensation program, but Medicaid still retains benefit management service in-house along with negotiation of prescription drug rebates.

- In 2001, **West Virginia's** Public Employees Insurance Agency (PEIA) led a coalition of RX Issuing States (LA, MS, MO, NM, and SC) to collaborate on executive activities and



## *Restructuring to Create Joint Purchasing and Resource Coordination Opportunities - Cont'd*

enabling legislation to create joint purchasing opportunities, counter detailing, utilization activities, pharmaceutical strategies, and advocacy activities for the group. As a result of the efforts of the initial steering Work Group, RXIS established an ASO (Administrative Services Only) model to hire a common Pharmacy Benefit Manager that negotiates and purchases drugs for states' employees and/or Medicaid.

The intended benefits: reduce pharmaceutical costs within state employee and/or Medicaid programs, capture rebates from manufacturers, and reduce per-unit administrative expenses. The hurdles were several: multiple state regulations, political will, different practice patterns, and time allocation. One year later, several benefits were realized and passed to the States: all rebates due to utilization, market share and rebate administrative fees. For West Virginia, PEIA's individual savings were \$6.6 million, with rebates of \$14 million (~11% of drug spend, up from 5% in 02). The drug trend for 2003 was 11%, far below the 23% originally projected for 2003. In July 2002, PEIA executed new contracts with participating states Missouri, New Mexico and West Virginia, followed by Delaware and lastly by Ohio, July 1, 2004. All total, over 700,000 lives are covered.

Recently, the *West Virginia* legislature passed the *West Virginia Pharmaceutical Availability and Affordability Act of 2004* creating the *WV Pharmaceutical Cost Management Council*. The mission: to promote healthy communities; protect the public health & welfare, and make every effort to provide affordable prescription drugs to all state residents. Membership includes five public members: a licensed pharmacist/retail, a pharmaceutical manufacturer with WVA operations, a primary care physician, a beneficiary, and an employer offering Rx coverage. The Council has authority to investigate the feasibility of purchasing Canadian drugs; establish a pricing schedule; explore numerous strategies, policies and programs associated with reference pricing for prescription drug purchases and pricing in the state; study fiscal impact of the Medicare Modernization Act (Part D Prescription Drug Card); implement certain programs, i.e., a pharmaceutical discount program; recommend state responsibilities and rule-making; and identify potential use of savings. In its short history, the West Virginia Council, comprised of lay professionals and state agency professionals, has delivered four statutorily mandated reports and was instrumental in passage of a resolution to establish a new position, that of Pharmaceutical Advocate.

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### *Rewarding High Performance and Cost Efficiencies*

- *Massachusetts* history of successes in managing employee health benefits provides a solid track record to build new initiatives such as sharing cost increases with enrollees and creating incentives for employees and providers to take responsibility for health decisions. The Group Insurance Commission (GIC), established fifty years ago, administers health insurance and other benefits to the Commonwealth's employees, retirees, dependents and survivors. In addition, GIC covers personnel from Housing and Redevelopment and some retired municipal employees and teachers. The Group Insurance Commission is a quasi-independent state agency governed by an 11-member Commission appointed by the Governor. Representation includes labor, retirees, public taxpayers, administration, and economic professionals. The

## *Rewarding High Performance and Cost Efficiencies - Cont'd*

mission: Deliver high quality care at a reasonable cost. Several health coverage options are available to employees: they include an indemnity plan, a Preferred Provider Organization (PPO), Point of Service Plan and multiple HMO plans. In addition, GIC also offers two-pretax programs – a Health Care Savings Account and Dependant Care Assistance Program.

Addressing *Massachusetts'* cost problem is a major goal. GIC works with vendors selected through competitive bidding to offer cost-effective services through rigorous plan design and careful management. GIC's strategic plan includes a major component of collecting data to demonstrate cost efficiencies of doctors and hospitals. Through collaboration with health plans, GIC has implemented tiered health benefit plans that reward high performing providers, and incent enrollees to choose quality and cost-effective providers by requiring less out-of-pocket. Tiered physicians' prescribing patterns are one of the various components that undergoes review. GIC has also received national attention as a model of government working collaboratively with the private sector to address cost and quality issues. These efforts are not without challenge, mainly coming from providers who are apprehensive with a ranking process and making results public. The initial findings are presently being discussed with providers.

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## *Building Infrastructure to Support Long-range Planning*

- *Mississippi's* Office of Insurance changed the way they managed their employees' health benefits plan in 1994. They are now self-insured supported by a new agency infrastructure that was recruited to gain the necessary functional expertise. Ten years ago, certain actions were taken, which included carving out the pharmacy benefit and utilization management from the contract with the state's third-party administrator, currently Blue Cross of Mississippi. According to the state, this helped the state capture and control the level of detail on the pharmacy benefit, associated costs and utilization of the drug benefit, and addressed concerns associated with the state agency's dependence on one vendor to do it all. Agency staff review claims data on a regular basis and evaluate trends and high cost/utilization patterns. The state agency receives recommendations from the PBM, consultants, and the agency's actuary. The agency then evaluates the impact of proposed changes and present final recommendations to the Plan's governing board for approval.

Rising costs associated with prescription drugs tops everything in the state's challenges to be addressed. The legislature says "*the state cannot pay for increases*" and the state employees say "*they can't shoulder any more out of pocket.*" According to the state's Insurance Administrator, Therese Hanna, the agency staff spends the largest share of their time, looking at containing costs with an eye toward developing a long-term strategic approach to benefit initiatives. *Mississippi's* personnel turnover is at a low 10%, meaning most employees stay with the benefit plan through retirement. According to Hanna, "Targeting cost containment on certain drugs might save us money today, but if it's not done right, it will cost us much more down the road." Hanna represents a unique skill set for her role as Insurance Administrator. The state specifically recruited leadership skills associated with experience in

public health and public policy. Hanna is quite unique among her peer group in the current industry.

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### ***Joint Labor-Management Committee Successfully Builds Consensus and Concessions***

- ***Ohio*** is a leader state in a highly organized labor market when it comes to influencing action on initiatives that ensure access and affordability of prescription drugs. Concern over big cost hikes for drugs and out-of-pocket costs motivate state workers to work with their unions and their employer. Efforts focus on how best to preserve health benefits and prevent additional cost-shifting to the workforce and their families. Health benefits are administered through the Human Resources Division, Office of Benefits Administration Services, the Department of Administrative Services (DAS).

***Ohio's*** state employee benefits are collectively bargained. Prior to contract negotiations, DAS and the Joint Health Care Committee, comprised of representatives from unions and management, explore a variety of options to curtail health care and pharmaceutical cost increases for the state and its employees. As a result of these joint labor-management efforts, the state has been able to successfully negotiate rates with health plans that included changes in the employees' copay and coinsurance amounts resulting in monthly premiums that remain relatively unchanged.

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### ***Policy Innovations in Response to Cost Crises Drives Heavy Emphasis on Evidence***

- ***Oregon*** has been a leader for a number of years in response to past cost crises by developing policy innovations that continue to serve as models to other state purchasers and managers of state-sponsored health benefit programs. Despite their innovations, the state still faces complex problems that according to Jean Thorne, Administrator for the Public Employee Benefit Board (PEBB), "requires a vision and a long-term strategy." In 2002, Oregon's Public Employees' Benefit Board (PEBB) characterized the current marketplace as 'broken' and sought help to actualize a Vision 2007 that focuses on a new state of health statewide for its members. A number of components underpin the State's vision: evidence-based medicine to maximize health and utilize dollars wisely; improving quality and outcomes; promoting consumer education and informed choices; market and consumer incentives to encourage the right care at the right time; system wide transparency through explicit and understandable reports on costs/outcomes/data; and benefits that are affordable to the state and its employees.

***Oregon's*** heavy emphasis on evidence-based medicine, is particularly important given the continual cost increases in health care and prescription drugs, Oregon's Public Employees' Benefits Board is seeking systems of care that include enhanced coordination, efficiency and accountability. During 2004, PEBB contracted with FACCT (Foundation for Accountability), a national nonprofit organization focused on health quality measures and consumer education, to help review the prescription drug programs to date and develop criteria and program recommendations that would be incorporated in an RFP released in 2005. Note: FACCT was disbanded in late 2004, and David Lansky, PhD, the former

## *Policy Innovations in Response to Cost Crises Drives Heavy Emphasis on Evidence - Cont'd*

President (and the person who worked with PEBB), is now working with the Markle Foundation, according to Jean Thorne, Administrator for the Board.

The work of **Oregon's** Health Services Commission is noted for its role in prioritizing health care services. The Commission's outputs include the Prioritized List of Health Services, the development of a Prioritized List of Benefit Packages and focused efforts on savings that could be achieved thru the 'elimination of obsolete treatments, redundant diagnostics, and ineffectively treated conditions'.

Perhaps, more importantly—and more directly tied to prescription drugs—is the work of the Health Resources Commission (HRC), says Jean Thorne, Administrator. The HRC, in collaboration with the Oregon Health and Sciences University (OHSU) Evidenced-Based Practice Center, has undertaken systematic evidenced-based reviews of prescription drugs. More information is found at:

<http://www.oregon.gov/DAS/OHPPR/HRC/index.shtml>

- **Washington's** General Fund and Health services accounts deficits have caused significant budget cuts across state agencies including the state's lead agency for four health programs, the Health Care Authority (HCA). Although the Public Employee Benefits Board (PEBB) received increase funding, the funds did not fill the gap of rising costs, so PEBB members saw increased premiums and higher out of pocket for brand name drugs. The increase of 20% to provide health care coverage to Washington state employees was not unique when compared its neighbor state of California who was experiencing similar increases for their employees during the same time period. The newly created *Prescription Drug Program* is a joint effort and consists of five main components: a Medicaid Prescription Drug Assistance Program, a Senior Prescription Drug Discount Card, a "Pharmacy Connections" program, a Senior Drug Education Program, and an evidence-based preferred drug list (PDL) with a Therapeutic Interchange Program (TIP). A progress report was just submitted as mandated in January 2005.

**Washington's** HCA uses its existing pharmacy benefits management contract with pharmacy benefit manager, ESI, to develop an endorsing practitioner database that allows practitioners to sign up as an endorsing prescriber and allows pharmacists to determine the status of the provider. ESI also coordinates with HCA on outreach, customer support, and providing statistical data to the agencies.

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## ***Worker Benefits Structure Contributes to State's "Fiscal Fitness"***

- **Rhode Island** is an early adopter of cost control strategies, but the current administration has identified the need for *additional* controls to achieve further reductions in health care costs. The executive office believes this requires an examination of all parts of the system: insurers, providers, usage, prescription drug costs and tort reform

## *Worker Benefits Structure Contributes to State's "Fiscal Fitness" - Cont'd*

**Rhode Island's** Governor Carcieri describes state spending as out of control with three years of structural deficits of more than \$200 million per year.<sup>9</sup> He described a vision for state spending that proposes \$62.8 million in carefully chosen cuts and state personnel reforms to close the gap in state spending deficits, citing a \$23.7 million-cost increase in state employees health care benefits believed to be "too generous." The increase of 18.3 percent in one year, reflects total spending of \$153 million, which has nearly doubled in past five years. Proposed state personnel reforms include higher individual contributions for health and prescription drug benefits.

For 2005 several actions are pending at the time of this report. The Governor is creating a senior level health policy advisor to identify options and opportunities, assembling community leaders to address major cost drivers causing escalating health premiums. The Department of Health is investigating the feasibility of Canadian drug purchases and rule changes to attract more insurers to the state, and legislation to reduce costs associated with lawsuits. In addition, the state will strive to be the first "well" state in America, with 20% of all workers having access to disease prevention and health promotion in the work site by 2006.

In 2004, **Rhode Island's** executive branch launched a "Fiscal Fitness" team of 55 employees, an outgrowth of the "Big Audit" to study ways to reduce costs and streamline operations. The primary target: \$180 million in savings per year for next five years, totaling \$650 million in savings. The scope of these savings will draw from organizational changes, overhead consolidations, personnel benefit reforms, and operational improvements. In examining worker benefits, Rhode Island concludes that the health benefit structure is "out of step" with private sector, federal employees and two neighboring states, Massachusetts and Connecticut. The full report was published March 2005.<sup>10</sup> Included in the report, are examples of Rhode Island's steps to smarter buying. For example, 'the new United HealthCare Contract to administer the state employee health care program will save taxpayers \$25 million in administrative fees over the previous contract with BCBS of Rhode Island. A new Preferred Provider Network will help Rhode Island better manage pharmaceutical costs, with actual savings as of February 28, 2005 of \$1.5 million. With better monitoring and controlling the "maximum allowable costs" of individual prescription drugs, Rhode Island has saved an additional \$468,000.'

State employees have a long history of generous health benefits at **no cost** to the employee! State employees will now share in the cost of health care benefits among non-union classified employees with resulting savings of \$400,000. A similar cost-sharing program is currently being negotiated with various unions of organized state employees that has projected savings of more than \$18 million annually. A comprehensive study of the state's current employee health plan recommends updating copayment amounts, evaluating covered services, and encouraging use of generic prescriptions.

### III. Pharmacy Benefit Management Strategies Examined

The root causes of inflation in pharmacy benefit costs and use are not new to state employers. Despite early adoption of traditional cost control methods, state employers are facing the reality that these traditional methods, inclusive of managed care plans' performance, are not sufficient to keep pace with today's challenges of ensuring a sustainable worker benefit.

In the states, employee benefit programs are leading the way through implementation of effective benefit design strategies that are cost-effective and member-attractive. States demonstrate that they are highly motivated to ensure that their employees and retirees' pharmacy benefit programs are focused on securing the best outcomes at the lowest possible cost.<sup>11</sup>

#### Case Study Snapshots

Below are descriptions of current state initiatives to control costs and use of employee drug benefits. Critical insights from each state are represented, often in the state's own words, on some of the most promising and pioneering approaches to managing employee prescription drug benefits.

#### *Administrative Efficiencies and Coordination*

- As of June 2001, **Georgia's** Department of Community Health (DCH) consolidated drug purchasing through a financial buying arrangement with a single **Pharmacy Benefit Manager** (PBM). Express Scripts, Inc. (ESI) was contracted to act as PBM for Medicaid, PeachCare for Kids, and the State Health Benefit Plan for employees (SHBP). In addition, the Board of Regents Health Plan (BORHP) was also included in this contract. Savings were expected to result from the network of providers, negotiating discounts and rebates, prior authorization of certain drugs, and significant plan design changes related to drug utilization the following year, i.e., three-tier formulary. The Medicaid drug purchases have since been excluded in order for the state to keep its Medicaid rebates.

**Georgia's** State Health Benefit Plan (SHBP) had recently incurred considerable losses with increases in drug expenditures of more than 25% before the pharmacy programs were combined under a single pharmacy benefit manager. The year after implementation of the PBM contract, DCH personnel say the rate of drug cost increases dropped to 17%. Georgia identified a number of tactics to achieve savings and streamlining such as changes to the health plan coverage options, expanding its Maximum Allowable Cost (MAC), implementing a "Customized Preferred Drug List," program oversight via a centralized super-agency, and contracting with one Pharmacy Benefit Manager. Of these, the state reports the top strategies having the most impact in managing the drug component for state employees are: "preferred drug list management," "prior authorization inclusive of quantity level limitations and adoption of step-therapy programs; concurrent and retrospective drug utilization review."

The Department has reduced the annual growth rate in its pharmacy program expenditures, but continues to look for ways to contain costs within this fastest-growing component among

### *Administrative Efficiencies and Coordination - Cont'd*

all four health plans. The state, through its PBM, implemented several drug management cost control initiatives: a point-of-sales system; an aggressive maximum allowable cost (MAC) program; a most-favored nation program with improved enforcement; a three-tiered co-payment structure applied to a preferred drug list; an expanded prior authorization program; a policy of cost avoidance for members with other health insurance; and clinical intervention programs

DCH is currently engaged in a contract re-bid<sup>12</sup> for the department's Pharmacy Benefit Manager. Objectives for 2005 range from developing a strong data infrastructure across program lines, education incentives for physicians, improving patient compliance and outcomes associated with treatment regimens, vendor transparency, passthrough of rebates, and helping DCH manage the pharmacy benefit as a more integrated component of total health care costs.

- In April 2004, **Pennsylvania** launched a new initiative, the *Commonwealth Pharmacy Policy and Administration Project*, intended to centralize prescription drug policies and administrative functions of all the state's pharmacy programs. The Pharmacy Policy and Administration Project is an outgrowth of work started in March 2003, by the Governor's Office of Health Reform, through its Medication Task Force. One co-director comes from the state's PACE program. The other co-director is the Governor's chief of staff in the Office of Health Care Reform.

The Governor's Office of Health Care Reform (GOHCR) plays the lead role in coordinating the project. Specific goals include: Uniform policies and procedures; negotiation of fees, prices, and rebates; centralized oversight of procurement of prescription drugs for programs that directly purchase from the manufacturer; coordinate collection, analysis and dissemination of data; act as clearinghouse of knowledge and technical expertise and monitor national trends and best practices in other states. The **Pennsylvania** Employees Benefit Trust Fund (PEBTF) management participates as part of this effort and is involved in a consolidated audit project every two months, to monitor the result and effectiveness.

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### *Consolidated Purchasing and Administration*

- **Georgia** covers almost two million recipients between Medicaid, the SHBP and the Board of Regents, with pharmacy costs and use rising substantially across all three plans. Between fiscal year 1999 and 2000, Georgia's Medicaid pharmacy expenditures increased almost 23% to approximately \$539 million, excluding drug rebates. Georgia's consolidation helped the state create a change agent in the Department of Community Health (DCH) with added flexibility to implement plan design changes, leverage purchasing power in aggregate purchasing arrangements with vendors, and optimize the impact of applying consistent management strategies across disparate programs and benefit silos. The *Drug Purchasing Program* is the only **consolidated purchasing** under DCH currently, and it has had its share of unique obstacles not encountered in the private sector.

## *Consolidated Purchasing and Administration - Cont'd*

The state's approach to consolidated purchasing and streamlining administration proved easier for **Georgia** to adopt in their traditional commercial plans offered in Georgia's State Health Benefit Plan (SHBP) for employees than in Medicaid. Medicaid and PeachCare for Kids (the state's SCHIP program) both have less program flexibility and must comply with Federal rules. According to Jerry Dubberly, Director of Pharmacy Services, all states face the same dilemma "when managing benefits in an environment where you must treat preferred and non-preferred drugs differently for different program coverage and different populations, it is not conducive to negotiate and contract drug rebates across three separate lines of business." Note: The state did originally plan to institute a common preferred drug list across all programs, but as of 2004, the state started using a different Preferred Drug List (PDL) for Medicaid and PeachCare for Kids, to maximize the state's ability to solicit supplemental rebates from drug manufacturers under these federally subsidized programs.

*In a recent internal evaluation, the question was asked. "To what extent has the state saved money by combining all health care purchases under DCH?"*

The state's evaluation confirms that drug purchasing is the only area of consolidated health care purchasing under DCH currently. The combined drug purchasing was achieved through the use of a Pharmacy Benefit Manager. DCH personnel believe the rate of increase in drug costs declined after implementation, but no information had been developed on the exact amount of cost savings directly attributable to combining drug purchases isolated from services provided by the PBM and resulting plan design changes. The report notes that the average increases in Per Member Per Month (PMPM) drug costs for state workers were only 5.27%, compared to most health benefit plans experience of 17%-19% during the same period.

- In **Oregon**, the Public Employees' Benefit Board (PEBB) was created in 1997 by merging two predecessor boards– the State Employees Benefit Board and the Bargaining Unit Benefits Board. By bringing two boards together, PEBB is expected to deliver increased efficiencies and more leverage in the marketplace to get a better deal for members and the state. PEBB is the largest employer-based purchaser covering a diverse geography of urban, rural, and frontier areas.

PEBB currently contracts and administers the medical, dental, life, accident, disability and long term care insurance benefits for ~ 110,000 employees, dependents and 3,000 retirees. PEBB operates within the **Oregon** Department of Administration Services and offers several health plans: a fully insured PPO underwritten by Regence Blue Cross Blue Shield of Oregon (95,691 PEBB members); a fully insured HMO option contracted out to Kaiser Permanente NW (15,236 PEBB members) and two lower cost medical and prescription drug plans through Regence Blue Cross and Kaiser Permanente with eligibility restricted to retirees and part-time employees only.

- Active employee benefits are administered by **Pennsylvania's** Employees Benefit Trust Fund (PEBTF) with joint management and union representation. All decisions are made by the Board of Trustees. The fund contracts with AON Consulting for professional advice on



### *Consolidated Purchasing and Administration - Cont'd*

benefit issues. Retiree benefit plans are set by the Governor's Executive Offices, supported by fund staff who serve as advisors to the active health plan and provide recommendations on the retiree benefits, generally to take advantage of the health fund's purchasing power when possible. Pennsylvania has a separate contract with Mellon Human Resource consulting to obtain professional advice on plan design. The Governor's Office of Health Care Reform (GOHCR) is charged with oversight and coordination of Pennsylvania's health care policy, and has input on retiree benefit design issues. The fund's PBM identifies patterns of use and recommends specific interventions, such as in the recommendation to cover and reimburse diabetic supplies for retirees. The Governor's Office of Health Care Reform, is looking at consolidation efforts, but there are no immediate joint purchasing efforts from the perspective of employee benefits due to the politics and realities of labor relations; most of the state's bargaining agreements were recently collectively bargained in August 2003.

- In *West Virginia*, the RXIS (Rx Issuing States) project was spearheaded by West Virginia and targeted public employees RX benefits in five states totaling 700,000 lives. ESI is the competitively bid PBM in each of the member states. A West Virginia-based pharmaceutical council is tasked to evaluate various methods to contain costs and improve administration through such actions as the creation of a "drug czar," a drug purchasing agreement, and reference drug pricing, etc. There is a possibility West Virginia may expand the eligible entities who can participate. A Joint Purchasing subcommittee has identified vertical and horizontal pooling opportunities to be evaluated by the newly created *Pharmaceutical Advocate*.
- Of the various pharmacy benefit strategies put in place, *Ohio* claims success in several accomplishments: becoming a member of a multi-employer coalition (RXIS) with annual state savings of \$4.3 million; achieving additional transparency standards in PBM contract negotiations as a result of RXIS and, individually implementing a four-tiered copay structure resulting in additional savings associated with increased generic utilization and cost shifting to employees.

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### *Information Systems and Common Data Repository*

- *Georgia* has taken aggressive steps to standardize its databases to enable data to be accessed and utilized for comparative studies and benchmarking across Medicaid, PeachCare, the SHBP and the Board of Regents Health Plan. As early as 2002, DCH decided to implement a comprehensive health care information system to consolidate three different computer platforms that could not interface across Medicaid, PeachCare for Kids, the SHBP, and the Board of Regents Health Plan. The state identified "significant opportunities" to gain administrative efficiencies, build data element uniformity, meet HIPAA requirements and realize savings from consolidation of data onto a single, common platform.

The customized state-of-the art technology project entitled "MHN" represented a highly complex project. The new system was intended to support DCH's needs in processing health care information, with implementation phased in through FY 2005. Ultimately, DCH planned

## *Information Systems and Common Data Repository - Cont'd*

to capture and analyze information about Georgia's health care system, identify health needs and trends, and develop policy recommendations and health outcome initiatives.

DCH launched competitive procurement and awarded the contract to Affiliated Computer Services, Inc. (ACS) as prime contractor and system integrator. The procurement represented the first time in the industry that a single vendor was hired by a state to process both Medicaid and state employee health benefit claims. The Medicaid phase of the project was implemented in April 2003. The second phase called for integration of the health claims payment system and membership enrollment management system for state employees. Increased costs associated with delays in system implementation, along with operational issues resulted in the second phase of the project between DCH and the vendor ACS being cancelled.

- The Group Insurance Commission recently received the *Massachusetts* Health Data Consortium's award, "**Investing in Information**," for two programs that help identify opportunities for potential intervention to improve members' care and reduce potential medical errors. The program through Tuft's plan uses software to detect inconsistencies with best medical practices and alerts the patient's physician. The "Unicare" program gives patients periodic health care statements to help the member improve his/her own health care. Commission personnel say they work with a great database, made up of both medical and prescription drug claims.
- In *Mississippi*, the state agency captures all medical and drug claims data from the *MEDSTAT* executive management system. It supports an important part of the state's strategy to have timely access to the data and to be able to constantly monitor what's going on in the benefit, according to the administrator. The state receives data from three vendors (the PBM, the Disease Management Vendor, and the Third Party health insurance administrator). Internal agency staff devote significant time to analyzing and modeling proposed benefit changes.
- *Ohio's* Human Resources Division, in the Department of Administrative Services (DAS) receives information and regular reports from the state's three vendors: the Third Party Administrator (Medical Mutual of Ohio), the PBM (Express Scripts), and the disease management vendor (Matria) for the state's self-insured PPO population of active employees. The state does not currently require uniform reporting guidelines and has difficulty in getting standard reporting form the managed care plans. The plans use different guidelines, show variation in target intervention and plan design, and have different ways of reporting data. This one issue was identified by the state as providing the impetus to carve out disease management from the PPO plan.

The state agency itself, belongs to the *State and Local Government Benefits Association* (SALGBA), a national organization whose membership includes municipal, county and state government benefits administrators and health promotion professionals. The association represents 40 states and 144 local jurisdictions comprised of five million employees, a million retirees, and gross health benefit expenditures over \$14 trillion per year. The State utilizes the resources and the network to research activities in other states and locals. In addition,

## *Information Systems and Common Data Repository - Cont'd*

DAS, is a new participant in the *Integrated Benefits Institute*, and a Benchmarking Program associated with absence management and state workers.

- In **Oregon**, AON, Inc. is the human resource and health benefits consultant to Public Employees' Benefit Board (PEBB). AON consulting conducts analyses upon request and serves in a role of being the keeper of the claims data, both medical and pharmaceutical. During 2004, PEBB contracted with FACCT, the Foundation for Accountability, to help review the prescription drug programming to-date and develop criteria and program recommendations that would be incorporated in the RFP released in 2005. FACCT was a national nonprofit organization and health policy research, now under the Markle Foundation.

AON Consulting was asked to 1) conduct an analysis of the PEBB prescription drug program including modeling potential use of an evidence-based reference-price formulary and 2) conduct a financial review to explore self-funding the prescription drug component of the PEBB program. AON Consulting provides insurance and risk management, human capital consulting in the areas of employee benefit, process redesign, and analysis of proposals.

- In **Pennsylvania**, top level reports are received from the state's PBM and the state has online access to the pharmacy data, which includes full range custom reporting capabilities. The Pennsylvania Employees Benefit Trust Fund (PEBTF) has a full-time auditor dedicated to monitoring the prescription drug program, including performance against the current guarantees in the PBM contract. All of the health plans, including the pharmacy benefit manager are required to send claims tapes monthly to PEBTF. PEBTF contracts with Ingenix, a firm created by UnitedHealth Group, to manage the data and allow for custom, detailed reporting. Ingenix is a national health data, information and research company that provides data warehousing and decision management systems.
- In **Rhode Island**, the department of administration and the benefits administrator solicited the assistance of the University of Rhode Island's (URI) Health Care Utilization Management Center (HUMC). HUMC is under contract with the State, provides consultant pharmacy benefit management services, whose scope includes clinical, strategic planning, marketing, contract development and maintenance, research, and quality management.

For specific conditions or disease states, i.e., asthma, HUMC examines utilization of products, costs, and drug product contraindications. Rhode Island through its contractor conducts pharmacy benefit review and analyses including utilization analyses. The HUMC scope under contract includes identifying opportunities for cost and utilization control that have not to-date been fully utilized, according to the Associate Dean at URI. HUMC expresses cautious optimism moving forward with the new insurance vendor for employee benefits, United Health Care.

- **Washington** state's goals include streamlining administrative procedures and making drugs more affordable. HCA contracts with Express Scripts, Inc. to develop and maintain a practitioner database to facilitate a **Therapeutic Interchange program (TIP)** statewide, which was started in 2004. There are preliminary statistics on those drug classes where TI

## *Information Systems and Common Data Repository - Cont'd*

is allowed. Cost impact studies are planned but not complete. The measurable goals have been set, but the interagency workgroup comprising three agencies, still needs to get together to establish common elements to enable comparisons of the data being examined. The State identifies a number of challenges that need to be addressed to examine effectiveness of such a program intervention. For example: How can you identify when a prescription was rejected for TIP? How can you identify what was actually dispensed and calculate cost savings?

- **West Virginia** emphasizes that the impetus behind a state choosing to sustain its own data warehouse is the reality of what happens when the state changes vendors (i.e., Third Party Administrator) on the medical side and the PBM on the pharmacy benefit side. The state is at risk of losing a lot of data if the losing vendor refuses to cooperate. WVA has data tapes from both vendors every month, enabling the state to examine outliers, disease states, drug trends, and other resource costs that might be going through the roof, according to Acting Co-Directors, Keith Huffman, Pharmacy Director, and Felice Joseph, Pharmacy Director. West Virginia wants flexibility, outside of reliance on individual vendors, in establishing how data is reviewed and to support specific efforts to manage and modify the design of employee benefits. There are specific monthly management reports generated within PEIA that trigger outlier pattern review.

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### *Pharmacy Benefit Plan Design: Stepwise Strategies to Managing Trends in Cost and Use*

- **Georgia** adopted a private sector approach to pharmacy benefit management in July 2001 by the state's pharmacy benefit manager, Express Scripts. Express Scripts recommends a stepwise approach to trend management and benefit design.<sup>13</sup> These steps include: formulary development, plan design with a three-year time horizon; a cost-sharing structure with emphasis on three tiers; use of OTC medicines; point-of-service programs, such as prior authorization/step therapy and quantity limits; and consideration of emerging plan designs such as member-incented consumer-driven plans and a basic-coverage option.

In Georgia, ESI implemented several of these strategies: a point-of-sales system; a maximum allowable cost program; a most-favored nation program (pharmacy network); a three-tiered co-payment strategy applied to a preferred drug list; expanded prior authorization; a policy of cost avoidance for members with other health insurance, and clinical intervention programs focusing on disease management and care management.

Express Scripts is the state's PBM for the State Health Benefit Plan, the Board of Regents Health Plan (BORHP), **Georgia** Medicaid and PeachCare for Kids programs. The overarching goal is to improve health by ensuring that prescription drugs are used appropriately and cost effectively. The Georgia Medicaid Drug Utilization Board coordinated with the PBM to create a customized preferred drug list (PDL) for the PPO and Indemnity plan types for state employees and Board of Regents education employees. State personnel describe how Express Scripts' national formulary served as a base to developing a customized list of drugs that specifically meet the needs of the diverse populations served by the aggregate purchasing group.

## *Pharmacy Benefit Plan Design: Stepwise Strategies to Managing Trends in Cost and Use - Cont'd*

The state health plan offers several coverage options including a PPO and Indemnity Plan that have two pharmacy plans: Basic and Premier. The Basic Preferred Drug List is not as extensive as the Premier Drug List; Co-payments are different and there are no Maximum Out-of-Pocket limits for the Basic pharmacy option. For the basic and premier drug lists, a medication becomes a preferred drug based first on safety, then efficacy, and finally cost-effectiveness according to Georgia's PBM, Express Scripts. The pharmacy drug lists are created, reviewed, and continuously updated by a team of health care professionals including physicians and pharmacists.

### ■ *Formulary Strategies*

- In **Ohio**, an unusual concession was negotiated in 2004 to adopt a four-tier copayment structure as part of the collective bargaining agreement to help close the gap of serious state budget crunches. Nan Neff, Benefits Administrator explains: "To the union membership, health care benefits remain the unions' number one priority—well over wages. The union leadership recognized that concessions were necessary and agreed to make changes in the prescription drug benefit in order to preserve the 90:10 split on their monthly health care premiums." The state has a history of being very responsive to its employees, and in return the unions work collaboratively with the state for short-term and long term initiatives. A recent example, was the state's response to the Vioxx, Celebrex, and Bextra scares. The state chose to wave individual copays for a sixty-day period as beneficiaries made the transition with their providers to generics and alternative drug products.
- **Rhode Island** adopted 1) a three-tier formulary with copayments four years ago with an overall goal to encourage the use of generics initially. Even though tiered copays are standard practice in the private sector, it is less common in state government, particularly in the northeast states, where according to a recent survey, only 14 percent of northeastern states offer three-tier copayment designs to state employees<sup>14</sup>. The measurable impact: The percentage of generics dispensed among worker populations is currently 43%, higher than the average for state governments at 39% and comparable to private sector rates. Although plateaued in payback, the trend is stable, with the most sizeable impact in years one and two, increasing the use of generics 6% in 2002 to 11% increase in 2003.

### ■ *Cost Sharing Structure (Copayments vs. Deductibles)*

Many state employers are following their private sector peers in adopting and expanding the use of patient cost sharing and incentive-based formularies. According to a Rand study, potential savings from a three-tier benefit depends on where the drugs are placed in the tiers and on utilization patterns within the plan.<sup>15</sup>

- At the request of **Georgia's** State Budgetary Responsibility Oversight Committee, an internal evaluation, was published in January 2005 focused on fiscal years 2003 and 2004. Georgia has increased employees' deductibles and co-payments over the years, but amounts remain slightly lower in its largest PPO plan than the national average. Interestingly, the Georgia

*Pharmacy Benefit Plan Design: Stepwise Strategies to Managing Trends in Cost and Use - Cont'd*

General Assembly passed a resolution in 1982, that employees should fund ~25% of the cost of the state's health benefit plan overall.

In 2002, the state implemented a three-tier co-payment structure for drugs, followed by additional increases in 2004. In 2005, under the state's "Basic Option" all drug copays were reduced for generics and preferred brand name drugs by \$5 per script. The non-preferred brand co-payment, changed from the 20% coinsurance (\$35-\$100 max) to \$40, and no maximum out-of-pocket requirement. For those employees choosing the premier coverage option, the copays increased: \$40 for non-preferred brands with a maximum out-of-pocket increase from \$100 per month to \$450 a quarter for single coverage.

Under the state's PPO, *Georgia* requires copayments of \$15 for generic drugs, \$25 for preferred brand, and \$25-100 for non-preferred brand. This compares to other southeastern states where the range for generics is \$5-11; preferred brands, \$15-35; and non-preferred brands, \$30-\$50.

- *Massachusetts* has already implemented what it considers to be a short-term cost saving approach, as did most employers, which included raising copays and deductibles in FY 03. The end results were reductions in the state's costs of more than \$100 million over the last three years. Prior to FY 2000, GIC used a two-tier copayment plan for brands (\$10 copay no matter the brand) and generics (\$5 copay). In FY 2000, GIC adopted a three-tier copayment design to direct members to cheaper and/or more effective brands, with copays currently at \$7/\$20/and \$40. In modeling this option, the state looked at the amount the copayment generates in savings, the tolerance of the member, and the current budget as a whole in the Commonwealth. The GIC HMOs already utilize a three-tier copayment structure (generics, preferred brand, and non preferred brand) which, according to the state, maintains a broad choice of covered drugs while providing incentives to use medications in a safe, effective, and less costly manner

"Generics Preferred" is Express Scripts program which provides incentives for GIC members to use the generic version of a brand-name drug. Not using the generic versions costs the member more. If the doctor writes, "Do Not Substitute" for a non-preferred brand, the member pays the generic drug copay and the difference in cost between the generic and the non-preferred brand drug. GIC knows what initiatives are showing results, i.e., the three-tier plan design is keeping their trend line down. Before the three-tiered plan, the PMPM cost trend was 20% and dropped to 14% in 2001. In July of 2000, following adoption of the three-tier design, it went down to 6%. According to the state, "That time span drop does not reflect the change to member copayments that did go up. It does reflect the shift in use of drugs that were less expensive." The next year the cost trend rose to 17%, primarily due to utilization. The demographics of employees and retirees in the self insured plan are older and more chronically ill. The average age is over 50 and almost all Medicare retirees are in this specific plan. Two years later, the GIC increased copayments and the trend line went back to 9%. Trend numbers are based on total gross costs. The following year, the cost trend was at 10%.

*Pharmacy Benefit Plan Design: Stepwise Strategies to Managing Trends in Cost and Use - Cont'd*

- Cost sharing, prior authorization, and hiring a PBM are the top strategies deployed in **Mississippi**. Although not measured in hard numbers, the cost sharing and deductibles are believed to have had a significant impact on cost containment. The state has a three-tier copayment plan with a generic incentive. The beneficiary pays a copay and the differential in cost, steering employees toward the generic or the preferred brands. The agency also wants to increase the rebates to offset the states overall cost. The state reviews performance metrics and has seen a shift toward generics and preferred brands. For example, the generic usage rate overall is currently 49%, which is higher than many state employee plans but not quite as high as the commercial sector. Mississippi was seeing an increase in utilization of 10-15 % per year. When the state implemented the three-tier copayment plan and added a deductible of \$50, it dropped to almost nothing. “That was staggering,” according to Therese Hanna. “In the late 90's, the state saw significant increases of 15% increase in price and 15% increase in utilization, with an overall increase of 30%. That was the impetus to add the employee cost sharing which drove the trend of increases relatively flat!”
- **Pennsylvania** PEBTF identifies three key design strategies it considers most important and effective in controlling costs and utilization: the employee’s copayment representing an average of 20% of the drug cost, a mandatory generic program, and formulary management. There are distinctions in the features offered to active employees versus retirees, with the newer initiatives applicable to the active plan members and those employees who retired after July 1, 2004. The following “results” for CY 2003 were provided:
  - Copayment Changes (including three-tier formulary): Estimated savings: \$5.1M-\$18.3M; Actual savings: \$19.6 M
  - Clinical Program Changes: Estimated savings: \$7.1M-\$8.6M; Actual savings: \$10.8M
  - Step-Therapy Module Actual savings: \$5,706,576.

Back in the early 90's, **Pennsylvania** gave retirees prescription drug cards with a flat \$7 copayment, calculated to be, on average, approximately 20% of the total cost of the claims over the initial four years it was implemented. The copayment has not been adjusted since then. The State currently has a three-tier copayment structure for active employees that was put in place with the formulary in 2003. Prior to that, the state had an open voluntary formulary, which essentially had no ‘formulary’ controls at all, according to Matt Waneck, Employee Benefits Division.

**Pennsylvania** PEBTF has applied a mandatory generic reimbursement policy for 15 years. If a generic is available in any case, the member (active and retirees) does have a choice to request the brand name drug, but must pay the differential. There is no annual maximum cap. The metrics are an easy measurement, say Waneck: “What the people voluntarily paid out-of-pocket to get the brand drug equals the savings to the plan.” One minor difference for retirees, is that all diabetic supplies are covered under the prescription plan versus the major medical plan. The state found that the PBM could get a better discount price versus

*Pharmacy Benefit Plan Design: Stepwise Strategies to Managing Trends in Cost and Use - Cont'd*

reimbursing at retail under major medical. The metrics are an easy measurement-- what the people voluntarily paid out of pocket to get the brand equals the savings to the plan.

- **Washington** continues to actively manage their pharmacy benefit for state employees. Uniform Medical Plan (UMP) has continued to maintain a percentage coinsurance for prescription drugs purchased at retail pharmacies since 1998 despite market pressure to move toward a flat dollar copay. In 1991 UMP implemented a 3-tier cost structure based on whether a drug was a generic drug, a branded drug with no generic available, or a branded drug with a generic available. In 2001 UMP implemented a prescription drug deductible (separate from the medical/surgical deductible) for all prescriptions and a maximum coinsurance of \$75.00 for retail prescriptions. In 2003 UMP moved toward an incentive formulary and changed the amount of the maximum retail coinsurance and it no longer included Tier-3 drugs or prescriptions purchased at out of network pharmacies. Along with previous changes to the enrollees' cost share structure these actions are viewed by the state to be the "biggest cost saver." Washington is concerned about shifting all of the increased drug costs to its employees. Therefore, the enrollees' cost compared to UMP's cost is monitored to ensure that the state is not cost-shifting all increases to the enrollees, which is currently at about a 30% cost-share, on average.

Of the various cost containment and drug utilization strategies and tools available, the state of **Washington** chose to adopt changes to the pharmacy benefit which included incentive formulary benefit design, a preferred drug list (PDL) which were all implemented in 2003, along with the therapeutic interchange program designed to impact utilization of specific drug classes on the Washington Preferred Drug list in 2004. As with most 3-tier formularies, Washington employees/retirees pay less for Tier-two brand drugs on the state's formulary. Between 2001 and 2003, there had been a \$75 cost-sharing limit across all three tiers, which was revised in 2003. The cost-sharing limit was removed for non-formulary brand drugs on Tier 3. In 2003, for Tiers 1 and 2, for both generic and on-formulary brand-name drugs employees pay 20% or 30% of the cost of the drug respectively up to \$50 (for up to a 30-day supply), \$100 (for a 31-60 day supply) and \$150 (for a 61-90 day supply).

- For **West Virginia**, managing specialty drugs, increasing generic utilization, and disease management are top priorities for the state employee programs. West Virginia is a mandatory generic state. The general target is to increase generic utilization which generates lower cost overall for the state program. Through several generic initiatives, PEIA has increased generic utilization from the high forties to low fifties percentile according to Felice Joseph, Pharmacy Director. These initiatives were pursued due to the fact that the average cost of a generic drug is \$19 and the average cost of a brand single-source drug is \$90 for PEIA. Generic prescribing is also a key message of the clinical educator materials developed by the Clinical Pharmacy faculty at the university. The information provided is peer-reviewed by the Health Sciences Center faculty and the medical director of AIMS and PEIA.



*Pharmacy Benefit Plan Design: Stepwise Strategies to Managing Trends in Cost and Use - Cont'd*

- In **Georgia**, the alignment and application of consistent management strategies and physician education efforts have presented more of a challenge. The pooling arrangement excludes negotiation and purchasing for Medicaid and Peach Care kids which is performed by a separate vendor under contract with the same department. Georgia Medicaid was one of the first states, in 2001, to attempt to implement a three-tier plan design based on the common preferred drug list developed for all three state programs in the group.
- Interestingly, **Massachusetts** does not have high expectations that utilization is going to go down. Their perspective, like many employers, is that “there is an ever expanding array of treatable conditions with new advancements in drugs available. To not recognize the role and the value of effective prescription drugs would be wrong.”

More important than driving utilization down is to have an effective PBM design and manager for the formulary of preferred and non-preferred drugs. The Employer must be confident the PBM is managing well, that there are no conflicts of interest, and the clinical decision making is independent of what they collect in rebates. The state’s current PBM relationship with Express Scripts, is productive and positive, especially with the independent structure of their P&T Committee. Ninety-nine percent (99%) of the drugs currently dispensed are drugs listed on the preferred formulary.

- **Pennsylvania** is committed to eliminating inefficiencies and redundancies across pharmacy programs and reducing the \$3 billion spent annually on prescription medications. The state is looking to move toward consumer-focused drug policies to maximize savings. Current strategies in place include: a three-tier copayment plan, an incentive-based formulary, PBM services, provider profiling, price discounts, key product initiatives for specific conditions, disease management and a hybrid mail order option.
- “Care-focused Purchasing” Results in Provider-Tiers and Drives Quality and Cost Efficiency
- **Massachusetts** GIC has tried to find new ways to save money while improving quality of care in calibrating tighter requirements in the GIC health plan contracts and in the recent PBM RFP. Using current research, as in the 2003 Rand study, that showed less than 55% of patients receive care that meets medical best practice standards, GIC decided to address their quality gap through a *Clinical Performance Improvement Initiative*. GIC, in conjunction with their consultant, analyzes provider profiles based on quality and cost effectiveness. The information is used by GIC and plan administrators to steer enrollees to receive care from high performing providers. For example, two health plans apply lower out-of-pocket costs for plan members who select a hospital that demonstrates higher quality and is more cost effective.

GIC is a member of the Leapfrog Group, a coalition of more than 150 organizations committed to improving patient safety. Benefit guides help steer patient choice to hospitals that meet the “Leapfrog Quality Index” based on scientific evidence and best practices shown to reduce preventable medical mistakes, inclusive of prescription drug order entry on

## *Perspectives on Alignment of Drug Management Strategies - Cont'd*

computerized systems. See the Leapfrog Group's website for more details: [www.leapfroggroup.org](http://www.leapfroggroup.org) Through its work with a coalition of employers, 94% of Massachusetts hospitals now report their progress on measures in CY 2003, an increase of 16% in one year. In addition, health plans received more than \$69,000 in incentive payments for increasing enrollee admissions at hospitals meeting Leapfrog standards.

- **Oregon's** Public Employees' Benefit Board (PEBB) believes the current health care system is in crisis from the member to the provider, to the insurer. The following values are believed to be critical to providing high quality benefits: employee choice, a competitive marketplace, plan performance and information, employer flexibility in plan design and contracting, quality customer service, creativity and innovation, plan benefits as part of total compensation, and improvement of employee health.

For the past six years, **Oregon** has studied and analyzed its options for improving prescription drug programming for the state and PEBB members and with its carriers. In 2005, the Board was poised to make changes to the plan design that would have shifted from a three-tier with a flat copay, \$10/15/25 to a hefty coinsurance design with an out-of-pocket maximum. The Board felt there was NOT enough differentiation currently on the brand side, to cause members to think twice about their choices. Due to collective bargaining issues, the current Governor requested no changes be made until 2006.

Since 2001, **Oregon** has used its RFP process to query vendors to consider implementation of an evidence based-formulary with reference pricing. Each renewal year with carriers, PEBB has asked for cooperation in advancing a concept "developed in collaboration with the Oregon Health Sciences University in evaluating the clinical effectiveness of twelve therapeutic drug categories." In 2006, Oregon's PEBB will pursue a competitive bid and contracts to accomplish several objectives in its new *Pharmacy Benefit Management Plan*. The objectives of the procurement are: to increase use of appropriate generics, to increase member appreciation of evidence-based medicine, to encourage the most effective drug at the best price, increase member knowledge of medication effectiveness, reduce medication errors, encourage a shift to e-prescribing, collaborate to measure and report patient outcomes related to Rx; and integrate data with primary care providers.

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## ***Medication Therapy Management, Clinical Interventions and Care Management***

### ■ *Point of Service at the Counter: Step Therapy*

- In **Georgia**, a new *Progressive Drug Management Program (PDMP)* instituted by the state's PBM is designed to find the most appropriate drug treatment, called *step-therapy*. Before decisions are made, i.e., for step therapy or prior authorization protocols, **Georgia's** DCH looks at the relevant evidence supplied by the PBM and other sources to determine if the evidence is sufficient to support step therapy protocols, or if in fact there is evidence on contraindications or lack of evidence, that may require an "exception" process for prior-approval for certain medicines. The first "step" provides a proven less-expensive treatment known to be effective and safe. If ineffective, the individual patient progresses to another drug, but a prior authorization is required to obtain the drug most suited to the patient for specific therapeutic categories such as ACE Inhibitors and brand NSAIDs. Maintenance drugs are defined for specific chronic conditions where members can obtain a 90-day supply at one time. A joint effort focuses on utilization data, and recommendations from the PBM. ESI administers the step therapy edits using a prebuilt structure used with other state and commercial clients. The department works closely with its PBM, who provides statistics and benchmarks from the marketplace relevant to step therapy programs. Typically the PBM provides info on what the state can expect in terms of member disruption and savings.
- In **Massachusetts**, GIC members are encouraged to use the most appropriate drug therapy, specifically the use of effective, first-line drugs before more expensive, second-line alternatives for target conditions. The target conditions include: ulcers, pain/arthritis, allergies, high blood pressure, diabetes, topical dermatitis, ADD, ADHD, and depression. The state reports that approximately \$5 million has been saved since 2004.
- **Oregon** started three years ago with disease management programs for CHF, diabetes, asthma, and coronary artery disease. The Public Employee's Benefit Board does not separately contract with disease management firms. The Kaiser plan already focuses on disease management. PEBB has established a workgroup from both plans including representatives from public health. The group is conducting studies of costs associated with those having chronic disease and those without with comparisons of clinical measures between the two carriers for the target diseases. Drug coverage is included in the current carriers' programs and will be addressed as part of future disease management initiatives for target populations.
- In January 2004, **Washington** state agencies implemented a single PDL. As of Jan 12, 2005, it consists of 12 drug classes. An additional eight drug classes will be added during 2005 and reaching 24 drug classes by January 2007. With passage of the *Prescription Drug Program*, HCA and other purchasers developed an evidence-based prescription drug program including a Pharmacy and Therapeutics Committee which meets quarterly to consider reports on evidence of drug safety and efficacy produced by the Evidence-Based Practice Center at Oregon Health & Sciences Center. Once prescribers endorse the PDL, pharmacists will be

## *Medication Therapy Management, Clinical Interventions and Care Management - Cont'd*

required to automatically substitute the preferred drug, unless the script is for a refill of an antipsychotic, antidepressant, chemotherapy, antiretroviral, or immunosuppressive drug.

### ■ *Targeting Workforce Beneficiaries at Risk for Intervention and Disease Management*

- **Georgia** did not stop at plan changes, but looked to internal quality improvements, coordinated administration of the Board of Regents health Plan and by better management of chronic illness and disease. As of 2000, the state plan offers several disease management programs to improve health outcomes in employees/ retirees having congestive heart failure, diabetes and cancer of breast, lung or colon. Beneficiaries have access to enhanced benefits with participation which is voluntary. Added benefits include coverage of educational services.

According to Jerry Dubberly, “prior authorization, quantity level limitations and step therapy programs were instituted to ensure appropriate utilization of medications while minimizing the impact to members and providers.” The PBM works closely with the state, bringing statistics from the marketplace for additional targeted interventions such as step therapy programs. Performance parameters are identified and monitored for resulting savings and member disruption. The Division describes the political realities when identifying priorities and targets for intervention. For example, certain factors the state must consider include those areas that are most vulnerable to challenge from stakeholders and beneficiaries. For Georgia, this meant mental health drugs and coverage of drugs, i.e., Singulaire for asthmatics.

There are a number of state employee programs set up for asthma, oncology, diabetes, hypertension, and congestive heart failure. **Georgia** contracts with a care management vendor, a Wellpoint subsidiary, Unicare has been in place at least three years. The state identifies it is difficult defining a quantifiable benefit and the return-on-investment (ROI) of these programs. DCH relies on information and anecdotal results from other states and employers in the private sector. Intuitively, DCH knows there is a benefit, but to establish baselines and measurable results is still a struggle for the state and the industry.

- In **Pennsylvania**, two vendor groups, the state’s PBM and the disease management vendor, Intracorp, analyze and recommend specific targets for intervention and specific therapeutic classes. PEBTF supplies all of the medical and pharmaceutical claims data to a contracted disease management firm, Intracorp; this program has been in place three years. Implemented disease management programs focus on diabetes, cardiac conditions and pulmonary disease.

Mercer Human Resources Consulting was the HR benefits consultant until July 2004. AON is PEBTF’s new benefit consultant, who will generate a review of impact. The measurement of disease management programs, according to state personnel, will be disputed anywhere you go and anywhere you look. PEBTF is “comfortable” they are saving money with these initiatives. Mercer also confirmed that Intracorp was saving the state money ‘with qualifications’, stating it is difficult to measure cost avoidance, but working with a program the size of PEBTF, gives credence to the vendors reported results. For CY 2003, PEBTF

## *Medication Therapy Management, Clinical Interventions and Care Management - Cont'd*

submitted verification that projected savings for disease management was \$2,600,000 and the PEBTF achieved actual savings of \$4,800,000.

- **West Virginia** implemented a renal disease pilot program that has been in place one year and a diabetes pilot that has been in place for six months. Multiple sources were reviewed to help the state to identify high prevalence and high ticket conditions to target. The state agency is adopting a North Carolina approach by using pharmacists to counsel and educate members with diabetes. The program was implemented six months ago in a six-county pilot. According to the state, "The assumption is that a compliant diabetic properly managing their disease will utilize less resources including hospital and emergency room visits." The pharmacists' association is working on a collaborative practice act that is independent from the state's initiative.

### ■ *Waiving Copays Provides Incentives to Help Consumers and Prescribers Take Control of Chronic Disease*

- In **Mississippi**, certain initiatives are "just common sense" as seen in recent state actions to reduce financial barriers for Plan participants with diabetes. The state agency recently placed all of diabetics drugs and supplies on the lowest copay. "The State and School Employee's Insurance Plan charges the generic copay for all insulin products, syringes, needles, and testing supplies (lancets and test strips) without regard to branding. Non-insulin drugs for diabetics are assigned a copayment based on the type of drug (generic, preferred, other), as with all other covered drugs," says Therese Hanna, State Insurance Administrator.

The step is not viewed as standard within the insurance industry, but the state's action was done purposefully to eliminate barriers to access to much needed medication and supplies for employee members. **Mississippi** does have a state law on the books that requires coverage for equipment and supplies, including monitoring and insulin self-management for those fully insured plans regulated by the State Department of Insurance. This law does not apply, however, to Mississippi's State and School Employees Health Insurance Plan, because it is a self-insured governmental plan. Hanna clarifies that "the agency does "condition-coverage" diabetes education on whether the member actively participates in the disease management program as an incentive to participate. *Note:* As of May 2004, the National Conference of State Legislatures reported that forty-six states have some type of law requiring health insurance coverage to include treatment products and supplies for diabetics. The states without laws on the books include Alabama, Idaho, North Dakota, and Ohio.

- **Ohio** drug trends & cost increases are slowing, according to state personnel, but utilization among state employees is "picking up." Digging into drivers of utilization are the responsibility of the Human Resource Division as they evaluate inflationary increases over time, the reason for prescription drug cost increases, and the impact of collective bargaining benefit changes on prescription drug costs. Ohio examines strategies that will play a bigger role in controlling costs and influencing member health such as tactics to encourage generics and targeting specific drug classes and high-cost conditions for step therapy interventions.

## *Medication Therapy Management, Clinical Interventions and Care Management - Cont'd*

Current targets include: diabetes, asthma, heart disease, and cancer for disease and care management interventions.

There is data exchange between the state's vendors: the TPA, PBM, and disease management vendors. One example is diabetes: Without being too intrusive, the PBM pushes data to the disease management vendor to advise **Ohio's** employees with diabetes that if they voluntarily enroll in the diabetes care management program, they will receive their diabetic supplies at no charge and have access to nutrition counseling visits two per year at no charge.

### ■ *States Move Toward Innovative Evidence-based Formularies and Methods to Target High Cost Conditions*

- **Mississippi** identifies it is starting to look at the Oregon model of evidenced-based preferred drug lists, with an emphasis on contracts and vendor selection based more on evidence and less on rebates. The state wants disease management to be integrated with case management and utilization management. The state contracts with Intracorp, responsible for medical management and disease management programs. The MEDSTAT data is used to identify what disease to target. Heart disease is the number one cost to the plan. Asthma and diabetes are not in the highest cost categories but are amenable to disease management, so they are also targeted. In January 2005, Mississippi issued an RFP that incorporates the concept of medical management and integration of case management, utilization management, and disease management and includes wellness and health promotion. Mississippi endorses that pharmacy benefit management is viewed as one component of an individual's comprehensive medical care.

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## *Communication and Education: Consumer and Provider Center Stage*

### ■ *Consumers and Physicians at Forefront of Health Care Decisions*

- The overall provider environment continues to be difficult to deal with in **Mississippi**. Information, including recent Medicare and Medicaid data, indicates the state is a low performer in quality and outcome indicators. Medstat has supplemented this information with specific reports of practice patterns around individuals suffering from diabetes. The state insurance administrator believes the state will benefit from help in educating physicians and getting agreement on changes that need to be made. Approaches to the various medical schools have not been of help, which surprised the administrator since they too are covered under the state plan. There is resistance or avoidance by state leadership to confront the issue with the doctors regarding changes to the practice of medicine. According to the state personnel, employee education can only go so far in accomplishing improvements in clinical outcomes.

One example of the current environment involves recent statements by drug manufacturer representatives, who commented that sales reps fight for territory sales to **Mississippi**

### *Communication and Education: Consumer and Provider Center Stage - Cont'd*

providers. In one scenario, the state monitored the time line of Prylosec going generic. Nexium, the brand drug, utilization went way up, according to the state. The agency felt helpless to alter the prescribing patterns, yet, they did so on Singulaire by putting it on prior authorization and step therapy once they isolated that prescribers were prescribing the drug for simple allergies versus using OTC therapies. Mississippi uses this as an example of how prescribers, without appropriate incentives and clinical guidelines, may not voluntarily change their prescribing patterns. Additional administrative costs are then borne by the state to influence responsible changes in prescribing behaviors.

- **Ohio** identifies its top three most effective drug benefit strategies as the four-tier copay design; mandatory mail-order and step therapy for selected medications. The step therapy program has been in place ~ four years as part of the state's collective bargaining agreement with state workers. Working with specific utilization data on various classes of drugs, along with support from the state's managed care consultant, discussions were held with the unions regarding the benefits of **step therapy** for the membership and the projected cost savings. Baseline projections and actual results of the program were not available at the time of the interview.
- **Oregon's** PEBB is not the employer, and is restricted to various channels of communication, i.e., newsletters with the membership and statewide email across diverse IT systems. There is a two-year history when benefits were capped with no COLA increase, so tension exists between the unions' desire to maintain full benefits and PEBB's vision for more cost sharing tied to performance and responsibilities. In addition, membership continues to have a level of push-back when discussions occur around evidence-based medicine and personal responsibility.
- **Pennsylvania** stresses the need to communicate changes effectively and on a constant basis with employees and retirees. Several provisions such as the step-therapy protocols and quantity limitations, met with initial resistance from beneficiaries, but were not a concern once adequately explained. This highlighted the importance of the state's communication and education programs.
- **Rhode Island** describes administrative difficulties when attempting to make a coordinated change in benefits by negotiating with 32 union contracts as well as multiple vendors with redundant responsibilities spanning different periods of time. Open communication is essential to the successful implementation of benefit and drug program changes within a state population that is heavily unionized.
- **Washington's** HCA entered into an interagency agreement with the Department of Health to provide information on practitioners who have prescriptive authority in the State. The PBM uses this information to maintain the endorsing practitioners' database and matches practitioners by program identification number for therapeutic interchange purposes. The agencies also use this data to communicate with practitioners in the state. To publicize the endorsing practitioner program, the agencies worked with the Washington State Medical Association (WSMA), the Washington State Pharmacy Association (WSPA), the National

### *Communication and Education: Consumer and Provider Center Stage - Cont'd*

Association of Chain Drug Stores (NACDS), the Board of Pharmacy (BOP) and other stakeholders to develop outreach information and training materials. The agencies also held various general information sessions. Ten (10) training sessions were held with the State Pharmacy Association.

- **West Virginia's** PEIA participates in academic detailing, which is a one-to-one provider education technique for disseminating evidence-based and unbiased drug therapy information as reported in current medical literature and summaries of drug comparisons. Based on the theory that physicians are the common pathway for all clinical decisions, academic detailing is designed to “enhance prescribing behavior through persuasive credible, timely and actionable information.” Studies have shown that ~80% of prescribers are receptive to clinical educators and that academic detailing helps reduce medical expenses for a physician's patients.
- *Targeted Messaging and Tailoring Pivotal to Success and Acceptance*
- According to a 2003 survey conducted by Segal, **Ohio** has one of the highest rates of mail order usage among state government employee programs. Both Ohio and Vermont report over half of total paid claims were spent on mail order drugs. The adoption of mandatory versus voluntary mail order can have a sizeable impact in driving down drug costs over traditional retail for both brand and generic drugs. The value of the mail service, according to Pharmacy Benefit Manager, *Express Scripts*, comes from targeted messaging using the following parameters: Patients on maintenance meds, have 2 + refills at retail, are receptive to change and see value of mail service.
- **Pennsylvania** offers an interesting plan design feature, which actually is a substitute to mail order prescription drugs. The program permits active employees and retirees to get their maintenance medications at any Rite-Aid pharmacy, in addition to traditional mail order. The costs are basically cost-neutral for PEBTF; members pay slightly higher copayments to use Rite Aid. A number of members indicated they were uncomfortable with using mail order, so a modified feature was developed that is viewed as a value-add benefit for employee members. Members had expressed concerns over extreme temperatures when drug products are left in outside mailboxes, stating fears that their prescriptions may freeze or deteriorate in temperatures that reach more than 100 degrees, as well as concerns that mailed prescriptions might be lost.
- **Washington** advises states to “make slow changes” and be sure to communicate with all the stakeholders. UMP has been most successful in keeping their drug spend trends down, due to implementing the percentage coinsurance at the retail pharmacy. “It really lets the enrollee know what their drugs actually cost.”



## *Communication and Education: Consumer and Provider Center Stage - Cont'd*

### ■ *Aligning Interests: Employer, Consumers and Providers*

- Multiple communication channels, training sessions and education tools with membership, providers and stakeholders are vital in **Massachusetts'** pharmacy benefit initiatives and eventual success. Use of ongoing contacts by telephone, email, "*For Your Benefit*" newsletters paired with the annual *Benefit Decision Guide* help enrollees take charge and make smart choices. Internal operational meetings maintain a focus on reviewing customer service benchmarks, complex medical cases, benefit reviews, operational and system concerns, financial statements and feedback.

### ■ *Tiered Provider and Hospital Approach Means Less Out of Pocket for Consumers*

- **Georgia** uses limited provider profiling currently but sees an opportunity to expand this further when the state rebids the PPO physician network. The state will look closely at the use of incentives tied to prescribing patterns, with preliminary discussion on creating an incentive based on performance or a different fee structure based on performance. Currently, program incentives that pay prescribers additional reimbursement are not very audit-able, nor are there clear ways to demonstrate value. Unfortunately, the current program uses retrospective DUR thru the PBM, and is limited to letter communication channels with providers. According to state personnel, there has been limited success having the current program customized to DCH's needs.

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## ***Vendor Relationships and Performance***

### ■ *Revising Current Contract Expectations*

- In **Georgia**, State Health Benefit Plan contracts are under review for possible changes to reflect tighter performance expectations. For example the SHBP PBM, Express Scripts, is expected to provide 'some reporting', i.e., savings from prior authorization and quantity level limits programs. This information was not, however, provided by the state for purposes of this report. The PBM contract will be rebid with the proposal due in May 2005. For disease management, DCH does intend to revise current contract expectations to explicitly require certain performance guarantees, including asking the vendor to take risk on the administrative fee based on results. This year, there is a procurement to address disease management in the Medicaid populations well as state employees. The focus or target conditions are being left open, along with inclusion of a care management organization for the state.
- **Massachusetts'** contract with the current PBM expires the end of June. The RFP responses are under review as part of the competitive bid process. GIC is striving for optimal transparency, what kind of money the PBM is receiving, and the lowest price in this contract. At first glance, the bidders are responding to the state's new requests. The top changes to requirements in the RFP include: source of revenue, amount of rebates on specific drugs, and restrictions on selling patient information. Legitimate concerns on the part of vendors include the proprietary nature of what is disclosed.

## *Vendor Relationships and Performance - Cont'd*

Other differentiations in the bid process, include higher expectations in area of member services, specifically the call center activities and response to beneficiaries on prescription drug questions. The state emphasizes that “prescription drugs are the benefits that more people use more often than anything else.” In this plan, 88% of our members are filling a prescription over the year. The volume of calls on prescription drugs far exceeds the calls received about physician office visits. Ideally, the state would like to have rebates go away and has asked vendors to identify how they would price the contract without rebates. In addition, the RFP asks bidding PBMs to respond to two primary scenarios under Medicare Part D.

- **Mississippi** characterizes the PBM audit as a very important tool for the state agency with regards to assessing specific compliance areas of the contract and validating performance against contract guarantees for discounts and rebates, price of generics and brand name products. The state has recovered \$2 million per audit over the past two audits, and recommends that this sector of the pharmaceutical industry requires close scrutiny. State representatives, indicate that the next RFP will be very “transparent” regarding the true cost and spread of drugs.
- In **Ohio**, a Planning and Analysis unit is supported by a national managed care consultant. Recently, the pharmacy management account was funded by the state’s PBM with funds that are used to contract with a pharmacy consultant specialist
- **Oregon** has established new criteria for vendor proposals. Vendors must demonstrate an infrastructure and an approach to interfacing with the use of evidence-based research from Oregon Health and Sciences University (OHSU). To monitor vendor performance, PEBB currently uses traditional measures, such as percentage of claims paid in “x” days and audits on accuracy of claims. Currently, there is nothing specific regarding performance management of the prescription drug benefit.

One of the biggest challenges, according to this state, “is to manage current vendors, current benefits while going through the process of an RFP!” The Board will soon have to decide if they want to carve out prescription drugs. The PEBB just received authority to self-insure during the last legislative session. The RFP scope is drawing responses from both health plans and PBMs. One looming obstacle centers around the risk of insufficient reserves for PEBB. Depending upon the final structure of the management bids, there is a risk of insufficient funds for PEBB to self-fund everything, according to the state.

**Oregon** has expressed strong interest in pharmacy benefit designs which promote use of medications based on scientific evidence and which use reference pricing to encourage selection of the most cost effective drug. PEBB’s selection criteria for Pharmacy Benefit Management includes:

**Network Maintenance and Flexibility**, i.e., progressive concurrent DUR with early triggers of contraindications and fraudulent abuse;

## *Vendor Relationships and Performance - Cont'd*

**Benefit Provisions**, i.e., evidence-based reference priced formulary and assessment of program benefit effectiveness;

**Administrative Services**, i.e., claims administration system with advanced cost management tools and comprehensive patient and provider education;

**Data Management**, i.e., infrastructure for close tracking and monitoring of medication by primary care providers;

**Risk Management**, i.e., accept risk through performance agreements;

**Clinical Services**, i.e., physician profiling, specialty pharmacy management programs, and integration of both medical and prescription drug claims to enhance disease management initiatives, and

**Financial**, i.e., maximize drug savings through competitive pricing, discounts, dispensing fees, rebate sharing and formularies, and transparency and passthrough network rates and discounts.

- **West Virginia** expects to stay with the transparent contracts in the procurement of the PBM agreement. The original RXIS RFP was written as an ASO (Administrative Services Only) model with a higher flat administrative fee to gain the 100% pass thru of the rebates.
- *State Employers Turn to Benefit Consulting Firms for Modeling, Benchmarking and Targeting Change Areas*
- **Mississippi** underscores the value of having benefit consultants, such as PricewaterhouseCoopers (PwC) and data-decision support services from Medstat. These Hanna feels state governments are often criticized for their use of consultants with some constituents and policymakers complaining it is a waste of taxpayer money. States that use human resources and benefit consultants, generally agree that this criticism is short-sighted and is probably penny-wise and pound foolish when it comes to developing a solid and effective benefit design and modeling the impact of proposed changes in coverage and incentive structure.

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## *Emerging Trends*

- *High-Deductible Consumer-directed Pilots*
- For fiscal year 2005, **Georgia's** state Plan started offering a new Consumer Driven Health care option as a pilot program at three school systems, primarily in metro Atlanta. The pilot's products combine a high deductible and a Health Reimbursement Account (HRA). The HRA offers beneficiaries a rollover incentive to monitor and manage their health care costs. The

## *Emerging Trends - Cont'd*

specific premium rates for this pilot option are ~20% less overall than the PPO Basic option. Implemented in June 2004, the number of participating enrollees is less than 500 and it is still too new to evaluate. The state predicts they will eventually fold the drug benefit into the medical benefit. The “theory,” according to Department personnel, is to “give the consumer the first dollar responsibility for the first script drawn from their account, which will drive the consumer to be more responsible.”

Informal conversation with health benefits personnel, say anecdotal feedback so far is very positive. The 2nd year of pilots will be more telling, given one full year of claims. The state’s expectations for expansion, in terms of time line, are: Pilots for two years, results to be reviewed 6.30.06. The state’s desire is to finalize action and begin using some hybrid or combination of consumer-driven products in the following FY. DCH has oversight over the pilots with three vendors who administer each of the pilots. Challenges: What to do with retirees since pilots focus on active employees only?

### ■ *Innovative Generic Sampling Policy*

- **Oregon’s** employee baseline use of generics is currently at 46.6% under the Regents program one of the largest carriers in Oregon. For Kaiser members, utilization of generics in 2003 was 69.9%. PEBB will establish specific ‘uniform’ goals for the new contract period over the next three years. The state knows there is room for improvement and expressed interest in a number of innovative programs such as generic sampling provided to clinics in the Portland area. This region has had noticeable positive shifts in providers prescribing generics for their patients. Certain OTC drugs (over-the-counter meds, i.e., *Prylosec*) are now covered, with measurable cost benefits.

### ■ *Customized Strategies to Increase Compliance for Specific Chronic Conditions*

- **Massachusetts** has modified its Plan design to include a 4th tier effective July 1, 2005. The changes will include very low copays for generic statins (cholesterol-lowering drugs) and H2 antagonists (anti-ulcer drugs). Given the rate of inflation, the state is taking in less in copayments than when it started. For specific drugs, the Commission may lower the copay or give the drugs for free, giving members a financial incentive to use them.
- **West Virginia** has adopted AIMS (*Accessible Intelligent Medication Strategies*) in two geographic regions of the state in Morgantown and Charleston West Virginia, the largest concentration of state members. The WVA University School of Pharmacy developed AIMS for the WVA Public Employees Insurance Agency (PEIA). It is the first program of its type to be implemented by a state-level publicly funded agency using the specialized resources of the state land grant university. AIMS is designed to impact the rate of growth of pharmaceutical costs through total health care management and reduce disparities of treatments among patients and providers.

The voluntary initiative is conducted in cooperation with the **West Virginia** School of Pharmacy. A clinical educator (registered pharmacist) in each of those two areas conducts

## *Emerging Trends - Cont'd*

academic detailing. The therapeutic classes include antibiotics, anti-hypertensives, lipid lowering medications, gastric suppression and NSAIDs (nonsteroidal anti-inflammatory) drugs. This program won the 2004 innovator award and is based on evidence-based guidelines. The outstanding issue: Is the role of the clinical educator in competition with the PhRMA reps of the individual drug manufacturer?

In *West Virginia*, the program evaluation for the AIMS program compares target physicians' prescribing patterns with a control group, which found that targeted physicians had higher percentages of new prescriptions written for generics in the target therapeutic classes with more pronounced increases during the period the message was reinforced by the clinical educators. AIMS was selected as an Innovation award winner by a panel of state officials at the Council of State Governments (CSG) Southern Legislative Conference in August 2004. AIMS was one of two programs selected from ten Southern Regional finalists that were originally one of 237 national applicants!

### ■ *Mail Order and Networks*

- As *Ohio* moves to calibrate the prescription drug benefit even further, they are exploring opportunities that include expanding copay options, considering mail order policies that include differentials (voluntary over mandatory) and evaluating changes to the size of the pharmacy network.

### ■ *Specialty Pharmaceuticals*

- *Pennsylvania* is taking a preliminary look at changing coverage of extremely expensive biotechnical drugs (i.e., genetically engineered, growth hormones) through separate sources and optimal pharmaceutical channels which may force the state's decision to carve out or stay with the existing PBM carrier. In the past, the growth hormone drug was required to be accessed thru mail order where the vendor was able to purchase the drug at a better price. For an employee trust fund the size of Pennsylvania's, the current scenario no longer makes sense. In the mail order area, a provision to mandate use of mail order or restricted outlets for maintenance drugs has met with stiff resistance from the pharmacists' lobby. The provision was repealed when savings did not materialize, due to the copayments not being set at a sufficient differential for mail vs. retail.

### ■ *Part D and Medicare Modernization Act*

- *Massachusetts* believes one major issue for many years to come is the selection and response to Medicare Part D. Nineteen percent (19%) of the 50,000 GIC members are Medicare retirees. Medicare Part D drug benefit is a primary challenge with serious implications for a state as an employer. The state noted how timing was exceedingly awkward, with GIC having to make a PBM selection prior to finalizing its own response to Part D regulations. Of the approaches reviewed by the state: 1) GIC maintains current benefits which are more generous than Part D Benefits and takes the federal subsidy for state drug spending or 2) GIC

## *Emerging Trends - Cont'd*

becomes, thru one of the PBMs, their own Prescription Drug Program under the Medicare Benefit for the GIC retirees only, the state chose the subsidy route.

- **Pennsylvania** indicates that current increases in costs are not sustainable in the long run. Current considerations in working with consultants, Melon and the state's attorneys include: carve-out of the drug coverage from the current retiree benefit plans and providing a supplement to Medicare Part D, or implementing a Medicare Part D employer-sponsored plan. The Fund could conceivably save significant money over what is currently available directly for reimbursement under Medicare Part D. No final decision had been made at the time of the interview, but it is expected that Pennsylvania's work needs to be completed by summer 2005 and they will meet the required time frames in 2006.

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## **Marketplace Dynamics**

### ■ *State Employer Calls for Evidence and Results to Support Prescription Drug Benefit Design*

- According to **Massachusetts'** Assistant Director and Program Manager, David Czekanski, the state's HMOs are not as successful in keeping the drug cost trend line down. GIC does not set specific drug benefit expectations for the health plan, but does ask Health Plans to break out the prescription drug costs and trends at the time of rate renewals. HMOs in Massachusetts, who cover about half of the GIC population, typically have younger demographics where the prescription drug trend is less important to the total cost of care than the state's GIC self-insured plan. GIC works with vendors selected through competitive bidding to offer cost-effective services through rigorous plan design and careful management. GIC's strategic plan includes a major component of collecting data to demonstrate cost efficiencies of doctors and hospitals. Through collaboration with health plans, GIC wants to design health benefit plans that reward high performing providers, and enrollees to choose quality and cost-effective providers.

### ■ *State Employers Seek Further Consolidation in the Number of Health Plans They Contract with*

- **Oregon's** Public Employees' Benefit Board operates with a lean administrative staff, limited staff resources and an administrative overhead cost of .6 %. At its inception as a consolidated Board, there were 15 separate plan contracts. After the formation of the board in 2001, the Board reduced the number of plans down to three. One small regional HMO has since went out of business. Jean Thorne explains the impact: "By consolidating the number of plans in 2002-03, PEBB's Premium increases have generally been less than 10%, while other employers have experienced double-digit inflation."

## **IV. Insights and Implications**

The various drug benefit management strategies described by the states in this report show promise, with the majority of states indicating that the newer strategies are, in fact, measurable and will help

states stay ahead of the curve, at least for the near future, in managing their employees' prescription drug benefit plans.

However, a number of insights and challenges are raised by the states for further investigation and potential action:

- Challenge: States are building experience in PBM contracting in their state employee programs, but less so in large programs such as Medicaid due to federal regulations surrounding rebate and discounts. State programs see PBMs generally in a positive light as bringing an array of administrator services and an immediate infrastructure intended to impact access to drugs, better manage utilization and the cost control of drugs. As states leverage their sheer size and purchasing clout, PBMs are playing significant roles as benefit administrators in state government drug programs while serious concerns around contract terms, transparency, and business practices still need to be addressed.

Action: Issues that merit close attention include PBM business practices, transparency, disclosure of pricing and payment structures, contract terms with drug manufacturers, use of savings, conflict of interest around steering patients to PBM-owned mail order services, retention and passthrough amounts of rebates.

- Challenge: Gaining functional efficiencies and measuring results of consolidation efforts of multiple health programs.

Action: Georgia believes there must be in an environment where you can treat drugs (preferred and non preferred) on an equal basis and drive market share. On Medicaid, prior-authorization is required, and on the commercial side for employees, there is a higher copay required. Despite this obstacle, DCH has gained more aggressive discounts from drug manufacturers wanting preferred status for products made available to state employees and board of regents' populations.

- Challenge: Mixed signals and timing of benefit changes. In Massachusetts, there was strong member reaction during implementation of the three-tier formulary and when the state raised the members' copay. Benefit changes were also implemented during the same period the state was making the transition to a new PBM. The incumbent PBM had lost the contract. The members directed a degree of ill will regarding benefit changes toward the new vendor versus recognizing the two issues were unrelated.
- Challenge: The role of the Federal Government. Some states suggest the federal government could play a stronger role in defining best practices and changing the public climate through education and outreach along the framework of the Dec. 9, 2004 Consumer Reports, "Best Buy Drugs: Proven, Effective, Affordable."
- Challenge: Mississippi is seeking additional information on strategies to address prescribing patterns of physicians. When new drugs are introduced, physicians are encouraged to prescribe the new drug. The plan members move from the old drugs to the new drug, which is much more expensive but may not offer any additional clinical value. In order to address

over-utilization, the state puts the new drug on prior authorization, which results in higher administrative costs and member and provider dissatisfaction.

- Challenge: Some states are looking for information, support, and specific tools that evaluate the link between benefit design and utilization on worker productivity and absence management.
- Challenge: Assessing the value of prescription drugs and measuring the payback for employees and employer-sponsored plans. How do employers, state agencies, and plans assess value of medications and coverage options to keep workers more productive and less absent?
- Further investigation? Ohio referenced the addition of a fourth-tier copay structure and the increased cost-shifting as having significant effect in influencing employee behavior. For mandatory mail order, Ohio has achieved levels of participation that are the highest in the country for state government. The work with the unions is also groundbreaking and should be of interest for heavy labor/unionized states.
- Alignment challenge: Tension between unions' desire to maintain full benefits and employers' vision for more cost sharing tied to performance and accountability. Explore additional information on tools and strategies to address member push-back when discussions occur around evidence-based medicine and personal responsibility.
- Challenge: Certain states are currently testing new options and innovations. The states' experiences with certain innovations are too early in their implementation to assess and provide an objective review of processes, strategic framework and results.
- Challenge: Given that this report captured top spending categories for nine state employee programs, the data may be useful to drill down into the specific uses of such information and resulting strategies or programs targeting prevalent chronic illnesses in the workplace and initiatives that reduce worker absenteeism, i.e., diabetes, migraines, depression.
- Challenge: Information sharing is welcome on cost-saving initiatives of other employers—state, local, and private. For example: what web-based tools for employees are effective in developing well-informed consumers? Are there best practices in employers' communication programs with members and with providers that have proven effective.
- Challenge: One recommendation for the Federal government is to place additional emphasis on managing the “patient as a whole” and the impact of lifestyle changes on health outcomes versus continued emphasis on management of just the drug component.
- Challenge: Provide More detailed information and further exploration of employer use of pilots to break down resistance barriers with members and with providers.
- Challenge: The state of Washington described the value of sharing regional information. For example, the NW Pharmacy Benefit Managers Association and Medical Directors meet quarterly, which also provides opportunities for networking between private payers and the



public sector. The state suggests it would be interesting to be able to compare PPO cost containment and drug benefit management approaches in the private sector.

## Endnotes

1. Stephen Heffler et al, "U.S. Health Spending Projections for 2004-2014," *Health Tracking*, W5-74, February 23, 2005.
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3. Sources: Data from CMS, Office of the Actuary; and the US Department of Commerce, Bureau of Economic Analysis and Bureau of Census.
4. Source: "Prescription Drug Trends," Kaiser Family Foundation, October 2004.
5. Helen Lippman, John Malley & Ron Bachman of PwC, Jon R Comola, Marcia Comstock, Wye River Group on Healthcare, et al, "An Employer's Guide to Pharmaceutical Benefits," March, 2003.
6. "Health Care Expectations: Future Strategy and Direction." Hewitt Associates, February 2005 release.
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8. Georgia Department of Community Health, FY 2000 Annual Report.
9. Governor of Rhode Island, Donald L. Carcieri, "State of the State Message"- February 3, 2004.
10. "Fiscal Fitness Highlights", Rhode Island's Governor Donald Carcieri, issued March 1, 2005, website accessed May, 2005, <http://www.governor.ri.gov/fiscalfitness/>.
11. Andrews, Sheila, "New Pharmacy Benefit Strategies for Union Trusts," *Benefits Compensation Digest*, Vol. 42, No.4, April 2005
12. Notes drawn from Offerors' Conference, PBM RFP, 4.13.05, State of Georgia, Department of Community Health.
13. Express Scripts, "Drug Trend Report, Featuring The Pharmacy Benefit Guide," June 2004.
14. "2003 Segal State Health Benefits Survey: Prescription Drug Coverage For Employees And Retirees." Winter 2004, Segal Benefits, Compensation and HR Consulting
15. Geoffrey Joyce et al, "Cost Sharing Cuts Employers' Drug Spending—but Employees Don't Get the Savings," Rand Health, Research Highlights, 2002.



## Participating States: Profile, Contacts and Key Links

Kudos to the participating states and those responders who invested time and effort to candidly share insights on pharmacy benefit management: strategies, successes, and lesson learned

### **Georgia**

Name: Jerry Dubberly  
Title: Pharmacy Director  
Name: John Upchurch  
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[jdubberly@dch.state.ga.us](mailto:jdubberly@dch.state.ga.us)  
Direct Phone: 404-657-4092  
Agency/Agencies Represented: Department of Community Health (DCH)  
Website: <http://www.communityhealth.state.ga.us/>

**No. of employees** enrolled in state's drug plans: 299,068;  
**No. of Retirees:** 95,294. CY 2004  
**Total Annual Drug Spend- Minus Copays:** \$283,741,386  
**Amount Paid PMPY:** \$1426.86  
**Average Scripts Dispensed PMPY:** 18.75  
**% Generics Dispensed When Available:** 42.2%

### **Massachusetts**

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Email: [david.czekanski@gic.state.ma.us](mailto:david.czekanski@gic.state.ma.us)  
Direct Phone: 617.727.2310 x7035  
Agency/Agencies Represented: Massachusetts Group Insurance Commission (GIC)

**No. of employees** enrolled in state's drug plans: 178,962 actives total ; 79606 in ASO;  
**No. of Retirees:** 86,611; 73,708 in ASO FY 04  
**Total Annual Drug Spend- Minus Copays:** \$153,157,326 ASO only; \$200,205,654  
**Amount Paid PMPY:** \$84.31  
**Average Scripts Dispensed PMPY:** 18.64  
**Generic Dispensing Rate:** 99.9% dispensed when available; 55.4% of scripts are generic

### **Mississippi**

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Department of Finance and Administration  
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Direct Phone: 601-359-6708, 601-359-5006  
Agency/Agencies Represented: Department of Finance & Administration  
Web: <http://knowyourbenefits.dfa.state.ms.us>

**No. of employees** enrolled in state's drug plans: 118,000  
**No. of retirees:** 18,000 CY 2003  
**Total Annual Drug Spend- Minus Copays:** \$90,549,049 FY 2004  
**Amount Paid PMPY:** \$455  
**Average Scripts Dispensed PMPY:** 13  
**Generic Dispensing Rate When Available:** 88%; overall 49%

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**Ohio**

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Agency/Agencies Represented:  
Department of Administrative Services

Name: Nan Neff  
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Direct Phone: 614-466-8857, Toll-free: 800-409-1205  
Agency/Agencies Represented:

Human Resources Division, Office of Benefits Administration Services,  
Department of Administrative Services  
30 East Broad Street, 28th Floor, Columbus, Ohio 43215  
<http://das.test.ohio.gov/hrd/benindex.html>

Web:

**No. of employees** enrolled in state's drug plans: 42,500 (self-funded PPO)/53,175 overall  
**Total Annual Drug Spend- Minus Copays:** \$59.8M CY 2004  
**Amount Paid PMPY:** \$1407  
**Total Scripts Dispensed PMPY:** 17.1  
**% Generics Dispensed When Available:** 46%

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**Oregon**

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Title: Director of Operations  
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Direct Phone: 503-373-0800  
Agency/Agencies Represented:  
Public Employees' Benefit Board (PEBB)

Name: Jean Thorne  
Title: Administrator for the Board  
Email: [Jean.I.Thorne@state.or.us](mailto:Jean.I.Thorne@state.or.us)

Website: <http://egov.oregon.gov/DAS/PEBB/index.shtml>

**No. of employees** enrolled: 45,606 and dependents for a total of 115,304  
**No. of Retirees:** 3482 non Medicare retirees 114 state agencies and 7 campuses of University System  
**Total Annual Drug Spend- Minus Copays:** \$47.2 million  
**Amount Paid PMPY:** \$ 484  
**Average Scripts Dispensed PMPY:** 9.6  
**% Generics Dispensed When Available:** 46.6%

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**Pennsylvania**

Name: Matt Waneck  
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Public Employee Benefits Trust Fund (PEBTF) Division

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Fax: 717-787-7763

Agency/Agencies Represented:  
Executive Offices

Website: <http://www.pebtf.org/default.asp>

**No. of active employees** enrolled in state's drug plans: 82,000  
**No. of Retirees:** 62,000 CY 2004  
**Total Annual Drug Spend- Minus Copays?:**  
\$276,550,000  
**Amount Paid PMPY:** \$1964  
**Average Scripts Dispensed PMPY:** 30  
**% Generics Dispensed When Available:** 49%

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**Rhode Island**

Name: Susan Rodriguez  
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Rita Marcoux, Center Director  
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[larrat@uri.edu](mailto:larrat@uri.edu)  
Direct Phone: 401-222-3454  
Agency/Agencies Represented:  
Department of Administration

**No. of employees** enrolled in state's drug plans:15697 actives; 3750 early retirees  
**Total Annual Drug Spend- Minus Copays:**\$ 34,051,160  
**Amount Paid PMPY:** \$1909  
**Total Scripts Dispensed PMPY:** 15.4  
**Generic Dispensing Rate:** 43%

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**Washington**

Name: Donna L. Marshall, PharmD  
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Direct Phone: (206) 521-2037  
Agency/Agencies Represented:  
Washington Health Care Authority

**No. of employees** enrolled in state's drug plans:83,077  
**No. of retirees:** 19,095 CY 03  
**Total Annual Drug Spend- Minus Copays:** \$70,701,971  
**Amount Paid PMPY:** \$692.50  
**Average Scripts Dispensed PMPY:** 12  
**% Generics Dispensed When Available:** 37.6%

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**West Virginia**

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['khuffman2@wvadmin.gov'](mailto:khuffman2@wvadmin.gov)  
Direct Phone: (304) 558-6244, Ext 243  
Agency/Agencies Represented:  
Public Employees Insurance Agency

**No. of employees** enrolled in state's drug plans: 137,000  
**No. of Retirees:** 44,000  
**Total Annual Drug Spend- Minus Copays:** \$148,406,547 before rebates  
**Amount Paid PMPY:** \$820.07  
**Average Scripts Dispensed PMPY:** 18.42  
**% Generic Dispensed When Available:** 99.03%