
Executive Summary and Recommendations
(excerpt related to drug co-pays)

- Continuing ongoing efforts that encourage the use of generic drugs, when available. Consideration should be given to a policy that requires employees to pay the full marginal cost of brand name prescriptions when medically equivalent generics exist. Further, policies should also be explored that further discourage the use of high priced drugs in instances where there is no scientifically credible evidence of significant benefit compared to the generic equivalent (e.g. Nexium vs. Prilosec OTC). Re-evaluating coverage for lifestyle drugs should also be considered.

(excerpt from Body of Document)

Variable cost sharing – pharmacy. The use of variable cost sharing is currently most advanced for the prescription drug benefit. The current drug benefit is four-tiered. The first tier, lowest co-payment, is $10.00 for generics based on a 30-day supply. Co-payments are generally more favorable for 90-day supplies through the Caremark Mail Service. For brand name drugs, the pharmaceutical benefit manager, Caremark, maintains a list (or “formulary”) of preferred drugs. Preferred brand name drugs have a $20.00 co-pay and nonpreferred a $40.00 co-pay. Bio-tech drugs are the fourth tier, with a $50.00 co-pay. Consultant Roger Feldman recommended taking this approach and going a step further. In cases where a generic equivalent is available, enrollees could be asked to pay the full difference in cost if they select a brand name drug. Such a policy would strengthen the incentive to adopt generics when they are available. It would preserve some coverage for brand name drugs when generics are an option but would place the full extra cost on an enrollee making this choice. The Task force believes that this recommendation is appropriate and fair.

In some areas of treatment, generics may exist along with brand name drugs that have no exact generic equivalent. For example, Nexium – prescribed for treatment of acid reflux and for preventing ulcers is a drug still under patent protection with close generic or over-the-counter substitutes. A generic may work well for some enrollees, while others respond much better to the brand name drug. A possible response is to create a protocol under which a generic (or lower costing brand name drug) is tried first, but if it proves ineffective, the patient is moved to the more expensive drug. Cost sharing might be set quite high (i.e., the full difference in cost between the high- and low-cost treatment) for those who do not follow the protocol and set lower for those who do. This is an idea well worth exploring, but it should be done in a way that maintains or improves quality, and the benefits in lower treatment costs need to be compared with the extra administrative costs required.