

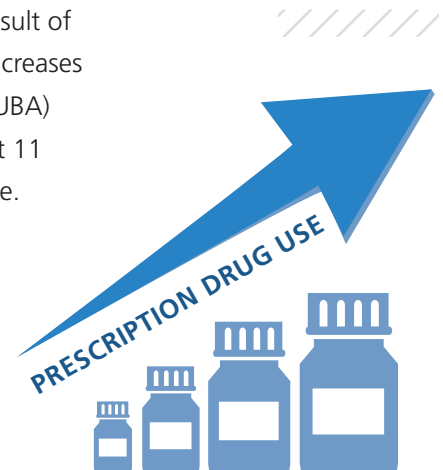
## SPECIAL REPORT: Trends in Prescription Drug Benefits



Prescription drug benefits of today look vastly different from just three years ago as a result of employer responses to the Affordable Care Act (ACA) as well as rising drug costs and increases in prescription drug use among Americans. According to The United Benefit Advisors' (UBA) Health Plan Surveys, tracking the benefit trends of around 10,000 employers for the last 11 years, we are able to see the specific changes in the prescription drug benefits landscape.

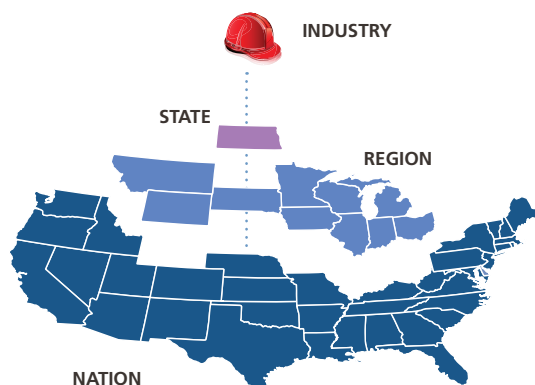
**In this special report, UBA's data trends show:**

- Most employers are choosing to fully insure their prescription plans.
- Only a very small percentage of employers still offer one- or two-tier prescription drug plans; most offer four tiers or more.
- Employers continue a steady move away from copay-only prescription models. Most employers utilize a combination of copay/coinsurance models.
- A majority of employers are moving to a single deductible for medical and prescription drugs; separate deductibles are quickly becoming a thing of the past.
- Mail order prescription drug plans continue to move toward becoming more of a convenience than a savings tool.



As employers continue to utilize cost containment strategies that shift more of the cost to employees, it is imperative that they continue to educate their employees on benefits coverage, drug coverage options, plan specifics, and of course, overall wellness as a preventative measure.

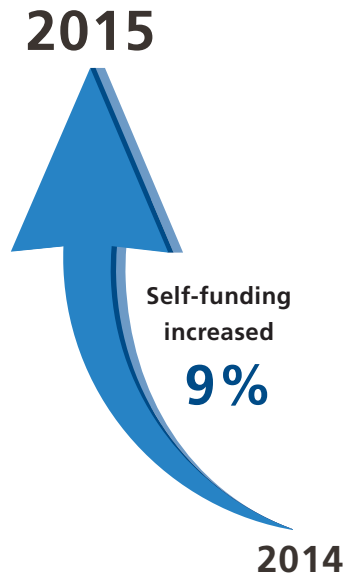
In this special report, we'll take a look at the latest employer trends in prescription plans by region, by industry, and by employer size.



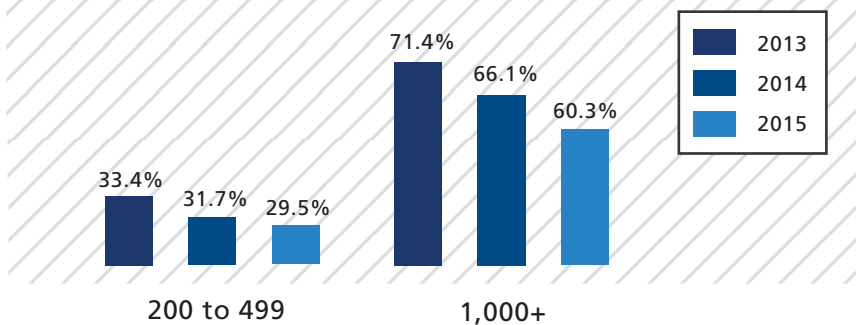
## SELF-FUNDING

On average, 11.9% of prescription plans are self-funded, with the vast majority (88.1%) of employers choosing to fully insure their prescription plans. Although self-funding has increased 9% from the past survey year, the move to self-funding is slow but positive among small groups (10 to 199 employees), while large groups are actually moving away from this model.

- Education, finance/insurance, government, and utilities employers have the most self-funded prescription plans (more than 20%), a trend that has persisted for three years.
- Regionally, there are vast discrepancies in self-funding trends. California has the fewest self-funded plans (1.9% — which has changed little in three years). Self-funding is the most common in the North Central U.S. (18.3%).
- Typically, the larger the employer, the more likely it is to self-fund the prescription drug plan. Over 60% of plans among employers with more than 1,000 employees are self-funded. However, this is a 15.5% decrease from two years ago. Similarly, employers with 200 to 499 employees have seen an 11.7% decrease in self-funding in two years.



### SELF-FUNDING BY EMPLOYEE GROUP SIZE

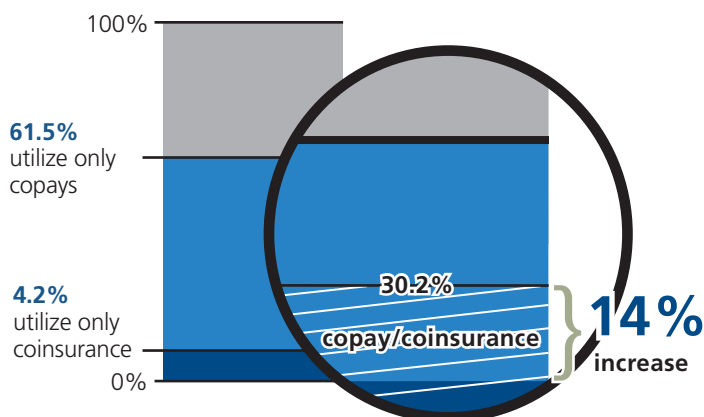


- Approximately 1.9% of employers with one to 49 employees have self-funded prescription plans—a small number, although that is a significant increase when you consider that only 1.0% of these plans were self-funded just two years ago.

“With the possible expiration of grandfathered and grandmothered ACA plans in 2017, many small employers are looking to self-funded and level-funded plans,” says Scott Deru, President of UBA Partner Firm Fringe Benefit Analysts. “Level-funded means funding a self-funded plan at the maximum potential liability so that no additional liability exists at the end of the plan year or upon termination of the plan. Many employers are also joining a pool that employs a self-funded or level-funded strategy. These plans can avoid many of the ACA provisions that employers consider unfavorable. A continued increase in adoption of these plans is anticipated.”

## COPAYS AND COINSURANCE

Of all plan models, 61.5% of prescription drug plans utilize only copays, 4.2% utilize only coinsurance, and 30.2% use varying combinations of copays and coinsurance. With a 14% increase in blended copay/coinsurance models, the move away from copay-only models is steady. Some plans may use a copay structure in the first two tiers and then employ a coinsurance model for the higher tiers. Other plans contain a percent-based cost-sharing model to accommodate higher priced “specialty” medications (for example, 20% with a \$100 maximum).



Overall, companies are beginning to implement copay/coinsurance models primarily with plans that have more than four tiers. The accommodation/food services, mining/oil/gas extraction, and utilities industries have been the early adopters of this model. This model is also growing among employers in the southeast and central U.S.

“With copays reaching the outer limits, employers have to look at other ways to manage drug costs. The main strategies are adding a fourth (or even fifth) tier or moving to a copay/coinsurance model,” says Les McPhearson, CEO of UBA.

Valerie Bogdan-Powers, Vice President of Employee Benefits Services for HORAN, a UBA Partner Firm, agrees. She sees the rise in specialty, high-priced drugs like those used to treat hepatitis C, as the most significant change to prescription drug plans in the past three years.

The market will continue to adapt and, in fact, we’re already seeing the advent of six-tier prescription drug plans, according to Deru. “We’re seeing traditional three-tier drug plans (generic, formulary brand and non-formulary brand) with a preferred and non-preferred category in each of the three bands. This allows payers the flexibility to adjust quickly to move drugs to a non-preferred status within a tier, especially as the costs of some drugs, even generics, have increased as much as 1,000% over the past year or two.”

## DEDUCTIBLES

When it comes to deductibles, 28.8% of plans treat prescriptions as any other medical expense (subject to plan deductibles and coinsurance). And 10.8% of plans have a separate prescription drug deductible, with a median single employee deductible of \$100 and a median family deductible of \$300.


“The ACA will drive a single deductible for medical and prescription drugs, so the option of having a separate prescription drug deductible will largely disappear from the marketplace,” says Les McPhearson.

Employers in the West have the most plans with a separate prescription drug deductible (16%) and high median deductibles (\$250 for singles and \$500 for families).

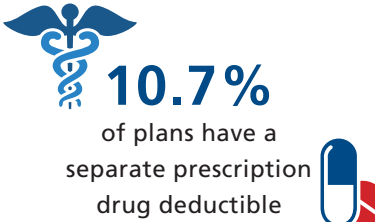
“Coinsurance models are more desirable from a payer’s perspective since they are somewhat inflation-proof. As the costs of all drugs go up, a percentage-based model adjusts, whereas a fixed copayment model does not.”

— Les McPhearson, UBA CEO

**28.8%**  
of plans treat prescriptions the same as any other medical expense

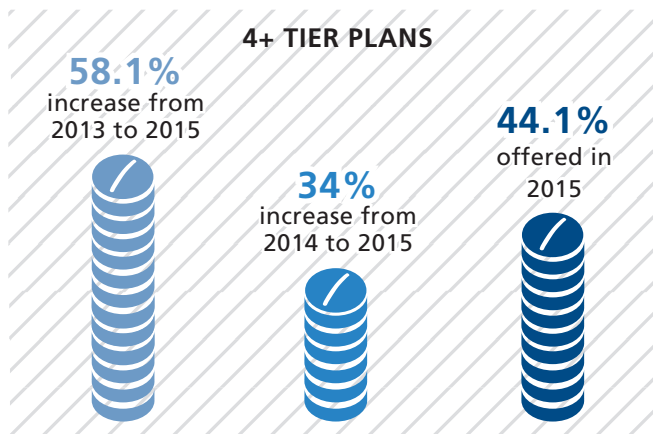


**10.7%**  
of plans have a separate prescription drug deductible



## MULTI-TIER PLANS

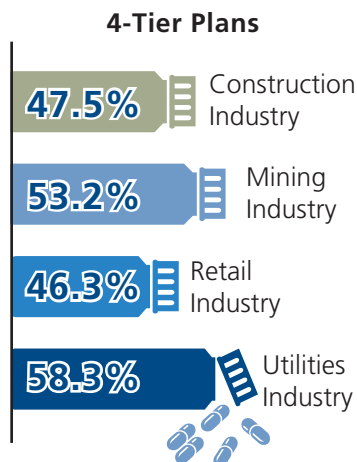
Almost half (48.9%) of prescription drug plans utilize three tiers (generic, formulary brand, and non-formulary brand); 4.3% retain a two-tier plan; and 44.1% offer four tiers or more. The number of employers offering drug plans with four tiers or more increased 34% from 2014 to 2015. The fourth tier (and additional tiers) pays for biotech drugs, which are the most expensive. By segmenting these drugs into another category with significantly higher copays, employers are able to pass along a little more of the cost of these drugs to employees. Over the last two years, the number of plans with four or more tiers grew 58.1%, making this a rapidly growing strategy to control costs.



- Employers with 1 to 99 employees have been driving the trend to adopt prescription drug plans with four or more tiers. In three years, plans with four or more tiers increased approximately 60% among these groups, making this the top cost-containment strategy for small employers, who make up the backbone of America.

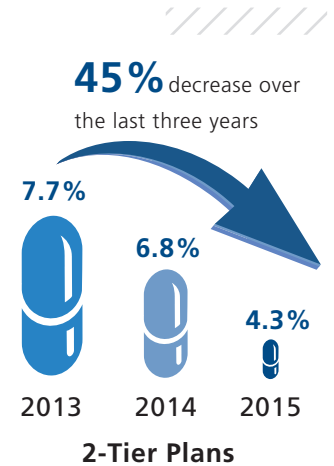
“Employers in this market have the least flexibility in plan design because rates and plans are filed by the insurers well in advance of the renewal, according to ACA requirements,” says Deru. “Because the cost to file and maintain plans is expensive and price sensitivity is high among small employers, carriers are offering a finite number of plans, with the prescription drug plan designs being dictated by the insurer, local market preferences and competition.”

- Even the largest employers (1,000+ employees), 81% of which historically have offered plans with two or three tiers, have seen a 12.9% decrease in these plans as they, too, migrate to plans with four or more tiers (albeit more slowly).
- The construction, mining and retail industries have also been steadily leading the migration to plans with four or more tiers over the last three years, and in the 2015 survey, 47.5%, 53.2% and 46.3% of their respective plans fall in this category. But this year, the utilities industry has made a more sudden switch, with 58.3% of those plans now consisting of four or more tiers, leapfrogging its perennial tier-climbing peers. This is a significant jump, considering nearly 20% of plans in the utilities industry were still two-tier plans just three years ago—far more two-tier plans than any other industry group at that time. However, this wasn’t a total surprise since, in the 2014 survey year, the industry had an above average amount of three-tier plans (65.9% vs. an average of 57.1%).
- The education and manufacturing industries are more reluctant to shift to plans with four or more tiers. Over the last three years those industries have maintained the highest amounts of three-tier plans, and in the latest survey, 52.8% of their plans remain at three tiers.



## MULTI-TIER PLANS (continued)

- Two-tier plans are becoming nearly as rare as single-tier plans, shrinking 45% to 4.3% of all prescription plans in three years. Agriculture has the most holdouts, with 14.8% of plans still comprised of one or two tiers.
- Regionally, the east central U.S. has been leading the migration to plans with four or more tiers for the last three years, followed by North Central and Southeast employers. In the 2015 survey year, Southeast employers eclipsed East Central employers with 60.7% of their plans with four or more tiers.
- Strangely enough, East Central and Southeast employers have the lowest percentage of three-tier plans (34.3% and 34.1%, respectively) but the highest percentage of single-tier plans (4.7% and 4.2%, respectively). Other Western employers (excluding California) also have below-average three-tier plans (40.6%), above-average four-tier plans (49.1%) and above-average (10.2%) one- to two-tier plans.

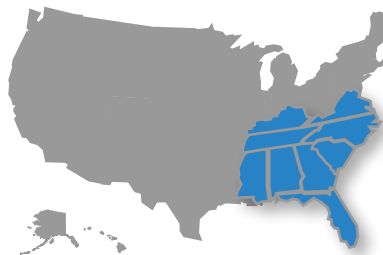


### GROUPS INCREASING TIERS MOST AGGRESSIVELY FOR COST SAVINGS

**Employers with 1 to 99 employees**

**Utilities, construction, mining and retail industries**

**East Central and Southeast employers**



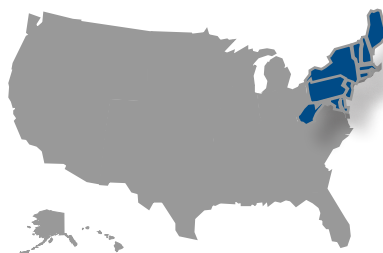
- California employers have the most two-tier plans (22.9% vs. the average of 4.3%) which, although still off the charts, represents a 20% decline from the previous survey year.
- Mid-Atlantic and New England employers have had the most three-tier plans for the last three years, making them the top resisters of plans with four or more tiers over time.

### GROUPS RESISTING 4+ TIER PLANS

**Employers with 1,000+ employees**

**Agriculture, education and manufacturing industries**

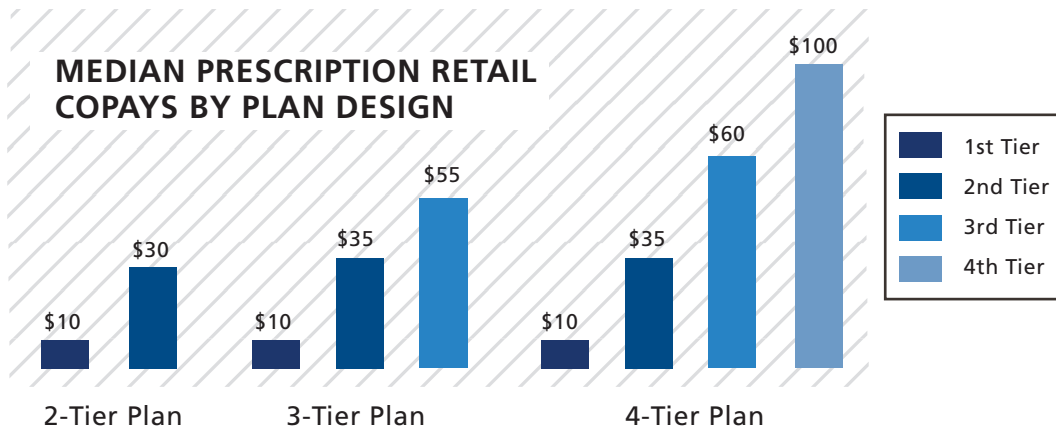
**Mid-Atlantic, New England employers**



- Those making the early leap to five-tier plans include small employers with one to 49 employees; the waste management, construction and mining/oil/gas extraction industries; and Midwest, North Central and Southeast employers—all of which have the most five-tier plans (approximately 10%).

## COPAYS

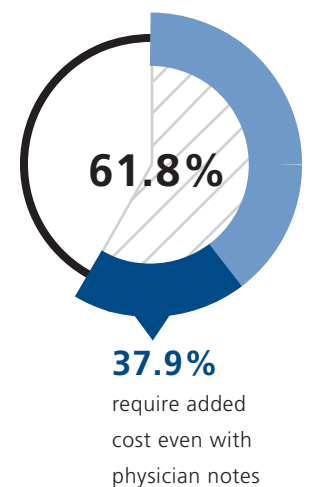
Median retail copays are \$10/\$30 for two-tier plans, \$10/\$35/\$55 for three-tier plans, and \$10/\$35/\$60/\$100 for four-tier plans. These amounts have remained largely flat from 2014. Generic drugs in the lowest tier generally cost less than \$10, so employees are paying all or most of the generic cost with the tier 1 copay. This makes it difficult to raise that amount, especially if employers are concerned about medication adherence. But in four-tier models, the tier 3 copay increased 20%. Since this tier covers non-formulary brands, copay increases may continue as drug costs in this category soar.



- While median copays in four-tier plans see no fluctuation among region, size or industry, three-tier plans show some creative cost management among some groups. For example, the largest employers (1,000+ employees) and Northeastern groups are pushing up the tier 3 copay above average.
- As five-tier plans emerge, the median copays are \$10/\$10/\$40/\$70/\$100. This will be an important baseline to watch now that the UBA Health Plan Survey will start to break this out separately. In predictable fashion, small groups tend to set copays higher than average, while the large groups are below average. Regionally, the West is experimenting with driving the fifth tier copay significantly higher than average (\$150) while keeping the other copays at or below average. The Central U.S. is pushing most copays in five-tier plans higher than average.

## BRAND VS. GENERIC

In 61.8% of plans, employees are required to pay more when they elect brand-name drugs over an available generic drug (a 5.5% increase from 2014); 37.9% of those plans require the added cost even if the physician notes "dispense as written." Only 1% of plans offer no coverage for brand-name drugs if generics are available and 37.2% offer no added cost coverage. While most employers aren't completely penalizing those who choose brand-name drugs, more and more plans are requiring employees to pay higher copays when they elect brand-name drugs. Some plans have a mandated step therapy program that makes sure employees try a lower class alternative before they move to a medication in a higher class (or try a generic or generic equivalent in a particular therapeutic class). Some plans exclude certain drugs altogether. This cost pressure has made employers more aware of drug costs, so many are beginning to educate employees about using benefits cost-effectively.



## BRAND VS. GENERIC (continued)

- ✔ Predictably, the larger the employer, the more generous it is in covering brand name drugs either with no added cost or at least not incurring added cost when the physician notes “dispense as written.” Fifty-one percent of small group plans and nearly 77% of plans for groups with 1,000+ employees fall in this category.
- ✔ Plans in the central U.S. and within the construction, agriculture, mining, and transportation industries are making the most aggressive push to generic drugs, with only 46.3% and 53.8%, respectively, providing relief for brand name drugs.
- ✔ While injectable drugs are often watched as a significant liability when it comes to cost containment, nearly all plans have no separate deductible for these medications. Additional tiers, coinsurance models and mail order benefits are overwhelmingly the way employers are dealing with the highest cost drugs.

In 2015 alone, 38 specialty drugs received FDA approval, and more are in the pipeline. “The latest development among aggressively managed drug plans is to move specialty drugs (oral and injectable) to the major medical portion of the policy, delivering an initial 7- to 15-day supply to confirm the drug’s effectiveness before dispensing a full 30- day supply” says Scott Deru. “Requirements also include frequent patient follow-up to verify adherence to the prescription schedule, any adverse reactions, and to verify that mail order drugs amounting to tens of thousands of dollars are being tracked and received by the patient. Other cost containment strategies include bringing a registered nurse to a patient’s home for infusion therapy to avoid the facility and prescription mark-up costs from inpatient and outpatient facilities.”

“Many specialty drugs are controlled and dispensed through a limited number of pharmacies, so cost containment is moving to the forefront of pharmacy benefit manager (PBM) and payer strategies.”

— Scott Deru, President of UBA Partner Firm Fringe Benefit Analysts

## MAIL ORDER

More than a third (35.9%) of prescription drug plans provide a 90-day supply at a cost of two times retail copays. Only 3% of plans require a single retail copay for mail order, a 43% decrease from 2014; 4.9% of plans now provide no reduced copay incentive for using mail order, a 22.5% increase from 2014. While mail order benefits are high for specialty drugs, the gap is closing on many maintenance drugs. As the cost escalates, mail order plans can’t cover the 90-day cost with a single or even two-times-retail copay.

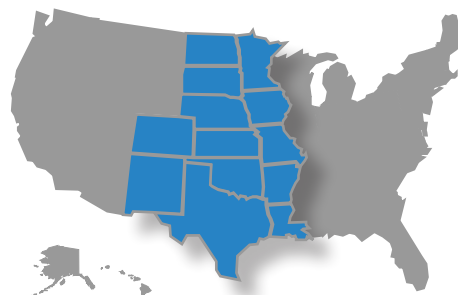
- ✔ Nearly 22% of employers in the central U.S., almost 15% of employers in the construction, agriculture, mining, and transportation industries, and nearly 12% of the smallest employers (one to 49 employees) offer no financial savings with their mail order plan design.

### WORST MAIL ORDER PLANS

Employers with 1 to 49 employees

Construction / agriculture / mining / transportation industries

Central U.S. employers





## MAIL ORDER (continued)

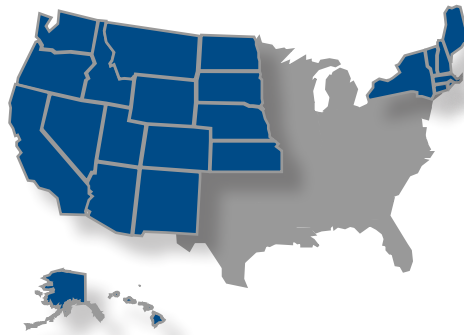
- Conversely, employers with 500 to 999 employees have the most plans with copay incentives for using mail order—approximately 56% of their plans offer a 90-day supply at a cost of one or two times retail copays. Similarly, nearly 60% of employers in the Northeast and West and approximately 48% of government, education, and utilities employers offer such mail order savings.

### BEST MAIL ORDER PLANS

Employers with 500 to 999 employees

Government / education / utilities industries

Northeast and West U.S. employers



“ Although the larger groups, government employers and Northeast plans continue to offer rich mail order plans, UBA Partners believe that soon mail order will offer only the convenient delivery of these drugs, not cost savings for the employee. ”

— Les McPhearson, UBA CEO

## PRESCRIPTION DRUG PLANS BY REGION

### North Central

Largely fully insured

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3-tier, copay-only plans

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Median copays \$10/\$40/\$60

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Largely no penalty for brand name drugs vs. generic

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Mail order plans that offer moderate savings (90-day supply at 2x retail copays)

### Northeast

Largely fully insured

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3-tier, copay-only plans

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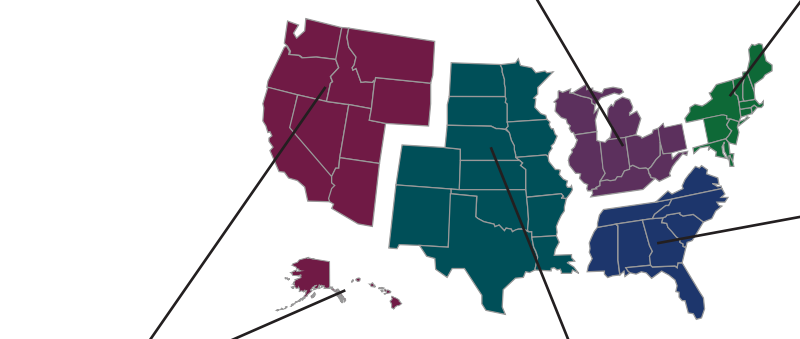
Median copays of \$15/\$35/\$70

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Largely no penalty for brand name drugs vs. generic

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Mail order plans that offer moderate savings (90-day supply at 2x retail copays)



### West

Largely fully insured

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3-tier, copay-only plans

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Mail order plans with the most savings (90-day supply at 1x or 2x retail copay)

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Median copays \$10/\$30/\$50

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Penalty for brand name drugs vs. generic

### Central

Largely fully insured

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3- and 4-tier, copay-only plans

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Median copays \$15/\$35/\$60 (three tiers) and \$10/\$35/\$60/\$100 (four tiers)

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Penalty for brand name drugs vs. generic

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Mail order plans with the least savings (90-day supply at 2.5x or 3x retail copay)

### Southeast

Largely fully insured

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3- and 4-tier, copay-only plans

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Median copays of \$10/\$35/\$55 (three tiers) and \$10/\$40/\$60/\$100 (four tiers)

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Some penalty for brand name drugs vs. generic

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Mail order plans with little savings (90-day supply at 2.5x retail copays)