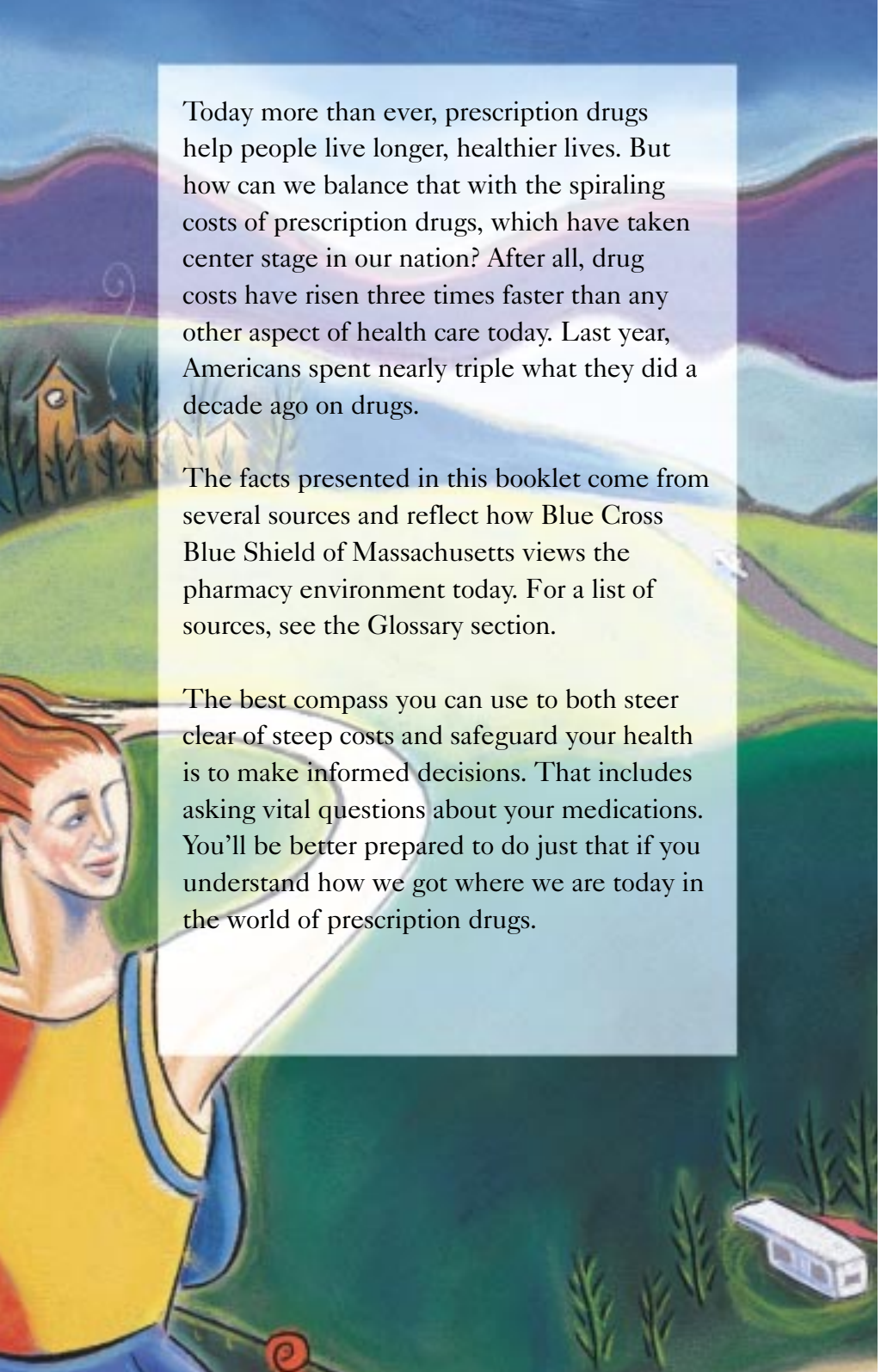
Drugs, Dollars, and Sense:

Why Prescription Costs Are Hard to Swallow and How to Find Relief

Blue Cross Blue Shield of Massachusetts



Today more than ever, prescription drugs help people live longer, healthier lives. But how can we balance that with the spiraling costs of prescription drugs, which have taken center stage in our nation? After all, drug costs have risen three times faster than any other aspect of health care today. Last year, Americans spent nearly triple what they did a decade ago on drugs.

The facts presented in this booklet come from several sources and reflect how Blue Cross Blue Shield of Massachusetts views the pharmacy environment today. For a list of sources, see the Glossary section.

The best compass you can use to both steer clear of steep costs and safeguard your health is to make informed decisions. That includes asking vital questions about your medications. You'll be better prepared to do just that if you understand how we got where we are today in the world of prescription drugs.

A Few Facts

- Throughout the last two decades, the use of medicines to treat illnesses ranging from allergies to heart disease increased greatly. Since the early '90s, the number of prescriptions dispensed has increased significantly when compared with the growth in the U.S. population.
- During the same period, new rules were created that allowed drug companies greater patent protection on brand-name drugs. This has allowed drug manufacturers to sell patented drugs exclusively for years, often at increasingly higher prices.
- The number of new drugs introduced to the market dramatically increased in the early 1990s. This is due in part to the expediting of the federal Food and Drug Administration (FDA) drug approval process in response to congressional directions.
- The biggest change in the last decade is direct-to-consumer (DTC) advertising to promote a specific drug. In part this is due to the relaxation of drug advertising regulations. This has spurred huge marketing campaigns for brand-name drugs in a competition-free environment. Spending on television advertising alone has increased nearly twentyfold since 1994.
- These television and magazine ads have raised the public's awareness of new drugs, resulting in a rapid increase in patients' requesting specific drugs by name – often without fully understanding what they are requesting.

A Brief History

What It Means to You

- As a result of the increase in DTC advertising, many people request that their physician prescribe the drug seen in the advertisement instead of having an informed discussion with their physician regarding all therapeutic alternatives.
- Drug makers' aggressive advertising and lengthy patents keep the competition (e.g., lower-priced alternatives and generics) at bay. This, in turn, leads to higher health care premiums and out-of-pocket costs for you.
- For many Americans, their health insurance pays most of the cost of prescription medicines. Because of their copayment structure, they are unaware of actual prescription costs. They may think, "The more expensive medicine isn't costing me more, so why not take it?" But prescription drug costs are a key driver of overall health care costs. Higher drug costs not only can increase premiums but out-of-pocket costs as well.

Our Challenge

The challenge today for employers and health plans is how to continue providing you with quality health care and still deliver value – at a time when the making and marketing of drugs has changed drastically and prices continue to rise rapidly.

In the following sections you'll see how health care companies, like Blue Cross Blue Shield of Massachusetts, are able to provide you with quality, affordable medications, by using innovative strategies such as:

- Pharmacy Benefit Management
- Pharmacy Formulary
- Generic vs. Brand-Name Drugs
- Three-Tier Pharmacy Program

What Is a Pharmacy Benefit Manager?

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Most health plans today contract with a pharmacy benefit management (PBM) company. For example, we partner with Express Scripts, Inc., and that's why their logo appears on your member ID card (as described later in the section titled *Your ID Card*). PBMs specialize in administering prescription drug benefit programs to help health plans effectively manage the quality and cost components of your pharmacy benefit.

The purpose of using a PBM is to provide health plans with special expertise and knowledge in managing prescription programs. PBMs help health plans by checking your eligibility, paying claims, and contracting with pharmacies and drug companies to obtain discounts that are passed on to you.

What Is a Pharmacy Formulary?

Most health plans have a pharmacy formulary, the list of drugs for which a health plan provides coverage. Our list contains more than 4,000 drugs. It was developed by our doctors and pharmacists, after evaluation of clinical studies to determine which FDA-approved medications are most effective, safe, and reasonably priced. Most plans also maintain a small list of drugs not covered in most situations. The vast majority of these drugs have one or more FDA-approved alternatives that are covered.

What Is a Pharmacy Formulary?

The Advantage of Generic vs. Brand-Name Drugs

What Is a Generic Drug?

Maybe you've gone to your local pharmacy to fill a prescription and wondered why the pharmacist gave you a generic drug. In some states, like Massachusetts, state law mandates that pharmacies *must* fill a prescription with a generic drug when one is available. The pharmacist will substitute generic alternatives for brand-name drugs unless the prescribing doctor specifically requests the brand-name version.

Although choosing a generic drug is one of the best ways to combat rising drug costs, this option often confuses those people who don't understand the difference between a generic and a brand-name drug. The generic name of a drug is its chemical name. The brand name is simply the name a manufacturer gives a drug. The FDA mandates that all generic drugs must have the same active ingredients, strength, and form (e.g., pill, liquid, injection) as brand-name drugs.

The reason generic drugs cost less is that they are *only* available *after* the patent that a drug maker holds for a particular brand-name drug expires. As a result, generic drug manufacturers don't need to pay huge research and development or advertising costs. Generic drugs are simply less expensive to make and sell.

An Overview of Three-Tier

What Is a Three-Tier Pharmacy Program?

Many employers are choosing health plans with a three-tier pharmacy program, which has different levels of copayments for covered drugs. Employers opt for this program because it helps control costs while still giving you and your doctor a wide choice of available prescription drugs. This program also encourages both doctors and patients to be more cost-conscious.

For example, a three-tier pharmacy program means that you'll pay one of three copayment levels for each covered prescription drug:

- Most generic drugs have the lowest copayment
- Preferred brand-name drugs have a higher copayment
- Non-preferred drugs (the vast majority of which have generic or preferred brand-name alternatives) require the highest copayment

Cost of Common Prescriptions

The example below is based on a $10, $20, and $35 three-tier copayment plan and compares the retail cost *without* prescription coverage with the copayment under a prescription plan.

Antibiotic Medication

Tier	Description	Retail Cost (Average AWP* per Rx)**	Copayment
1	Amoxicillin 500mg	$11.10	$10.00
2	Cefzil® 250mg	$49.84	$20.00
3	Keflex® 500mg	$83.72	$35.00

** The AWP is the average wholesale price charged by the national drug wholesalers for a given product.*

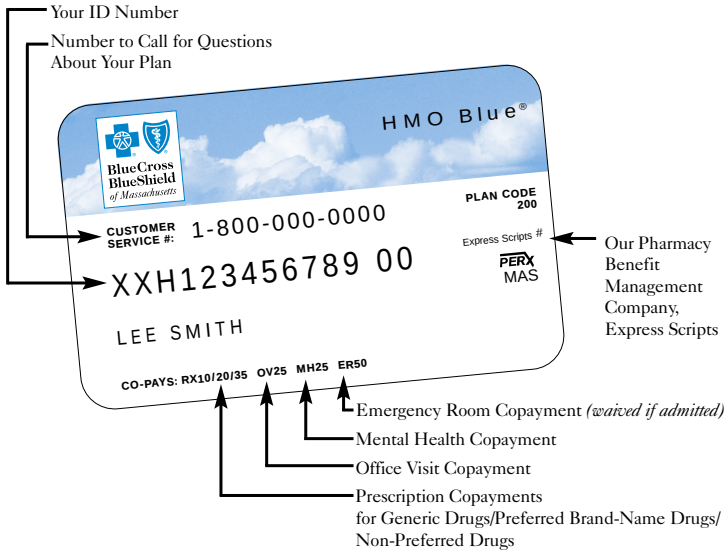
***Based on average prescription dose/day supply*
Date: July 2001
Source: First DataBank

Your ID Card

Why Your ID Card Is Important

Your ID card is packed with information you need to get your prescriptions. Your pharmacist relies on your ID card to get the most up-to-date information on your plan and coverage. Be sure to carry it with you at all times and show it each time you visit your doctor and your pharmacy.

You may have wondered why you sometimes receive a new ID card from Blue Cross Blue Shield, even though you may not be a new member. New ID cards are issued when there is a significant change in your benefits. This might be the result of your employer's decision or a change in Massachusetts law. When you receive a new card, you should immediately put it in your wallet to have with you, and discard your old card.



(If your current member identification card does not list pharmacy copayments, please refer to your plan literature or call the Member Service number listed on your ID card for this information.)

Helping to Ensure the Safety of Your Medications

Helping to Ensure the Safety of Your Medications

If you've ever gone to the pharmacy to fill a prescription and been told that your pharmacist must call your doctor to check your prescription first, here's why:

Every prescription you fill through your pharmacy program – whether at a local pharmacy or by mail service – is reviewed by registered pharmacists. These licensed professionals check every prescription to help safeguard your health. For patients with multiple doctors or multiple medications, this review serves as a safety net. It alerts pharmacists to potential drug interactions and helps them to provide safe and effective medications. And if questions about your prescription arise, your pharmacist may try to contact your doctor before filling your prescription.

Health plans also work with doctors and pharmacists to ensure that the quantity and dose of prescription medications are within the recommendations set by the FDA. If a doctor prescribes a quantity or dose of a medication that differs from the generally accepted recommendations, the plan may provide coverage only for the FDA-recommended quantity or dose. However, your doctor can request continued coverage for the same quantity or dose of medications you are correctly taking if medically necessary.

Your Role: The Rx You Need

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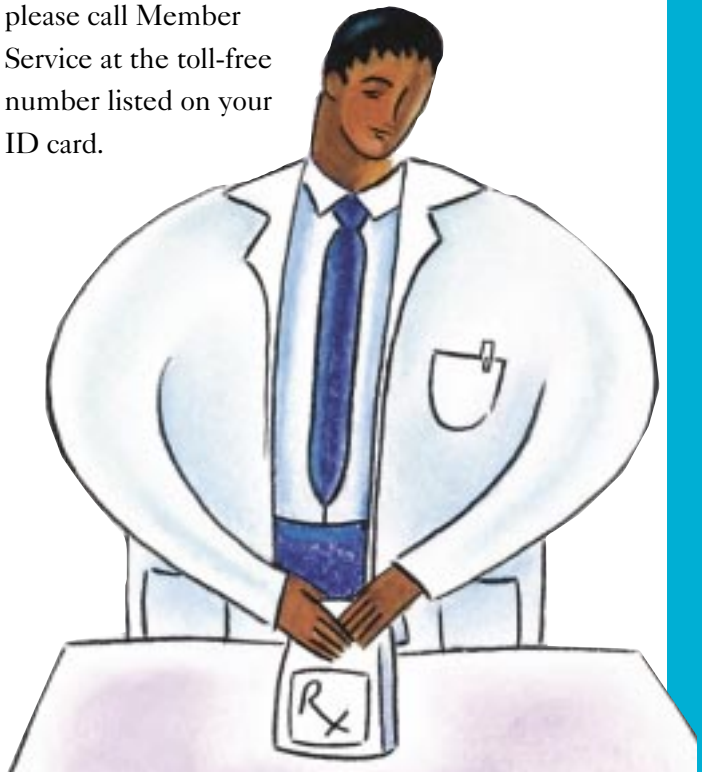
We believe that you and your doctor play critical roles in ensuring that you receive quality health care. That's why your doctor always determines which medication is most appropriate for you, and why we want to help you make informed decisions about your health.

Here's how you can be an advocate for your health and save on prescription costs:

- Always be sure to discuss with your doctor the best prescription therapies for you, and follow your doctor's direction on how to take your medication.
- Ask your doctor to prescribe generic drugs whenever possible. If one isn't available, ask if there is a less expensive brand-name alternative available in Blue Cross Blue Shield's formulary.
- Know your copayment structure. Copayments are determined by the specifics of your plan.
- If you would like to check the copayment level of a drug, you can go to our website ***www.bluecrossma.com*** and click on "Pharmacy."
- Take full advantage of the savings and service of your pharmacy program by always utilizing participating pharmacies. Most pharmacies in Massachusetts participate in our program. If you're not sure, ask your pharmacist.
- Always present your ID card at the pharmacy.
- Your particular health plan may include a Mail Service option. If you take long-term medications, consider asking your doctor to prescribe them for a 90-day supply, plus refills. That way you can enjoy the convenience and savings of our Mail Service Prescription Drug Program. (If you're already taking medication on a long-term basis, ask your doctor for a new prescription.) You can call us at 1-800-262-BLUE to request a brochure or print a copy of the order form from our website at ***www.bluecrossma.com***.
- Do not rely solely on drug ads for your prescription information. Instead, ask questions and encourage your doctor to make a sensible choice for you.
- If you have any questions about your benefits, please call Member Service at the toll-free number listed on your ID card.



Your Role: The Rx You Need

Glossary of Pharmacy Terms

Brand-Name Drug. A drug that is protected by a patent.

Copayment. The amount some members pay the pharmacy for medications covered by their health plan. The health plan pays the rest.

Deductible. The amount some plan members must pay before insurance coverage begins.

Drug Utilization Review (DUR). An electronic check of prescription drug use, physician prescribing patterns, or patient drug use, conducted by plan pharmacies, to ensure that members receive appropriate medications and to prevent potential problems with drug interactions. Three kinds of DUR are conducted: prospective review before a drug is dispensed, concurrent review conducted at the time a prescription is filled, and retrospective review after a drug has been dispensed.

Formulary. The list of drugs for which a health plan provides coverage.

Formulary Management. Clinical programs developed and maintained by plan doctors and pharmacists to manage the appropriate utilization of covered drugs by balancing clinical effectiveness and cost-effectiveness.

Generic Drug. A drug that is a chemical and therapeutic equivalent of a brand-name drug for which the patent has expired. Generic drugs are usually less expensive than the equivalent brand-name drugs.

Generic Substitution. Filling a prescription with a generic drug in place of a brand-name drug. In some states, like Massachusetts, state law mandates this, unless otherwise specified by the physician.

Mail Order/Mail Service Pharmacy. A pharmacy that dispenses long-term prescriptions through the mail. This usually saves members money, because in most cases they can purchase a 90-day supply for the same copayment they pay for up to a 30-day supply at a retail pharmacy.

Non-Formulary. Medications not listed on a plan's formulary, and therefore not covered by the plan.

Pharmacy Benefit Manager (PBM). A company that specializes in administering prescription drug benefit programs for health plans.

Pharmacy Network. A group of retail pharmacies with which a PBM contracts to provide services to members.

Prior Authorization. The process of obtaining prior approval of certain medications from health plan pharmacists and physicians before the medications are dispensed.

Three-Tier Copayment. A three-tier pharmacy program means that you'll pay one of three copayment levels for each prescription:

- Most generic drugs have the lowest copayment
- Preferred brand-name drugs have a slightly higher copayment
- Non-preferred drugs (the vast majority of which have generic or preferred brand-name alternatives) require the highest copayment

Sources of information for this brochure include:

Prescription Drug Trends - A Chartbook,
The Henry J. Kaiser Family Foundation,
July 2000

"Advanced Strategies for Managing the Pharmaceutical Landscape," Presentation, Express Scripts, Inc., 2001

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Glossary of Pharmacy Terms