

PERSPECTIVES

PROVIDING INSIGHT INTO TODAY'S EMPLOYEE BENEFITS ISSUES

Increasing Healthcare Costs and Your Employee Health Plan

Sixth Edition

HEALTHCARE costs, and consequently health insurance premiums, have been increasing at an alarming rate for nearly a decade. While the upward trend seems to be slowing, cost increases that are outpacing the rate of inflation are still the norm. Avoiding rising healthcare costs is nearly impossible, but you can learn about why they continue to rise and what you can do to minimize the fallout for your organization and your employees.

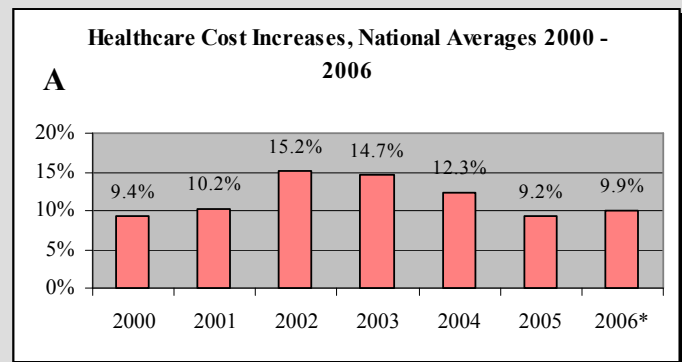
The next few pages will discuss the latest healthcare cost figures, the factors leading to nearly a decade of unprecedented rate hikes, and some solutions that firms around the U.S. are undertaking to help soften the blow.

National Healthcare Cost and Renewal Rate Projections

To understand why the costs of employee health benefits are rising so dramatically, one must understand that overall national healthcare costs are skyrocketing — reflecting the biggest surge in medical inflation since the early 1990s. From 1994 to 1998, average annual healthcare cost increases hovered around 2 percent. From 1999 to 2000, however, costs leapt 9.4 percent, and the annual percent change has since entered and stayed in the double digits. The lowest rate increase in six years — 9.2 percent — was reported in 2005.

Exhibit 1A, right, depicts the percent change in average annual healthcare cost increases from 2000 to 2006. This number is projected to reach near the double-digits again from 2006 to 2007.

As the overall cost of healthcare has risen, there has been a subsequent rise in the rates employers are paying for employee health benefits. These rate hikes have varied across the country over the last several years, hitting some metropolitan areas much harder than others. **Exhibit 1B**, right, illustrates the cities that



*Projected

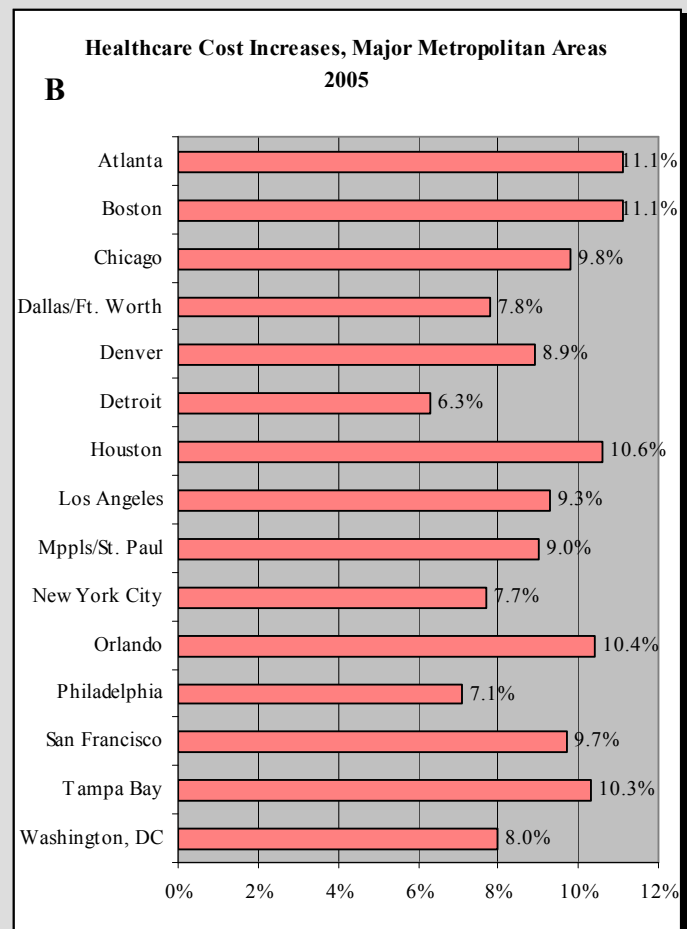


Exhibit 1

Source: Hewitt Associates, news release, "U.S. Companies Face Lowest Health Care Cost Increase Since 1999, According to Hewitt Associates," October 10, 2005.

recorded the highest rate increases in 2005.

While the rate of increase has slowed in recent years, experts expect the high rate of annual increases to continue indefinitely. According to the *Mercer National Survey of Employer-Sponsored Health Plans 2005*, the average cost of healthcare benefits for active employees rose 6.1 percent in 2005 — from \$6,679 per employee in 2004 to \$7,089 per employee in 2005. This represents the lowest increase since 1998, and is well below the 10.1 percent increase seen in 2003.

Exhibit 2A, below, shows the average total health benefits cost for active employees for the years 1995 to 2005. **Exhibit 2B** depicts the annual percent change in health benefit costs from 1988 through 2005. Note especially the dramatic upward trend since 1998, and the positive trend that is now emerging — a drop in the annual percent increase since 2002.

The Mercer survey found that cost-shifting was the primary tactic employers used to lower costs from 2004 to 2005. Rather than requiring a greater employee premium contribution, however, employers more often increased employee cost-sharing at the point-of-service. According to the survey, 80% of PPO plans now require an individual deductible for in-network care. Among large employers (500 or more employees) the average deductible amount rose from \$250 to \$300. The average deductible amount for small employers remained unchanged, but the percentage of small employers that required a deductible of

more than \$1,000 reached 34 percent, up from 31 percent in 2004. Fewer large employers required such a large deductible, but the number did increase from 2004 to 2005.

The use of coinsurance as a means of sharing the cost of office visits also increased; 9 percent of all PPO sponsors and 18 percent of all large sponsors now require coinsurance for office visits. Among jumbo employers (20,000 or more employers) the use of coinsurance jumped from 26 percent to 37 percent. These data indicate a significant departure from the era in which PPOs moved to copays to compete more effectively with HMOs for enrollment. Now, the more consumer-oriented coinsurance tactic requires employees to share more of the cost and become more exposed to the actual cost of the service provided.

According to the survey, employers see consumerism and care management as the most effective way to manage health benefits costs for the future, as opposed to the simple cost-shifting measures that have been used traditionally. **Exhibit 2C**, below, depicts employer cost management strategies for the next five years. It indicates that the respondents are most interested in undertaking “consumerism” strategies (defined as “promoting informed and responsible spending by employees for health care”) and “care management” strategies (defined as “a range of programs designed to improve employee health, including disease management”).

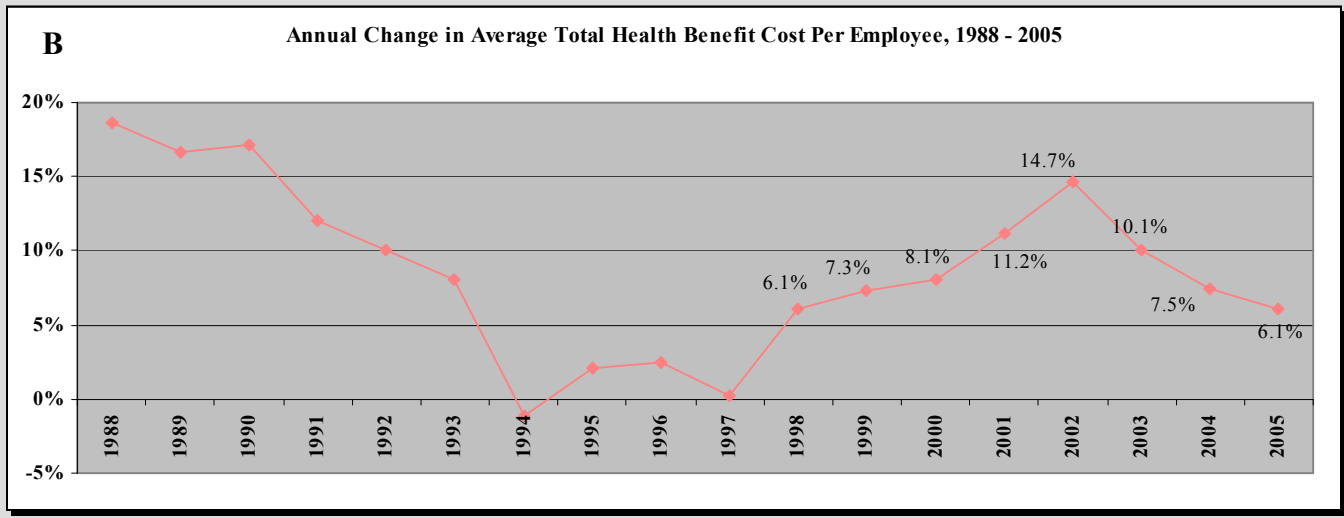
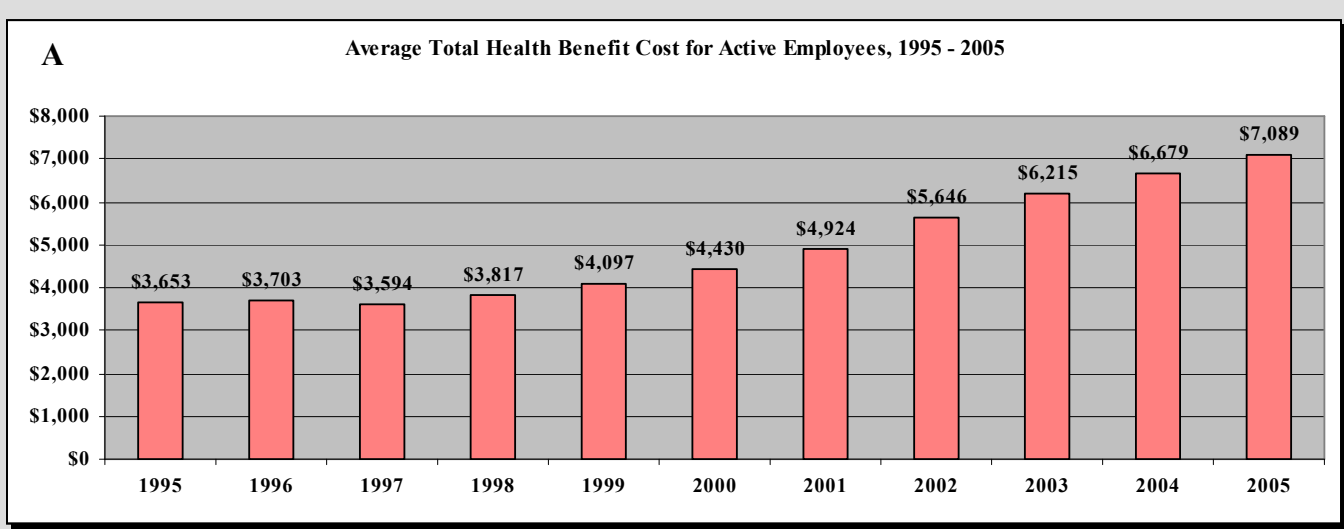


Exhibit 2

C

Employer Cost-Management Strategies for the Next Five Years

Percent of Employers Indicating Strategy Will be Significant or Very Significant

	All Employers	Large (>500) Employers
Consumerism	34%	55%
Care management	32%	62%
Collective purchasing	29%	25%
Data transparency	28%	35%
High-performance networks	26%	33%
Scaling back benefits/cost-shifting	21%	24%

Source: Mercer National Survey of Employer-Sponsored Health Plans, 2005.

Factors Leading to Increased Healthcare Costs

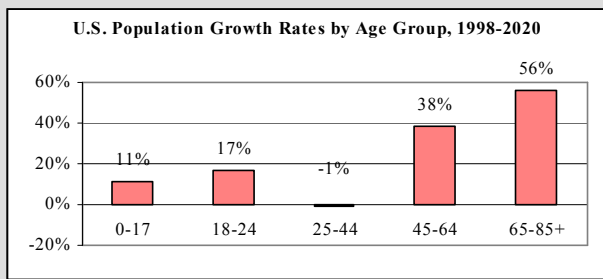
Why are U.S. healthcare costs skyrocketing? Several market conditions working in tandem have led to a decade of unrelenting increases. Understanding why your annual health plan renewal rates may be significantly higher than the previous year is the key to formulating alternatives and solutions to your particular plan’s challenges. It is also the key to educating your employees about the reasons behind any plan or contribution changes you may decide to introduce.

Demographics: The Aging of America

It is an inescapable fact: the U.S. population is aging. While the population of older Americans is increasing, the number of children and younger people is remaining stable and even decreasing for some age groups.

As this population shift occurs, there is a subsequent rise in the occurrence of chronic diseases like asthma, heart disease, and cancer, and a resultant need for more resources to fight these diseases. This leads to elevated utilization of prescription drugs and other medical services, and an overall rise in dollar expenditures on healthcare.

Exhibit 3, below, shows projected U.S. population growth rates by age group from 1998 through 2020.



Source: Kiplinger Washington Letter, December 23, 1998.

Dramatic Rise of Prescription Drug Costs

Please turn to the attached *Special Report: Prescription Drug Costs and Your Employee Health Plan* for a discussion of why prescription drug costs are on the rise.

Expansion of Providers

One of the major factors driving up the cost of healthcare is the growth of healthcare providers. Expansive healthcare systems that offer acute care hospitals, specialty facilities, clinics, labs, physician practice groups, and other services are becoming prevalent. Much of this expansion took place during the mid- to late-1990s and continues today. While these systems provide many benefits to the communities they serve, they also require a great deal of capital to fuel their growth. These capital expenditures by hospital systems and other providers place upward pressure on the costs of many medical services.

Consolidation of Managed Care Companies

As managed care boomed throughout the 1990s, competition among industry giants — and among smaller regional players — became fierce. A desire to leverage economies of scale into bigger discounts from providers and to gain enrollees and market share induced many of the large organizations to consolidate and acquire smaller, weaker firms. They also kept premiums low and often did not keep them in line with the rate of medical inflation in order to gain business from rival companies and maintain their current customers.

Now, the landscape of the industry has changed. Years of under-pricing, weak underwriting, and the costly process of assimilating acquisitions has led to serious dips in profitability and stock prices for a large number of carriers. Those who couldn’t make the cut have either sold off their managed care operations to a bigger fish, or have completely gone out of business. Companies that haven’t exited the market altogether are now faced with much less competition and a renewed commitment to achieving healthy returns. This has ultimately resulted in increased rates.

Political Environment and Government Regulation

Healthcare issues, particularly those surrounding health plans and medical liability, have become one of the most hotly debated topics in the political arena, while health insurance is one of the most regulated insurance sectors on both the state and federal levels.

State and federal mandates have increased 25-fold over the last three decades. Often these mandates duplicate or conflict with each other, and they almost always come with increased

costs for the healthcare system. For example, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) continues to impact the operations of many health plans seeking compliance. According to an April 2002 study by PricewaterhouseCoopers, HIPAA alone is responsible for adding billions of dollars of new compliance costs to the healthcare system.

Aside from HIPAA, there are over 1,500 mandated benefits at the state and federal level. Each of these has a cost associated with it, and together they have had a significant impact on healthcare costs.

On the political front, concerns about timely access to quality healthcare services and calls for federal laws to protect consumers led to a variety of legislative initiatives, including the now defunct Patients' Bill of Rights. Homeland security interests, a slowing economy, the war in Iraq, and other domestic issues have since forced most of the political debate to the backburner. However, if the Patients' Bill of Rights were resurrected or other legislation regarding medical liability were initiated, the negative impact on healthcare costs is expected to be significant.

Issues such as prescription drugs for seniors, Medicare reform, and coverage for the uninsured will also continue to play a big role on political and legislative agendas in the coming years, and will undoubtedly continue to place upward pressure on costs.

Increased Utilization and Consumer Demand

Utilization of many healthcare services has risen over the decade. A number of factors such as improvements in medical procedures and technology, the influence of managed care, elevated consumer awareness and demand, and a boost in the number of practicing physicians, caused health services like the number of surgical procedures and the number of prescription drugs dispensed to rise significantly. Other services, such as breast cancer screenings, immunizations for children, and diagnostic procedures like CT and MRI have also experienced sharp utilization increases.

New Medical Technology

Life expectancy and disease-specific mortality rates in the U.S. are steadily improving. Developments in medical technology, including methods for early detection of disease and the introduction of new treatments and medications for acute illness, have played a major role in enhancing these statistics. Old techniques are being replaced with new, often expensive treatments using new medical devices, diagnostic products, drugs, and surgical procedures. These include everything from digital mammography to hip replacement to radioactive "seeds" used to treat prostate cancer.

It is not surprising that these new procedures come with hefty price tags, and therefore drive the overall cost of healthcare — and subsequently health benefits costs — upward.

Weakening of the Managed Care System

The booming economy of the late 1990s, consumer demand, and the regulatory environment discussed above have led to a general weakening of the managed care system.

In the early 1990s, managed care was seen as a temporary fix to high medical inflation. By cutting payments to doctors and

hospitals and requiring strict oversight of expensive drugs and procedures, managed care reduced insurance rate increases for a few years (average premium increases per year from 1994 to 1998 were only 2 percent). Without the surge in managed care plans the total amount spent on healthcare nationally — about 16.2 percent of gross domestic product — would be higher.

During the economic boom of the late 1990s, patients and employers migrated away from the tightest forms of managed care, HMOs. Employers seeking to hire the best employees in the tight job market moved towards offering plans that allow patients to see doctors that are "out-of-network" or have much less strict referral processes, such as Point-of-Service (POS) plans. In addition, many employers making health plan purchase decisions focused on keeping employees happy by ensuring that most doctors in an area were in the chosen network, rather than choosing narrower networks with deeper discounts.

Provider contracting has also placed a strain on the managed care system. Many hospitals that have taken a beating due to the Balanced Budget Act of 1997 — which cut billions of dollars from Medicare managed care payments — and by other financial difficulties are now willing to walk away from health plans that they view as offering insufficient reimbursement rates and prohibitive payment practices. In many cases, these threats have won hospitals and other providers significant increases in reimbursement for the first time in several years. These actions are having a domino effect as other providers become more courageous and attempt to exert power during negotiations with health plans.

With the level of premium increases seen over the last several years, employers have backed away from offering rich benefits, and instead have employed a number of tactics to reduce costs.

Healthcare Spending and Medical Cost Inflation

Overall healthcare spending and medical cost inflation are ascending, often due to many of the factors discussed above. Below are summaries of each of these trends.

NATIONAL HEALTHCARE SPENDING

The Centers for Medicare & Medicaid Services¹ (CMS) annually releases national health expenditures projections. Some of their most recent findings for the period 2005 - 2015 include:

- ✓ Healthcare spending in the U.S. is projected to grow 7.4 percent and surpass \$2 trillion in 2005, down from the 7.9 percent growth experienced in 2004. This represents the third consecutive year of decelerating growth, following six years of acceleration from 1996 through 2002.

Old techniques are being replaced with new, often expensive treatments using new medical devices, diagnostic products, drugs, and surgical procedures.

- ✓ Healthcare spending is expected to reach 16.2 percent of GDP by 2005. By 2015, U.S. healthcare spending is expected to reach \$4.0 trillion and 20 percent of GDP.
- ✓ Growth in private health insurance premiums are expected to slow for the third consecutive year.
- ✓ CMS projected out-of-pocket spending to remain essentially flat in 2005, and then decrease substantially due to Medicare Part D coverage in 2006.
- ✓ Driven by a slowdown in drug utilization, prescription drug spending was projected to grow 8.0 percent in 2005 — significantly less than the previous year's projection.
- ✓ Hospital spending growth for 2005 was expected to outpace growth in total personal healthcare spending for the second consecutive year. Private payer spending growth was expected to slow slightly in 2005, grow again in 2006, and then moderate around 7.9 percent for the remainder of the projection period.

MEDICAL COST INFLATION

Medical cost inflation figures tell a similar story. However, inflation differs from overall spending in that the GDP figures depict *actual dollars spent* on healthcare services in a year, while inflation reflects the *cost difference* for medical services relative to a base year.

One measure of inflation in the United States is the Consumer Price Index³ (CPI). The U.S. Department of Labor Bureau of Labor Statistics recently released CPI figures for the period ending March 31, 2006.

Exhibit 4, below, shows the percent change in CPI for various consumer expenditure categories since 1999. *Medical Care* is one of the categories.

Overall consumer prices rose 3.4 percent during 2005. So far in 2006 overall consumer prices have risen 4.3 percent.

Costs for goods and services in the Medical Care category rose 4.3 percent in 2005, and 4.2 percent as of March 2006 — nearly even with the overall inflationary rate. One can see that medical costs are increasing at a higher rate than most of the other expenditure categories, with the exception of the

Transportation category. The continued acceleration of medical care expenditures and inflation places additional upward pressure on health benefits costs.

Employers React — What Can You Do?

You and other employers are undoubtedly trying to determine how to keep accelerating health plan rates from having debilitating repercussions on your organization. After years of trying to absorb most of the costs because of attraction and retention issues, many firms are now trying to attack the root causes of rising costs with sustained, systemic changes. Small businesses in particular continue to face the critical decision to raise employee contributions or to discontinue offering the coverage altogether.

In previous years, the majority of employers were using tactical, short-term approaches that shifted costs to employees. A 2005 Hewitt survey, *Health Care Expectations: Future Strategy and Direction* (and its follow-up 2006 survey) found that employers now plan to control costs with long-term strategies that go further in addressing the actual causes of rising costs. The primary strategies involve introducing more consumer-driven plans, improving employee education, influencing positive employee behavior changes through condition management and wellness programs, and improving the amount and quality of data available on healthcare costs and quality.

Introducing or Expanding Consumerism

While basic cost shifting remains a prevalent means for managing costs, there is evidence of a movement toward more consumer-oriented solutions. Those companies that want to balance costs and employee relations are incorporating more of a consumerist focus into their plans for 2005 and beyond.

Essentially, employers are finding ways to make healthcare a shared responsibility and commitment between employer and employee by putting more decision making power (and potentially cost-management power) into the hands of employees. Then, by providing appropriate tools and education, employers can help employees assume this responsibility.

According to the Hewitt survey, companies' interest in offering consumer-driven health plans as a means for controlling costs and providing more choices for employees continues to grow. The report offers the following results regarding the most

Annual Percent Change in CPI⁴, 1999-2006

	1999	2000	2001	2002	2003	2004	2005	2006 ⁵
All Items	2.7%	3.4%	1.6%	2.4%	1.9%	3.3%	3.4%	4.3%
Food & Beverages	2.0%	2.8%	2.8%	1.5%	3.5%	2.6%	2.3%	2.7%
Housing	2.2%	4.3%	2.9%	2.4%	2.2%	3.0%	4.0%	3.2%
Apparel	-0.5%	-1.8%	-3.2%	-1.8%	-2.1%	-0.2%	-1.1%	1.4%
Transportation	5.4%	4.1%	-3.8%	3.8%	0.3%	6.5%	4.8%	10.5%
Medical Care	3.7%	4.2%	4.7%	5.0%	3.7%	4.2%	4.3%	4.2%
Recreation	0.8%	1.7%	1.5%	1.1%	1.1%	0.7%	1.1%	1.8%
Education and Communication	1.6%	1.3%	3.2%	2.2%	1.6%	1.5%	2.4%	3.2%
Other Goods & Services	5.1%	4.2%	4.5%	3.3%	1.5%	2.5%	3.1%	2.3%

Source: United States Department of Labor Bureau of Labor Statistics, news release, Consumer Price Index, March 2006.

prevalent models of consumer-driven health plans:

- ✓ 17 percent of surveyed employers use a health account plus high-deductible coverage model;
- ✓ 6 percent use multi-tier networks;
- ✓ 5 percent use a defined contribution approach; and
- ✓ 4 percent of employers use a customized design.

As the use of these consumer-driven models grows, they are expected to have lower rates of increase than traditional PPO, POS, and HMO models.

Hewitt's survey also addressed the use of Health Savings Accounts (HSAs). It found that employers are very interested in the HSA option, but few are offering them. Fifty-seven percent of employers surveyed are considering using HSAs in the future, but only three percent planned to provide access and contributions for active employees in 2005.

Improving Employee Education and Communication

The Hewitt survey and other recent studies agree that the only way for consumer-driven strategies to have their desired impact (to drive smarter consumer behavior among employees) is for companies to also invest heavily in the communication, education, and decision support tools that will result in better decision-making by employees and their dependents.

REQUIRING ACTIVE ENROLLMENT

2005 marked a turning point in which many employers began requiring their employees to take part in active enrollment. This means that employees are required to take action with their enrollment or risk being enrolled into a default plan that may not meet their needs. Employees who don't comply may even lose their coverage. Active enrollment ensures that employees are aware of their options and that they review them to ensure they are making the best possible choices.

IMPROVING DECISION SUPPORT TOOLS

Realizing that the new choices available to employees can be overwhelming, employers are offering an unprecedented number of decision support tools to help employees evaluate their options. These new tools include medical expense estimators, health plan comparison charts, provider quality data, patient education and condition management information, health risk assessments, and expense account explanations and estimators.

The most outstanding trend in this regard is the increasingly popular move toward using the Internet to help employees become more educated healthcare consumers. One recent survey

found that most employers are using Web-based solutions to implement consumer-oriented elements into their traditional plan designs. For example, many companies are providing Web-based employee health portals — often as part of an overall human resources portal — to support preventive care and wellness initiatives.

Increasing Disease Management and Wellness Programs

Hewitt's *Health Care Expectations: Future Strategy and Direction* found that the number of companies using disease management programs has grown significantly, from 73 percent in 2004 to 83 percent in 2005. In addition,

- ✓ 49 percent of companies profile prevalent chronic conditions in their workforce (up from 42 percent in 2004);
- ✓ 30 percent offer incentives to encourage employee participation in wellness programs (up from 21 percent the previous year); and
- ✓ 27 percent of respondents measure the impact of disease management programs on health and productivity (up from 22%).

Also noteworthy, employers appear to be taking great strides to address obesity, with 64 percent providing coverage for bariatric surgery and 56 percent offering weight management programs.

Improving Data

Hewitt's survey suggests that employers are attempting to control costs by creating greater market transparency with more and better data. These measures include encouraging the use of accredited plans, reviewing HEDIS and other available data, and using narrower networks based on provider quality data.

Other Strategies for Reducing Costs

The following are some additional tactics that employers are using to reduce healthcare costs.

CONTRIBUTION STRATEGIES

Employers are looking for ways to control costs by evaluating how they differentiate contributions for employees and their dependents. Pay-based contribution models are also commonly used.

DEPENDENT COVERAGE CHANGES

Changing the rules for dependent coverage may be one way to influence employee behavior. The most common practices include:

- ✓ implementing higher cost sharing for dependents (31 percent);
- ✓ providing flexible credits for opting out of coverage (24 percent);
- ✓ requiring additional contribution if an employee's working spouse does not accept coverage from his or her own employer; and
- ✓ requiring an employee's working spouse to accept coverage from his or her own employer.

Employers are offering an unprecedented number of decision support tools to help employees evaluate their options.

CHANGE PRESCRIPTION DRUG COVERAGE

Efforts to control overall healthcare costs by making changes to prescription drug benefits include:

- ✓ using a three-tier design,
- ✓ increasing coinsurance,
- ✓ requiring step therapy,
- ✓ requiring the use of generics,
- ✓ requiring mail order of certain drugs, and
- ✓ using a therapeutic MAC/reverse copay design.

GOVERNMENT INTERVENTION

According to Hewitt's research, three-fourths of employers are looking to the government to restrict malpractice awards, restrict patent extensions for brand name drugs, and allow employees to access their Flexible Spending Accounts (FSAs) before HSAs to enable savings for retirement coverage. More than half of the employers surveyed feel that the government should make Medicare available to early retirees at their own cost, and that U.S. consumers should be allowed to purchase prescription drugs from foreign countries.

Which solution is right for you? Should you pass costs on to employees at the risk of losing some of them? Or, should you try to manage costs in some of the other ways discussed in this report. Ultimately, it is a decision that you need to come to through thoughtful and detailed analysis of your plans and with the advice of your broker-consultant.

Below are some questions you can address in order to begin developing an effective strategy that is right for your organization.

- ✓ Is our program structure, plan design, and pricing appropriate?
- ✓ Do we have the right vendors, services, contracting, and funding in place?
- ✓ Are our employee communication efforts appropriate and effective?
- ✓ Do we have the right disease and case management programs for our employees?
- ✓ Do our pricing and plan design features encourage cost-conscious behavior on the part of our employees?
- ✓ Do our employee communication efforts and resources motivate our employees to become educated and effective healthcare consumers?

What Should I Tell My Employees?

It's a fact: healthcare costs and health benefits costs continue to increase at exceptionally high rates from year to year. You want to continue to offer valuable health benefits to your current and future employees, and you want those benefits to help you attract and retain good employees. However, you also need to consider the cost-effectiveness of those benefits at a time when hefty rate hikes are the norm, rather than the exception.

The information contained in this report is designed to help you understand why your renewal rates may have increased, and to consequently help you educate your employees about the reasons for any plan or contribution changes you may have to

make. If your employees understand current trends in the healthcare industry, they will be more supportive of any such changes and will appreciate the resources required to provide them with their healthcare benefits.

Notes:

¹Formerly the Health Care Financing Administration (HCFA).

²Gross Domestic Product (GDP) is the total market value of all final goods and services produced within a country in one year.

³The Consumer Price Index (CPI) is a measure of the average change over time in the prices paid by urban consumers for a market basket of consumer goods and services. It is the most widely used measure of inflation. The CPI is generally expressed as an index relative to a reference base. Most CPI indices have a 1982-84 reference base, meaning that the Bureau of Labor Statistics (BLS) sets an average index level (representing the average price level) for the 36-month period from 1982 to 1984. The BLS then measures changes in relation to that figure. The figures here represent changes in consumer prices for each year shown, relative to the 1982-1984 base year.

⁴Reference base: 1982-1984.

⁵Seasonally adjusted annual rate three months ended in March 2006.

Perspectives is provided to [B_Officialname] clients for informational purposes. Please seek qualified and appropriate counsel for advice on how to apply the topics discussed herein to your employee benefits plan.

PERSPECTIVES

PROVIDING INSIGHT INTO TODAY'S EMPLOYEE BENEFITS ISSUES

SPECIAL REPORT: Prescription Drug Costs and Your Employee Health Plan

Sixth Edition

Prescription Drug Spending Trends

Prescription drug costs continue to represent an increasingly large portion of healthcare expenditures. Understanding the pharmaceutical market is key to determining new approaches for addressing these rising costs.

According to CMS, spending in the U.S. for prescription drugs was \$188.5 billion in 2004 — over 4 ½ times more than the \$40.3 billion spent in 1990. Prescription drugs made up 10 percent of overall healthcare expenditures in 2004, and will make up nearly 11 percent of spending on healthcare services by 2015.

Payers and plan sponsors have responded to the trend by moving toward more aggressive plan designs — like higher copayments or three- and even four-tier copayment plans — that shift more of the cost burden to members. Partly due to these changes and a concurrent drop in utilization, some significant progress has been made. The annual rate of increase in prescription spending has declined from a high of 20 percent in

1999 to 8 percent in 2004.

Exhibit 1, below, compares the annual percent change in prescription drug spending to other selected national health expenditures, from 1980 to 2004.

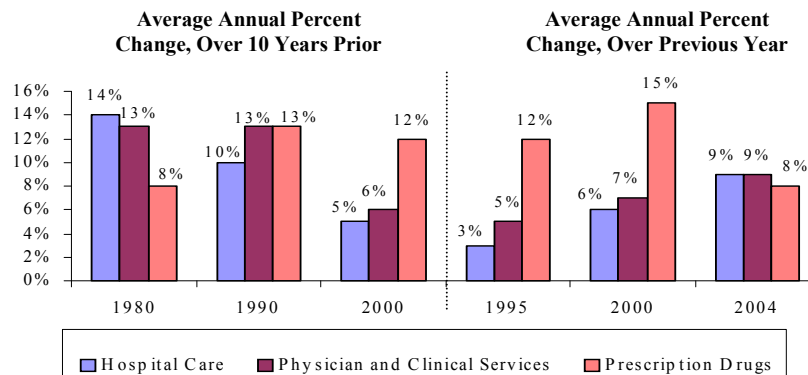
Driving Forces

Pharmaceutical costs are rising due to a variety of factors that can be linked to two major driving forces: the increased flow of new drugs to market and increased utilization.

Flow of New Drugs to Market

A primary force behind the growth of overall prescription drug spending is the introduction of new branded drugs to the marketplace. New drugs are classified as those approved by the Food & Drug Administration (FDA) since 1992. Expedited by a rise in the number of FDA new drug approvals, federally funded research, and growth in private research and development

Annual Percent Change in Selected National Health Expenditures, 1980 - 2004



Notes: With the 2004 estimates, CMS incorporated new concepts, methods, and data sources and revised the entire time series back to 1960.

Source: Kaiser Family Foundation calculations using National Health Expenditures data from Centers for Medicare & Medicaid Services, at <http://www.cms.hhs.gov/NationalHealthExpendData/>, as reported in Kaiser Family Foundation's "Prescription Drug Trends," June 2006.

spending, the number of new drugs being introduced to the marketplace is greatly accelerating. These new drugs are often more effective than old therapies that they replace, yet this innovation bears a hefty price tag.

- ✓ New drug approvals by the FDA fluctuated over the past decade, with 21 approvals in 1994, 36 in 2004, and 20 in 2005.
- ✓ New drugs can increase overall spending if they are used in place of older, less expensive medications, if they supplement rather than replace existing drug treatments, or if they treat a condition not previously treated with drug therapy.
- ✓ New drugs can reduce spending if they come into the market at a lower price than existing drug therapies, such as when a new drug enters a therapeutic category with one or two dominant brand competitors.
- ✓ Retail prescription prices increased an average of 8.3 percent per year from 1994 to 2005 (from an average of \$28.67 to \$64.86), more than triple the average annual inflation rate. These price increases reflect both manufacturer price changes for existing drugs and changes to newer, higher-priced drugs.

Increased Utilization

It is a fairly simple concept: more people are using more prescription drugs, thereby driving overall spending upward. The number of prescriptions dispensed has been growing dramatically from 1994 to the present, and is projected to continue at a similar pace for years to come.

- ✓ From 1994 to 2005, the number of prescriptions purchased increased 71 percent (from 2.1 billion to 3.6 billion), compared to a U.S. population growth of 9 percent.
- ✓ The average number of retail prescriptions per capita increased from 7.9 percent in 1994 to 12.3 in 2005.

The following sections address the most significant reasons for the growth in utilization of prescription drugs.

INSURANCE COVERAGE FOR PRESCRIPTION DRUGS

Individuals with insurance are more likely to use prescription drugs than those without. Only 26 percent of drug costs were funded by third party coverage in 1990; in 2004, private health insurance paid for 48 percent of drug costs. Likewise, consumers paid for 56 percent of drug costs out-of-pocket in 1990; currently, out-of-pocket funding accounts for only 25 percent of drug costs.

It should be noted that lack of drug coverage also has a variety of adverse affects. A 2003 survey found that uninsured adults (51 percent) are twice as likely as insured adults (25 percent) to say that they or a family member cut pills, did not fill a prescription, or skipped medical treatment in the past year.

Exhibit 2, below, depicts prescription drug expenditures by type of payer, from 1990 to 2004.

THE AGING OF AMERICA

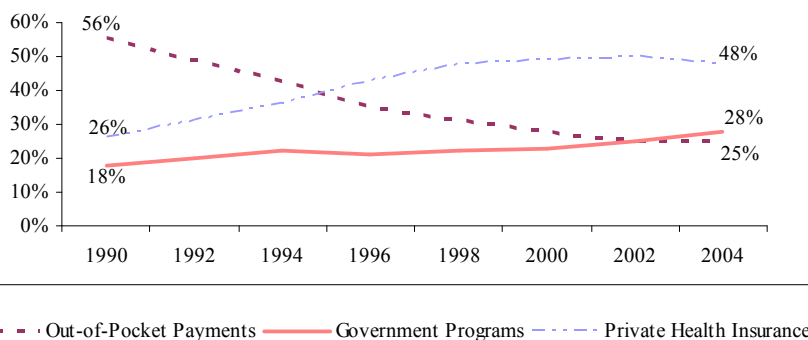
As discussed earlier in this article, Americans are growing older and are expected to live longer than ever before. With this general aging of the population there is a higher incidence of chronic disease, and a resultant increase in the use of pharmaceuticals to treat those conditions. This demographic trend is the leading cause of increased utilization of prescription drugs.

SPECIALTY MEDICATIONS

Specialty medications are emerging as a significant factor in overall pharmacy spending. Specialty drugs are those that are used to treat a variety of complex diseases (hemophilia, cancer, cystic fibrosis, and others). These drugs often require special handling, administration by infusion or injection, or other specialized patient support. According to Medco's *2006 Drug Trend Report*,

- ✓ Specialty drugs accounted for 9.7 percent of total pharmacy spending in 2005, up from 8.5 percent in 2004.
- ✓ Spending on specialty drugs rose by 16.9 percent in 2005, compared to an average 5.4 percent growth in overall drug spending.

Percent of Total National Prescription Drug Expenditures by Type of Payer, 1990 - 2004



Notes: Out-of-Pocket payments includes direct spending by consumers for healthcare goods and services not covered by a health plan and cost-sharing amounts (coinsurance, copayments, deductibles) required by public and private health plans. It does not include consumer premium payments and cost-sharing paid by supplementary Medicare policies, which are included in the Private Health Insurance category. With the 2004 estimates, CMS incorporated new concepts, methods and data sources and revised the entire time series back to 1960.

Source: Kaiser Family Foundation calculations using National Health Expenditures data from Centers for Medicare & Medicaid Services, at <http://www.cms.hhs.gov/NationalHealthExpendData/>, as reported in Kaiser Family Foundation's "Prescription Drug Trends," June 2006.

AGGRESSIVE DIAGNOSIS AND TREATMENT METHODS

New technology and clinical protocols have brought increasingly aggressive diagnosis and treatment methods and a greater emphasis on preventive measures. Pharmaceuticals often play a primary role in these more aggressive ways of diagnosing and treating diseases.

PHARMACEUTICAL MARKETING

In 1985, the FDA lifted its moratorium on direct-to-consumer (DTC) advertising of prescription drugs. Prior to this change, pharmaceuticals were marketed solely to physicians and other medical professionals. Now, prescription drugs have become one of the most highly marketed product categories.

- ✓ After a decade of increases, the total amount drug manufacturers spent on advertising declined 3.5 percent from 2004 to 2005, from \$11.9 billion to \$11.4 billion.
- ✓ The share of advertising dollars directed towards consumers increased 5 percent in 2005 (from \$4.0 billion to \$4.2 billion), while the share directed towards physicians declined by 8 percent (from \$7.8 billion to \$7.2 billion).
- ✓ Spending on consumer advertising in 2005 was over five times the amount spent in 1996 (\$0.8 billion), while 2005 physician advertising was two times the amount spent in 1996 (\$3.5 billion).

Many feel that both prescription utilization and shifts to higher-priced drugs can be influenced by advertising. In addition, critics of the drug companies charge that pharmaceutical prices could be lower if exorbitant amounts of money were not being spent on advertising.

What Can Employers Do?

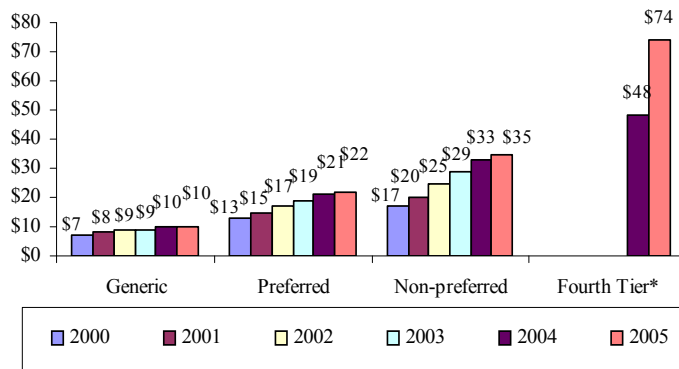
Employers and health plans are implementing a variety of strategies to attempt to contain their rising drug costs.

- ✓ Health plans have responded to increasing prescription drug costs by excluding certain drugs from coverage, using quantity dispensing limits, increasing enrollee cost-sharing amounts, and implementing step therapy protocols.
- ✓ In 2005, about three-quarters (74 percent) of workers with employer-sponsored coverage had a cost-sharing arrangement with three or four tiers. This is more than 2 ½ times the proportion enrolled in these type of drug plans in 2000 (27%).
- ✓ Copayments for nonpreferred drugs (those not included on a formulary or preferred drug list) have doubled from an average of \$17 in 2000 to \$35 in 2005.
- ✓ Copayments for preferred drugs (those included on a formulary or preferred drug list, such as a brand name drug without a generic substitute) increased 69 percent, from \$13 in 2000 to \$22 in 2005.

Exhibit 3, below, compares average drug copayments among covered workers from 2000 to 2005.

Clearly there are many options to explore if you are trying to contain prescription drug costs associated with your employee health plan. Educating your employees about the reasons for rising drug costs and their impact on your health plan will be the key to successfully introducing changes to your plan or increases in the amounts you require them to pay out-of-pocket.

Average Drug Copayments Among Covered Workers Facing Prescription Drug Copayment Amounts, 2000 - 2005



*Fourth-tier copayment information was not obtained prior to 2004.

Notes: Average copayments for generic, preferred, and non-preferred drugs are calculated by combining the weighted average copayments for those types of drugs among firms with a single copayment amount or a multi-tier cost-sharing structure. The average copayment for fourth-tier drugs is calculated using information from only those plans that have a fourth-tier copayment amount.

Source: Kaiser Family Foundation and Health Research and Educational Trust, Annual Surveys of Employer-Sponsored Health Benefits, 2000-2005, at <http://www.kff.org/insurance/.7315/index.cfm>, as reported in Kaiser Family Foundation's "Prescription Drug Trends," June 2006.

Exhibit 3

Perspectives is provided to [B_Officialname] clients for informational purposes. Please seek qualified and appropriate counsel for advice on how to apply the topics discussed herein to your employee benefits plan.