

# PERSPECTIVES

PROVIDING INSIGHT INTO TODAY'S EMPLOYEE BENEFITS ISSUES

## Increasing Healthcare Costs and Your Employee Health Plan

Seventh Edition

**HEALTHCARE** costs, and consequently employee health benefits costs, 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 commonplace. 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.

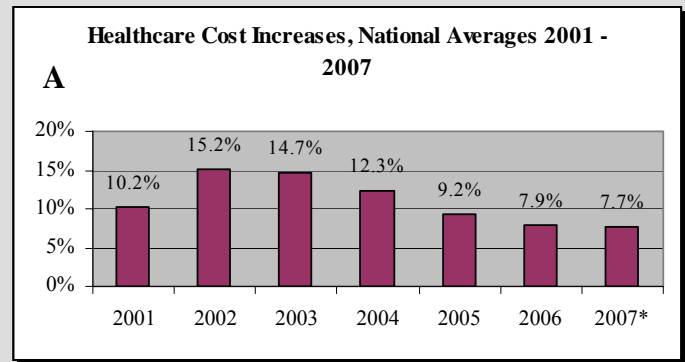
The next few pages will discuss the latest healthcare cost figures, the factors leading to nearly a decade of unprecedented rate hikes, and some solutions that firms around the U.S. are undertaking to help soften the blow.

### National Healthcare Cost and Renewal Rate Projections

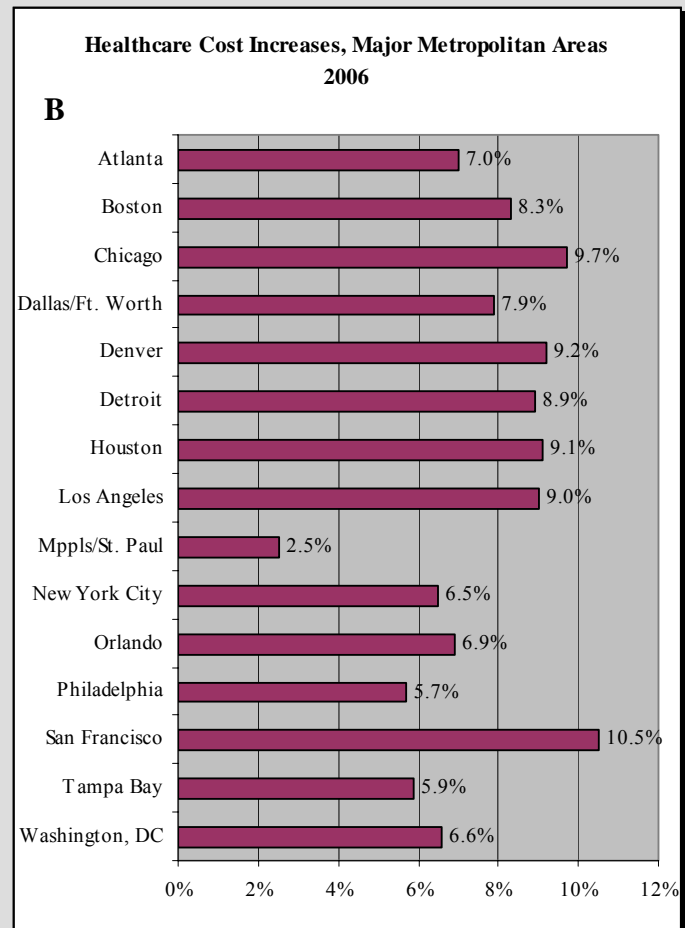
Overall national healthcare costs have been skyrocketing for over a decade, and are now just beginning to level off. From 1994 to 1998, average annual healthcare cost increases hovered around 2 percent. From 1999 to 2000, however, costs leapt 9.4 percent and the annual percent change then entered and stayed in the double digits until finally taking a slight downturn in 2005.

**Exhibit 1A**, right, depicts the percent change in average annual healthcare cost increases from 2001 to 2007. While healthcare costs are still increasing significantly, it appears that the downward trend is continuing. Hewitt projected the increase in healthcare costs for 2007 to be around 7.7 percent, compared to 7.9 percent in 2006.

The overall cost of healthcare has a direct impact on the rates employers pay for employee health benefits. Still, health benefits costs have varied widely across the country for the last several years, hitting some metropolitan areas much harder than others. **Exhibit 1B**, right, illustrates the cities that recorded the highest



\*Projected



Source: Hewitt Health Value Initiative™, 2006

healthcare cost increases in 2006.

While the rate increase has slowed in recent years, experts expect significant annual increases in healthcare costs to continue indefinitely. According to the *Mercer National Survey of Employer-Sponsored Health Plans 2006*, the average cost of healthcare benefits for active employees rose 6.1 percent in 2006 — from \$7,089 per employee in 2005 to \$7,523 per employee in 2006. 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 benefit costs for active employees for the years 1996 to 2006. **Exhibit 2B** depicts the annual percent change in health benefit costs from 1989 through 2006. Note especially the dramatic upward trend since 1998, and the positive trend that is now emerging — an ongoing drop in the annual percent increase since 2002.

According to the survey, employers see consumerism and care management as the most effective way to manage health benefit costs for the future, as opposed to the simple cost-shifting measures that have been used traditionally. Mercer’s survey shows that average deductibles, copays, and out-of-pocket maximums — which rose significantly from 2000 to 2005 — showed only modest growth in 2006. **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”).

**Shift to Consumerism Yields CDHP Growth**

The percentage of all employers offering a consumer-directed health plan (CDHP) based on either a health reimbursement account (HRA) or a health savings account (HSA) tripled in 2006, from 2 percent to 6 percent, as small employers began adopting the new type of plan in significant numbers for the first time. Growth in CDHPs was also strong among larger employers, where offerings rose from 5 percent to 11 percent among employers with 500 or more employees, and from 22 percent to 37 percent among jumbo employers (20,000 or more employees). Nationally, enrollment in CDHPs jumped from 1 percent to 3 percent of all covered employees.

CDHPs delivered substantially lower costs per employee than either PPOs or HMOs in 2006. CDHP costs averaged \$5,770 per employee, compared to \$6,616 for HMOs and \$6,932 for PPOs.

While the news about CDHP costs is encouraging, Mercer’s experts caution that it is still too early to celebrate. CDHPs may currently be chosen more often (when offered with a choice of plans by the employer) by those with lower-than-average health risk, a significant factor in keeping costs low.

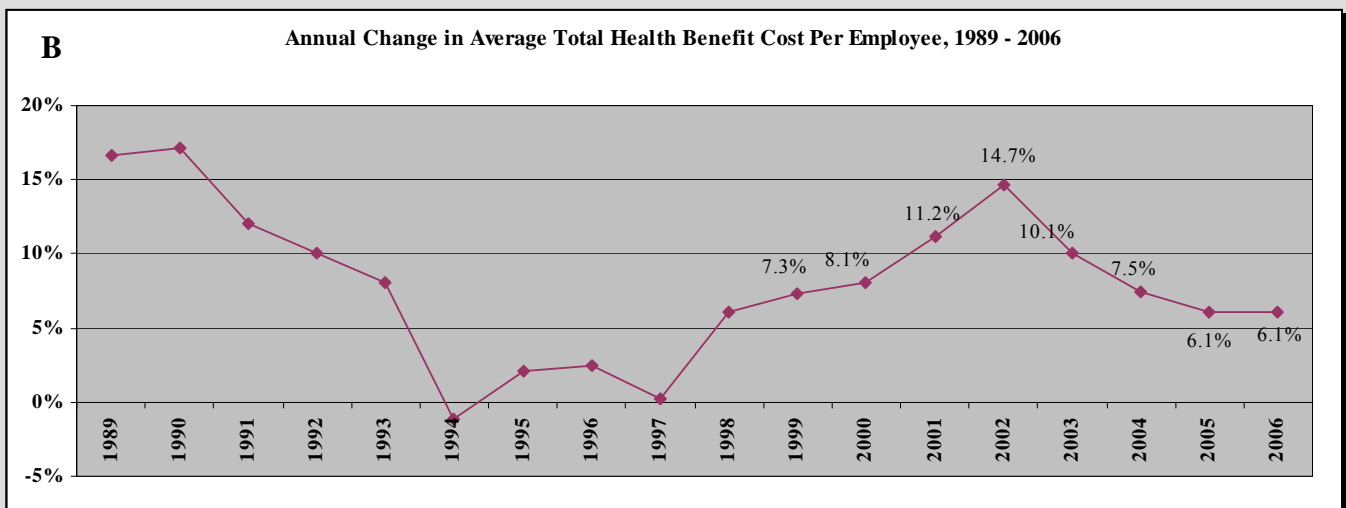
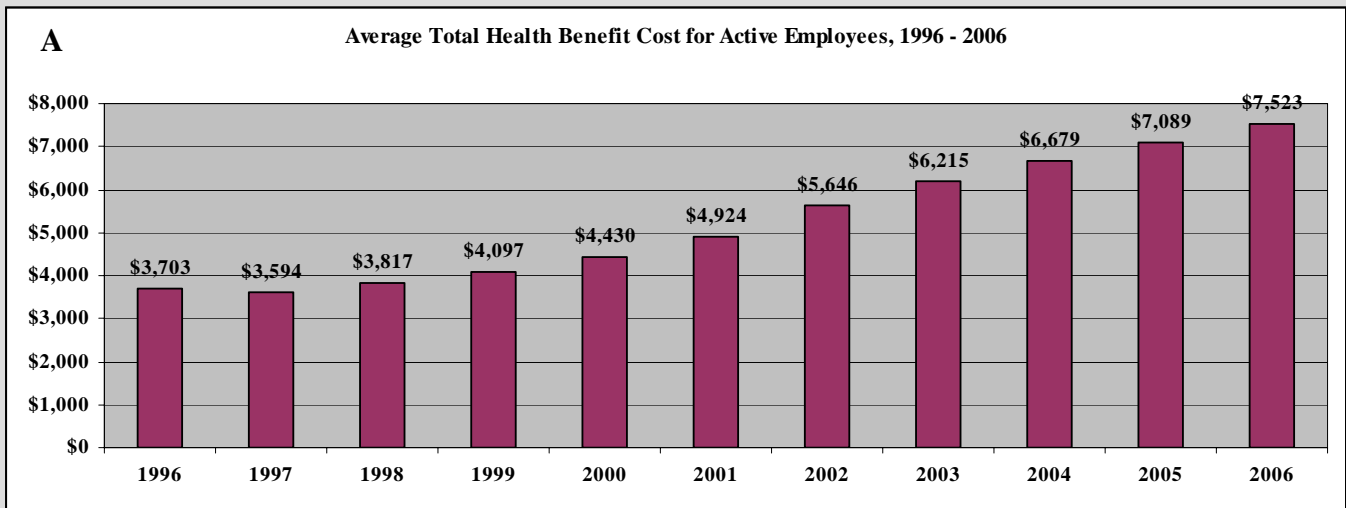


Exhibit 2

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**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
Care management	43%	71%
Consumerism	43%	64%
High-performance networks	34%	41%
Collective purchasing	45%	37%
Scaling back benefits/cost-shifting	31%	37%
Data transparency	34%	34%

Source: Mercer's National Survey of Employer-Sponsored Health Plans, 2006.

**Factors Leading to Increased Healthcare Costs**

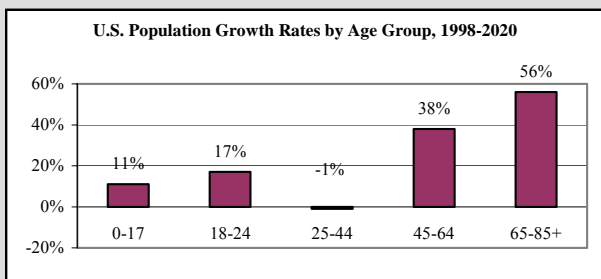
Why are U.S. healthcare costs skyrocketing? Several market conditions working in tandem have led to a decade of unrelenting increases. Understanding why your annual health plan renewal rates may be significantly higher than the previous year is the key to formulating alternatives and solutions to your 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 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 Services<sup>1</sup> (CMS) annually releases national health expenditures projections. Some of their most recent findings for the period 2006 - 2016 include:

- ✓ Healthcare spending in the U.S. was projected to grow 6.8 percent in 2006, down slightly from the 6.9 percent growth in 2005. This marks the fourth consecutive year of slowing growth since a peak of 9.1 percent in 2002, and is the slowest rate of growth since 1999.

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

- ✓ Healthcare spending as a percent of Gross Domestic Product (GDP) was expected to hold steady at 16 percent for 2006. By 2016, healthcare spending in the U.S. is expected to reach just over \$4.1 trillion and make up 19.6 percent of GDP.
- ✓ Over the projection period (2006 – 2016) growth in healthcare expenditures is expected to remain relatively stable, averaging 6.9 percent per year.
- ✓ Physician spending growth was projected to decelerate to 6.1 percent, driven mostly by a slowdown in price growth.
- ✓ Prescription drug spending growth was expected to accelerate to 6.5 percent, driven by increased utilization for certain classes of drugs, such as cardiovascular, central nervous system, endocrine, and diabetes drugs.
- ✓ Hospital spending growth for 2006 was expected to slow substantially to 6.6 percent. Since hospital spending makes up about one-third of health spending, the slowdown is a major driver of deceleration in health spending in 2006.

#### 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 Index<sup>3</sup> (CPI). The U.S. Department of Labor Bureau of Labor Statistics recently released CPI figures for the period ending June 31, 2007.

**Exhibit 4**, below, shows the percent change in CPI for various consumer expenditure categories since 2000. *Medical Care* is one of the categories.

Overall consumer prices rose 2.5 percent during 2006. So far in 2007 overall consumer prices have risen 5.0 percent.

Costs for goods and services in the Medical Care category rose 3.6 percent in 2006, and 4.7 percent as of June 2007 — 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 and Food and Beverages categories. 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 CPI<sup>4</sup>, 2000 – 2007**

	2000	2001	2002	2003	2004	2005	2006	2007 <sup>5</sup>
<b>All Items</b>	<b>3.4%</b>	<b>1.6%</b>	<b>2.4%</b>	<b>1.9%</b>	<b>3.3%</b>	<b>3.4%</b>	<b>2.5%</b>	<b>5.0%</b>
Food & Beverages	2.8%	2.8%	1.5%	3.5%	2.6%	2.3%	2.2%	6.2%
Housing	4.3%	2.9%	2.4%	2.2%	3.0%	4.0%	3.3%	3.2%
Apparel	-1.8%	-3.2%	-1.8%	-2.1%	-0.2%	-1.1%	0.9%	-2.9%
Transportation	4.1%	-3.8%	3.8%	0.3%	6.5%	4.8%	1.6%	12.3%
<b>Medical Care</b>	<b>4.2%</b>	<b>4.7%</b>	<b>5.0%</b>	<b>3.7%</b>	<b>4.2%</b>	<b>4.3%</b>	<b>3.6%</b>	<b>4.7%</b>
Recreation	1.7%	1.5%	1.1%	1.1%	0.7%	1.1%	1.0%	0.6%
Education and Communication	1.3%	3.2%	2.2%	1.6%	1.5%	2.4%	2.3%	3.1%
Other Goods & Services	4.2%	4.5%	3.3%	1.5%	2.5%	3.1%	3.0%	4.1%

Source: United States Department of Labor Bureau of Labor Statistics, news release, Consumer Price Index, June 2007.

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 employers 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 benefit 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:

<sup>1</sup>Formerly the Health Care Financing Administration (HCFA).

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

<sup>3</sup>The 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.

<sup>4</sup>Reference base: 1982-1984.

<sup>5</sup>Seasonally adjusted annual rate six months ended in June 2007.

*Perspectives* is provided to Corporate Health Systems, Inc 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.

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## SPECIAL REPORT: Prescription Drug Costs and Your Employee Health Plan

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### 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 \$200.7 billion in 2005 — almost 5 times more than the \$40.3 billion spent in 1990. While prescription drug spending has been a small proportion of national healthcare spending compared to spending for hospital and physician services (10 percent in 2005, compared to 31 percent and 21 percent, respectively), it has been one of the fastest growing components, increasing from 1994 to 2003 at double-digit rates compared to single-digit rates for hospital and physician services. However, the annual rate of increase in prescription spending declined from a high of 18 percent in 1999 to 6 percent in 2005.

Prescription drug spending growth declined because of the slowdown in Medicaid drug spending, the increased use of generic drugs (driven partly by the expansion of tiered copayment benefit plans), changes in the types of drugs used, and

a decrease in the number of new drugs introduced.

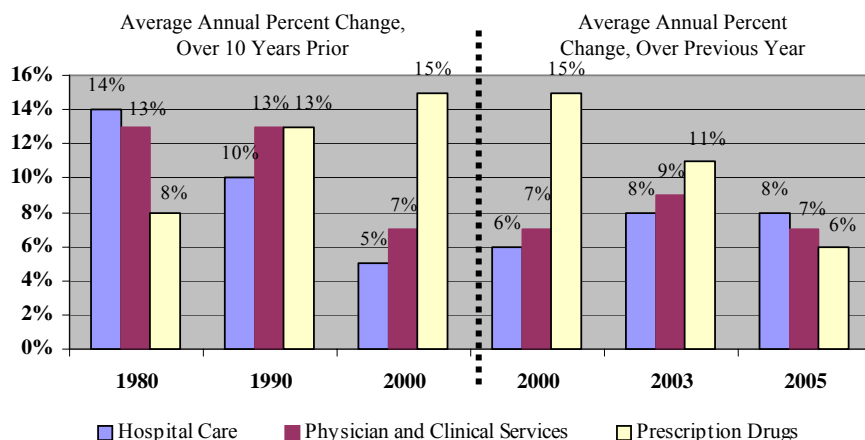
**Exhibit 1**, below, compares the annual percent change in prescription drug spending to other selected national health expenditures, from 1980 to 2005.

The portion of prescription drug expenses paid for by private health insurance has increased substantially over the past decade (from 26 percent in 1990 to 47 percent in 2005). This trend has contributed to a decline in the amount that people pay out of their own pockets (from 56 percent in 1990 to 25 percent in 2005). However, the U.S. Department of Health and Human Services (HHS) expects that these shares will change significantly in 2006 due to the Medicare Part D prescription drug program.

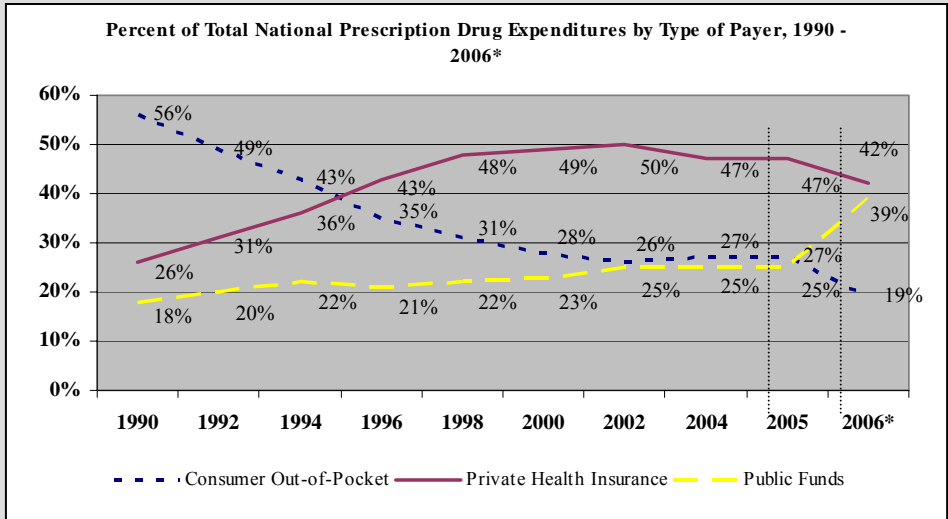
According to HHS, the portion of prescription drug expenses paid for by private health insurance will drop to 42 percent in 2006, while the portion of drugs paid for with out-of-pocket funds will decline to 19 percent, and those paid for by public funds will increase to 39 percent.

**Exhibit 2**, on page 9, depicts prescription drug expenditures by type of payer from 1990 – 2006.

Average Annual Percent Change in Selected National Health Expenditures, 1980 - 2005



Source: Kaiser Family Foundation calculations using National Health Expenditures data from Centers for Medicare and Medicaid Services, at <http://www.cms.hhs.gov/NationalHealthExpendData/>, as reported in Kaiser Family Foundation "Prescription Drug Trends" May 2007.



Notes: Consumer Out-of-Pocket includes direct spending by consumers for health care 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.

\*Projected.

Source: Kaiser Family Foundation calculations using National Health Expenditures data from CMS, Historical and Projected, at <http://www.cms.hhs.gov/NationalHealthExpendData/>, as reported in Kaiser Family Foundation "Prescription Drug Trends" May 2007.

**Driving Forces**

According to the Kaiser Family Foundation's May 2007 "Prescription Drug Trends" report, changes in prescription drug spending are primarily driven by three main factors: changes in utilization, price changes, and changes in the types of drugs being used.

**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 12.4 in 2006.

**Increased Prices**

Retail prescription prices (which reflect both manufacturer price changes for existing drugs and changes in use to newer, higher-priced drugs) increased an average of 7.5 percent a year from 1994 to 2006 (from an average price of \$28.67 to \$68.26), almost triple the average annual inflation rate of 2.6 percent.

The average brand name prescription price was over three times the average generic price in 2006 (\$111.02 versus \$32.23).

**Changes in Types of Drugs Used**

When new drugs enter the market and existing drugs lose patent protection, prescription drug spending is affected. If new drugs are used in place of older, less expensive medications, they can increase overall drug spending. In addition, if they supplement rather than replace existing drug treatments, or if they treat a condition not previously treated with drug therapy, they can lead to increased drug spending. New drugs can reduce

overall drug spending if they enter the market at a lower price than existing drug therapies, for instance, if a new drug enters a therapeutic category with one or two dominant brand competitors.

The number of new drugs approved by the FDA has fluctuated over the past decade, with 53 approvals in 1996, 27 in 2000, 36 in 2004, and 22 in 2006.

Drug spending can also be reduced when existing brand drugs lose patent protection and face competition from new, lower-cost generic substitutes. Approximately three-quarters of FDA-approved drugs have generic counterparts. In 2006, 20 percent of prescription drug sales and 63 percent of prescriptions dispensed were generic medications. Generic sales grew by 22 percent and generic prescriptions dispensed grew by 13 percent from 2005 to 2006.

**Advertising**

Prescription use in general and movement to higher-priced drugs can be influenced by advertising.

- ✓ After increasing for over a decade, the total amount manufacturers spent on advertising prescription drugs declined 3.4 percent from 2004 to 2005 (from \$11.9 billion to \$11.4 billion).
- ✓ The share of dollars spent on direct-to-consumer advertising increased 5 percent in 2005 (from \$4.0 billion to \$4.2 billion), while the share directed toward physicians declined by 8 percent (from \$7.8 billion to \$7.2 billion).
- ✓ Spending on direct-to-consumer advertising for prescription drugs in 2005 was two times the 1996 amount (\$3.5 billion).

The FDA and Congress are considering changes to prescription drug advertising rules in order to help mitigate the affect it has on drug prices and spending.

## What Can Employers Do?

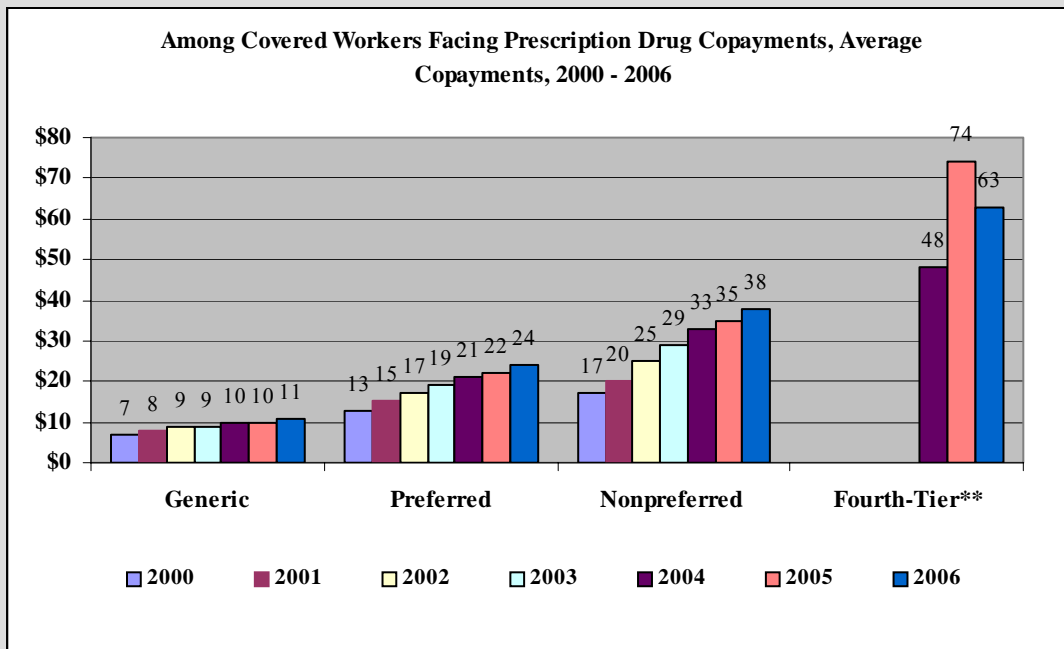
Employers and health plans are implementing a variety of strategies to attempt to contain their rising drug costs.

- ✓ Health plans have responded to increasing prescription drug costs by excluding certain drugs from coverage, using quantity dispensing limits, and increasing enrollee cost-sharing amounts.
- ✓ In 2006, 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 types of drug plans in 2000 (27%).
- ✓ Copayments for nonpreferred drugs (those not included on a formulary or preferred drug list) have more than doubled from an average of \$17 in 2000 to \$38 in 2006.

- ✓ Copayments for preferred drugs (those included on a formulary or preferred drug list, such as a brand name drug without a generic substitute) increased 84 percent, from \$13 in 2000 to \$24 in 2006.

**Exhibit 3**, below, compares average drug copayments among covered workers from 2000 to 2006.

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.



\*\*Fourth-Tier drug copay information was not obtained prior to 2004. The average copayments for preferred and nonpreferred drugs include values for firms where cost-sharing is the same regardless of drug type. Because in some cases drugs covered as fourth-tier drugs may be covered by health plans through other portions of their coverage (e.g., as part of major medical coverage), the average copayment for fourth-tier drugs is calculated using information from only those plans that have a fourth-tier copayment amount.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2000-2006, at <http://kff.org/insurance/7527/index.cfm>, as reported in Kaiser Family Foundation "Prescription Drug Trends" May 2007.

*Perspectives* is provided to Corporate Health Systems, Inc 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.