

MAKING THE MOST OF GENERICS

Free generics*: Rx relief without the side effects

In a health care landscape that seems to offer little respite from rising costs, the threat of ever-pricier therapies and more expensive technological solutions, generic drugs have long served as an oasis. Employers scan the horizon eagerly to see which billion-dollar blockbuster drug will be next to lose patent protection, soon to resurface as a vastly more affordable version of its former self.

Encouraging employees to choose generics seems like the least risky of benefit management strategies: generics are chemically equivalent to their brand-name counterparts; they've proven their clinical effectiveness

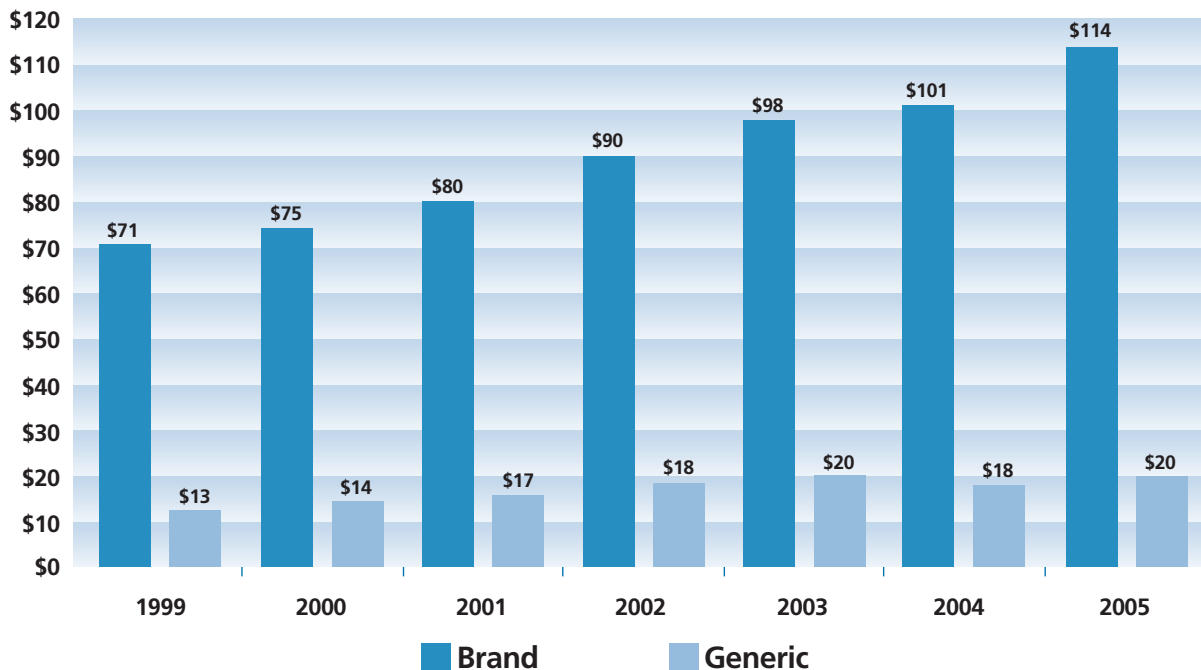
and safety over years of use; and they're typically 80% cheaper than brand drugs.

Despite this sterling profile, one report estimates that \$20 billion in generic savings went untapped in the U.S. last year¹ — and that's among consumers insured by commercial health plans, most of which have benefit designs expressly intended to promote the use of generics!

That's \$20 billion more than we needed to spend to achieve the same health outcomes.

*\$0 copay to member, cost of generics included in premium or claims cost

Average cost difference between generic and brand-name drugs:



Source: Blue Cross and Blue Shield of Minnesota data



When halfway isn't good enough

Slightly more than half (53%)² of prescriptions written in the United States are filled with generic medications, with significant variation among states. Experts suggest that the Generic Fill Rate, as it is referred to in the industry, could easily be 70% or higher if all opportunities to prescribe generics were realized.

The disparity is even more striking when you look at individual drug categories. In one of the highest-volume, highest-cost categories — cholesterol-lowering drugs — which includes very effective generic medications, generics could be prescribed 70% of the time — a far cry from the 7% of prescriptions in this drug category currently filled with generics.³

Each one-point uptick in an organization's overall generic utilization rate can translate into a one-percentage-point reduction in drug costs.

The good news is, gaps of this magnitude represent excellent opportunities to achieve savings by focusing on increasing consumers' use of safe, effective generic medications. In fact, each one-percentage-point uptick in an organization's overall

generic utilization rate can translate into a one-percentage-point reduction in drug costs.⁴

The time to focus on generics has never been better. With 25 of the 57 most-prescribed drugs in America scheduled to become available as generics in the next five years, now is an ideal time to implement strategies that will help you and your employees avoid the unnecessary and costly practice of treating conditions with brand-name drugs that can be treated just as successfully with generic medications at a fraction of the cost.

How large is the opportunity?

In a study of 3 million commercially insured members across the U.S. by Express Scripts, the generic fill rate by state ranged from 41 percent to 55 percent. Minnesota's overall rate (in 2004) was 51 percent.

Those rates could — and should — be much higher, according to health industry experts. In fact, at least one source contributing to an industry publication on drug trends anticipates that generic fill rates could reach 80%.⁵

Using the 1:1 ratio observed by Express Scripts, that approximately 30-point difference could mean 30% lower drug costs.

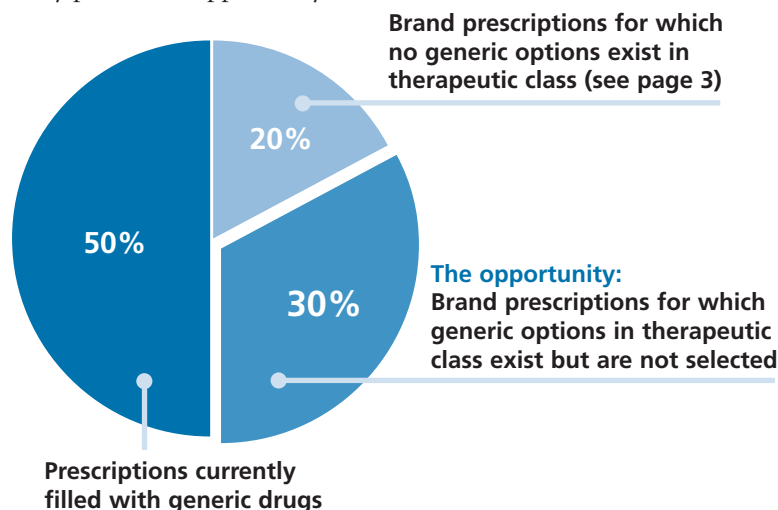
Why the large gap?

Why are so many opportunities for generic drugs going unrealized — even among health plans that boast generic substitution rates higher than 90%? It's the way generic "opportunities" are defined:

Generic fill rate:
percent of all prescriptions written that are filled with generic drugs

Generic substitution rate:
percent of brand-name prescriptions for which generic drugs are substituted (either at the patient's request or as a requirement of the health plan or state law)

Those generic substitution rates approaching 100% measure only those instances when the exact generic counterpart for a specific drug is available and is dispensed in place of the brand-name drug. And, in fact, seeing high generic substitution rates may lull some employers into thinking they have achieved all they can with generic drugs. But generic substitution is only part of the opportunity.



Therapeutic alternatives ... where the action is

For most conditions, doctors can select among several medications in a therapeutic drug class. These therapeutically equivalent drugs may contain different active ingredients, but they are grouped in the same class because they produce similar clinical results. While all drugs in a therapeutic class are FDA-approved drugs, most state laws currently allow — and, in fact, mandate — automatic generic substitution only for drugs that are chemical equivalents. As a result, many instances where a consumer could realize the same clinical benefits — and greater cost benefits — from a generic drug go unrealized.

Let's look at an example from the high-volume drug category of cholesterol-lowering drugs called statins, which includes the top-selling drug in the world — Lipitor.⁶ Despite there being a generic drug — lovastatin — available in this category, fewer than 8% of prescriptions dispensed in this category in 2005 were for the generic drug.

Lovastatin, the first statin to be approved by the FDA, appears on the Consumer Reports Best Buy Drugs list, which considers effectiveness, safety, and cost in its recommendations. The report notes that, at a cost of \$1 to \$1.88 per day (compared to \$4.00 per day for Lipitor) lovastatin is substantially less expensive than other statins.

Drug	2005 U.S. Sales	2005 Dispensed Scripts
Lipitor	\$16.0 billion	79 million
Zocor	\$4.4 billion	28 million
Pravachol	\$1.8 billion	12 million
Crestor	\$0.8 billion	9 million
Generic Lovastatin	\$0.3 billion	11 million

Source: IMS Health, IMS National Sales Perspectives, 2/2006

Express Scripts, evaluating the use of statin drugs in its 2004 study, notes that 80% of patients started and stabilized on a brand-name statin prescription could instead take generic lovastatin and continue to benefit from comparable reductions in “bad” LDL cholesterol.

Similar opportunities exist in other high-volume drug categories, as shown in the table below.

Therapy Class	Generic Fill Rate Actual 2004	Generic Fill Rate Target	Gap	Potential Savings if Generic Fill Rate Target Reached
Gastrointestinals	31%	95%	64%	\$5.4 billion
Antihyperlipidemics	7%	70%	63%	\$5.1 billion
Calcium Channel Blockers	43%	90%	47%	\$484 million
Antihypertensives	48%	75%	27%	\$3.2 billion
NSAIDs	47%	85%	38%	\$3.9 billion
Antidepressants	41%	75%	34%	\$3.2 billion
Total Savings				\$20 billion

Source: Express Scripts, 2004 Generic Drug Usage Report

Breaking the brand-name habit

One good way for organizations to increase their generic fill rate — and hence, their overall drug savings — is to encourage employees to request generic drugs at the point of care. As consumers engage with their physicians and express their preference for lower-cost alternatives, they will counter physicians' tendency to prescribe brand-name medications first. Reviews of prescription drug claims have shown that when a drug's patent expires and the manufacturer ceases promoting it, market share within the relevant drug class shifts substantially to other brand-name drugs within the class (now more heavily promoted, of course) rather than to the newly available generic.

Perfect timing

In 2006, an unusually high number of blockbuster drugs will go off patent, including cholesterol-lowering Zocor, the second-biggest-selling drug in the nation; the antidepressant

Zoloft; another cholesterol-reducing drug Pravachol, and the sleep aid Ambien. In the next five years, patents will expire on more than 70 brand name drugs. Now is a very good time to implement strategies to help your employees and their families choose generic medications.

Generics first ... Generics free

Making generic drugs free for your employees and their families is one of the surest ways to move the dial on your generic utilization rate and to lower overall drug spend.

- ◆ It gives employees a clear message that you are willing to help them save money on their medications
- ◆ It encourages adherence to drug therapy, which reduces the need for medical services (more on this later)
- ◆ It simplifies what employees need to remember when they talk with their physicians about drug therapy

Brand Name	Common Uses	Anticipated Patent Expiration*	
Pravachol	High Cholesterol	2nd Quarter	2006
Zocor	High Cholesterol	2nd Quarter	2006
Zoloft	Depression	2nd Quarter	2006
Ambien	Insomnia	4th Quarter	2006
Lamisil	Nail Fungal Infections	4th Quarter	2006
Allegra and Allegra D	Allergies	4th Quarter	2006
Zofran	Nausea	–	2006
Prevacid	GERD, Peptic Ulcers	1st Quarter	2007
Imitrex	Migraine Headache	3rd Quarter	2007
Zyrtec and Zyrtec D	Allergies	3rd Quarter	2007
Fosamax, Fosamax Weekly and Fosamax Plus D	Osteoporosis	1st Quarter	2008
Depakene and Depakote	Seizures	–	2008
Effexor and Effexor XR	Depression	2nd Quarter	2008
Topamax	Migraines, Seizures	3rd Quarter	2008

Source: FDA, Approved Drug Products with Therapeutic Equivalence Evaluations (Electronic Orange Book) – via on-line resources
 FDC Reports, 'The Pink Sheet' – 2004-2005

*Anticipated patent expiration dates are subject to change as a result of litigation, pediatric or other exclusivities, etc.

The economics of free generics

Generics currently comprise 8-12% of the nation's overall drug spend.⁷ Blue Cross and Blue Shield of Minnesota modeling shows that most self-insured organizations implementing a Free Generics program will reach a breakeven point when their generic utilization rate rises between five and 10 percentage points, for example from 55% to 60%. That is, at that point, the money spent on absorbing the full cost of their covered population's generic drugs will be fully offset by the money not spent on brand-name drugs (recall the average difference of almost \$100 between generic and brand-name prescriptions).

While this breakeven point is typically reached within the first few months of the program, organizations may wish to consider making the program immediately cost-neutral by raising the copay or coinsurance on all brand-name drugs.

The two scenarios below show the change in the mix of generic and brand prescriptions necessary to offset the cost of covering a Free Generics program. In Scenario 1, the copay for formulary brand drugs is maintained at \$30. In Scenario 2, the copay for drugs is increased by \$10 (the same amount as the former copay for generic prescriptions), making the program almost immediately cost-neutral.

Scenario 1: Self-insured, no change to brand copay, 57 employees, 125 covered members, average 8 scripts annually per member

Total scripts	1,000	1,000
Mix (generic/brand)	50/50	60/40
Total generic scripts	500	600
Total brand scripts	500	400
Avg generic cost	\$20*	\$20*
Avg brand cost	\$114*	\$114*
Total generic cost	\$10,000	\$12,000
Total brand cost	\$57,000	\$45,600
Total cost	\$67,000	\$57,600
Member copay – brand formulary	\$30	\$30
Member copay – generic	\$10	\$0
Total member contribution	\$20,000	\$12,000
Total group contribution	\$47,000	\$45,600

What to expect

A number of Blue Cross and Blue Shield plans* across the country have implemented Free Generics programs with their fully insured members, typically for a defined period of three or six months. Their experience shows:

- ◆ A consistent five-point increase in Generic Fill Rate
- ◆ A 4%-8% increase in utilization (to be expected due to increased adherence to drug therapy)
- ◆ One plan estimated that 22% of members switched to generic drugs during a several-month “copayment holiday” in 2004.
- ◆ Prime Therapeutics, the PBM that serves Blue Cross and Blue Shield of Minnesota, implemented a Free Generics program with its own 1,100 employees in January of 2006. During the program's first month, the generic fill rate increased from 56.2% to 62.3%.

*Each plan is an independent licensee of the Blue Cross and Blue Shield Association

Scenario 2: Self-insured, increase brand copay by \$10, 57 employees, 125 covered members, average 8 scripts annually per member

Total scripts	1,000	1,000
Mix (generic/brand)	50/50	53/47
Total generic scripts	500	530
Total brand scripts	500	470
Avg generic cost	\$20*	\$20*
Avg brand cost	\$114*	\$114*
Total generic cost	\$10,000	\$10,600
Total brand cost	\$57,000	\$53,580
Total cost	\$67,000	\$64,180
Member copay – brand formulary	\$30	\$40
Member copay – generic	\$10	\$0
Total member contribution	\$20,000	\$18,800
Total group contribution	\$47,000	\$45,380

*Source: Blue Cross and Blue Shield of Minnesota data

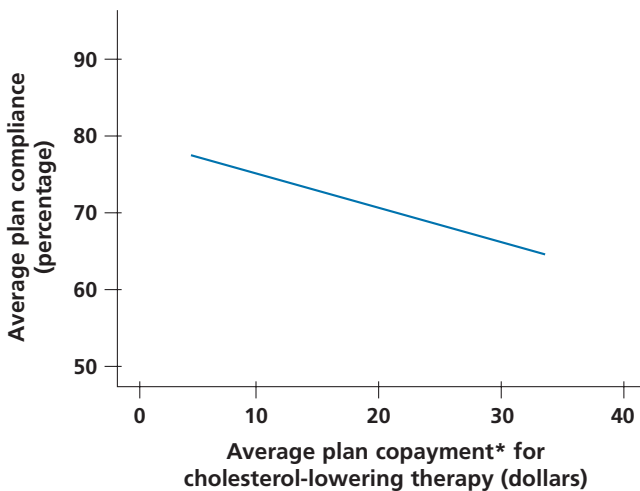
Long-term health benefits of Free Generics

While the short-term financial benefits of shifting more prescriptions to low-cost generic medications are obvious and immediate, there are significant expected long-term benefits, as well.

Prescription drugs have proven to be very cost-effective treatments for chronic illness. In a 2005 study conducted by Medco, for patients with diabetes, every dollar spent on medication saved \$7 in medical costs.⁸ The effectiveness of drug therapy in reducing cardiac events and hospitalization has also been documented.⁹

Yet patient adherence to drug therapy averages only 50% to 65% for common chronic conditions.¹⁰ As employers and health plans have moved to reduce pharmaceutical cost by increasing employees' share of the cost, researchers have been prompted to investigate possible connections between the cost of medications and patient adherence to drug therapy.

As copayments go up, compliance goes down:



*Average copayment for each plan year is for a 30-day supply of cholesterol lowering therapy

Source: Rand Fact Sheet: Cutting Drug Copayments for Sicker Patients on Cholesterol-Lowering Drugs Could Save a Billion Dollars Every Year

The Rand Corporation observed a large inverse relationship between copayment amount and patient adherence to drug recommendations. For each \$10 rise in copayment, average adherence fell by five points.

In another study, patients who received generic medications had 62% greater odds of achieving adequate adherence than those who received non-preferred branded medications.¹¹

This study focused on how decisions at the physician-patient level affect medication use. It concluded that physicians can influence long-term adherence by choosing wisely within a drug class and prescribing generic drugs when initiating chronic therapy.

Talking about cost

Research has shown that doctors don't discuss out-of-pocket costs with their patients nearly as often as they might. A study of cost-related skipping (that is, not taking prescription medications because of the cost) among Medicare beneficiaries called communication between physicians and patients about the cost of prescription medications "suboptimal,"¹² and noted that efforts to improve physician and patient awareness of cost requirements at the time of prescribing can have an important effect on adherence to drug therapy.

One benefit of a Free Generics program is that it gives consumers an opportunity to bring up the subject of generics with their physicians. Currently, only 37% routinely ask their physicians about generic medications.¹³ The simple message "I have free generic drug coverage" makes it much more likely that your employees who need drug therapy will leave the doctor's office with a prescription for a generic drug. For members initiating therapy for chronic conditions, starting off with a generic can mean years of significant savings.

We all win with Free Generics

Promoting the use of lower-cost generic drugs is one of the best ways to keep health care affordable, and one of the most effective weapons in pharmacy trend management. Implementing a Free Generics program will significantly increase the number of pharmacy claims that come through at \$20 rather than \$114.

Making generics free for employees and their families encourages them to ask their doctors to consider generics first. As consumers initiate these conversations, the emphasis on generics will help to shift provider behavior toward greater consideration of generics as a first line of therapy.

Making generics free also reduces economic barriers that have been shown to influence adherence to drug therapy. Patients who continue recommended drug therapy typically experience better outcomes: better management of their condition, less need for more expensive medical services down the road, and, when their medications are generics, more value for their health care dollars.

Endnotes:

- 1 Express Scripts, 2004 Generic Drug Usage Report.
- 2 Generic Pharmaceutical Association, dated 5/18/05, accessed 3/19/06.
- 3 Express Scripts, 2004 Generic Drug Usage Report.
- 4 Express Scripts, Optimizing the Copayment Differential: Impact on Generic-Fill Rate.
- 5 Reported in Off the Record Research, 1/9/06.
- 6 Herper, Matthew, "The Best-Selling Drugs In America." Posted on Forbes.com, 2/27/06, accessed 3/30/06.
- 7 Generic Pharmaceutical Association web site, accessed March 29, 2006.
- 8 Medco research reported in Employee Benefits News, August 2005.
- 9 Abarca, Jacob, Pharm. D., et al, "Angiotensin-Converting Enzyme Inhibitor Therapy in Patients with Heart Failure Enrolled in a Managed Care Organization: Effect on Costs and Probability of Hospitalization." *Pharmacotherapy* 2004; 24(3):351-357.
- 10 Medco research reported in Employee Benefits News, August 2005.
- 11 Shrank, William H., et al, "The Implications of Choice: Prescribing Generic or Preferred Pharmaceuticals Improves Medication Adherence for Chronic Conditions." *Archives of Internal Medicine*. 2006;166:332-337.
- 12 Wilson, Ira B., MD et al, "Cost-related Skipping of Medications and Other Treatments Among Medicare Beneficiaries between 1998 and 2000." *Journal of General Internal Medicine* 2005; 20:715-720.
- 13 AARP, Prescription Drug Use Among Persons Age 45+: A Chart Book, June 2002.



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