

» DRUG PRICING 102

Last issue we described how drug pricing works from a pharmacy point of view. This time we're going to switch it up and look at drug pricing from a plan member's point of view.

When plan members receive their prescribed drugs, the receipt shows information about the prescription and the cost. But this receipt can be puzzling as it's usually not clear how the reimbursement was calculated and how the design of the benefits plan impacted that calculation. The GSC Customer Service Centre gets numerous calls every day from plan members confused by their drug receipts or from pharmacies struggling to explain how the plan works.

So, let's take a look at the information shown on a typical prescription drug receipt which can vary from province to province.

INFORMATION SHOWN ON THE RECEIPT USUALLY INCLUDES:

- Pharmacy information (name and address of the store)
- Date the prescription was filled
- Prescription number assigned by the pharmacy
- Patient information (name, address, etc.)
- Name of the prescriber
- Name of the drug, its drug identification number (DIN), and the quantity dispensed
- Cost of the drug (this is the ingredient cost*)
- Dispensing fee* (also called the professional fee)
- The total cost (drug cost plus the dispensing fee – note that sales tax doesn't apply to prescriptions)
- To whom the amount was billed (i.e., what drug plan)

THE FIRST PHARMACY
1234 MAIN STREET, YOURTOWN, ON A1A 1A1
416.555.5555 STORE # 1345

OFFICIAL PRESCRIPTION RECEIPT March 1, 2014

Rx: 21754888
YOUR NAME
 Your Address
 Your City, Province
 (000) 000-1234

Dr. A. Lee
DRUG Z 500MG 21 Cap Days: 7 Ref: 3

DIN 1234567

Pricing GS/CA
 C: \$45.40 F: \$11.99 T: \$57.39

Patient Pays: \$11.48

Pharmacist's Signature

But the key part of the receipt for plan members is "Patient Pays" or just "Pays." While the details aren't shown on the receipt, this is where any plan-design features are reflected in the cost of the prescription. For example, these could include:

Dispensing fee caps – Some drug plans cap (or limit) the amount reimbursed for the dispensing fee. In that case, a fixed amount is paid toward the dispensing fee charged on each prescription. Plan members pay any difference between the fee cap amount and the dispensing fee charged by the pharmacy.

* See our Winter 2013 issue of *Follow the Script*™ for definitions. Not all provinces require ingredient cost and dispensing fee to be shown as separate items.

Coinsurance – The percentage of the cost of a prescription that is covered by the drug plan regardless of the total cost. For example, the plan may pay 80 per cent of the cost for each prescription, with the remaining 20 per cent to be paid by the plan member.

Co-payment – A flat amount paid by the plan member for each prescription regardless of the total cost. For example, the plan member may be responsible for paying \$10 for each prescription.

Deductible – The amount of covered charges incurred over a set time period (typically annually) that must be paid by the plan member or dependent out of pocket before reimbursement will be made by the plan.

Mandatory generic substitution – When a brand-name drug is prescribed, many plans will cover only the cost of a generic equivalent. While the plan member can choose to receive the brand-name drug and pay the difference between it and the generic, the amount reimbursed will be limited to the cost of the generic drug. See more information on this below.

In the past, plan design often incorporated just one cost containment strategy, like a coinsurance. Recently, however, we are seeing more plans designed with complex combinations of cost-sharing tactics. For example, a plan may include mandatory generic substitution, an annual out-of-pocket deductible, and a coinsurance.

When plans are designed with a number of features that will affect the amount reimbursed, effective plan member communication often can alleviate confusion and can be used to promote understanding of why cost containment features are put in place.

› GSC'S COST SAVING EXPERTISE

As a pharmacy benefit manager, GSC is continually developing innovative ways to help our customers save on claim expenses without compromising plan member care. In the next few issues of *Follow the Script*[™], we'll highlight some of our most popular cost-management features.

MANDATORY GENERIC SUBSTITUTION

GSC's Mandatory Generic Substitution feature substitutes the cost of a brand-name drug with that of its generic equivalent, regardless of a "no substitution" request from either the plan member or the prescriber.

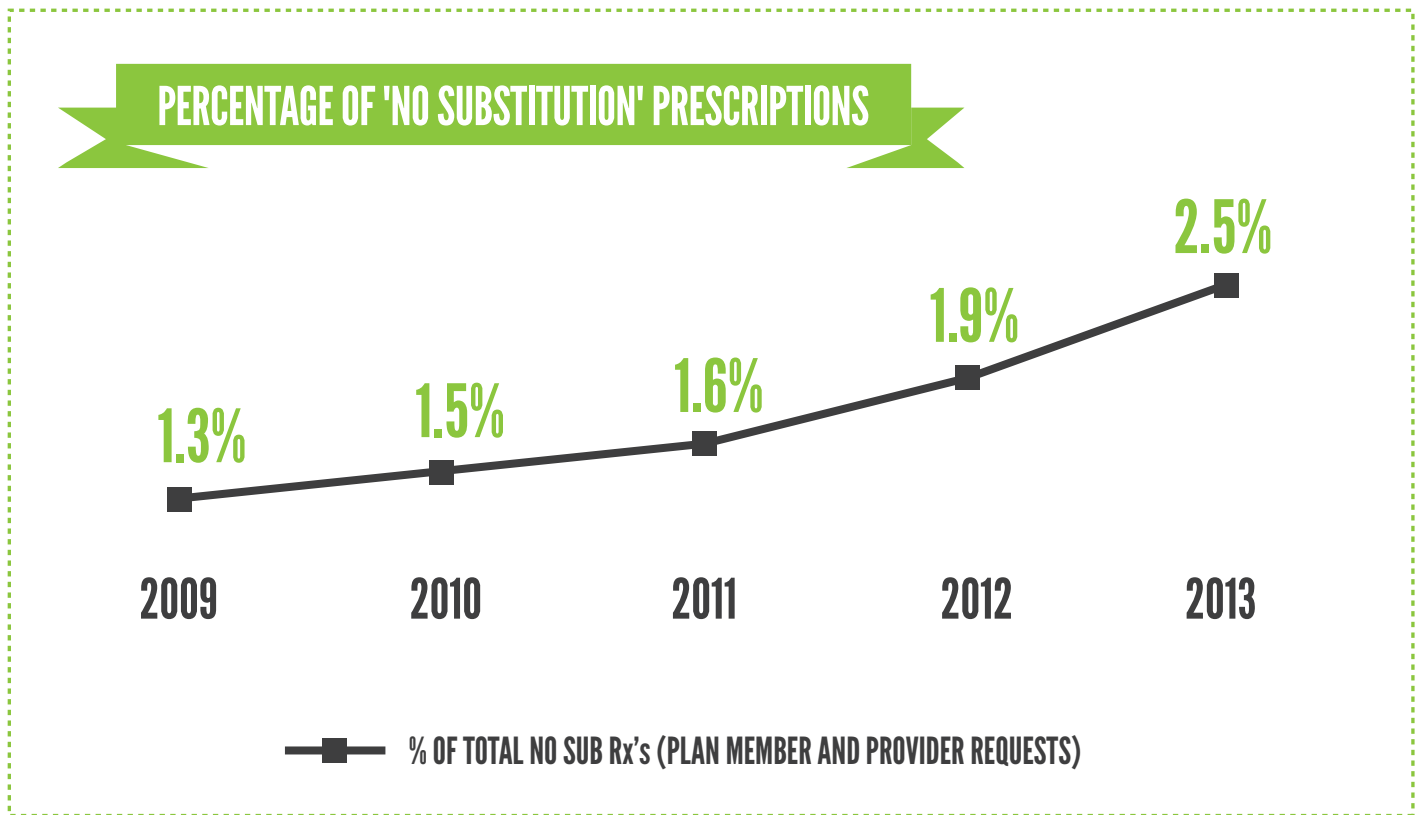
HOW IT WORKS...

When a plan member is prescribed a brand-name drug where an interchangeable generic equivalent drug exists:

- ➔ The plan member can choose either the brand-name drug prescribed or the generic equivalent drug; however, GSC will only reimburse the cost of the generic.
- ➔ To receive the brand-name drug, the plan member must pay the difference between it and the generic drug.
- ➔ If the plan member has an adverse reaction to at least two versions of the generic drug, their doctor can request that the brand name be covered by submitting a completed **Canada Vigilance Adverse Reaction Reporting Form** to GSC. This form can be downloaded from the Health Canada website.

THE IMPACT ON YOUR PLAN

With Mandatory Generic Substitution everyone gets more out of the drug plan. Plan members receive quality drugs at a lower cost and plan sponsors receive the most value for every drug-plan dollar. In addition, data drawn from across GSC's book of business shows that the frequency of "no substitution" requests is increasing over time, illustrating the significance of a mandatory generic plan:



Based on 2012 claims data, plan sponsors currently allowing either the prescriber or the plan member to request "no substitution" could save approximately 3% of their total drug cost by switching to mandatory generic substitution. Plan sponsors currently allowing only prescribers to request "no substitution" could save about 1.3% of their total drug cost with this change in plan design.

Given all the environmental factors at play, such as loss of patent protection on a number of old blockbuster drugs, reductions in prices of generic drugs, the increasing prevalence of brand-name drug assistance cards, and an increase in "no substitution" requested prescriptions, a mandatory generic policy not only offers savings but also insurance against such factors.

Something to keep in mind...



Our adjudication system is designed around the lowest cost alternative, not necessarily the lowest cost generic. Usually, the generic is the lowest cost alternative available, but we've seen situations where the brand-name drug is actually cheaper than the generic. Therefore, all GSC drug plans take advantage of the lowest cost alternative, whether that's a brand or a generic product.

BEHIND THE COUNTER

EXPLAINING DRUG PLANS

In each issue of *Follow the Script*[™], we interview a member of our pharmacy team about a current topic. In this issue, GSC pharmacist Atul Goela is talking to us about his experiences explaining drug coverage to plan members at the pharmacy counter.

FtS: A plan member comes up to your counter and presents their prescription and drug plan ID card. What happens next?

ATUL: First thing, they often think the drug plan ID card has to be swiped, but that's not the way it works. We don't even need to see the actual card; we really just need the numbers displayed on the card. However, having the actual card – especially the first time the plan member is in the pharmacy – ensures everything is set up properly – that identification numbers are entered into required fields in the pharmacy computer system. For GSC coverage, I just need the plan member's unique ID number. Once the drug plan is in the pharmacy computer system, we only need to see the ID card (or get the numbers) if the patient's card has been reissued with new numbers or their drug plan has moved to a different carrier.

FtS: Okay, no card swiping needed. You just input the information yourself?

ATUL: Yes, we input the patient's ID number, their demographics (if it's their first time getting a prescription at the location), and information about the prescribed drug into the pharmacy computer system. The system sends a claim to the drug plan for real-time processing (i.e., adjudication, which is also sometimes called OLTP – online transaction processing). The adjudication screen shows right away how much the pharmacy will be paid and how much the patient has to pay out of pocket for the prescription. By reviewing the adjudication output, we can sometimes determine what is impacting the "patient pays" amount – for example, the amount the patient has to pay can be affected by a plan dispensing fee cap, coinsurance, or a co-pay.

FtS: Do plan members generally understand their drug plan coverage or do you end up explaining to them how their plan works?

ATUL: Some patients need more education than others, and usually the questions come when patients get to the till and have to pay an out-of-pocket amount that they were not expecting and/or a different amount than what they paid previously. Then we have to go back and pull up the adjudication record on the pharmacy computer system again to see how the plan paid. Keep in mind that we only see what the adjudication screen shows – there could be other elements of the plan that affect the charges, such as annual plan deductibles, tiered formularies, etc. If the patient has questions about the claim that I can't answer, I direct them back to the insurance carrier.

I encourage people to always ask the pharmacist about the charges for their prescriptions if they have questions. But on the other hand, it's in their best interests to understand their plan before they even go to the pharmacy.

FtS: What kind of questions do you get?

ATUL: Often it's simply "why am I paying this amount" or "why do I have to pay [anything] when I have insurance?"

FtS: Are they suspicious that it's some kind of unnecessary extra charge?

ATUL: Sometimes, yes. But patients generally don't understand how coinsurance, co-pays, dispensing fee caps, annual deductibles, etc., combine to make up the portion that the drug plan covers and what they are responsible for paying. Sometimes pharmacists don't know either because we are not aware of the intricacies of everyone's plans. As I mentioned, I explain the best I can – based on what I can infer from the adjudication screen – being as forthcoming as possible, which usually does help remove their suspicions.

FtS: Do you encounter difficult situations where you wish you could do more to help a patient?

ATUL: I do feel for people that truly need a drug but may not be able to afford any portion of the cost. I also see people who take a lot of different drugs and have no private coverage – the costs can add up quickly. Or people on high-cost drugs that may not be covered by their drug plans.

Since I work in Ontario, I talk to people about the Trillium Drug Program and other government programs that could help... it's hard to see people not getting a drug they really need when I know that it would really help them.