



*2006 Arxcel Prescription Benefit
Research Survey*

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2005 Arxcel Prescription Benefit Research Survey

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2006 Arxcel Prescription Benefit Research Survey Executive Overview

CONCLUSIONS

Causes of High Prescription Benefits Costs

Among benefits, compensation, and human resources executives within corporate America, rising prescription benefits costs are seen as being caused by:

- Direct-to-consumer advertising, followed by the expense of developing new drugs
- Direct-to-consumer advertising has historically been pegged as the primary culprit in Arxcel surveys for five years in a row. While in the first year, it was seen as the primary culprit by 6 in 10 respondents, its results have declined but have since plateaued to the one-third of respondents range. Therefore, a steady number of benefits executives continue to place blame with pharmaceutical companies' product ads directly targeting consumers
- Close behind direct to consumer advertising, research and development costs have received consistent finger pointing over the life of this annual study

It is interesting to note that both of these two responses chosen by survey participants are direct functions of pharmaceutical companies, whereas the other possible causes (inflation, aging of the population) are external to pharmaceutical companies' control.

Possible Solutions

Corporate executives believe that the most likely solutions to escalating prescription benefits costs center around:

- Patient education and increased clinical oversight, and
- Providing incentives for using mail order service also came up high on the list
- Limiting coverage for high-cost medicines, and increasing member cost share fell somewhat in popularity as potential solutions
- Educating doctors continues to garner split opinions



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Member Cost Share

This year, the research results saw a slightly maintained upward trend regarding co-pay levels. Not only did respondents lean toward a slightly elevated co-pay as being the ideal, but the levels of their companies' actual co-pays inched from the lowest levels to middle levels.

Again, three-quarters (76%) of respondents felt that a member's co-pay should be 30% or less. Their response was in the 20% or less range in 2004 and earlier. When asked about co-pays in reality, 74% of respondents' answers were in the 30% or less categories compared to 75 - 88% in previous years. This is because more respondents are saying their actual co-pays are in slightly higher-level categories. For example, while 1% felt the co-pay should be in the 31-40% range, 5% of companies' co-pays were actually in that range.

Carving Benefits In or Out

In responding to questions about carving in or carving out prescription benefits with or from their overall health plan, 61% said they carve in while 38% carve out.

Most respondents indicated their companies were not considering switching program methods. Only 8% were considering a change.

Interestingly, respondents who used either method seemed to regard their particular method as having the same administrative and management benefits, although those who carved in gave this method higher marks in comparative ease of program administration.



2006 Arxcel Prescription Benefit Research Survey Executive Summary

INTRODUCTION

This is the fifth annual study regarding the impact of and perceptions toward prescription benefits provided as a part of employee health benefits in corporate America.

The purpose of this Study was to provide Deveney Communication and its client, Arxcel, with data upon which to build a public relations media placement campaign that will be part of the overall ongoing Arxcel marketing plan. The objective was to provide data that can be cited in press releases and during interviews with the media. The population surveyed consisted of benefits knowledgeable executives from companies that employ 1,000 or more people at all of a company's locations. Both privately and publicly held companies participated.

To accomplish the purpose, we conducted a primary research survey among high-ranking corporate executives residing primarily in employee benefits, compensation, and human resources departments.

The study examined the respondents' perceptions regarding causes of high prescription benefit costs, potential solutions for slowing continuing cost increases, and premium and co-payment price points. This year, perceptions were also measured on the following topics: self-funding of prescription benefits and whether or not companies 'carve out' or 'carve in' their prescription benefit program from their overall health benefit plan.

Lastly, the study captured the demographic profiles of respondents, including the number of individual lives their company's benefit plan covered, title of respondent, and geographic location.

Key findings and recommendations are summarized in the Executive Summary, following.



2006 PRESCRIPTION BENEFIT RESEARCH SURVEY

Survey Backgrounder

METHODOLOGY

This study was conducted during March of 2006. The study utilized telephone research interviews to capture the information desired. One hundred usable surveys were completed from interviews with corporate executives from companies across the United States that employ at least 1,000 employees.

The sample was randomly selected from a list of companies and executives purchased from a nationally known business list provider. While the sample is not large enough to be a scientific study of the total population of large U.S. companies, the sample is large enough to provide an understanding of the perceptions of this population and to identify some basic trends. Based on the population and the sample of 100, the survey has a margin of error of $\pm 10\%$

In order to qualify as a completed interview, respondents had to be willing to complete the entire survey.

Telephone calls were placed during the working day of the four U.S. time zones.



2006 Arxcel Prescription Benefit Research Survey Summary of Findings

Causes of High Prescription Benefit Costs

Respondents were read a list of causes that contribute on various levels to the escalating cost of prescription drug benefits. This is the fifth year that this question was asked with the same response choices. When asked to select the one cause that they believe plays the largest role in these escalating costs, the survey revealed that:

- Direct to consumer advertising, which had been the leading response in previous surveys, again was selected most often as the one cause playing the largest role in escalating prescription prices. 36% of the respondents chose direct to consumer advertising in 2006.
 - in the 2005 survey, 30% of the respondents chose direct to consumer advertising, but an almost equal number, 29%, chose the expense of developing new drugs as the cause playing the biggest role.
 - In the 2004 survey, 40% of respondents chose direct to consumer advertising
 - In the 2003 survey, the number of responses was similar to 2004 results with 38.6% choosing direct to consumer advertising
 - In the 2001 survey, the overwhelming majority of respondents (6 in 10, or 61.3%) chose this as the number one cause
 - Although the level of “blame” attached to this cause has decreased from the first survey, when direct to consumer advertising was newer in the marketplace, it has held steady as being seen as the main culprit by about one-third of the respondents for five years now.

The remaining causes selected were as follows:

- The expense of developing new drugs was chosen by 26% of the respondents in 2006 compared to 25% of the respondents in 2004
 - 29% chose this cause in 2005;
 - 17% chose this cause in 2003;
 - 20% chose it in 2001
- Aging of the population was noted as the principal cause by 16% of the respondents in 2006 and 16% of the respondents in 2005, compared to 10% of the respondents in 2004, 9.9% in the 2003 survey and 10.7% in the 2001 survey



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- The increased price of medicines due to inflation was chosen by 14% of the respondents
 - 20% chose this as the leading cause in 2005
 - The 2004 research showed that 18% chose this cause
 - In 2003, this figure was 22.8%
 - In the 2001 survey, 4% chose this as the number one cause

- Changes in use of pharmaceutical product was selected by 8% of the respondents
 - In 2005, this cause had dropped to 5%
 - In 2004, it was selected by 10% of respondents
 - The 2004 result was consistent with the response received in 2003 which was 10.9%
 - This reason was chosen by 4% of respondents in the 2001 survey

Possible Solutions for Slowing Pharmacy Cost Escalation

As in previous surveys, respondents were asked to rate a series of potential solutions on the viability of each as a solution for slowing down the cost increases in prescription benefits. They were asked to rate the solution on a scale of 1 to 4, with 1 meaning the solution would have the most potential impact and 4 meaning it would have very little impact.

The potential solutions that netted the top three most positive responses were, in order, patient education, increasing clinical oversight, providing incentives to use mail order.

Patient education about cost effective use of medicines

- came in as the highest rated solution with three quarters of respondents choosing this as a 1 or 2 favorable response
 - In 2005, 66% rated this a 1 or 2
 - In 2004, 58% of respondents had a favorable response to this solution rating it a 1 or 2
 - In 2003, 67.3% rated it a 1 or 2

Increasing clinical oversight

- Had a more favorable response rate from previous years
- 72% of respondents gave this solution a positive rating
- This is significantly up from 2005's results where there was a split decision of 53% positive versus 47% giving it a low rating of 3 or 4
- This is back up over where the results were in 2004 at a 61% positive rating and a 60.4% positive rating in 2003



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Providing incentives to use mail order service

- This solution was high on the list again. The only year it fell in popularity as a potential solution was in 2004
 - In 2006, 69% gave this potential solution a rating of 1 or 2
 - In 2005, 7 in 10 respondents rated it a 1 or a 2
 - In 2004, 50% of the respondents rated it a 1 or 2.
 - In 2003, 72.3% gave it a 1 or a 2.

Increasing the member's cost share through tiered co-payments or overall higher co-payments

- Was selected by 65% of respondents as a good potential solution
 - This was down a little from previous years
- In 2005, 7 in 10 respondents saw this as the most viable solution as 70% rated this a 1 or a 2 in our current survey
 - 71% rated it a 1 or 2 in 2004
 - 81.2% gave it a 1 or 2 in 2003

Limiting coverage for high cost medications

- Popularity of this potential solution has remained very steady over the years
- Generally, 2 of 3 respondents give this solution a positive rating
- In 2006, 64% gave this a favorable rating of a 1 or 2
- In 2005, 61% gave this a favorable rating of 1 or 2, same as 2004 and similar to 2003 at 60.4%

Educating doctors on the cost of pharmaceuticals and their proper use

For the fourth year in a row, there was little consensus on the viability of this option. Results were split among respondents. However, there continues to be little enthusiasm for this being a viable option.

- 54% rated this a 1 or a 2 and 46% gave it a 3 or 4
 - 48% rated this a 1 or 2 in 2005 and 52% gave it a 3 or 4
 - 46% rated this a 1 or 2 in 2004 (a drop from 53.4% in 2003)
 - 54% rated it a 3 or 4 in 2004 (46.6% in 2003)

Price Points and Member Cost Share

When asked what their company's total monthly cost was for its prescription benefit program for a single employee, about half the respondents could not break out this cost. This is a reduction in "Don't Know / Not Sure" answers seen in the past.

In the 2006 survey, 54% of respondents said they could not name the total monthly cost for their prescription benefit for a single employee and 55% could not name the figure for a family level employee premium.



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By comparison, in the 2005 survey, 70% of the respondents did not know or were not sure of this approximate figure. In the 2004 survey only 27% could not name the figure, while in 2003, 50.5% did not know the amount of the prescription benefit portion of the total health premium.

It is a little difficult to see details of a shift in premium costs cited over the years because so many were unsure of the breakout figure. Of the total respondents and those who did have knowledge of their prescription benefits premium:

- In 2006, 9% said their single employee prescription benefit cost was less than \$30.
 - In 2005, 10% said it was \$30 or less compared to 13% in 2004 and 15.8% in 2003
- In 2006, 12% said the single employee cost was between \$31 – 45
 - In 2005, 4% said it was between \$31 – 45 compared to 12% in 2004 and 13.9% in 2003
- This year, 15% cited the \$46 – 60 figure
 - In 2005, 6% said it was between \$46 – 60 compared to 29% in 2004 and 8.9% in 2003
- Only 5% said their cost was in the \$61 – 74 range
 - In 2005, No one cited the \$61 – 74 figure range
- Another 5% said it was more than \$75
 - 9% said it was \$75 or more in 2005 compared to 17% in 2004 and 8.9% in 2003

Of the respondents who did have knowledge of their prescription benefits premium for an employee plus family:

- In 2006, 10% said it was less than \$75
 - In 2005, 8% said it was \$74 or less compared to 7% in 2004 and 17.8% in 2003
- This year, 12% said their company paid between \$75 and \$120. This was close to results in previous years.
 - In 2005, 11% said it was \$75 – 120 compared to 9% in 2004 and 10.9% in 2003
- 14% said their company premium was between \$121 and 150
 - In 2005, 2% said it was between \$121 and \$150 compared to 17% last year and 4% in 2003
- 5% cited the \$151 – 200 figure in 2006
 - In 2006, 2% cited between \$151 and \$200 compared to 19% in 2004 and 5% in 2003



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- The results for this category have not differed much over the years of the study. This year 6.5% said their company cost for an employee plus family was more than \$200
 - In 2005, 4% said it was more than \$200 compared to 17% in 2004's survey and 9.9% in the 2003 survey

Respondents were asked what overall percentage increase they expected in their prescription benefit cost for calendar year 2006. Again, 6 in 10 expect an increase of up to 15%

- Again, in 2006, 18% expected it to stay the same (same for 2005 and compared to 14% in 2004 and 18.8% in 2003)
- 46% expected an increase of 1 – 10%, (compared to 37% in 2005, 43% in the 2004 survey and 4.8% in 2003)
- 14% 21% expected an increase in the 11 – 15% range (compared to 21% in 2005, 26% in the 2004 research and a similar to 24.8% in 2003's research)
- 6% expect an increase of 16 – 20%, (7% selected this response in 2005 and 2004 compared to a drop from 19.8% in 2003)
- Non one said they expect it to increase by more than 20%, (compared to 3% in 2005, 2% in 2004 and 6.9% in 2003)
- 3% of respondents expected a decrease, compared to 4% in 2005 and 1% in 2004
- 11% did not know

When asked how much of this cost increase would be passed on to the employee as a premium increase (if there was an increase in cost), about half of the companies plan on passing 50% or less of the premium increase on to the employee.

Additionally, it appears that in general, the amount to be passed on to the employee would be higher compared to responses in the previous year.

- 14% said the company would absorb the whole increase so that none of it would be passed on to the employee.
 - This was an increase from 12% in 2005, but a decrease from 18% in 2004 results and even less than a quarter of respondents in 2003
- In 2006, 45% said their company would pass on up to 25% of the price increase to their employees
 - In 2005, this number was also 45%
 - This was an increase from 35% in 2004 respondents, as well as an increase from 2003 respondents at about 40%



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- In 2006, 47% said they would pass on up to half of the price increase to their employees
 - This was big jump from the 11% who said between 26 and 50% would be passed on to the employee
 - 2005's was a decrease from 20% in 2004 but an increase from 8.9% in 2003
- 3% said they pass on up to three quarters
 - Compared to 1% in 2005 and 6% and 4% in 2004 and 2003 respectively
- No one responded in this category compared to the 1% in 2005 who said the employee would have to pick up between 76 to 99% of the increase, down from 4% in 2004 and 2% in 2003
- Only 1% said the employee would have to pick up all of the increase, down from 4% in 2005 which was a slight up tick from 3% in the previous year's survey but down compared to 5% in 2003

When asked about the ideal percentage of the cost of a prescription a member should contribute, the respondents leaned heavily toward the lower end of the scale. However, more respondents are saying that the cost share should be higher. 76% said the cost share should be at 30% or less. This was the same result in 2005.

But in 2004, 72% of respondents chose the lower 10 – 15% or 16 – 20% categories.

In 2003's survey, the responses were similar with 78% choosing these first two categories. Both of those were a significant increase from the 2001 survey when 39% chose a level at 20% or less (however, that audience was of a somewhat different ilk). This year's results are as follows:

- 3% said it should be zero
- 21% said the co-pay should be in the 10-15% range
- 28% said the co-pay should be in the 16-20% range
- 27% said the co-pay should be in the 21 – 30% range
- 1% chose the 31 – 40% range
- 5% chose the 41 – 50% range
- 2% said it should be higher than 50%
- and 13% didn't know

When asked what the reality was, that is, what their employees' actual co-payment is as a percentage of the total prescription cost, 74% of respondents said 30% or less, thus citing a figure not too far off from their "ideal" category. But again, more respondents are saying their employees actual co-pays are falling in a higher co-pay category. In 2005, 58% of the responses landed in the 30% or less categories.



Overall, it appears the level of co-pays is increasing. This would reinforce previous years' surveys where higher co-pays were selected as a positive solution to escalating costs. In 2006

- 23% said their co-pay was in the 10-15% range (compared to 14% in 2005 and 32% in 2004)
- 20% said their co-pay was in the 16 – 20% range (compared to 19% in 2005 and 34% in 2004)
- 31% said their co-pay is in the 21 – 30% range (compared to 25% in 2005 and 22% in 2004 and only 10.9% in 2003)
- 1% said it was in the 31 – 40% range (compared to 15% in 2005 and 2% in 2004 and 2003)
- No one cited the 41 – 50% category, down from 3% in 2005 and up from 1% in 2004
- 1% said it was in the greater than 50% range compared to 2% in 2005 and zero in 2004 and 2003
- 1% chose a zero co-pay
- 19% said they were not sure or did not know

Carving In and Carving Out Prescription Drug Benefits

A new area was explored in this year's survey, that of whether U.S. companies "carves in," meaning includes, or "carves out," meaning separates, their prescription drug benefit program from their overall health plan.

Self-Insured?

Respondents were asked if their company self-funded or self-insured their prescription benefit program.

- 84% said Yes, 16% said No

Carve In or Carve Out?

Respondents were read definitions and explanations of the terms "carve in" and "carve out" relative to prescription drug benefit programs for employees. They were then asked if their company carved out or carved in its prescription drug program. About 6 in 10 respondents said their companies carve in, or include, these benefits within their overall health plan.

- 61% said they carve in
- 38% said they carve out



Reasons for Choosing A Particular Method

Based on their particular response, respondents were then read a list of reasons why companies carve in (or carve out, as applicable) and asked which reason was the one most important their company.

Respondents whose companies carved out:

- 16% said carving out reduces overall program cost
- 12% said it allows better management of prescription drug benefit
- 6% said carving out prescription benefits allows for more flexibility in plan design
- 4% said it gives greater access to program data and plan performance
- 62% were not asked this question because their company carved in

For respondents whose companies carved in:

- 22% said it allows for integration of medical and prescription data
- 12% said carving in makes overall program administration easier
- 10% said carving in reduces overall program costs
- 1% said they had a bad experience in the past when they carved out
- 1% said they had not seen any data that shows the benefit of carving out
- 16% said they have not evaluated carving out
- 38% were not asked this question because their company carved in

Respondents were asked if their company was considering switching to the other method. Most were going to stick with the method they currently were using.

- 36% said they would continue carving out compared to the 38% who currently carve out
- 55% said they would continue carving in compared to the 61% who currently carve in
- 6% said they were considering changing to carving out
- 2% said they were considering changing to carving in

Those respondents whose company currently carved out or were considering switching to carving out were asked which market factors were driving such decisions. Respondents were allowed multiple responses.

- 26% chose lower overall cost in administrative fees and network discounts
- 20% chose the increasing costs of prescriptions benefits
- 18% chose comparative ease of program administration
- 11% chose availability of timely and meaningful data for program evaluation
- 58% were ineligible to answer this question



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Those respondents whose company currently carved in or were considering switching to carving in were asked which market factors were driving such decisions. Respondents were allowed multiple responses.

- 33% chose the ability to integrate medical and prescription data for clinical management programs
- 30% chose comparative ease of program administration
- 24% chose availability of timely and meaningful data for program evaluation
- 23% chose the increasing costs of prescriptions benefits
- 2% said they were dissatisfied with their current program's performance
- 43% were ineligible to answer this question

Sources of Information for Decision Making

Respondents were asked which sources of information they used when seeking information for making decisions on how to manage the company's prescription benefits. Multiple responses were allowed.

- 88% said they use external consultants
- 38% said they look to trade and industry publications
- 22% said they use in-house experts and staff
- 22% said they go to conferences and seminars
- 16% use associations or industry groups
- 15% use the Internet
- 10% use the consumer and general media
- 6% use other sources



Demographics

Lives Covered

The respondents represented an excellent cross section of companies across the United States and as last year, there was more representation from very large companies than prior to 2004

- 56% of respondents' companies covered less than 5,000 lives
- 26% covered between 5,000 and 10,000 lives
- 6% covered between 10,000 – 15,000 lives
- 6% covered between 15,000 to 25,000 lives
- 4% covered between 25,000 to 50,000 lives
- 1% covered between 50,000 to 75,000 lives
- There were no respondents in the 75,000 – 100,000 category
- 1% of the responding companies covered 100,000 or more lives

Respondents' Titles

Most respondents deal daily with the issues addressed by the research and were in high-level executive positions in their companies

- 31% were Benefits Managers
- Directors of Benefits and/or Compensation accounted for 20% of the respondents
- 8% were Directors of Human Resources or Director of Personnel
- 2% were at the Vice President level
- 10% were Managers of Personnel
- 15% were Benefits Administrators
- 14% were Benefits Analysts

Geographic Breakdown

There was a good sampling from all over the United States

- 19% of the respondents were from the Northeast Region of the U.S.
- 23% were from the Southeast
- 33% were from the Midwest
- 10% were from the Southwest United States
- 15% were from the Pacific and Northwest area