"ESSENTIAL HEALTH BENEFITS" – WHAT IS TYPICAL?

According to the Patient Protection and Affordable Care Act, Essential Health Benefits are to be defined using the "typical" employer healthcare plan standard. We summarize current information on what is typical, with an emphasis on prescription drug benefits.

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Table of Contents

A. INTRODUCTION: ESSENTIAL HEALTH BENEFITS AND THIS REPORT

The Patient Protection and Affordable Care Act (PPACA) introduced the concept of "Essential Health Benefits" (EHB), which will establish minimum requirements for the services covered by Exchange-sold policies. Section 1302 requires the Secretary of Health and Human Services (HHS) to set EHB based on the "typical" employer plan, but the act does not define "typical." This report summarizes available data on "typical" health benefit plans, which the authors broadly define as the most common coverage (median) rather than the average (mean) coverage. Our report emphasizes prescription drug coverage.

Because no single source provides comprehensive information and some present inconsistent information, our summary necessarily reflects the authors' experience in the actuarial and benefits world. We find most health benefit plans cover the same services – hospital inpatient, hospital outpatient, physician services, preventive care, and prescription drugs, all of which are explicitly required categories of EHB.

This similarity in covered services across employer-sponsored plans does not surprise the authors. Health benefits have evolved into a huge industry over the past 60 years. Labor force mobility, patient advocacy, regulation, evidence based medicine, and insurer consolidation have each contributed to standardization. We expect few surprises in HHS' decisions about EHB.

We note that consideration of EHB focuses on *what* medical services are covered rather than *how* they are covered. For example, the application of deductibles, copayments and coinsurance seem to fall outside EHB. However, from the perspective of an employee benefits manager or member, the distinction between what is covered and how it is covered is not sharp; particular covered services with much higher patient cost sharing or much more limited access than most other services could be thought of as outside the core benefits.

In addition to the issues addressed in this report, we expect that at least some of the following issues will emerge during the EHB deliberation:

- Use of particular reimbursement levels for what is considered "Reasonable and Customary."
- Coverage of drugs prescribed by out-of-network physicians, and the cross-application of in-network and out-of-network deductibles to out-of-pocket limits.
- Rules for specific categories of drugs (e.g. psychiatric drugs, obesity drugs, home infusion drugs, vaccines and drug-related durable medical equipment).
- Requirements for dispensing fees, administrative fees, and rebates.
- Prescription drug cost sharing in the specified Bronze, Silver, Gold and Platinum benefit designs.

Some significant benefit design and coverage issues may not receive detailed guidance in EHB, such as the use of medical management, the definition of "medical necessity," and the use of formularies. Guidance from HHS may be less prescriptive than in other areas of EHB, to the extent they deal with them directly.

This report was commissioned by Pfizer Inc, a pharmaceutical company. The content reflects the findings of the authors and should not be considered an endorsement of any position or legislation by Milliman, Inc. Healthcare reform is dynamic and the reader should expect future developments that may supersede the material in this report. One of the authors, Bruce Pyenson, is a Member of the American Academy of Actuaries and meets its qualification standards to issue this analysis.

B. EXECUTIVE SUMMARY - WHAT IS A "TYPICAL" EMPLOYER HEALTHCARE PLAN

PPACA specifies that EHB shall include at least the following ten categories[1]:

- Ambulatory services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse services
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive, wellness and disease management services
- Pediatric services

The vast majority of employer-sponsored benefit programs include some form of these services, with the exceptions of habilitative services and wellness. "Habilitative" refers to services intended to help people acquire new abilities, while rehabilitative services, which are typically covered, aim to restore abilities that have been lost by illness or injury. Wellness services are frequently part of employee benefits programs, especially for larger employers, but these services often fall outside employers' health benefits programs or are not included in policies sold by insurance companies.

Almost all employers (99%) with at least 200 employees offered their employees healthcare benefits, and 69% of all employers (of all sizes) did so.[2] Almost all employers (99%) with healthcare coverage offered prescription drug benefits.[3] Prescription drug benefits almost always covered brand and generic drugs with little exclusion.[4]

It is not clear the extent to which cost sharing will be defined by EHB.[*] However, the most common prescription drug cost-sharing structure is three-tier, used by approximately 66% of employers. Co-payments are much more common than coinsurance as a prescription drug cost-sharing mechanism.[5] At least 66% of employers use a formulary for brand name drugs. The median co-payments for generic and brand drugs are commonly $10 and $25 (or $30), respectively.[6] This pattern is consistent regardless of employer size, employment status, wage level, and regional location.

Surveys indicate the following "typical" member cost sharing for prescription drugs[7]. Generally, mail order prescriptions are for 90-day supply and retail prescriptions are for 30-day supply.

[*] EHB might not define cost-sharing, as this may be included in the rules for Exchange-sold policies and Qualifying Health Plans.

"Typical" Employer Drug Coverage		
	Member Cost-Share	
`Prescription Drug Type	Retail	Mail Order
Tier I (Generics)	$10	$20
Tier II (Formulary Brand)	$25 or $30	$40 or $50
Tier III (Non-Formulary Brand)	$45 or $50	$75 or $90

The National Compensation Survey (NCS) from the Bureau of Labor Statistics is the source of employer healthcare plan survey information used by the Department of Labor in its, "Selected Medical Benefits" report on EHB, published on April 15, 2011. The NCS information is basic and provides general coverage information for brand and generic drugs and copayments levels. It does not address many of the nuances of how prescription drugs are managed within plans.

Note that PPACA's Preventive Regulations already requires non-grandfathered group health plans to cover all preventive services and drugs rated A or B by the US Preventive Services Task Force (USPSTF) without any member cost sharing. Therefore, the authors believe it is likely that the preventive services and drugs recommended by the USPSTF will be included in the definition of EHB.

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This report is based on data sources that reflect slightly different time periods, do not use consistent survey and adjustment methods, and do not present findings on consistent bases. Application of these findings should be made cautiously. This report reflects research conducted by its authors. It should not be considered an endorsement by Milliman, Inc. of any position or legislation. This report was commissioned by Pfizer Inc, which manufactures and markets prescription drugs.

C. ELEMENTS OF TYPICAL EMPLOYER PRESCRIPTION BENEFITS

Most health benefit plans cover the same services – hospital inpatient, hospital outpatient, physician services, preventive care, and prescription drugs, all of which are required categories of EHB. PPACA further specifies that EHB shall include at least the following ten categories[8]:

- Ambulatory services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse services
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive, wellness and disease management services
- Pediatric services

The above ten categories are very broad. In the authors' experience, how plan sponsors apply the following five elements of plan design will help determine EHB details for prescription drugs:

1. Extent of healthcare coverage
2. Extent of prescription drug coverage
3. Cost sharing provisions for prescription drug benefits
4. Prescription Drug Benefit Management Programs
5. Coverage of preventive services and medications

We examine these elements of plan design and how they are applied today below.

1. Extent of Healthcare Coverage

The authors expect EHB to be defined as comprehensive benefits, which would cover to some extent almost all generally accepted acute care medical treatments.

Healthcare benefits are widely offered to full-time employees. Most health benefit plans cover the same services – hospital inpatient, hospital outpatient, physician services, preventive care, and prescription drugs, all of which are required categories of EHB. The broad consistency of services covered by employer-sponsored health benefits does not surprise the authors. Labor force mobility, patient advocacy, regulation, evidence-based medicine (EBM), and insurer consolidation have each contributed to standardization.

We note that consideration of EHB focuses on *what* medical services are covered rather than *how* they are covered. For example, the application of deductibles, copays and coinsurance seem to fall outside EHB. From an employee benefits perspective, the distinction between what is covered and how it is covered is not sharp; particular covered services with much higher patient cost sharing or much more limited access than most other services could be thought of as outside the core benefits.

Our sources contain information for 2009 through 2011. Benefit designs are changing rapidly and the broad trend in benefit design is toward greater cost sharing and restricted choices for providers. However, we do not expect significant changes in which services are covered.

Providing health care benefits is also "typical." Surveys show that mid-size and large-size employers tended to offer healthcare benefits more often than small employers. 68% of employers with fewer than 200 lives offered coverage, compared to 99% for employers with at least 200 employees.[9] The reported percentages vary by industry, wage level, union presence, and workforce age.[10] The tough economy has reduced the number of employees covered, but this has been attributed to job loss, not employers dropping coverage.[11]

59% of all employees were covered by their employer plan.[12] For employers that offered healthcare benefit plans, 79% of employees were eligible for the benefits, and 63% were covered by the plans[13] with variation by employer characteristic.[14]

Employer-sponsored coverage is associated with full-time, active employment. Only 25% of all employers that offered healthcare benefits offered them to part-time employees and only 2% to temporary employees.[15] Only 6% or 7% of employers offer healthcare benefits to retirees.[16]

2. Extent of Prescription Drug Coverage

The authors expect that if EHB defines prescription drug coverage, the definition will be similar to the broad definitions typical in the industry, which will allow flexibility through formularies and other common drug management programs.

Almost all employees (99%) with healthcare coverage have a prescription drug benefit[17], which almost always covers both brand and generic drugs,[18] and "coverage for the cost of outpatient prescription drugs is available to nearly all plan participants".[19] In the authors' experience, prescription drugs that are typically covered by employer plans include[20]:

1. Federal legend drugs (i.e., FDA approved drugs). Federal legend drugs can be dispensed only by prescription from a licensed physician or other licensed provider.
2. State restricted drugs (medicines required by State law to be dispensed by prescription only).
3. Compounded medications (medications that require prescriptions from doctors, and are prepared by pharmacists who mix or adjust drug ingredients to customize medications to meet patients' individual needs).
4. Insulin and self-administered injectable medications.
5. Needles and syringes for insulin and other covered injectable medications.
6. FDA-approved glucose strips, tablets and lancets.

Health plans, PBMs and others work with sponsors to evaluate and decide what should be covered within an employee benefit plan. Consistent with the list above, Medco describes coverage as "any drug or biological agent (such as certain specialty medications) that requires a written prescription to be dispensed. These drugs must bear the federal "legend." Commonly covered non-legend products (over-the-counter or OTC drugs) include insulin, insulin syringes, and diabetic testing supplies. With these exceptions, most pharmacy benefit plan designs exclude OTC products"[21]

The following types of drugs[22] are not typically covered by employer prescription drug plans, although some categories, notably immunizations and devices, are almost always covered through medical benefits and anti-smoking drugs are often covered through wellness benefits and preventive services requirements.

1. Non-federal legend or over-the-counter drugs
2. Cosmetic drugs
3. Anti-obesity drugs and amphetamines and/or anorexiants for weight loss
4. Erectile dysfunction drugs
5. Investigational or experimental drugs
6. Anti-smoking drugs
7. Immunizations
8. Devices
9. Medication covered by Workers' Compensation or Occupational Disease Laws or by any state or governmental agency
10. Medication provided without charge
11. Drugs available in the same strength as an OTC version

Plan sponsors manage costs and choose formulary options by excluding some drugs or drug categories from coverage. In some benefit plans, product exclusions may be general and described by the excluded drug's legal status (e.g., controlled substance), source or distribution channel (e.g., mail order, specialty), or the dosage form (e.g., injectable forms when oral forms are available). These decisions are sometimes driven by individual employers' preferences and may not be typical. Exclusion decisions are driven by the sponsor's overall pharmacy and employee health benefit objectives.

According to the authors' analysis, about 3.7% of NDC codes are generally excluded from employer prescription drug coverage. However, some of these may be covered under the medical benefit (and some may be required under PPACA's prevention and wellness provisions). Examples of excluded categories or drugs are,[23]

- Anorexic, Anti-obesity (e.g. Xenical)
- Blood Component (e.g. Human Albumin)
- Cosmetic Alteration Drugs (e.g. Botox Cosmetic)
- General Anesthetics
- Immunization (e.g. immune globulin)
- Impotence Agents (e.g.,Cialis)
- Non-Oral Systemic Contraceptives (e.g., Norplant System)
- Smoking Deterrents (e.g., Zyban)
- Supply/Device/Ostomy

Some prescription benefit designs include a "specialty tier" for specialty drugs where cost sharing is subject to coinsurance rather than copays. Specialty drugs, which are typically covered, may be brand or generic. Specialty drugs have a wide array of definitions, and due to considerations such as special handling, disease management needs and cost, they may be subject to different benefit coverage criteria and utilization management programs and may be provided through the medical benefit or the pharmacy benefit.

The following are examples of the variation of definitions for specialty drugs:

- "Specialty drugs (Biotech Drugs): Drugs manufactured through biologic processes to treat chronic, complex or life-threatening conditions."[24]
- "Specialty pharmaceuticals (are) medications generally administered by injection or intravenously"[25]
- "Specialty drugs are high-cost medications (typically generating charges of $1,500 - $2,000 per month) used to treat chronic and complex conditions such as multiple sclerosis, hemophilia, hepatitis and cancers."[26]
- "The CMS guidelines require that…only Part D-covered drugs with plan-negotiated prices greater than $600 per month be placed in the [specialty] tier…."[27]

To the extent EHB defines the extent of prescription coverage; we expect it will use the kind of broad definitions typical in the industry, while allowing flexibility through formularies and other common drug management programs.

3. Cost Sharing and Formulary Provisions for Prescription Drug Benefits

   To the extent EHB specifies cost sharing and formularies, we expect the definition to allow a range of options for each.

   As stated above, the vast majority (99%) of employers with healthcare coverage offer prescription drug benefits,[28] which almost always covers brand and generic drugs with little exclusion.[29] However, there is a wide array of options on how the drug benefit is managed. Common tools include the use of formularies and cost sharing.

   The table below summarizes four different data sources. Formularies are common. Between 66% and 85% of employers use a formulary for brand name drugs. The three tier formulary is most common with about two-thirds of employers using that structure. Two, four and five tier formularies are used far less frequently.

   Copayments (a fixed dollar amount per script) are also typical. The median copayments for generic and brand drugs are $10 and $25 (or $30 in some surveys), respectively.[30,31] This pattern is consistent regardless of employer size, employment status, wage level, and regional location. The Federal Employees Health Benefits Plan uses copays for its core benefit plans,[32] and copays are the dominant structure in State employee plans as well.[33] Copayments are much more common than coinsurance for prescription drug coverage.[34]

Percentage of Employers with the Prescription Drug Cost Sharing Structure*							
			Tiers				
				Formulary for Brands			
Data Source	Deductible Only	The Same Payment for Every Drug	Two**	Three	Four	Five	Sub-Total
KFF[35]	4.0%	5.0%	11.0%	65.0%	13.0%		78.0%
Mercer-Retail[36]		8.0%	22.0%	61.0%	5.0%***		66.0%
Mercer-Mail Order[37]		10.0%	16.0%	67.0%	3.0%***		70.0%
NCS[38]							74.0%
Takeda[39]			15.0%	66.5%	17.3%	1.2%	85.0%

*Rows may not add to 100% due to the exclusion of a small "Other" category.
**In this report, a two-tier cost-sharing structure (i.e. different cost-sharing amounts for generic and brand drugs) is not included as a formulary structure. A formulary defines a subset of brand, and sometimes generic, drugs.
***Includes four-tier and five-tier.

While not a prescription drug utilization management tool, 49.5% of employers have adopted some form of value-based benefit design. In particular, 31.7% of employers reduced copayments for specific drug classes and 7.9% reduced copayments for members with specific health conditions.[40] The rationale for value-based designs is that reduced copayments encourage adherence, which, in turn, may improve health outcomes.

Employee cost sharing varies based on where the drug is dispensed and how it is classified (e.g., specialty). As cited in the table below, on average, employees paid 25.3% of the cost of retail drugs, 20.1% of the cost of mail order drugs and 15.9% of the cost of specialty drugs.[41]

Range of Patient Cost Sharing as A Percent of Drug Price by Type of Prescription and Pharmacy			
	Retail	Mail	Specialty
Lowest percentage	1.0%	1.0%	1.0%
Average	25.3%	20.1%	15.9%
Highest percentage	80.0%	75.0%	50.0%

Source: Takeda Pharmaceutical Company Limited: 2010-2011 Prescription Drug Benefit Cost and Plan Design Outline Report, p 15

In this report, we consider drugs (including specialty drugs) that are covered through the pharmacy benefit, not drugs covered through the medical benefit, such as drugs for hospitalized patients or infused drugs. The relatively low average percentage cost sharing for specialty drugs is likely due to the typical benefit of fixed copayments per script applied to high cost specialty drugs. More attention is being placed on the management of specialty drugs today, but the surveys reviewed show that most employers do not use aggressive cost sharing or attempt to shift specialty drugs to the prescription benefit. According to the 2009 Mercer national survey of employers with at least 1,000 employees[42],

- 15% covered specialty medications at a fourth tier or higher cost-share tier.
- 10% used a medical lockout feature (excluding select specialty drugs from medical benefits to shift utilization to the prescription plan).
- 23% used a retail lockout (not allowing some specialty drugs to be filled at retail pharmacies to shift utilization to specialty pharmacies).

The use of specialty tiers in formularies is becoming more common but is still relatively small. According to the Kaiser Family Foundation's Annual Employer Health Benefit Survey, "Thirteen percent of covered workers are in a plan that has four or more tiers of cost sharing for prescription drugs. For covered workers in plans with four cost-sharing tiers, 46% face a copayment for fourth-tier drugs and 24% face coinsurance."[43] These figures mean about 3% of plans (13% x 24%) have specialty tiers that use coinsurance.

Although detailed requirements for the Bronze, Silver, Gold and Platinum plans have not been released, PPACA defines these plans as paying 60%, 70%, 80% and 90%, respectively of plan costs (members pay, on average, 40%, 30%, 20% and 10%, respectively). We note the "Average" row shown above for all three prescription types has significantly less coverage than the Platinum plan, but significantly more coverage than the Bronze or Silver plans.

4. Prescription Drug Benefit Management Programs

To the extent EHB defines prescription drug benefit management programs, we expect the definition will allow a range of such programs. Common drug utilization management programs are discussed below.

Utilization management tools are very common. The following table taken from a Takeda survey summarizes prescription drug utilization management tools typically used by employers and the percentage of employers that use them.[44] According to this source, Refill Too Soon Supply Limits, Quantity Limits, and Prior Authorization are typical utilization management tools; followed by Step Therapy and Dose Optimization. Pill Splitting and Copayment Relief are not typical. The definitions below are those reflected in the survey tool. There may be slight variations of these terms from other sources.

Utilization Management Tool	% of Employers Using Tool
Refill Too Soon Supply Limit **A system edit that rejects a drug claim if a refill is requested before a redefined number of days have passed since the initial fill date of prescription.**	89.2%
Quantity Limits **Limit on the number of pills or dosages allowable per claim.**	87.7%
Prior Authorization **A process where the prescription claim is initially denied, but provides a mechanism for the claim to be covered via criteria established by the managed care organization (MCO) or the pharmacy benefit manager (PBM). This requires action from the physician, pharmacist, or patient to obtain coverage.**	76.8%
Step Therapy **Treatment guidelines used to recommend drug therapy beginning with the least expensive therapy. More expensive therapies are only used when the patient fails to respond to the first-line drug.**	56.7%
Dose Optimization **Pharmacist-driven program to ensure patients are taking the best dosages and strengths of a given medication to manage costs of drug therapy.**	43.8%
Copayment Relief or Waivers **Reduced or zero-dollar copayments commonly used as incentives for plan members to use generic drugs and adhere to medication regimens.**	25.1%
Pill Splitting **Cutting prescription medications in half to double the number of days supply from a prescription written for twice the intended dose. This practice, which decreases total cost of the drug therapy, is commonly used to manage the cost of cholesterol-reducing medications.**	23.6%

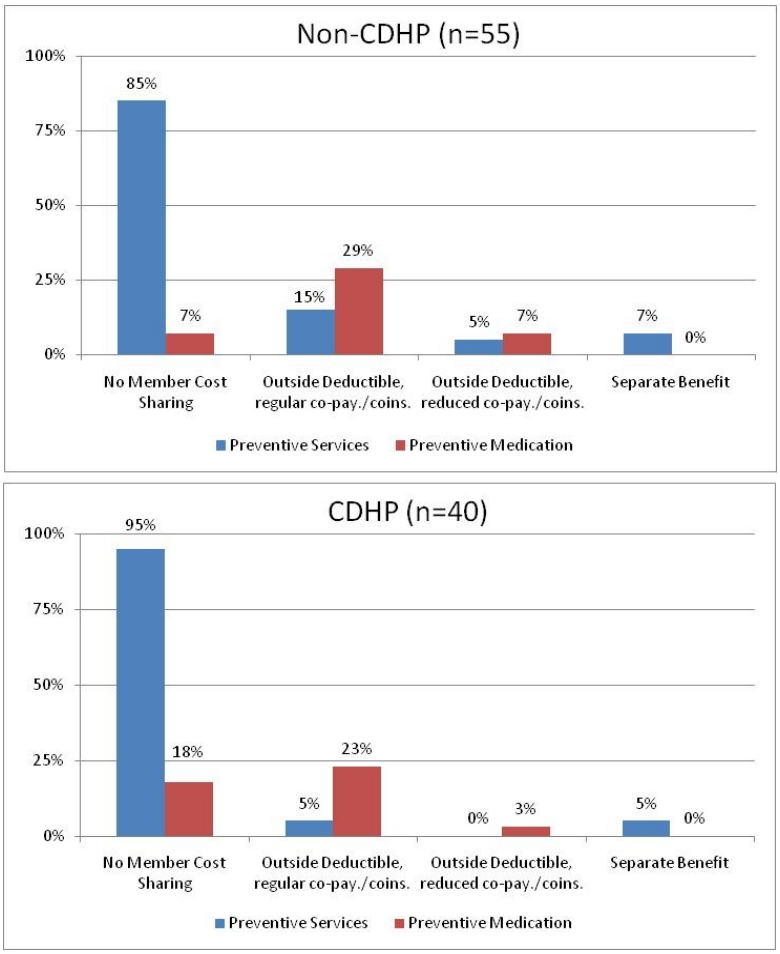
Source: Takeda Pharmaceutical Company Limited: 2010-2011 Prescription Drug Benefit Cost and Plan Design Outline Report, p. 34

5. Coverage of Preventive Services and Medications

In the authors' interpretation of PPACA, coverage of preventive services and medications, unlike the coverage of other services, does not depend on typical employer coverage, because such coverage is explicitly required.

The following graphs[45] show how plans apply cost sharing structures to preventive services and preventive medications. The vast majority of plans (both traditional and Consumer Directed Health Plans) provide 100% coverage (no employee cost sharing) for preventive services, but less than 20% of plans provide 100% coverage for preventive medications. Similarly, more plans apply reduced employee cost sharing to medical preventive services than to preventive drugs. Respondents were allowed to select more than one option, so the total of the options may be more than 100%.

Percentage of Plans that Apply Various Member Cost sharing Structures To Preventive Services and Preventive Medications



Source: National Business Group on Health: Large Employers' 2011 Health Plan Design Changes (August 2010), p. 16

PPACA's Preventive Regulations[46] require non-grandfathered group health plans to cover all preventive services rated A or B by the US Preventive Services Task Force without any member cost-sharing. Recommended preventive services include:

- Various vaccines (typically covered through medical, not pharmacy, benefits)
- Cancer chemoprevention for certain women
- Prophylactic ocular topical medication for all newborns
- Various screenings and counseling

Since these services are required to be covered by the legislation, these benefits will likely be explicitly included in the definition of EHB, regardless how employers typically cover them.

DATA SOURCES

This report is based on a review of and compilations of relevant findings from the following data sources.

- Bureau of Labor Statistics: National Compensation Survey: Health and Retirement Plan Provisions in Private Industry in the United States, 2009 (NCS)
  Data Source Internet Link: http://www.bls.gov/ncs/ebs/
- Express Scripts, Inc: 2009 Drug Trend Report
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  http://www.express-scripts.com/research/studies/drugtrendreport/
- Federal Employees Health Benefit Program (FEHBP)
  Data Source Internet Link: http://www.opm.gov/insure/health/planinfo/guides/index.asp
- Institute of Medicine, Determination of Essential Health Benefits Committee (IOM)
  Data Source Internet Link:
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- Kaiser Family Foundation: Employer Health Benefits 2010 Annual Survey (KFF)
  Data Source Internet Link: http://ehbs.kff.org/
- Kaiser Family Foundation: Prescription Drugs Trend (May 2010)
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- Medco Health Solutions, Inc: Plan Design Review Guide
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  http://www.medcohealth.com/medco/corporate/home.jsp?ltSess=y&articleID=CorpPDFPlanDesignReviewGuide
- Mercer National Survey of Employer-Sponsored Health Plans: 2009 Survey Report and 2009 Survey Tables
  Data Source Internet Link: http://www.mercer.com/ushealthplansurvey
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- The Segal Company: Study of State Employee Health Benefits (Summer 2009)
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  http://www.segalco.com/publications/surveysandstudies/2009statestudy.pdf
- Takeda Pharmaceutical Company Limited: 2010-2011 Prescription Drug Benefit Cost and Plan Design Outline Report (Takeda)
  Data Source Internet Source Link: http://www.benefitdesignreport.com/
- Wolters Kluwer Health, MediSpan Master Drug Data Base v2.5
  Data Source Internet Source Link: http://www.medispan.com

The KFF and Mercer reports provided information most relevant to this report.

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[3] Kaiser Family Foundation: Employer Health Benefits 2010 Annual Survey, p 144
[4] Bureau of Labor Statistics: National Compensation Survey: Health and Retirement Plan Provisions in Private Industry in the United States, 2009, Table 15
[5] Kaiser Family Foundation: Employer Health Benefits 2010 Annual Survey, pp 148-152
[6] Bureau of Labor Statistics: National Compensation Survey: Health and Retirement Plan Provisions in Private Industry in the United States, 2009, Table 16
[7] Mercer National Survey of Employer-Sponsored Health Plans, 2009 Survey Tables, p. 32 and Takeda Pharmaceutical Company Limited: 2010-2011 Prescription Drug Benefit Cost and Plan Design Outline Report pp 21-23
[8] PPACA §1302(b)(1)
[9] Family Foundation: Employer Health Benefits 2010 Annual Survey, p 38
[10] Kaiser Family Foundation: Employer Health Benefits 2010 Annual Survey, pp. 39-40
[11] Mercer National Survey of Employer-Sponsored Health Plans, 2009 Survey Report, p 11
[12] Kaiser Family Foundation: Employer Health Benefits 2010 Annual Survey, p 48
[13] Kaiser Family Foundation: Employer Health Benefits 2010 Annual Survey, p 49
[14] Kaiser Family Foundation: Employer Health Benefits 2010 Annual Survey, pp. 50-52
[15] Kaiser Family Foundation: Employer Health Benefits 2010 Annual Survey, p 41
[16] Mercer National Survey of Employer-Sponsored Health Plans, 2009 Survey Tables, p 44
[17] Family Foundation: Employer Health Benefits 2010 Annual Survey, p 144
[18] Bureau of Labor Statistics: National Compensation Survey: Health and Retirement Plan Provisions in Private Industry in the United States, 2009, Table 15
[19] Bureau of Labor Statistics: Selected Medical Benefits: "A Report from the Department of Labor to the Department of Health and Human Services" April 15th , 2011.Accessed from: http://www.bls.gov/ncs/ebs/smb_health.htm p 8
[20] This list is based on our professional knowledge of the prescription drug coverage market and was internally validated by a review of many employer Summary Plan Descriptions.
[21] Medco Health Solutions, Inc., Plan Design Review Guide
[22] This list is based on our professional knowledge of the prescription drug coverage market and was internally validated by a review of multiple employer Summary Plan Descriptions.
[23] Based on the authors' analysis of prescription drug exclusions from many self-insured health plans and professional experience. We identified the most commonly excluded types of drugs and their active NDCs, and compared these NDCs to the total number of active NDCs in the MediSpan Master Drug Data Base v2.5 from Wolters Kluwer Health.
[24] Takeda Pharmaceutical Company Limited: 2010-2011 Prescription Drug Benefit Cost and Plan Design Outline Report, p 45
[25] Medco Health Solutions, Inc., Plan Design Review Guide, p 13
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[38] Bureau of Labor Statistics: National Compensation Survey: Health and Retirement Plan Provisions in Private Industry in the United States, 2009, Table 15
[39] Takeda Pharmaceutical Company Limited: 2010-2011 Prescription Drug Benefit Cost and Plan Design Outline Report, p. 17
[40] Takeda Pharmaceutical Company Limited: 2010-2011 Prescription Drug Benefit Cost and Plan Design Outline Report, p10
[41] Takeda Pharmaceutical Company Limited: 2010-2011 Prescription Drug Benefit Cost and Plan Design Outline Report, p 15
[42] Mercer National Survey of Employer-Sponsored Health Plans, 2009 Survey Report, p 35
[43] Kaiser Family Foundation: Employer Health Benefits 2010 Annual Survey, p 144
[44] Takeda Pharmaceutical Company Limited: 2010-2011 Prescription Drug Benefit Cost and Plan Design Outline Report, p 34 and Glossary
[45] National Business Group on Health: Large Employers' 2011 Health Plan Design Changes (August 2010), p 16
[46] http://www.healthcare.gov/center/regulations/prevention/regs.html