Issue Brief
Findings from HSC

CONSUMERS FACE HIGHER COSTS AS HEALTH PLANS SEEK TO CONTROL DRUG SPENDING

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Faced with relentless growth in pharmaceutical spending during the 1990s, health plans in recent years have tried to rein in costs by negotiating lower drug prices, encouraging more cost-conscious physician prescribing patterns and moderating the volume and mix of drugs demanded by consumers. Because of limited success with these strategies, plans have moved rapidly to three-tier benefit packages that offer broader drug choices but shift more costs to consumers. The move to three-tier pharmacy benefits appears to have slowed drug-spending growth for some plans—at least for the short term—but raises questions about the cost and quality of pharmaceutical care for consumers. Based on interviews with health plan executives in the 12 nationally representative communities the Center for Studying Health System Change (HSC) visits every two years, this Issue Brief examines plans' strategies to contain drug spending and the possible consequences for consumers.

Pharmacy Spending Trends

Since 1990, U.S. spending on prescription drugs has more than doubled, far surpassing the growth rate for other types of health care and raising concerns about the continued affordability of pharmaceutical products. These trends have helped push insurance premiums to ever-higher levels, accounting for 35 percent of the cost increase faced by private insurers in 1999.[1]

Expansions in insurance coverage for prescriptions have reduced financial barriers to drug therapy for many consumers—with out-of-pocket costs declining from 48 percent of all prescription drug spending in 1990 to 27 percent in 1998—but expanded coverage also has fueled large increases in drug use.[2] At the same time, drug utilization has shifted toward newer and more costly brand-name products, a trend attributed in part to more permissive regulation of direct-to-consumer advertising.[3] While increased drug prices contributed to spending growth during the 1990s, more than three-fourths of the growth was related to changes in the volume and mix of drugs used, rather than to price increases.[4]

In 2000, the rate of growth in prescription drug spending declined for the first time in seven years.[5] While this is good news for health plans, it raises concerns that consumers may be experiencing growing financial and administrative barriers to drug therapy. In particular, plans' rapid adoption of three-tier pharmaceutical benefits provides consumers with more choice in drug therapy but at a higher cost.

Plans have attempted to control pharmaceutical costs through a mix of four basic approaches: benefit design, drug selection, utilization management and drug purchasing (see Table 1). Since these efforts have had limited success in changing prescribing and utilization patterns, plans are taking additional approaches—many of which shift costs to consumers.

Changes in Benefit Design

Health plans have moved rapidly to three-tier pharmacy benefit designs over the past two years—by far the most pronounced and widespread

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Table 1

Selected Strategies for Containing Pharmacy Costs

Strategy	Plan and Community	Year Introduced	Characteristics
Benefit Design			
Three-tier copayment benefit	*AvMed, Miami*	*2000*	*$10 copayment for generics, $20 preferred brands, $30 for non-preferred drugs*
Three-tier coinsurance benefit	*Regence BlueShield, Seattle*	*2000*	*10 percent coinsurance for generics, 30 percent for preferred brands, 50 percent for non-preferred brands*
Reference pricing	*Blue Cross of Calif., Orange County*	*2002 (expected)*	*A fixed monthly drug benefit for each therapeutic class; patients pay costs exceeding cap*
Drug Selection			
Closed formulary	*BC/BS of Mass., Boston*	*1999*	*Covers formulary drugs only unless plan grants exception for medical necessity*
Formulary exclusions	*Arkansas BC/BS, Little Rock*	*2000*	*Excludes second-generation drugs that replace older drugs facing patent expiration*
Utilization Management			
Physician profiling with prompts	*Tufts Health Plan, Boston*	*1998*	*Identifies patients who could be switched to less-expensive drugs and sends detailers to consult physicians and place prompts in medical charts*
Prior authorization	*Blue Cross of Calif., Orange County*	*2000*	*Requires prior authorization for drugs subject to misuse*
Pharmacy management bonus	*Arkansas BC/BS, Little Rock*	*2000-01 (pilot test)*	*Provides physicians with a bonus if established drug utilization targets are met*
Purchasing Strategies			
Mail order pharmacy option	*CIGNA, Greenville, S.C.*	*2000*	*33 percent discount on consumer copayment if drugs are ordered through mail order option*
Preferred buying	*Blue Cross of Calif., Orange County*	*1997*	*Negotiates discounts directly with manufacturers in exchange for placing drugs on preferred tier*

BC/BS = Blue Cross and Blue Shield

change in pharmaceutical management during this period. Under three-tier designs, consumers incur the lowest out-of-pocket costs when using generic drugs, higher costs for preferred brand-name drugs and the highest costs for non-preferred drugs. This strategy is designed to reduce drug spending growth by shifting costs to consumers, steering them to less-expensive drugs and creating incentives for manufacturers to offer deeper price discounts in exchange for placing their drugs on preferred tiers.

Nationwide, the proportion of health plans offering a three-tier design jumped from 36 percent in 1998 to 80 percent in 2000,[6] and all but two of the plans interviewed adopted a three-tier design for their commercial products over the past two years—most during 2000. Some plans also introduced the three-tier design in Medicare+Choice products, but many have not because they fear Medicare beneficiaries would choose not to enroll.

So far, most plans using the three-tier design have retained the fixed copayment structure that characterized pharmacy benefits under managed care throughout the 1990s, such as the $5-$10-$25 design prevalent in Boston. However, plans in some markets have raised cost sharing further by replacing fixed copayments with coinsurance rates that tie consumer costs to the price of the drug, such as the 10 percent-30 percent-50 percent design used in Orange County, Calif., and Seattle. Plans in several other markets are considering a switch to the tiered coinsurance design.

A few plans have resisted three-tier benefits altogether despite their growing popularity among employers. Kaiser Foundation Health Plan in Orange County and Group Health Cooperative in Seattle, both traditional health maintenance organizations (HMOs), were concerned tiered benefits could penalize people who chose appropriate but costly therapies, thereby interfering with optimal treatment decisions. Citing similar concerns, Blue Cross of California waives higher coinsurance payments for second- and third-tier drugs for members who participate in disease management interventions.

Although it is too early for most plans to assess the impact, some reported slower spending growth during 2000 in response to the three-tier designs. Encouraged by these initial signs, most plans expect to expand the tiered pharmaceutical benefit concept over the next year. Several plans are adding a fourth tier for injectable drugs and other high-cost medications or for lifestyle drugs such as Viagra that are currently excluded from coverage. And, some are considering subdividing the generic tier to increase cost sharing for high-use and high-cost generics. Many of the nation's top-selling prescription drugs will come off patent over the next two years, which could cause overall consumer cost sharing to decline unless generic cost sharing is increased.

Blue Cross of California is considering another approach to consumer cost sharing, known as reference pricing. Under this approach, widely used in Europe, plans establish a fixed monthly benefit limit for certain classes of drugs—such as those used to treat diabetes or high blood pressure—based on the cost of a low-priced drug within the class. Because consumers must pay the additional cost of drugs priced above the cap, drug manufac-

turers face incentives to price their products in line with the caps.

Plans in Phoenix and Lansing, Mich., are considering annual caps on pharmaceutical coverage in commercial insurance products—an approach already common in Medicare+Choice plans providing pharmaceutical benefits. Still other plans are considering a pharmacy deductible. Whether employers will embrace these emerging models remains unclear and is likely to hinge on how consumers respond and the magnitude of cost savings for employers.

A New Look at Formularies

Most plans have avoided or abandoned the use of closed formularies that restrict coverage to a narrow list of drugs and, instead, have opted for open formularies that cover all prescriptions except a small number of drugs specifically targeted for exclusion. Closed formularies attracted considerable attention during the 1990s because of the advantages they offered plans in limiting the use of high-cost drugs and in negotiating price concessions from manufacturers. However, these arrangements failed to grow because of consumer dissatisfaction, regulatory restrictions in some states and lack of physician compliance with formularies—particularly among physicians contracting with multiple plans using different formularies.

Because open formularies place fewer restrictions on physician prescribing, plans using them have encountered less difficulty with physician compliance but also fewer opportunities for cost containment. Not surprisingly, some plans have recently begun to restrict open-formulary policies by increasing the number of drugs excluded from coverage, particularly new drugs deemed not cost effective or medically necessary. Boston's Tufts Health Plan, for example, evaluates new drugs and makes coverage conditional on evidence of superior cost effectiveness over existing drugs. Taking a novel approach to drug exclusion, WellPoint Health Networks, the parent company of Blue Cross of California, has petitioned the U.S. Food and Drug Administration to allow several popular allergy medications to be sold over the counter—a development that would eliminate the drugs' coverage as prescription drugs and probably force manufacturers to reduce prices. While consumers might lose insurance coverage for these drugs, they could pay less overall if manufacturers dropped prices significantly.

New Expectations for Utilization Management

Most health plans have realized only modest cost savings from reviewing physician prescribing patterns and encouraging the use of lower-cost therapeutic alternatives, prompting many plans to step up utilization controls such as prior-authorization requirements and targeted physician education initiatives. Automated pharmacy systems maintained by pharmacy benefit managers (PBMs) have allowed plans to review prescriptions for safety and appropriateness at the point of sale and to limit the amount of drug supplied with each sale, but most plans have declined to use these concurrent review systems to actively steer consumers and physicians toward lower-cost drugs—in part because of a reluctance to create administrative hassles for consumers.

Instead, most plans are retrospectively profiling physician prescribing patterns and encouraging high-cost physicians to make wider use of generics and discounted, preferred-brand drugs. Like formularies, however, most of these efforts have not changed physician behavior appreciably because most physicians contract with multiple plans using different profiling approaches and preferred-drug lists. Some HMOs have attempted to change prescribing behavior by using contracts that require providers to assume a portion of the financial risk for pharmaceuticals, but providers have become increasingly resistant to these arrangements as drug costs continue to rise.

In response, over the past two years many plans have expanded the number of drugs requiring prior authorization in an effort to reduce utilization of high-cost drugs that are frequently misused or that offer limited therapeutic benefit. Similarly, a few large plans in Boston and Lansing are experimenting with step-therapy protocols, which require consumers to try older and lower-cost drugs in a therapeutic class before resorting to newer, higher-cost drugs. Plans also are strengthening efforts to educate high-cost physicians by conducting in-person pharmacist consultations (called counterdetailing), placing reminders in their medical charts and sending them letters whenever nonpreferred drugs are prescribed.

Many plans are introducing or expanding disease management interventions designed to improve care delivery and health outcomes for high-cost and high-risk populations, but relatively few view them as important strategies for addressing pharmaceutical cost growth. Although these interventions may lower the total costs of care for some diseases, they often cause pharmaceutical use to rise as instances of underutilization are identified and corrected.

Despite past difficulties, some plans expect to develop new tactics for influencing physician prescribing patterns over the next year. A Little Rock plan, for example, is pilot testing a fee-for-service incentive system to reward primary care physicians who meet established drug utilization targets. Other plans are exploring working with PBMs and generic drug manufacturers to distribute generic drug samples and other marketing materials to contracted physicians—in much the same way that branded drugs are marketed. Still other plans are developing exclusive provider arrangements for purchasing and delivering high-cost injectable drugs, which represent a rapidly growing component of pharmaceutical spending. These plans expect to reduce expenditures by steering members to high-volume providers that can negotiate lower prices from drug manufacturers and offer economies of scale in drug administration.

In addition to provider-focused strategies, a few plans are considering alternative ways to influence consumer demand for pharmaceuticals. Some hope to combat the impact of direct-to-consumer advertising by launching campaigns to inform users of high-cost drugs about lower-cost alternatives. Others expect to introduce new disease management programs that

potentially can both reduce pharmaceutical spending and lower total treatment costs. Seattle's Group Health Cooperative, for example, plans to reduce the length of pharmaceutical treatment for some patients through disease-specific protocols that entail more frequent and intensive evaluation of patients' drug regimens.

Purchasing Strategies

The move to tiered-benefit designs has strengthened plans' ability to negotiate lower drug prices from manufacturers, wholesalers and pharmacies. Many plans have sought additional cost savings by encouraging consumers to fill prescriptions through mail-order programs offering bulk-purchasing discounts. Because these arrangements largely focus on drug pricing rather than on drug utilization, most plans view them as limited for containing costs. Nevertheless, plans expect their negotiating leverage to increase as they demonstrate to manufacturers an ability to steer drug utilization through tiered-benefit designs.

Policy Implications

Despite some recent successes with three-tier designs, plans have little optimism that drug utilization and cost trends will slow considerably. As the limits of cost-control efforts are reached, plans see few alternatives to higher consumer cost sharing if they are to preserve pharmaceutical choice for consumers while holding down employer premiums. This strongly suggests a return to the pre-managed care era of modest prescription drug benefits—except that tiered benefits provide consumers with more choice and purchasing power than they had with indemnity insurance. Nevertheless, because consumers rely on and benefit from pharmaceutical care more than they did a decade ago, a reduction in drug benefits could cause some consumers considerable financial burdens—particularly low-income and chronically ill populations.

As tiered-benefit designs proliferate, consumers facing choices among therapeutically equivalent products may adopt more cost-conscious utilization patterns, thereby helping to constrain overall drug spending. However, where choices among perfect therapeutic substitutes do not exist, the movement toward higher, tiered consumer cost sharing has some risks. Some argue that higher costs may influence consumers to choose less effective drugs or deviate from prescribed dosage or duration instructions, undermining the quality of care and compromising treatment outcomes.[7]

As drug spending continues to rise, state and federal policy makers will continue to face pressure for action to contain costs. As health care purchasers, some states are adopting cost-containment tools much like those used by health plans and PBMs, including counterdetailing, preferred-drug lists, disease management programs and purchasing pools to negotiate lower prices from drug manufacturers. Most state actions focus on Medicaid drug expenditures, but some also offer savings to Medicare beneficiaries and the uninsured.

Policy makers also are considering regulatory responses that include limits on drug pricing and direct-to-consumer advertising and allowing reimportation of drugs sold at lower prices outside the United States. Price controls and reimportation may offer some relief but are unlikely to yield long-term solutions because much of the current spending growth results from rising drug use rather than price inflation. Whether savings produced through these regulatory actions would be worth the political and possible public health risks they entail is unclear. By comparison, new limits on direct-to-consumer advertising could potentially curb consumer demand for possibly unneeded drugs, but they also raise concerns about constraining free speech and informed consumer decision making.[8]

Given the likelihood of continued growth in pharmaceutical spending, heightened consumer concerns about access to prescription drugs and lack of large-scale federal intervention, state policy makers and health plans—as agents of employers—will continue to face pressure to reduce drug costs and utilization. ●

Notes

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