

Pharmacy Benefits: New Concepts in Plan Design

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OVERVIEW — *This issue brief examines changes to prescription drug benefit coverage in large employer plans and implications for a Medicare prescription drug benefit. The brief discusses reasons behind employer benefit plan redesign and recent coverage trends, as well as potential paths to modernize benefits. Information is based on a literature review and conversations and interviews with employers, benefit consultants, and pharmacy benefit management executives.*

Pharmacy Benefits: New Concepts in Plan Design

Thirty years ago, few health insurance policies included pharmacy benefits. Annual spending for prescription drugs was under \$6 billion, accounting for about 9 percent of health care spending¹ and just 2 to 3 percent of the private-sector health benefits dollar.² Consumers with drug coverage could be reimbursed for a percentage of their drug purchase, once they met their annual deductible, by mailing a claim form and receipt from the pharmacy to their insurer.

Today, prescription drugs are an integral part of health care and the subject of more than \$2 billion in print and television ads, extensive economic analysis, and heated political debate. More than three-quarters of Americans under age 65 have pharmacy coverage, most through employer-sponsored plans.³ Advances in benefits administration and information technology, such as prescription drug card programs, mail order pharmacies, and online links for real-time claims processing, have helped consumers conveniently access more and better drugs. By 1999, annual spending for prescription drugs totaled \$100 billion,⁴ a little more than 9 percent of the health care dollar⁵ but about 15 percent of private-sector health benefits spending.

Even as consumer advocates rally against rising prescription drug costs, the share of drug expenses paid by employers is growing. In 1990, private insurance paid 34 percent of drug costs, while consumers paid 48 percent out-of-pocket and government programs covered 17 percent. By 1998, private insurance picked up 51 percent of the tab, while the consumer share dropped to 28 percent and government programs remained relatively stable at 21 percent.⁶ One reason for the rising employer share is a basic element of plan design: consumer cost-sharing. Most employers ask employees to share drug costs through flat fees or copayments. Introduced with drug card programs, copayments are easier than coinsurance for consumers and claims administrators to understand and process, but do not index consumer out-of-pocket spending to drug cost.

As drug expenditures climb, more employers are introducing new employee cost-sharing strategies. Perhaps more importantly, many employers are rethinking the design elements and management of their plans in light of the new pharmaceuticals marketplace and the sluggish economy.

Although current events have delayed congressional action on a Medicare drug benefit, justification for senior coverage is still strong. When

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Congress takes up Medicare reform again, the economic downturn and a new federal budget outlook will bring cost concerns to the forefront of the debate. Lessons from the private sector suggest that unless the government is willing to use strong management controls, a quality, affordable Medicare drug benefit will be elusive.

WHY REDESIGN PHARMACY BENEFITS?

Manage Costs

The most obvious reason employers are redesigning their plans is lack of success in containing prescription drug benefit costs. Employer prescription drug expenditures rose by 17 percent in 2001, on the heels of an 18 percent increase in 2000.⁷ One large employer interviewed for this brief said the increase in 2000 meant another \$100 million, on top of the almost \$500 million the company was already spending on prescription drugs. In contrast, total health benefit costs rose by 11 percent in 2001, the biggest increase in ten years, and by 8 percent in 2000.⁸

As employers work with their pharmacy benefit managers to slow expenditure growth, proponents of pharmaceutical value criticize some of these efforts as shortsighted. Large employers are bombarded by the pharmaceutical industry and independent researchers with studies demonstrating the value of pharmaceutical use. From fewer hospitalizations and shorter stays to disease prevention and improved functioning, there is strong evidence many drug therapies reduce medical costs and lost workdays. In a recent *Health Affairs* article, J.D. Kleinke observes "high-price new drugs may be the cheapest weapon we have in our struggle against rising overall medical expenses."⁹ However, few employers can demonstrate the cost offsets so well-documented in research.

Benefit consultants analyzing employer drug expenditures are beginning to reveal why. Most of the spending growth appears to be concentrated in a few therapeutic categories. The top five in total-dollar growth are typically antidepressants, cholesterol reducers, anti-ulcerants, antihistamines, and antihypertensive drugs.¹⁰ In some of those categories, direct medical cost-offsets might not show up for years. In other instances, the medications do not replace costly procedures. Instead, they relieve symptoms without treating the underlying condition.¹¹ There is evidence that symptom relief can positively impact worker productivity and safety—the case of nonsedating antihistamines for factory workers, for instance. But unmanaged use of drugs that treat only symptoms can raise plan costs and interfere with sponsor intentions to provide coverage first and foremost for medically necessary care.

Even though prescription drugs were the fastest-rising component of employer health care spending throughout the 1990s, few employers were willing to implement aggressive strategies for pharmacy benefit

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management. Employee relations, vendor contracting, bargaining agreements, and competition for top-notch workers usually combine to guarantee measured changes in the benefit. Some employers fear aggressive management might inadvertently create barriers to needed care and unnecessarily hassle consumers and physicians. In addition, some employers do not believe the growth in prescription drug use is necessarily inappropriate. Many of them object to drug prices, however. Employers with a global presence say they pay less for drugs outside the United States.

Improve Safety and Plan Value

Safe and appropriate medication use by retirees, in particular, is an oft-cited issue in plan redesign. The average American over age 65 fills about 20 prescriptions per year, according to AdvancePCS, a pharmacy benefit management firm.¹² More than half of seniors over age 65 are on two or more medications.¹³ Analysis of drug use by retirees reveals problems such as inappropriate prescribing and dangerous drug interactions.¹⁴ In one example, Omnicare, Inc., a geriatrics health care company working with a large employer, found a significant number of the employer's retirees were prescribed a gastroesophageal reflux medication known to have serious side effects for many seniors, even though a safer alternative was available.¹⁵

In terms of efficiency and plan value, sponsors want resources maximized to meet objectives in the least costly way. Any time brand drugs are used when a generic is equally effective, or drugs are prescribed unnecessarily, there are opportunities to improve plan efficiency. Pharmacy benefit experts believe employer plans could become more efficient by encouraging consumers to take better advantage of generic drugs.

Moderate the Effects of Direct-to-Consumer Advertising

A growing emphasis behind both changes to pharmacy benefit plans and consumer education efforts is to moderate the effects of direct-to-consumer (DTC) advertising. In 1997, the U.S. Food and Drug Administration (FDA) relaxed prescription drug marketing rules to allow DTC advertising. Since then, industry spending on print and television ads has grown rapidly, topping \$2.5 billion in 2001, up from \$55 million in 1991.

A recent study by the Kaiser Family Foundation found 30 percent of Americans asked their physician about a drug they saw advertised to treat their condition. Forty-four percent of those patients received a prescription for that drug.¹⁶ In another study, the National Institute for Health Care Management found the 50 most-advertised drugs accounted for about half of the increased prescription drug spending last year.¹⁷

These studies suggest DTC ads have created greater demand for prescription drugs, especially newer, more expensive medications. Many

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plan sponsors are concerned that patients are taking medications they do not need or that are less effective and more costly than another treatment.

Engage Consumers in Weighing Treatment Options

The cost of health care is going up, and employers are sharing the increases with their employees through higher contributions and other cost-sharing requirements. As consumers pay more out-of-pocket for health services, they have reason to be more involved in care-management decisions and will likely want more information. Beginning with work by John Wennberg at Dartmouth University in the late 1980s, numerous studies show patient participation in health care decisions leads to more appropriate and less costly care. Employers hope informed and engaged consumers will increase the appropriateness and efficiency of drug use.

Pharmacy benefit consultants Kim McDonough and Carol Chandor provide an example that may lend support for using consumer cost-sharing to encourage a drug plan's best values. They cite an employer plan with utilization of symptom-only medications, such as antihistamines, 12 to 15 percent above the national average. An employee education program and a three-tier copayment structure with symptom-only drugs in the most expensive tier were put in place. Utilization in tier three dropped dramatically, while treatment options were not taken away from employees.¹⁸

Keep Pace with Innovation

The FDA approved an average of 38 new drugs per year during the late 1990s, up from 19 per year in the early 1980s.¹⁹ From new treatments for diabetes, depression, impotence, and arthritis to medicines for heartburn, hair loss, and toenail fungus, the pipeline is filled with new drugs. Advances in genetics and biotechnology will only mean more breakthrough therapies.

Undoubtedly, the result will be more options for physicians and consumers and a greater need to assess drug appropriateness on a patient-by-patient basis. Current plans are not designed to accommodate such finely tuned decision making and the numerous choices ahead.

HOW ARE PLANS BEING REDESIGNED?

The term *plan* is often confused with member cost-sharing mechanisms, such as deductibles and copayments. Basically, the pharmacy benefit plan is the coverage agreement between the employer and enrollees. "The plan is the logic for determining what is covered and what isn't," says Patricia Wilson, a pharmacy benefits consultant.²⁰

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In a recent book on pharmacy benefit management, Randy Vogenberg and Joanne Sica of Aon Consulting summarize pharmacy plan design basics:

Benefit design basics include such issues as what drugs the plan covers (and doesn't cover), in what quantities, from what pharmacies and other drug sources, and at what out-of-pocket cost to members. Plan design also involves such operational issues as pharmacy reimbursement, claims processing and utilization review.²¹

As employers consider redesign of their pharmacy benefit plans, they are addressing a number of interrelated issues, from member cost-sharing and coverage rules to the plan's administration.

Member Cost-Sharing

Many employers are reconsidering their employee cost-sharing strategies. In its 2000 national survey of employers, consulting firm William M. Mercer, Inc., found nearly all employers require employees to pay a portion of the cost of each prescription; about 90 percent of the benefit plans require flat copayments as shown in Table 1. In two-tier plans with mail order services, the average copayment for generic drugs is \$11, while the brand-drug copayment averages \$23.²²

TABLE 1
Percentage of Employer-Sponsored Health Plans Using
Various Pharmacy Cost-Sharing Tactics in 2000

	Mail Order	Card
No cost-sharing requirement	3	1
Coinsurance	6	10
Copayment:	91	89
One copay all drugs	17	10
Generic/Brand copays	54	29
Generic/Brand copays + nonformulary tier	27	29
Other form of copay	2	4

Source: William M. Mercer, "2000 National Survey of Employer-Sponsored Health Plans."

Three-tier copayment structures were introduced in the late 1990s. Adopted quickly by the commercial market, early three-tier designs required members to pay different copayments for generic, brand drugs on the formulary, and nonformulary brand drugs. Now there are many variations of the three-tier design, such as one payment for generic drugs, another for name-brand drugs with no generic substitute, and a third

for name brands with generic substitutes. Another variation builds tiers based on drug cost. And still another design includes on the highest tier drugs prescribed in circumstances when lifestyle modifications might also work but have not been tried.

Four-tier and five-tier arrangements are becoming more common in the commercial sector. Often, a fourth tier includes so-called “lifestyle” or “cosmetic” drugs and requires patients to pay 100 percent of the drug’s cost. Unfortunately, distinctions between “lifestyle” and “medical” uses are not always clear. The top tier also typically includes most injectables, gene therapies, and biotechnology treatments.

In a recent study by pharmacy benefits manager Express Scripts, a shift from a two-tier (\$7 generic, \$12 brand-name drug) to a three-tier (\$8 generic, \$15 preferred brand, \$25 nonpreferred brand) design yielded 17 percent cost savings.²³ Ten percentage points of savings were attributed to increased member cost-sharing, 5 percentage points were accounted for by decreased usage, and 2 percentage points were due to lower ingredient costs.

Self-insured employers have been slower than health plans to adopt multitier arrangements. Some experts believe employers have been less willing to shift costs to members through tiered structures because they have a lower tolerance for member dissatisfaction and greater sensitivity to productivity issues related to prescription drugs.²⁴ Others believe the potential cost savings do not justify the increased complexity and new rules for enrollees. About a third of employers used a three-tier copayment structure in 2000. For those that did, the average third-tier copayment was \$36.²⁵

In a 2000 survey of 268 employers by the International Society of Certified Employee Benefit Specialists, almost two-thirds of respondents agreed with a statement saying rising drug costs would result in more plan sponsors shifting from copayment to percentage-based coinsurance. A shift to coinsurance can save purchasers anywhere from 2 to 20 percent on drug costs, depending on the plan design.²⁶ The primary reasons behind a switch to coinsurance are to sensitize plan members to medication costs and automatically index member contributions to price increases.

Among other consultants, Aon’s Sica advises employers to modify coinsurance: “We usually suggest they consider coinsurance with a minimum and sometimes, a maximum.”²⁷ For example, the employee share might be the greater of 20 percent or \$10 for generics and 20 percent or \$20 for brand drugs, with a maximum of \$75 or \$100 per prescription. Some plans are shifting to a combination of copayments and coinsurance; for example, coinsurance at retail and copayments for mail order. Very few employer-sponsored plans currently use dollar caps or maximum limits on the pharmacy benefit: just 2 percent of firms with 200 or more employees and 4 percent of firms with 3 to 199 employees.²⁸

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In 2001, the trend of employers' prescription drug costs began to slow (from 18 percent growth in 2000 to 17 percent growth in 2001) due to increased consumer copayments and greater use of tiered designs. As experts predicted in 2001, the move to multitier designs has continued, and more than half of people with pharmacy coverage are now in three-tier plans.²⁹ There are now a variety of tier designs.

Coverage Rules

Although it is too early to call it a trend, a few large employers are rethinking pharmacy plan goals and rules to design benefits that, in the words of Bruce Taylor at Verizon Communications, "pay for what people need, but not always what they want or what their physician prescribes."³⁰ The approach makes sense in terms of spending trends and the growing need to evaluate drug appropriateness on an individualized basis, but it is not the norm. And it will require pharmacy benefit managers (PBMs) to function as more than claims adjudicators and eligibility managers. PBMs will need to manage benefits in accordance with fairly complex rules.

In rethinking coverage rules, sponsors first identify what they and their enrollees value most in the plan, such as access to essential care, financial protection, and safety. Then they define coverage criteria and rules consistent with those values.

A model generating a lot of interest and some controversy is a four-tier design with a "rules-driven" third tier. Introduced by Verizon³¹ for some of its employees and under consideration by other plan sponsors and PBMs, the plan incorporates coverage rules based on drug manufacturer and FDA recommendations for safe and appropriate use of medications, as well as research on the role of lifestyle in disease prevention and management. The rules apply to many of the brand medications featured in DTC advertising in therapeutic categories with the greatest growth, such as cholesterol reducers, antihistamines, antidepressants, and antihypertensives.

Tier one contains generic drugs, with a \$7 copayment; tier two has brand drugs on the formulary, with a \$15 copayment; tier three is rules-driven, with a \$35 copayment; and tier four has nonformulary drugs, with consumers responsible for 100 percent of the cost. For example, if a cholesterol-reducing drug on the formulary is prescribed for primary prevention of coronary heart disease (CHD), the consumer pays \$35. On the other hand, if the drug is prescribed for secondary CHD or for diabetes and the physician chooses that drug because it is the most appropriate to the individual's circumstances, the consumer copayment drops to \$15.

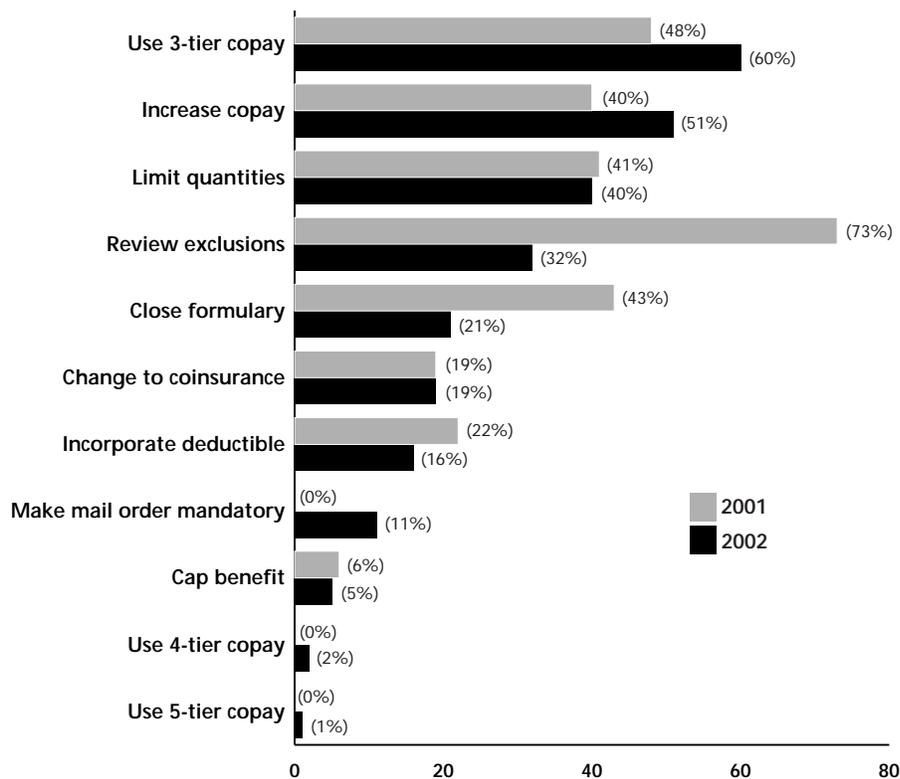
The design addresses a number of sponsor concerns: best-practice prescribing guidelines, safety and efficiency, individualized decision making, and cost management. But because even experts disagree about

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best practices, some physicians and patients see the design as intrusive. In addition, it is not always easy for consumers to know the extent of their coverage. Drugs covered by the plan cannot necessarily be determined with a list. There is a formulary, but plan rules include an exception process that allows coverage for drugs not on the formulary in circumstances when it is determined to be medically necessary. "It is a different way of looking at formulary construction," says Wilson.

Some experts think the plan is state-of-the-art, while others see it as meddling. Verizon takes a pragmatic view. James Astuto, regional health care manager with Verizon, defends the program by saying, "the current cost increases are not sustainable. As an alternative, we could use a 50 percent copay for all drugs. With this plan, people who need care have affordable access to that care."³²

FIGURE 1
Percentage of Employers Using
Various Pharmacy Benefit Design Tactics in 2001 and 2002



Based on a survey of 700 employers.

Source: Hewitt Associates, "Health Care Expectations: Future Strategy and Direction 2002," September 2001.

Plan Administration

About half of employers with more than 10,000 employees contract directly with a pharmacy benefit manager. PBMs are responsible for managing the benefit in accordance with plan rules. Many of the coverage rules being revised by sponsors for 2002 address generic dispensing rates and more aggressive formulary management. PBMs are also stepping up efforts in disease prevention and management to improve early intervention and treatment outcomes.

Generic Drugs — A number of brand-name drugs, accounting for about 11 percent of annual spending on drugs, have recently or soon will be available in generic form.³³ Merck-Medco, a pharmacy benefits management firm, estimates that an increase in the generic dispensing rate by 1 percent yields a ½ percent decrease in drug spending.³⁴ Consequently, many plan sponsors have PBM performance expectations related to generic dispensing rates.

Employers and plan administrators are launching member education programs about generic drugs. One example is the campaign by Blue Cross Blue Shield of Michigan called “Generic Drugs: The Unadvertised Brand.” Part of the campaign is a competition among retail pharmacies to increase generic dispensing.³⁵ In another effort, Louisville-based insurer Humana, Inc., is mailing letters to patients taking medications with generic equivalents, asking them to speak with their doctors about options. Since May 2001, about 10 percent of patients receiving letters switched to a generic drug.³⁶ Generics First, launched in October 2000 by Merck-Medco, works with almost 8,000 physicians nationwide, providing pharmacist consultations and access to generic drug samples and patient information.

Plan administrators are also contacting members and physicians about specific medications that recently have become available in generic form to counter marketing by manufacturers encouraging consumers to switch to new, patent-protected reformulations such as extended-release versions. One high-profile example is Prozac, a depression medication made by Eli Lilly that went off patent in August 2001. Merck-Medco contacted more than 25,000 of the “top Prozac-prescribing doctors” to encourage them to switch to the generic form. Within two weeks of the patent expiration, physicians had switched more than 15,000 patients to the generic drug.³⁷

Formulary Management — More aggressive management of the formulary, the list of a plan’s preferred drugs, is another target for plan administrators in 2002. “Formulary management varies among PBMs,” says Ron Kocher, a pharmacy benefits consultant with AELRx. “There can be significant opportunities to slow expenditure growth and improve efficiencies through administration of a cost-effective, customized formulary.”³⁸

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A number of plan sponsors are adding coverage rules that require greater attention to formulary management. The four-tier model noted earlier is one example. Other examples involve new restrictions and exclusions. Some plans require pharmacy and therapeutics committees to review and approve new drugs before they can be added to the formulary. Others exclude from the formulary specific new drugs, require prior authorization for coverage of new drugs, or use a standard six-month waiting period before new drugs are covered.

In the past, prior authorization programs were used primarily for high-cost drugs with a potential for misuse. Now, prior authorization rules, including step-therapy protocols and quantity limits, are being applied to popular brand drugs as well. For example, a number of plan sponsors are excluding Nexium, a new medication for heartburn and ulcers, from the formulary or are using prior authorization requirements to deny coverage until less expensive alternatives are tried.

Disease Management — Although PBM disease-management programs are common, many have had marginal success reaching target populations. To maximize savings through disease prevention and management, some employers and health plans are beginning to use health plan case managers to work with physicians and consumers to improve drug-therapy and medication compliance. Supported by data and software designed to predict acute episodes, case managers are communicating with physicians to avoid adverse events. Going beyond typical disease-management programs to assist physicians with individual cases is a good use of resources," says AELRx's Kocher.³⁹ "It's all about taking care of people. And in the long run, that costs less."

IMPLICATIONS FOR MEDICARE

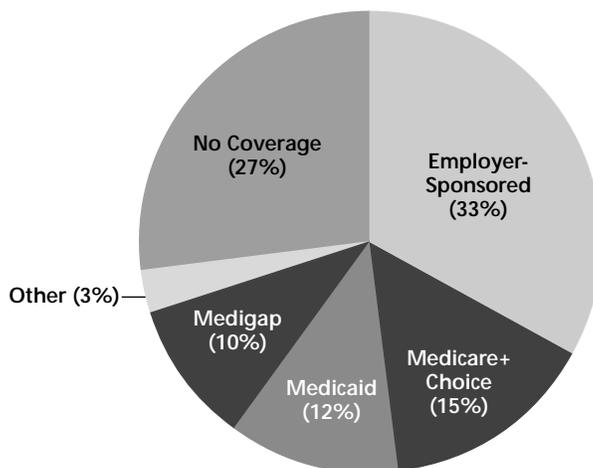
Senior drug coverage was a major issue during the 2000 presidential campaign and early in the 107th Congress. With bipartisan agreement on the need for an outpatient drug benefit, the debate centered on who would be eligible, how would it be administered, and at what cost. The September 11 terrorist attacks, coupled with the slowing economy, abruptly stopped Medicare reform momentum and reordered legislative priorities.

Political experts predict health care will be a prominent midterm election issue, although there is some disagreement about whether Medicare prescription drugs will be at issue. In the meantime, senior drug coverage is eroding. Currently, almost three-quarters of Medicare beneficiaries have some drug coverage through employer-sponsored plans, Medicare+Choice (M+C) plans, Medicaid, or Medigap policies. Some seniors also get help with drug costs from state-run pharmacy assistance programs. But coverage from the two leading sources, employer and M+C plans, is declining as a result of cost pressures.

Drug coverage from employer and M+C plans is declining as a result of cost pressures.

In 1995, more than a third of large employers offered health care coverage with drug benefits for Medicare-eligible retirees. Now, less than a quarter do so.⁴⁰ During the late 1990s, many seniors opted for M+C plans in order to get prescription drug coverage, which is not a benefit in traditional Medicare; about 14 percent of Medicare beneficiaries were in M+C plans in 2001. But there has been a dramatic decline in the number of plans participating in Medicare: 179 in 2001, down from 346 in 1998.⁴¹ While Medicare has increased payments by 2 percent per year in the last two years, plans continue to withdraw from the program. Many of those remaining either reduced or dropped drug coverage. In 2001, only 67 percent of M+C enrollees had prescription drug coverage, down from 84 percent in 1999.⁴² More than a third of M+C plans with drug coverage have a cap of \$750 or less, raising concerns about access to needed therapies.⁴³

FIGURE 2
Sources of Prescription Drug Coverage for Medicare Beneficiaries, 1998



Source: Kaiser Family Foundation, "Medicare and Prescription Drugs," Fact Sheet, May 2001; accessed February 28, 2002, at <http://www.kff.org/content/2001/1583b/Rxdrugs0201.pdf>.

To stem the tide, President Bush revived his discount card plan in early 2002 to help the neediest seniors with drug costs until Congress acts on more comprehensive reforms. Introduced in July 2001, the plan was blocked by a federal judge in the fall on grounds the administration lacked the authority to implement it without action from Congress or new regulations. The Department of Health and Human Services introduced new regulations in January 2002, opening the way for executive action.

States are also helping seniors in the absence of comprehensive reforms. More than half of states administer pharmaceutical assistance programs, albeit with shrinking resources. The state programs fall into one of five categories, according to the Henry J. Kaiser Family Foundation: "direct benefit programs (21 states), insurance programs (3 states), price reduction programs (7 states), buying pools (6 states), and tax credit programs (2 states)."⁴⁴

Drug discount programs, such as the one proposed by Bush, are receiving increased scrutiny and criticism about their value to seniors. The administration predicts its program could lower drug prices by 15 to 40 percent. But a recent General Accounting Office (GAO) report assessing the value of privately sponsored drug discount cards found the programs produced an average savings of less than 10 percent.⁴⁵

Pharmaceutical manufacturers are stepping into the fray by offering their own discounts to seniors. Pfizer, Novartis, and GlaxoSmithKline all introduced senior discount programs in recent months, with varying eligibility criteria and rules. Seniors are enrolling in the programs; many are enrolling in multiple programs to get most of the drugs they take covered by a discount. GlaxoSmithKline's program, introduced in October 2001, enrolled 20,000 seniors by January 2002.⁴⁶ Several consumer advocacy groups have criticized the programs as self-serving and an attempt to skirt growing criticism about drug prices. The manufacturers themselves see the programs as temporary help to seniors until Congress enacts Medicare reforms.

As real reforms languish, pharmacy benefit managers (PBMs) are also coming under increased scrutiny for their relationship with drug manufacturers. Critics claim PBMs, which administer drug plans for about 200 million people, are influenced by contractual relationships with drug manufacturers and do not act in their customers' best interests. PBMs counter they have slowed drug spending trends for their customers and have accountability through the competitive bidding process.

When congressional debate on a Medicare prescription drug benefit resumes, rising drug costs, shrinking resources, and competing demands will make affordability a principal concern. Experience from the private sector suggests strong drug utilization management is needed to administer a program that is affordable for both the plan sponsor and the beneficiary. For instance, Medicare could limit its spending by incorporating hefty consumer copayments. But anecdotal evidence and research show consumer out-of-pocket spending affects treatment compliance. One survey found more than one in five adults had not filled at least one prescription because of cost, and one in seven said they had taken a prescription drug in smaller doses because of cost.⁴⁷ The study authors predict noncompliance will increase with copayments.

Rigorous drug-utilization management techniques help contain spending for purchasers and beneficiaries. They also help prevent adverse

Strong drug utilization management is needed to administer a program that is affordable for both the plan sponsor and the beneficiary.

health outcomes and avoidable costs associated with noncompliance and inappropriate prescribing. One study showed inappropriate medication prescribing for seniors was associated with higher health care costs and utilization. Potentially inappropriate medication use was found for almost a quarter of the studied population. Those individuals had “significantly higher total, provider, and facility costs, and a higher mean number of inpatient, outpatient, and emergency room visits than comparisons.”⁴⁸

Drug expenditure projections make the prospects for affordable Medicare coverage even gloomier unless the program can benefit from offsets in hospital and physician spending. U.S. drug spending is expected to reach \$243 billion by 2008, up from \$100 billion in 1999.⁴⁹ But cost is not the only complicating factor. Aon’s Vogenberg and Sica predict future pharmacy coverage will be challenged by continual medical innovation and change:

All indications point to increasing complexity, cost, and health management challenges that will surely test the creative limits of benefit managers over the next several decades as the nation begins to reap the rewards of the human genome project.⁵⁰

A promising development is the use of information technology for real-time, aggressive drug utilization management in compliance with the formulary and based on clinical guidelines for safe and appropriate use. Risking criticism about meddling in the doctor-patient relationship, employers see influencing appropriate medication use as one of the few alternatives to raising consumer cost-sharing to the point where needed therapies may no longer be affordable. “Strategies for the future should be aimed at changing provider and/or member behavior,” says Bridget Eber, a pharmacist with Hewitt Associates. “One such effective strategy might be to effectively promote the drug program’s ‘best values’ while simplifying the member cost sharing methodology.”⁵¹

Experience from private prescription drug plans also suggests that sensitizing consumers to actual drug costs results in more efficient choices. Flat copayments do not index consumer spending to price increases. And they do not inform consumers about the relative cost of treatment options. To sensitize consumers to drug costs, many employers will be shifting to multitiered copayments and/or coinsurance models in coming years.

With cost sure to be a major sticking point in the Medicare prescription drug benefit debate, it may make sense to look again at private-sector benefit management techniques designed to manage costs while encouraging safe and appropriate prescribing and medication use. To provide an affordable drug benefit, employers sometimes make plan design changes that are not popular. That level of management is a poor match for the political environment in which Medicare operates. Unless Congress can reform Medicare so it can behave like a knowledgeable purchaser, it may be difficult to achieve an affordable, quality drug plan for seniors.

“Strategies for the future should be aimed at changing provider and/or member behavior.”

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