Prescription Benefit Design: Perspectives, Reimbursement Issues, and Future Trends

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Designing an effective pharmacy benefit requires balancing drug access, quality, and cost to provide maximum value. Because pharmaceuticals have been a cost leader for health plans and self-insured employers, an increasing amount of attention has been placed on managing a drug benefit that is comprehensive and affordable. From the perspective of an employer, healthcare costs represent a significant portion of total overhead. As costs increase, this pressure may strain the financial viability of many employers. **Figure 1** illustrates the net impact of this trend based on the earnings per share. Projections for healthcare expenses for 2000 to 2005 are 7% to 20% per employee per year[1] for self-funded programs. Health plans are expected to increase premiums at an even greater rate during the same period. Yet, one survey indicates, paradoxically, that health plans are slightly less concerned about managing drug costs relative to employers placing a greater emphasis on quality of care (**Figure 2**).[2]

Employers and health plans approach benefit design from different perspectives. **Figure 3** presents an employer decision tree to build the coverage to be offered to employees. This focus includes a clinical review and an assessment of the profitability to the business. This process also examines how the addition could impact the competitive status of the company.

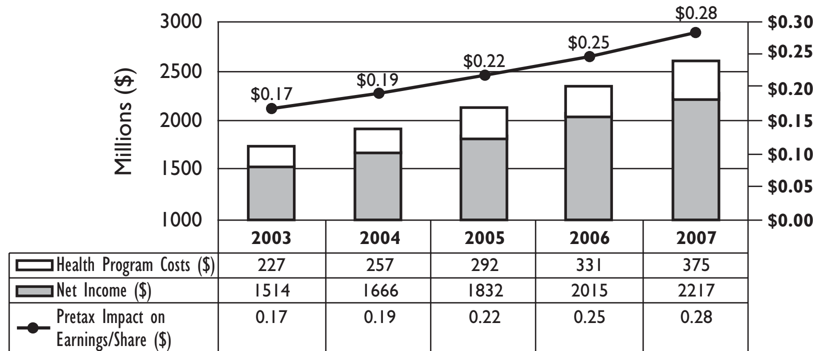
The process for coverage decisions will vary by health plan (**Figure 4**). Primarily, the emphasis on clinical data and input from the provider network have the most significant impact on the decision process. The economic impact is focused solely on healthcare-related expenses versus the employer with a broader evaluation on business profitability.

All stakeholders, including employers, managed care organizations (MCOs), and benefit consultants, have the challenge of offering cost-effective healthcare. High-cost therapies require close scrutiny to assure unexpected costs do not arise.

Nationwide, healthcare plans have experienced a striking increase in the frequency of recombinant human growth hormone (hGH) requests for adult treatments in recent years and a corresponding elevation in plan costs even with utilization controls. If this trend continues, the cost of hGH to prescription plans would be unsustainable. hGH is only 1 variable in the escalating drug cost process. Most patients receiving hGH therapy are adults; thus, employees and the number of adults receiving this form of therapy continues to grow. With a high average wholesale cost of hGH of $2760 per patient per month,[3] employers fear the impact of this single product will increase substantially with increased utilization.[4] Additionally, hGH products are an approved treatment in most formularies, or as part of the medical benefit plan, and no generic substitution is foreseen in the near future.

Even though these products require prior authorization, payer costs remain substantial, whereas the member's cost remains relatively low. For example, even a $250 per month patient cost on a $1000 dose of hGH is only 25% of the total cost. The self-funded employer, therefore, is liable for 75% of the cost. Because of these cost drivers, the methods for managing injectables, such as hGH, have changed dramatically in the last

Figure 1. The Business Impact of Increasing Costs



	2003	2004	2005	2006	2007
Health Program Costs ($)	227	257	292	331	375
Net Income ($)	1514	1666	1832	2015	2217
Pretax Impact on Earnings/Share ($)	0.17	0.19	0.22	0.25	0.28

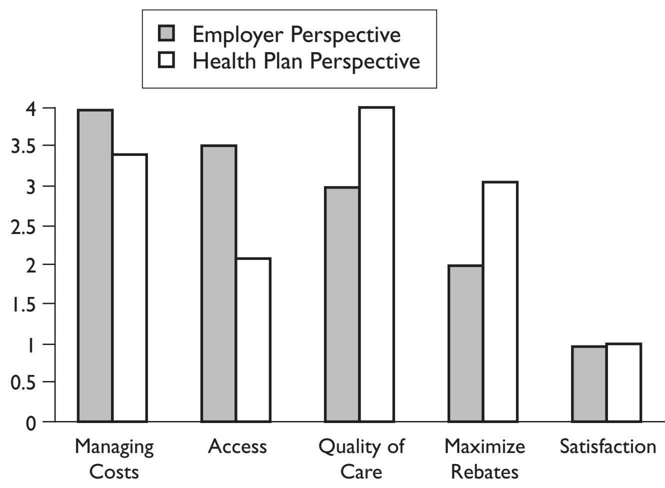
N = 3000.
Source: Mercer National Survey of Employer-sponsored Health Plans.

3 or 4 years, and they continue to evolve. Some design considerations that are emerging include placing injectables like hGH in the pharmacy benefits category. This represents a major shift in the management of injectable drugs and often a greater patient responsibility for the cost of the product. Emerging prescription benefit trends for these products include the implementation of a fourth (injectable) formulary tier to establish separate copayments. Also, the use of specialty drug vendors provides an opportunity to decrease cost in the supply chain.

Member copayments are becoming a major issue with hGH treatment. Plan members are sharing more of the direct product costs over time. For injectables, a 4-tier copay system is emerging as an alternative for injections. As an example of a fourth tier pharmacy benefit design, which includes virtually all self-administered injectables, the members are responsible for a 30% copayment with a maximum out-of-pocket expense of $250 per fill per month. Prior authorization is required for many drugs in this tier.

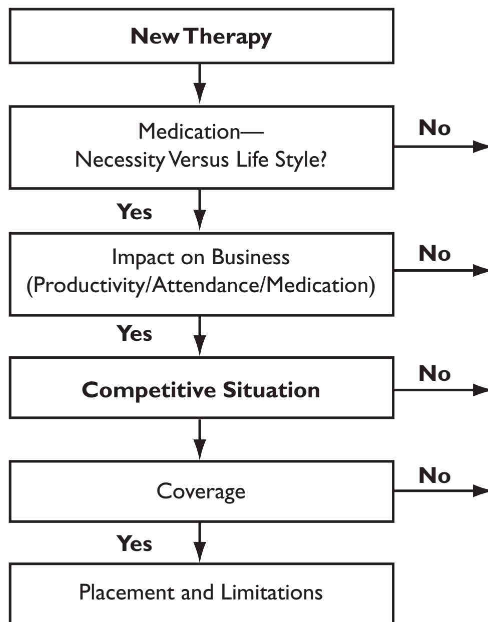
In a specialty drug benefit program, the prescription is processed through a specialty pharmacy that usually handles only injectable medications. Orders are processed within 24 to 72 hours, drugs are delivered directly to the provider or patient, and the health plan is billed directly. The benefits of this approach include reduced provider inventory and cost, reduced provider administrative costs, and reduced costs to members and employers. Further, data can be collected on drug utilization and the plan has more effective control of drug approvals. More important, these programs also offer a disease management program and, depending on the disease state, the program may integrate a case manager or a team of clinicians into the program to optimally manage the member's disease with the prescribing physician. This program can also include direct member phone contacts to encourage compliance. For growth hor-

Figure 2. Rx Benefit Formulary Design Factors



N = 3000.
Source: Mercer National Survey of Employer-sponsored Health Plans.

Figure 3. Employer Coverage Decision Tree



mone deficiency, some plans use a case management approach that includes a patient education component and direct member delivery of the product. This approach provides for inventory and billing fee reductions to reduce plan and member costs. In the immediate future, provider incentives will likely spur an expansion of the specialty vendor concept and more intensive case management.

Moving forward, a more flexible approach to drug benefit design may be based on value (**Table**). In this benefit model, the copayment tiers are matched to the value received. The benefit may be based on the traditional formulary or drug use paradigm or can shift to health management or total value. This design allows the employer or MCO to offer all 3 approaches based on the product or disease state.

Some drugs are best managed through existing systems. Others can be incorporated into a disease management program. The total value approach will require integration of medical and pharmacy services and therefore may be limited to select therapies.

To manage the increasing cost of drug therapy, innovative techniques must be employed. Strategies to decrease costs and gain efficiencies in the system need to be developed. Streamlining distribution can significantly reduce costs. Also, providing

Figure 4. Medical Policy Development Algorithm

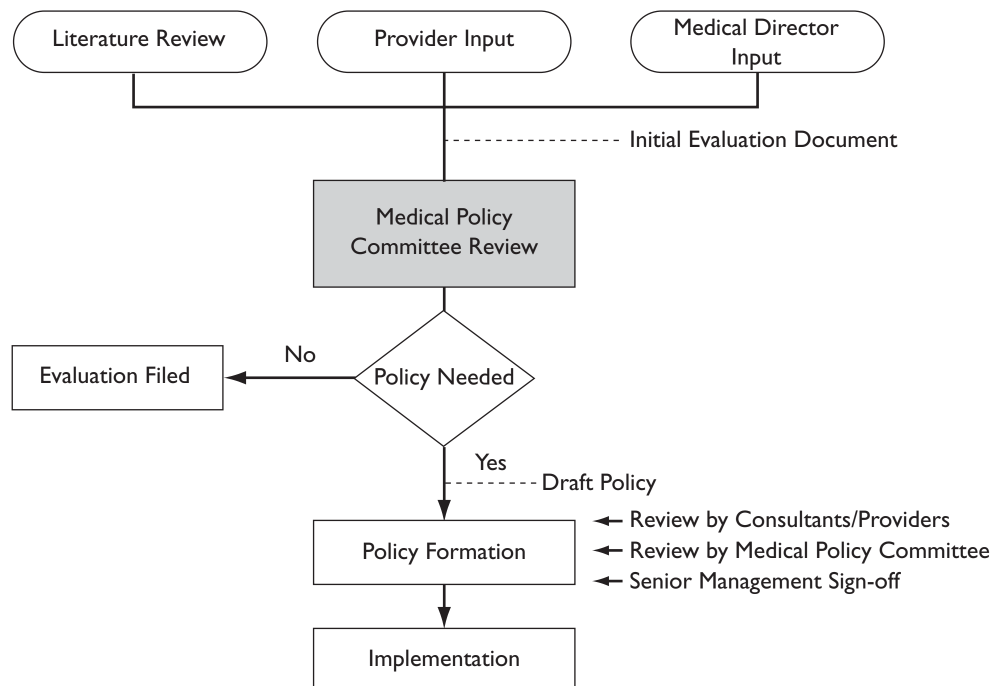


Table. Options to Manage the Rx Benefit—The Future of Plan Design

Copay Levels	Approach A Usage	Approach B Health Management	Approach C Total Value
Highest	Not a chronic or life-threatening condition; duration varies; symptomatic relief	Chronic condition; noncompliance with health improvement	No discernible link to other medical costs or productivity
Middle	Life-sustaining or functional; maintenance duration	Acute condition; no real health management opportunity	No measurable impact on other medical costs or productivity
Lowest	Acute condition; limited duration; immediate consequence if not taken	Chronic condition; full compliance with health improvement	Proven and measurable impact on other medical costs or improved productivity

Source: Mercer National Survey of Employer-sponsored Health Plans 2003 (Employers ≥500 Employees).

clarity on diagnostic criteria can reduce system costs for testing and physician visits. Placing greater costs on the patient through copay tiers will provide at least short-term benefits. Overall access to distribution of appropriate drugs needs to be proactively managed to provide a cost-effective health benefit.

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