The Drug Cost Gap and the Diagnosis-Prescription Connection

by David Dross

Although the rise in pharmacy benefit costs continues to outpace overall medical cost inflation, the gap is narrowing. Employers can improve cost and employee wellness even further with an innovative technique for drug therapy compliance called the Diagnosis-Prescription (Dx-Rx) approach. This article reports results from a 2007 national employer survey on pharmacy benefits and describes how the Dx-Rx innovation can keep patients and their doctors on track when it comes to controlling disease and driving down overall medical costs.

Prescription drug costs rose 9.3% among large employers (500 or more employees) in 2007, while overall medical costs rose 5.1%, according to Mercer’s National Survey of Employer-Sponsored Health Plans 2007. But that gap has been shrinking since 2000, when drug benefit costs rose nearly 20% and health costs rose by only 6.6%. The impact of tiered formulary structures and increased copay percentages has helped to narrow that divide, but the challenge for further cost reduction is now upon employers, which must find better ways to attack cost and promote employee wellness more proactively.

While pharmacy benefit cost increases still exceed medical benefit cost increases, the gap has been shrinking steadily as employers have adopted a range of approaches to manage pharmacy benefit costs. Having already experienced the impact of cost sharing and tiered copayment structures, employers are looking to other cost-reduction strategies to decrease costs over time, such as more actively encouraging members to use generic drugs and mail-order plans.

And as will be discussed later, they are also exploring innovative techniques to improve drug therapy compliance as a way to control total health plan spending in the future.

Indeed, employers and their pharmacy benefits managers (PBMs) have made significant changes, such as moving from an open formulary to a tiered structure or increasing the percentage of drug expenditures paid by members. But the Mercer survey indicates that many employers have achieved as high a level of member cost share as they deem appropriate—for now, at least—and are exploring other ways to manage costs. This presents new challenges, especially in the management of highly expensive specialty drugs. A look at some of the other key survey findings is helpful in charting how employers have adapted to prescription drug cost inflation.

PBM COST STRATEGIES

According to Mercer’s 2007 employer-sponsored health plan survey, most employers use tiered copayments for their prescription drug benefit; the most common arrangement is a three-tier structure with
increasing copayment amounts for generic, formulary brand-name and nonformulary brand-name drugs (72% at retail and 68% at mail order). Among employers that offer a card plan, 5% of employers with 500 or more employees and 10% of those with 20,000 or more employees have implemented four- or five-tier structures.

Coinsurance offers greater price transparency and allows employers to share costs consistently with employees, even when drug prices increase or fluctuate. In addition, coinsurance supports consumerist strategies; the pharmacy benefit has been identified as one area in which the use of coinsurance can have an immediate effect on member buying habits.

More than one-fifth of all large employers, and nearly half of those with 20,000 or more employees, require coinsurance for one or more drug categories. Coinsurance offers greater price transparency and allows employers to share costs consistently with employees, even when drug prices increase or fluctuate. In addition, coinsurance supports consumerist strategies; the pharmacy benefit has been identified as one area in which the use of coinsurance can have an immediate effect on member buying habits.

Virtually all respondents provide a mail-order plan. According to Mercer’s May 2007 Hot Topics survey on pharmacy benefits (which surveyed in greater depth on pharmacy issues the respondents to the national employer-sponsored health plan survey), members have a copay incentive to obtain drugs through the mail in most plans (77%). A small portion penalize members who don’t use the mail-order plan for maintenance drugs: 6% require an additional copay from members who continue to use retail pharmacies after a specified number of fills, and 10% discontinue retail coverage altogether. More commonly, employers use targeted communication to educate members on the value of the mail-order plan (36%). Only 13% of respondents do not use any mail-order incentives or penalties.

_The Generics Opportunity_

There is a large opportunity to lower costs now and over the next several years as some significant brand-name drugs become available as less-expensive generics. To encourage the use of generics, some employers require members to pay the difference in cost between a brand-name and a generic drug, in addition to the generic copay, if they request a brand drug when a generic equivalent is available.

Nearly one-half of respondents to the 2007 Hot Topics survey (49%) are using such a program, often called a _dispensed-as-written (DAW)_ 2 penalty, and over one-fourth (29%) reported using a tougher version, DAW 1, which imposes the penalty even if the physician requests the brand drug. Use of these penalties appears to be growing; an additional 9% of respondents said they will implement DAW 1, and 10% of respondents said they will implement DAW 2 within the next two years.

Very few employers surveyed (4%) waived generic copays for a period of time as an incentive. However, the use of targeted communications intended to educate members and/or prescribers about generic alternatives is increasing; 64% of respondents now use targeted communications, up from 48% in 2005.

_Importance of Specialty Drugs_

The management of specialty or biotech drugs is becoming increasingly important for employers, and a growing number of respondents say they have recently reviewed plan benefits and limits for specialty or biotech drugs (45% in 2007, up from 34% in 2005). This figure rises to 68% among the largest employers (up from 51% in 2005). Another 30% of respondents said they plan to review plan benefits for specialty drugs in 2008.

Mercer research has established that employers see health management as the single most important health benefit cost-management strategy over the next five years. And one important aspect of health management is encouraging evidence-based clinical practices. The 2007 Hot Topics survey asked employers specifically about using incentives in pharmacy plan design to improve drug compliance and adherence, a strategy that has received much publicity in the past year. In particular, employers were asked if they are providing financial incentives (by lowering or waiving drug copays/coinsurance for specific drug therapies) for members to maintain higher levels of drug compliance.

The survey findings suggest that this is still an emerging trend used only by a limited number of em-
ployers. Only 6% of employers use financial incentives for diabetes treatment, the largest percentage in any therapeutic category. Over one-fourth (26%) of employers, however, are considering implementing a financial incentive program for diabetes therapy in the future, and approximately one-fourth are considering the same approach for other therapeutic classes used to treat chronic conditions (e.g., cholesterol, asthma, high blood pressure).

A slightly smaller percentage of employers now waives or reduces copays for specific classes of drugs, contingent upon the member's participation in a related disease management program. This incentive is most commonly used by employers for diabetes management (4% of employers report offering this benefit to employees). About one-fourth of all respondents say they are considering this approach.

Many employers have heard about evidence-based designs or value-based formularies, and a small group of them have become early adopters of this approach. Meanwhile, other employers are still weighing their options but are asking very good questions about how to apply these concepts to their own employee population.

THE DX-RX INNOVATION

In answering these questions, it has become clear that the strategy of increased cost shifting is, on its own, not sustainable for the long term. It will take innovation and a commitment to wellness on the part of employers and employees to keep reining in health care costs—and prescription drug costs in particular. Fortunately, there are new approaches that can make a difference: prime among them is Mercer’s Dx-Rx Pairing™, or diagnosis-prescription pairing, an evidence-based pharmacy benefit design that focuses on combinations of medical diagnoses and prescription drug therapies that have been proven to improve certain high-cost chronic conditions and lower overall health care costs by driving better compliance. Mercer developed Dx-Rx Pairing™ in conjunction with Niteesh Choudhry, M.D., Ph.D., a leading researcher at Harvard Medical School, and several other national experts.

Rather than attack prescription drug costs from the strictly bottom-line perspective of copays and pricing, the Dx-Rx approach acknowledges that pharmacy benefit plans are designed not to sustain inflation but to reduce the cost of providing drugs to plan members. Given the enormous cost of research and development, approval and marketing processes for drug companies, prescription prices are as certain as death and taxes to keep spiraling upward, while the pressure to control expense on the provider side is a fact of life that largely defines the reach and rationale of drug benefit plans.

Unfortunately, because of this focus on cost, today’s pharmacy plans miss opportunities to spur health improvement by monitoring the adherence of members to prescription regimens—particularly for disease states that are high cost to employers and life altering for patients. Is it possible to improve employee adherence and health status and reduce employers’ total health care spending through the use of existing evidence-based drug therapies?

One clear solution is to encourage patients to follow the most effective pharmacy treatment plans for certain high-cost chronic conditions such as diabetes, heart disease and hypertension. But the key is not merely to encourage patients so much as to remove the common barriers to adherence that stand in the way of effective treatment and ultimate cost control.

Dx-Rx pairing addresses some key flaws in today's pharmacy design and delivery systems. It is arguably unique among evidence-based designs since it targets only those combinations of diagnoses and drug therapies that have been medically proven to improve patient health, thus leading to lower overall care costs.

What makes Dx-Rx different is that it can drive better adherence by addressing the key barriers to optimal adherence. It does so by reducing or eliminating any member cost sharing for the designated diagnosis/drug pairing, so financial barriers are eliminated or minimized. Next it addresses other barriers to adherence through proactive counseling and communication to plan members whose utilization patterns may indicate reduced or minimal adherence. (This proactive communication is designed to educate patients about their disease and help patients better understand side effects and the importance of adherence. Participation in disease management is also recommended as a carrot for patients to be eligible for waived or reduced copays.) Lastly, there is focused outreach to prescribing physicians, in order

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to optimize the first-time prescribing of evidence-based Dx-Rx pairings. This tripartite approach addresses the financial, personal and clinical barriers to adherence.

Significant examples of proper Dx-Rx pairing would include the prescribing of ACE inhibitors for plan members with diabetes or statins and other medications following heart attacks. If practiced properly, the tripartite Dx-Rx strategy can yield improved adherence to the drug regimens and improved outcomes for patients and (from a cost standpoint) their employers. The strategy holds particularly high potential for employers with a stable workforce, in which chronic conditions are ongoing facts of working life, and poor drug adherence rates for those conditions.

As with any design innovation, especially in the realm of health care, Dx-Rx pairing is not a panacea, and shades of gray are inevitable in implementing the design. For example, there are some drug pairings that clinicians may strongly feel will result in improved outcomes and lower cost based on limited or anecdotal evidence, even though such a conclusion is not supported, or not sufficiently supported, by third-party studies in peer-reviewed journals and existing evidence. Typically, such a drug would not be eligible for the preferred status of the Dx-Rx approach, but a plan sponsor could choose to include it in the preferred list for its population.

This decision would require careful consideration of clinician feedback and the limited data, an unlikely level of discretionary decision making on the part of most plan sponsors. And yet, the Dx-Rx strategy at least invites pharmacy benefit plans to encourage patient adherence with prescription regimens by widening the net of eligible Dx-Rx pairings, which may lead to more and better data about which pairings truly pay off.

Even though the Dx-Rx approach is evidence based and represents improvement in drug design, a certain degree of variation will continue to exist. Specifically, individual differences in drug efficacy still exist by patient, even for preferred pairings. However, it is anticipated that the Dx-Rx plan structure will begin to incorporate the impact of genomic testing results once it becomes commercially viable to address these variations. Commercial viability will vary by disease state but it may be available within the next few years.

Even so, the very real potential of such an approach need not be tied to eventual breakthroughs in science and their eventual application to the pharmacy. Today, the reliance on traditional pharmacy benefit plan designs—those built almost exclusively on the reduction of drug costs—tends to inadvertently discourage the pairing of diagnoses with the most effective medication simply by requiring higher copayments for many of those proven drugs.

By taking a proactive stance, plan sponsors can achieve a great deal for their stakeholders. Through innovations such as Dx-Rx, they can make the most of the existing evidence and provide not only a financial incentive for patients to begin the most effective drug regimen but also back up that incentive with targeted communications that can keep patients and their doctors on track when it comes to controlling disease and driving down cost.

Endnote

1. Mercer’s National Survey of Employer-Sponsored Health Plans 2007. The annual survey is conducted using a national probability sample of public and private employers with at least ten employees. Nearly 3,000 employers completed the survey in 2007. The survey was conducted in late summer, when most employers have a good fix on their current-year costs. Results represent about 600,000 employers and more than 90 million full- and part-time employees and have an error range of +/− 3%.