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Employers advised to tweak formularies to increase users' awareness of drug costs

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NEW YORK—Although employers have had some success controlling the costs of their prescription drug benefits over the past few years, they can still do more to reduce their drug benefit expenses.

In particular, employers should rethink their reliance on rebates and discounts and tweak the standard three-tiered drug formula to more effectively influence employees' decisions regarding their health.

Discounts and rebates reward increased cost and utilization and lack financial disclosures, said Bridget Eber, a Chicago-based senior consultant in the specialty practice of Towers Perrin, during the 2006 Employee Healthcare Conference, which was sponsored by the consulting firm in New York earlier this month.

"If you look at what's broken in the system, we've been chasing drug discounts that are volume-driven," she said. "If you increase the utilization of drugs that generate rebates, you're increasing your spend and perhaps marginally increasing some credit. In terms of real-time claims processing, your cost spirals upward and then any credits you might see come way down the line."

Benefit plan designs could be more effective if they expose members to the true cost of drugs and create financial incentives to shop for affordable medicines, she said. The traditional formulary/nonformulary method of designing drug benefits does not create sufficient financial incentives to make affordable medicines more accessible to members and more economical for employers. "Rebate credits just don't reduce the costs of formulary drugs enough to make it worthwhile," Ms. Eber said.

The rebate model shields employees from the true costs of drugs, said Dr. Brent Pawlecki, associate medical director for Pitney Bowes Inc. in Stamford, Conn. "We want to be able to get rid of rebates and give it right back to the employees as much as possible, because it's unclear to the employees what's actually happening and we want them to make an informed decision."

Employers should use their leverage through volume purchasing and collaborative purchasing arrangements to negotiate away some of the misaligned incentives in the traditional model, Ms. Eber said.

"We're working very closely with our PBMs to see what's out there in the marketplace," Dr. Pawlecki said. "While they may be pushing one thing, we might not always agree with them, so that's one thing we definitely have to watch out for."

Employers should look at their pharmacy expenses as an investment in the health and productivity of their employees, Ms. Eber said. "Drugs are a tool to manage the health of your population."

Pitney Bowes Inc. took this approach when it revamped its pharmacy benefit in 2000. Through predictive modeling, the company discovered that 50% of its employee population had a chronic medical condition such as diabetes, coronary artery disease, cardiovascular disease or asthma. Company officials also realized that a lack of compliance with pharmaceutical treatments for these conditions was contributing to increased medical costs, he said.

The company decided to place all generic and brand-name drugs used to treat asthma and diabetes in the first tier of its plan design, meaning that prescriptions for these conditions would only be subject to 10% coinsurance from the employee. In contrast, preferred and nonpreferred brand-name drugs for other conditions are subject to 30% and 50% coinsurance, respectively.

Pitney Bowes took this approach to encourage employees to get appropriate care, Dr. Pawlecki said. "We said `let's get rid of the barriers for these conditions that cost us the most money,'" he said. "The thought was if we do that, our people will be healthier, they will be compliant with their medications, there will be less barriers to their getting proper care and our overall health care costs will go down.

"Everybody said `you're crazy, your pharmacy costs are going to go through the roof,'" he said.

Since the changes, though, the average cost of care for treating diabetes in the company dropped by 6%, while the average cost of care for asthma fell 15%. Also, the company's average annual pharmacy costs for diabetes fell by 7% and pharmacy costs for asthma fell by 19%. Dr. Pawlecki called the drop in pharmacy costs surprising and attributed it to the declining need for expensive rescue medications.

Employees with these chronic conditions also saved money in the new plan as their average contributions decreased by 50%, he noted.

Last year, the company added drugs treating hypertension to the first tier, but it does not yet have enough data to determine the impact of that decision, he said. It is also considering whether drugs treating other conditions, such as depression, should go in Tier 1.

Compliance incentives should be integrated in the plan design, Ms. Eber said. "Compliance is key to maintaining a healthy workforce," she said. "If members perceive their medicines are unaffordable to them, they're going to be noncompliant with that program. We're looking at drug utilization because people who work for our companies have chronic conditions or are at risk for developing chronic conditions and they need to control these conditions so they're more productive."