Causes and Cures:
Stakeholder Perspectives on Rising Prescription Drug Costs in California

Abt Associates
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Stakeholder Perspectives on Rising Prescription Drug Costs in California

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Prepared by:
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Acknowledgments

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I. Interview Process and Key Findings

What do the key players affected by rising prescription drug costs see as its causes and cures? How do they perceive each other and the potential for joint efforts toward solutions? From where they sit, what is working and what is not? And where do we go from here?

To answer these and other questions, Abt Associates interviewed 30 stakeholders across California who play a major role in defining the trends and in determining the future direction of prescription drug cost and use:

* medical directors and pharmacy managers at 13 large medical groups and six managed care organizations
* medical directors or human resource managers at five large purchasers, including employers and purchasing cooperatives
* chief financial officers, directors of finance, and directors of pharmacy—at five hospitals or health systems.

To capture the perspective of the government on prescription drug trends, we also interviewed a resource person at the state legislature.

Each of the interviews lasted for approximately 90 minutes and followed a structured interview guide created specifically for each of the stakeholder groups. Table 1 summarizes the interview process.

Key Findings

Despite the often intense acrimony and strain that characterizes relationships among major players involved in today’s prescription pharmacy market—each tends to blame the others for contributing to current conditions—all agree that they must find a way to cooperate if workable solutions are to be found and implemented.
They also agree on at least some of the major causes of the recent unprecedented rise in prescription drug costs: (1) the availability of new and expensive drugs along with new uses for existing drugs; (2) a newly empowered and assertive health care consumer whose increasing demands often reflect the impact of direct-to-consumer (DTC) advertising and the desire for “lifestyle drugs”; and (3) a burgeoning senior population whose need for medication is greater than that of younger consumers.

Our respondents enumerate a daunting list of barriers to finding viable solutions:

- A lack of access to complete, timely, and adequate information about the cost/benefits of new drugs, patients’ utilization patterns, and physicians’ prescribing patterns
- A shifting risk-sharing picture with physicians withdrawing from risk and dismantling critical utilization management infrastructures while health plans reluctantly retake risk with fewer resources to reconstruct pharmacy management processes
- A lack of price sensitivity and accurate information among consumers
- A low unemployment environment that makes employers reluctant to risk alienating valuable employees by curbing pharmacy benefits
- The threat of damaging government interference—politically motivated legislation and regulation based on limited understanding.

Despite all these obstacles—or, as some interviewees suggest, because of desperation engendered by the current drug cost crisis—innovative solutions are likely to arise. Stakeholders are counting on technology to improve information within and among groups, a multilayered benefit system to enhance consumer responsibility, a renewed focus on quality to bring the drug cost-benefit ratio into balance, and “outside the box” thinking to create an entirely new system for providing and managing prescription drugs.

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II. Physicians and Medical Groups

“In the early 1990s, pharmacy risk represented a bonus to the groups. By the mid-1990s, it was a break-even proposition. By the late 1990s, we were paying out of our own pocket.”

– Pharmacy director, northern California medical group

Caifornia Medical Group Respondents have passionate opinions about the changes taking place in medicine today—about pharmaceutical firms’ TV ad campaigns, health plans that no longer collaborate, patients who bring them reams of information from an Internet search, and regulators who may not have the entire story before they introduce legislation for new mandated benefits. They deliver a candid review of factors driving the unparalleled increases in pharmacy costs and place their bets on the changes that will occur in California to gain control over these costs.

We spoke with 13 physicians or pharmacists in medical groups across the state. In general, medical groups in California are more organized, larger, and have more management structure compared to groups in other parts of the country. The groups we interviewed have between 100 and 600 physicians, six and 15 managed care contracts with health plans and insurers, and 10,000 to 350,000 covered members.

Overall, medical groups report that the pharmacy budget is “high on the radar screen” in their organization. They view prescription drugs as critical to their ability to deliver efficient quality care. Trends in new drug development and unexpected costs related to pharmacy use and price have hit physicians in four key ways:

1. Prescription drugs strain budgets and doctor-patient relationships.
2. Physicians are moving rapidly away from financial risk for prescription drugs.
3. Medical groups are systematically withdrawing from investment in pharmacy management.
4. Relations with health plans are deteriorating.
Prescription Drugs Strain Budgets and Doctor-Patient Relationships

Across the state, there was universal agreement that prescription drugs are an increasingly important element of today’s medical office visit. Prescription drugs are elemental to the care process, and they are highly effective. Many new drugs enable physicians to address disease in far better ways than they previously could. Because medical groups seek ways to increase patient satisfaction yet deliver treatment as efficiently as possible, prescriptions frequently become the patient’s tangible result of an abbreviated encounter. Telephone refills for prescriptions are a mechanism for ensuring compliance with treatment and loyalty to the medical group.

Although pharmacy topics are of high interest for medical groups across California, the degree of importance respondents attached to rising costs of prescription drugs varied, depending upon their group’s financial risk for these costs.

In medical groups that share risk for prescription drugs, pharmacy is the single fastest growing part of the budget. Information is seen as a key tool for containing utilization and cost of prescription drugs within the organization. Groups are continually generating or receiving health plan data on comparative patterns in prescription use and cost. Individual physicians are ranked according to their judicious or capricious prescribing of high-cost drugs. All in all, prescription drugs are coloring the financial picture for practices, influencing interactions with payers and employers, and injecting new tension into the doctor-patient relationship.

Tension in the doctor-patient relationship. Physicians report a rising level of tension with patients around prescription drugs. In conflict with their doctors’ focus on shorter, more tightly managed encounters, patients are attempting to assume more control of their medical encounters. Patients are increasingly challenging their doctors, asking more questions, and demanding specific drugs they have learned about through advertisements, the Internet, or friends.

These blunt observations by two northern California physicians illustrate a new level of frustration or impatience with patients:

“If they can’t have the prescription, they want to know why. Telling them they don’t have the condition addressed by the drug does not resolve the problem! The nature of the visit has changed. There is more tension, more debate, and less satisfaction.”

“I’m keenly aware of the impact of direct-to-consumer-advertising on my practice. My patients come in demanding a specific drug and I’m afraid to say no for fear of losing my patient.”
Physicians Move Rapidly Away from Financial Risk for Prescription Drugs

California medical groups universally report that the high level of managed care enrollment in commercial and Medicare health plans has dramatically affected their organizations’ financial exposure. Despite an interest in promoting appropriate use of innovative and effective prescription drugs, medical groups have been anxious about the costs of drugs for the past few years. Until very recently, they were sharing the risk for patient care, particularly for their senior patients in Medicare plans. In the most recent contracting cycles with health plans, many groups have refused to retain a high portion of the risk for drugs—a signal that they view this area of cost containment as “beyond their control.”

Medical groups originally had a large incentive to assume risk for pharmacy costs. Their willingness to bear risk was consonant with their belief that physicians should manage all components of patient care and reap the benefits of appropriate utilization of newly efficacious pharmaceutical interventions. However, with the growth of increasingly expensive drugs and DTC advertising, medical groups’ ability to manage the cost increases degraded. Explains a southern California group’s medical director/CEO:

“We were managing pretty well for a while. Pharmacy has been the thing that has really tipped the scale for the worst possible outcome. Even with modest premium increases, our medical group is back to where we were in 1994.”

Senior plans compound the risk. Medical groups and health plans deal with capitation for prescription drugs separately from capitation for primary care/office visit services. They address pharmacy benefits for members in senior plans—those who are covered by Medicare—in still separate negotiations, which they describe as “very challenging.” This is because the pharmacy budget for seniors represents a substantially higher proportion of the overall premium allocation—as much as three times higher than the amount allowed for a commercial health plan member—compared to pharmacy for commercially covered populations.

Medical groups report that the negotiations for changes in risk arrangements on senior plans are not only separate but more acrimonious. The medical director of a southern California group reports: “The average age of senior members is 76 years. People are enrolled longer, are using more drugs. Demand is increasing. The plans systematically underfund pharmacy for seniors. Some plans didn’t do their homework, but others just used their market power to get the contract terms. It is impossible to meet the pharmacy budget goal for seniors.”

Scrambling to give it back. Among our respondents, we found a majority of those holding pharmacy risk had negotiated new contracts for commercially covered members. Across the board, they were taking no greater than a 50 percent share of risk on pharmacy cost, with a stop-loss of 10 percent on the upside or downside. Only one group still held 100 percent risk for any enrolled lives, but this group also negotiated a 10 percent upside limit (stop-loss amount) on prescription drugs.

“Until last year,” says the director of pharmacy at a southern California medical group, “we were seeking full risk for prescription drugs in our managed care contracts. Now, we are scrambling to give it back!”
Medical Groups Systematically Withdraw from Investment in Pharmacy Management

When medical groups began taking financial risk for pharmacy in the early 1990s, they hired pharmacists and developed strategies for tracking their physicians’ prescribing behaviors. They put in place processes to better recognize a member’s health plan and use the correct formulary at the time of prescribing. Of course, they also introduced financial incentives related to brand-name/generic drug prescribing, procedural compliance with health plan rules (such as pre-approval for certain drugs), and so forth. The goal was to “keep it simple” and easy for physicians to use good clinical and economic judgment when deciding on a prescription drug regimen. Respondents report that investment within the medical groups ran into millions as large practices sought to ensure tighter control over this high-cost area of medical care delivery.

Tensions between drug company reps and pharmacists. One side effect of pharmacy management within the medical group has been tension between the medical group pharmacist and drug company representatives, who have historically played an important educational and economic role for physicians. Respondents report new levels of control over the sample closet in physician offices, with medical groups often policing the samples being brought in or delivered by pharmaceutical companies. They recount new protocols, rules and guidelines, even debate over whether the drug company rep can buy pizza for the office staff on Fridays!

According to the director of pharmacy at a southern California medical group, “We keep careful tabs on the sample closet, and have circulated a written policy for manufacturer reps regarding their access to our groups and to our sample closet. If it isn’t on the formulary, it isn’t in the sample closet. But we still see a lot of unauthorized samples being doled out to patients!”

Physicians in the group may see these activities as restricting their ability to learn about new drug developments or provide optimal care. For instance, in the past they have used the sample closet to test a patient on a new regimen before prescribing the drug, or to subsidize low-income patients. Respondents are challenged to show that all of these changes are worth the animosity and ill will being created.

Says a director of pharmacy for a northern California medical group: “Even though we have our disputes with the reps, the elimination of ‘academic detailing’—that is, the educational information on research related to drugs—is a loss to our physicians. It creates a void.”

Returning to the status quo. Since a majority of California medical groups have now effectively shifted the pharmacy financial risk back to the health plans and the sponsors or employers, will the efforts to understand and manage prescription drug use be abandoned? We asked how this shift in risk affects medical group and physician attention to formulary decisions or cost trade-offs with high-volume prescriptions. We heard that genuine management of pharmacy requires consistent interaction between physicians and a group’s pharmacist. Patients also need information and access to data on new drugs. But such efforts draw resources away from other activities in the medical group. When there is little or no financial risk for pharmacy, groups estimate that they are spending less time and energy on managing this aspect of premium dollar.
We heard about a systematic and ongoing withdrawal of investment in pharmacy-related management efforts. What has taken a decade to construct—the information infrastructure, the disease management protocols, and the peer-review processes—is being dismantled at a breathtaking pace. While medical group pharmacy departments continue to argue for using information and education to influence physician and consumer behavior, there is general agreement that draconian practices related to financial incentives and constant surveillance of physician prescribing are no longer needed within the medical groups themselves. Remaining control infrastructures focus on compliance with managed care plan formularies and protocols rather than drug management.

A director of pharmacy explains how a northern California group is divesting itself of pharmacy management along with risk: “Drug management has been really important to our group! We hired two pharmacists for 100,000 enrolled lives. As we start losing risk, pharmacy management probably won’t be as big a focus. We will lay off at least one of our pharmacists, since we have to control overall administrative cost—after all, we no longer have control or responsibility when it comes to pharmacy.”

Will behavior changes in prescribing be lost as soon as risk is given back to the plans? It isn’t clear that anyone cares. To a large extent, respondents view the return on their investment as unsatisfactory. While medical groups were developing tools to change behavior, delivering data to physicians, and lobbying health plans for better information, pharmacy costs rose an average of 15 percent to 20 percent in a year. The impact is clear, reports a southern California medical group pharmacy services specialist: “Our physicians are saying, ‘Stay out of my face; I don’t want to hear anymore. Let me do my job.”’

Relations with Health Plans Are Deteriorating

Relations between medical groups and health plans in California are strained. While our results confirm the stresses in these relationships, the purpose of this study did not include an analysis of the causes of this tension. However, the interviewers did ask about the impact of pharmacy management issues on contract negotiations and collaboration with plans.

Respondents note three causes for deterioration in relations with plans: (1) Managed care contracts create an “us vs. them” atmosphere; (2) rebates and multiple formularies create animosity; and (3) health plans have a disjointed information strategy.

An “us vs. them” atmosphere. While medical groups acknowledge that “partnership” with health plans was the idealized goal in the 1990s, many cite the tension created by new bureaucratic red tape in today’s interactions. Health plans are actively trying to influence prescription writing from afar. When health plans have the risk for prescription drug costs, and the physicians write the prescriptions, there is “more and more tension.” The HMOs focus on better management of formulary compliance, and their efforts to control prescription volume and cost create a new set of procedures to be followed.

One chief medical officer in northern California describes a typical interaction: “There is a huge hassle factor with everything we do. If you try to prescribe the drug you think is best for the patient, but is not the preferred drug of the HMO, you can expect to have several calls from a pharmacy technician or a retail clerk with no clinical experience—asking a set of predefined questions before they are able to authorize the prescription.”
The interviews also revealed an underlying feeling that the health plans have ulterior motives for every change in formulary, drug management process, or contracting. For example, while it is probable that plans underpredicted pharmacy costs for the most recent period, medical groups are likely to suspect that plans knew something was coming and purposefully kept it under wraps.

Says the medical director of a southern California management services organization: “The health plans bought market share with our money. They did this by shifting the risk to groups, and then selling out those who took the risk. They sold short the value of medicine, at $70 per member per month!”

Some medical group leaders are more philosophical about the roles of the plan and group, and describe their differences as a natural set of checks and balances needed in the health care system: “I see more and more tension between the plans and groups in the future. This is good. There needs to be more tension, since it is a natural tendency for people to use way too many prescription drugs. The health plans that fight back the hardest are the ones I like the best,” says a southern California management services organization medical director.

For the most part, however, medical groups see relations with health plans at a low point in California. They are on opposite sides in a frantic economic skirmish. Last year, for example, groups experienced a large cost overrun in many managed care contracts after an unexpected surge in pharmacy costs due to the launch of high-priced, new injectable medications in the middle of the contract year.

Injectables:
Health Plans Needle Medical Groups

Recently introduced high-technology injectable compounds are extremely expensive—averaging more than $5,000 for a single treatment. A crisis in medical groups’ injectable budgets—and in relations between medical groups and health plans—arose last year, when these new injectable drugs came out but were not covered in the prescription drug plan.

Since the vast majority of traditional office injections, such as immunizations or flu shots, are relatively inexpensive, groups have historically borne this cost in their primary care budget without much debate. When health plans give medical groups capitation payments for primary care services, it is customary to include office injections as a covered expense.

While some health plans had alerted the groups to the potential implications of the new drugs, there was no budget for what turned into a large cost overrun in many managed care contracts.

This latest experience is typical of the type of thing that throws a monkey wrench in relations between the health plans and medical groups. For the medical groups, injectable medications, posed a sudden and significant unreimbursed budget item. The new drugs—much more effective than any treatment previously developed—are also exponentially more expensive, yet were not included in the pharmacy budget. Therefore physicians were caught scrambling to cover the shortfall until the new contract cycle let them reopen discussions with the plans.

“Do you administer this expensive, but highly effective, drug to a patient—and hope that you have a cushion in your budget to cover the office-based expense? Or do you postpone the treatment until the argument over coverage is resolved in the next contract year? Of course, you could ask the patient to pay—but patients with prescription drug coverage and primary care coverage believe they are entitled to such treatment, at no extra cost.”

– Medical director of a southern California medical group
Medical group respondents saw the health plans as unwilling to offer financial relief. They depicted the budget crisis over injectables as a typical “gotcha” with health plans. “They simply threw up their hands and said it wasn’t their problem,” reports one medical director in San Diego.

One health plan executive described the dilemma from the payers’ vantage point:

“We had been briefed by the pharmaceutical reps that new injectables were on the launch pad, but employers were not interested in pre-funding an expense that was yet to occur. Our suspicions about the impact on medical group operating budgets were borne out. There was an outcry across the physician community. However, our hands were tied. The contracts stipulated that these expenses were included in the primary care capitation payment.

“When medical groups propose that we cover these unanticipated drug expenditures for the first year or so, it is unreasonable. We all get paid through the employers and other sponsors. If they are not willing to pay more, where would we come up with the extra money?”

In many cases, managed care contract negotiations have made allowances for the shortfall medical groups experienced last year. For others, there was no recourse. The lesson we heard about was one of discouragement and increased tension between the key players in the delivery of health care.

Rebates and multiple formularies create animosity. Medical groups believe health plans are compromising clinical value for financial reasons when they put rebates above good clinical decision making. Pharmaceutical company rebates lead to a preferred drug list that is not clinically superior and constantly changes as new deals are made with manufacturers.

Discussions of health plan formularies quickly move to concerns about rebate arrangements between pharmaceutical manufacturers and health plans. Since plans receive discounts or incentive payments (rebates) for achieving volume thresholds on prescriptions for preferred drugs, medical groups see the rebates as driving decisions that should be strictly clinical. As a new deal is made, one formulary drug is removed and another takes its place. Or a new blockbuster drug is added to the formulary, but so are two other less effective but costly drugs from the same manufacturer (as when drugs are “bundled” for rebate arrangements). Medical groups see the health plans making self-interested deals that hurt relations with their physicians, or undermine patient trust in physician decision making.

According to a pharmacy services specialist with a southern California medical group: “Health plans tout ‘partnerships.’ We should be able to work things out. But rebates and the bundling of medications create more hostility.”

One source of constant friction is the health plan preferred drug list or formulary—and the frequency of changes in drugs on the formulary list. Their frustration is exacerbated by multiple-tiered benefit plans that further complicate formularies as drugs move from one tier to another. If a typical medical group has six to eight contracts with plans, there are an equal number of formularies. It is safe to summarize their reaction by saying that medical groups hate multiple formularies and that health plans vary in their ability to keep groups current with formulary changes.
When a patient receives a prescription for a nonpreferred drug or a nonformulary drug, that patient faces a higher copayment and a possible delay at the pharmacy. Of course, the patient is more likely to be dissatisfied with the physician. When the patient calls the health plan to complain, respondents say, the plan representative may state that it was the physician’s choice to order the drug.

“My biggest problem with the health plans? That’s my biggest problem, the fact that their formularies are always changing!” says a southern California group pharmacy services specialist.

Through the mid-1990s, before cost minimization became the dominant concern with pharmacy benefits, medical groups had representatives on the health plan’s pharmacy and therapeutics (P&T) committee that jointly evaluated the efficacy of new drugs. These committees assessed the effectiveness of new drugs, considered the value to patients and the community at large, and set policies for use for the health plans’ members.

With the precipitous increase in prescription drug expenditures, physicians saw a new emphasis on the economics of a particular drug. Medical group respondents report that the rebate the HMO receives from a manufacturer is the single largest factor in decisions about which drug is “preferred” for a given therapeutic class.

“Plans chase the rebates!” exclaims one director of pharmacy for a large medical group in northern California.

Another medical director in northern California notes that the increased tension between health plans and medical groups has affected the joint P&T committees, and “many have stopped involving representatives from medical groups altogether.”

The medical director of a southern California group sums it up like this: “Health plan partnering? No, not really. It’s more of a ‘good guy/bad guy’ thing. A patient will complain to the plan about a medication we feel forced to administer (by their formulary)—we will try to work with the plan, but I am struck by how they will persistently let us take the hit for the patient’s unhappiness.”

Health plans’ disjointed information strategy. Information on prescription drug use and cost is essential to a successful pharmacy management approach. Plans typically administer the payment for prescriptions, so they have the current data on physician prescribing, patient compliance, changes in volume of particular medications, cost trends, and so forth. These data are essential to a medical group’s understanding of its own patterns and of the longer-term disease management potential of particular protocols. Respondents report that the information they receive is better than ever, but that it is still received in ways that make it difficult to merge across all health plans and that it comes to groups at varying times throughout the year.

According to a northern California group’s chief medical officer: “I think the whole pharmacy benefit management thing will go the way of [other obsolete ideas of the past]—we’ll see that they are not cost effective! In the meantime, we have two full-time pharmacists trying to facilitate appropriate utilization, while our physicians are being hassled by clerks from the plans. I can’t remember anything that’s been turned down for anything other than capriciousness. What a waste of time and money.”

Medical groups crave information that will help them perform in a cost-effective manner but also help them improve the quality of care they provide to their patients. Interviewees report a lack of information from health plans not only about individual physician performance but also about the effectiveness of a new drug versus the alternative drugs in a class already available.
What's Ahead?

Our respondents offer a view of the future of prescription drug costs in California that is colored by relief that they no longer hold drug risk—since they see little slowdown in the escalation of costs related to new drugs and increasing use of existing drugs. Discouragement about the doctor-patient relationship and what it will look like in the next few years also colors their viewpoint.

**No slowdown in sight.** When it comes to escalating prescription costs, physician groups say that DTC advertising is the main culprit. Until manufacturers are required to communicate objectively and consumers have access to complete clinical information, medical groups do not harbor hopes for a slowdown in expenditures.

They report that patients are increasingly educated about their drug choices through information available on the Internet and ads. Since these patients are buffered from the full cost of their drug choices, they continue to make demands during office visits. These demands are more frequently for lifestyle drugs—in some cases, they are drugs that are not on the preferred drug list or are not covered under their plan.

The proliferation of lifestyle and DTC-promoted drugs has heightened the tension in the doctor-patient relationship, laments a medical group PCP in Los Angeles: “We have created a false sense of knowledge with the information that is floating around out there. People confuse ads with clinical data, and come in here ready for a fight. We are fighting with patients all the time.”

As to future changes, physicians predict two major trends:

**Escalating tiers.** Among the major changes medical groups expect to see are three-tier—even four-tier —benefit designs that should encourage the gradual emergence of more rational consumer behavior. Says a southern California group medical director: “Three-tier benefit plans take us out of the middle. Our patients come in and say that they want us to prescribe a drug that is tier one or tier two—they make the trade-off themselves!”

**Automation.** Groups expect electronic record keeping and data transmission to become the standard. They hope that the return on their investments in automation will finally be realized. Their continued interest in prescription drug data reflects their view that disease management successes will require continuous information on patient status, prescription patterns, and drug research results.

“*We’re betting everything on an electronic medical record,*” declares the director of pharmacy at a northern California medical group. “*We’ve been working on it for the past four years. We will have automated prescribing, automatic entries into the medical record, and real-time data updates. It will dramatically improve our control over our group’s prescription drug trends.*”
III. Hospitals and Health Systems

“*The hospital and physician are at risk for costs on HMO products. One seven-year-old hemophiliac cost us $5 million last year—and 90 percent of that was for blood and blood products. We reached our max on reinsurance, but the hospital kept paying out of its own pocket.*”

— CFO, Orange County health system

Senior management at California hospitals have a great deal to contend with right now. Responses to the instability of managed care plans, payer contracts, government reimbursement rates, legislative requirements (for such items as seismic rebuilding), clinical quality, information requirements, and skyrocketing costs compete for strategic emphasis. Among those strategic priorities, hospitals have recently begun to focus on prescription drugs.

We interviewed senior executives at five hospitals or health systems located in southern and northern California in December 2000 and January 2001. Respondents were chief financial officers, directors of finance, and directors of pharmacy. Each of the hospitals has at least 350 staffed beds and offers a significant number of outpatient services. Of the five hospitals, one was part of a larger health system; one was a free-standing, not-for-profit institution; one was an inner-city, publicly owned institution; and two were multi-hospital academic medical centers.

Hospital executives’ chief focus is on the quality of care issues that most closely affect their patients and could adversely impact public perception of the institution, such as medication errors. However, more hospitals recently have begun addressing the cost implications of prescription drugs.

In their new focus on inpatient pharmacy, hospital executives across California report four areas of concern:

1. Escalating pharmacy costs overwhelm hospital budgets.
2. Hospitals are searching for effective cost control measures.
3. Relationships with health plans and payers are impaired.
4. Patient safety is a big investment.
Escalating Pharmacy Costs Overwhelm Hospital Budgets

Acute care hospitals have always been responsible for prescription drugs dispensed to patients during an inpatient stay. Until recently, the cost of pharmacy was a relatively small supply item easily included in a per diem or other negotiated rate. In general, supply costs had a comparatively marginal impact on the cost of hospital care. However, steady growth in supply costs, driven by huge increases in prescription drug costs, has shifted hospitals’ focus squarely onto this issue.

“We’re seeing pharmacy costs increasing three to five times faster than any other supply cost,” reports the vice president and director of finance at a northern California medical center.

An Orange County health system CFO echoes the alarm: “Right now supplies represent 20 percent of our inpatient costs and nearly all of that is pharmacy!”

Such significant growth in cost is a mounting source of pain to the hospital respondents because payer reimbursement is not keeping pace. “We’re predicting a 20 percent increase in drug costs next year and only 10 percent of that will be covered—the rest is dollar-for-dollar ours,” laments the CFO of a northern California public hospital.

Adds a Los Angeles area hospital executive vice president/CFO, “Drugs are purely added cost. There is no revenue for drugs, they are nothing but overhead.”

What’s causing the increases? Hospital administrators state strongly that most rising drug costs have been driven by inflation and the development of new, highly effective drugs. Respondents, like the following CFOs, cite technology as the largest contributor to soaring pharmacy costs:

“Drivers aren’t hospital over-bedding and physician salaries, but new technologies. Technological innovations in the last five years have driven trends way up. The technology is amazing and it will get even more expensive with genetics coming down the pike.”

— CFO, Orange County health system

“Right now the trend is towards more and more costly drugs. It is so hard to measure the benefit versus the cost. A new one comes and we say ‘that’s a wow,’ and they keep coming up with those.”

— Executive vice president/CFO, Los Angeles area hospital

Respondents also criticize the pharmaceutical manufacturers for purposely driving up drug costs to increase profits. Along with other stakeholder groups, hospital executives observe that the pharmaceutical industry is benefiting from price and volume trends that are multiplying at an unprecedented rate. Respondents point to DTC advertising that raises patient expectations, consolidation in the pharmaceutical industry that limits competition, and supply strategies that drive up costs for high-demand products.

“In 20 years drug costs have increased, but never like this. I think it is really fishy that drug costs have skyrocketed since competition decreased through consolidation in the pharmaceutical industry,” suggests the vice president and director of finance at a northern California medical center.
The director of pharmacy at a Los Angeles health system is equally suspicious: “We’re seeing drug shortages that drive up costs and then miraculously reappear. Like this year’s flu vaccine. There was a reported shortage that was highly publicized, then all of a sudden there was plenty to go around but it cost twice as much.”

Respondents cite recently launched drugs for cancer and AIDS and psychotropic medications that are extremely expensive and did not exist when reimbursement rates were negotiated with health plans. They also point out that new injectables and blood products that hospitals dispense under per diem contracts quickly overwhelm hospital budgets. Often costing more than $500,000 per month, these new products exceed even hospital reinsurance or stop-loss levels.

Cost increases are not limited to these new classes of drugs. Hospitals are seeing growth in the cost of oral drugs as well. “Orals” constitute the highest volume of drugs in inpatient and outpatient settings, so the impact of this trend is felt widely across the institution. “We never had to deal with these kinds of costs on an oral tablet five years ago,” remarks a Los Angeles health system director of pharmacy. Oral medications are an area of focus for hospitals that see opportunities in group purchasing to contain costs for the most commonly used products.

Hospitals Search for Effective Cost Control Measures

The increases in pharmacy costs felt across all stakeholders in California are only now hitting hospitals, and cost control measures are just being implemented. Our respondent hospitals are starting to adopt some of the cost control strategies for pharmacy that medical groups or managed care plans have already demonstrated to be effective. While senior management hastens to point out that their first efforts focus squarely on pricing, they are also looking at controlling drug utilization.

Formulary control and clinical guidelines. One of the most powerful tools for containing pharmacy costs for managed care plans has been the tight administration of a restrictive drug formulary. Hospitals, because they have neither been able to make their formularies restrictive nor assure strict physician compliance, have been less successful in using this strategy.

Each of the hospitals we interviewed has developed a specific formulary of preferred drugs that are stocked in the inpatient pharmacy. Developing and maintaining the formulary is the responsibility of the hospital’s P&T committee. All committee decisions are clinically based and members are staff physicians. Still, most P&T committees have financial data available and some have significant finance department input. “We are really fortunate that the pharmacy area and the VP are tuned in financially,” says the CFO of an Orange County health system. “They will put in for the lowest cost drug and if all clinical issues are resolved, the doctors go along.”
Some of the respondents are implementing clinical guidelines, particularly for injectables and other really expensive drugs. Others have pathways that include drug recommendations. One of the hospitals reports implementing pre-printed order forms to facilitate compliance with the recommendations in the protocols.

Despite these measures, the enforcement described by all of the hospital managers is largely voluntary. There are no “teeth” for physicians who are not compliant with the formulary or clinical pathways. “Our P&T committee tries to contain costs,” explains the CFO at a northern California public hospital, “but they seldom say ‘no.’ The state formulary is liberal, but ours is even more liberal. If a drug is not on the state formulary but it is on ours, the doctors push us to provide it and we usually do.”

In the most aggressive hospitals, physician volunteers review orders for nonformulary or off-pathway drugs and call the ordering physician to see if that is indeed the right drug for the patient. In many cases, the prescribing physician will modify the orders; otherwise the drug is usually approved. Other hospitals may require a co-signature by another physician for approval.

“Our physicians are all independent practitioners,” explains the executive vice president/CFO of a Los Angeles area hospital. “They order what they want. The formulary is easy to override. If a physician orders something off-formulary, the pharmacy director or someone on the P&T committee might talk to them, but if they still want it, we get it for them.”

Almost across the board, the approach of the hospitals to controlling utilization and adhering to the formulary is educational. The P&T committees gather information about therapeutic value and outcomes from the literature to try and shape physician preferences. If there is a robust information system, a hospital may also use reporting tools, such as utilization or prescribing patterns, to modify behavior.

“We monitor utilization and cost using our decision-support system,” reports an Orange County health system CFO, “but it is not tied into the patient record. Our information system is good at financial reporting but it’s missing the clinical-financial marriage that would allow us to profile physician utilization.”

Some hospitals are hiring pharmacist educators to inform formulary development as well as educate doctors. That too, has run into barriers:

“We’re hiring specialized pharmacists to control costs and help the physicians understand how to use the drugs. But we can’t find the pharmacists!” declares a northern California public hospital CFO.

Purchasing power. Some hospitals are currently part of purchasing groups for pharmacy that offer price relief through the clout of large purchaser discounts—a tool previously established to control other supply costs. They have achieved savings for the most commonly prescribed drugs but not for the very expensive blood products or injectables.

Respondents report that although they have had some success in containing costs through the purchasing consortia, they anticipate bigger savings through utilization changes that they hope will occur over the longer term. “Last year we undertook a huge project to get drugs off of the formulary. The physician group was charged with getting savings. They ended up benchmarking costs through the university consortium and then joining the purchasing consortium to get some clout,” explains the vice president and director of finance at a northern California medical center.
**Relationships with Health Plans and Payers Are Impaired**

In our interviews with medical groups, respondents reported serious breaches in their relationships with health plans. Many of these rifts were driven by a feeling that they were left “holding the bag” when health plans should be sharing in the financial responsibility for increasing drug costs. The same situation is shaping up between hospitals and health plans.

Most of the hospitals have per diem, case rate, or other fixed-price contracts with their payers. These amount to risk-bearing contracts as they relate to drugs because pharmacy costs are included with other supply costs under the negotiated rate. Therefore, hospital respondents cite concerns that are very much like those of other risk-bearing stakeholders (such as medical groups and health plans). They worry about curbing the upward trend in drug cost and utilization, and see pharmacy as a major problem in their ongoing relationships with other stakeholders.

“We do not get another dime from payers to account for high pharmacy costs,” points out the vice president and director of finance at a northern California medical center. “If we try to carve specific drugs out, the managed care plans decrease the per diem [to make up the difference].”

**Perverse incentives.** Hospitals also cite specific examples where health plans’ reimbursement policies actually drive up pharmacy costs for inpatient care. One problem is with chronic medications that require clinical monitoring, such as infusions where nurses need to watch the procedure. Because of low reimbursement to physicians by payers, patients are being admitted for the treatment. These infusion drugs are extremely expensive and the hospital is responsible for the whole cost.

In another example, HCFA is pushing back on what it will pay physicians to administer oncology drugs. Hospitals report that oncology admissions are increasing as physicians admit patients rather than accept declining reimbursement. So the trend that was originally sought by managed care—a shift to lower levels of care where appropriate—is being reversed to avoid high drug charges in outpatient settings.

**Poor coordination.** Additional serious concerns focus on clinical issues in the continuity of care for patients because hospital formularies are not integrated with managed care company formularies. Each of the hospitals has its own formulary that reflects the needs and preferences of its physicians. In creating the formulary, the physicians do not consider the formularies of the managed care companies or other payers (Medi-Cal has its own formulary as well). A different group of pharmaceutical company sales staff (“drug reps”) focus exclusively on institutional providers.

The result is a lack of coordination that, at worst, can seriously compromise patient health and, at best, confuse and annoy the patient. The most common scenario occurs when the patient is started on one drug in the hospital and then goes home to discover the drug is not on their managed care organization’s formulary. They either have to change drugs in mid-treatment or seek a plan override.

The same situation can occur in reverse at the time of admission, as described by this director of pharmacy at a Los Angeles health system: “This is our number one dilemma. Patients are admitted for surgery who are on a whole host of chronic meds. Then you find out two of the six drugs aren’t on our formulary so we don’t have them in stock. The patient won’t change drugs because of their insurance, so you send a family member home to get the patient’s supply. The hospital looks foolish, patient satisfaction is affected, and the potential for drug errors increases.”

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Patient Safety Is a Big Investment

Each of the respondent hospitals is in the process of undertaking a strategic effort to assure the safety of patients in the distribution and dosing of prescription drugs. Hospitals are making significant investments to eliminate medication errors through better prescribing tools and delivery systems.

While these institutions report that they have not experienced a catastrophic medication error, they are reacting to the possibility of a potential error—particularly in light of the high level of public scrutiny that has followed the Institute of Medicine’s widely publicized 1999 report on medication errors.

Interventions to reduce medication errors range from low-tech, such as mandating that physicians print instead of write all orders, to high-tech bedside devices and automated dispensing to be implemented over the next several years.

“This is an area of investment for us. We are implementing an automated distribution system. We have paper systems now, but we are bringing up a physician order entry system that will enable our doctors to order drugs online,” says the vice president and director of finance of a northern California medical center.

“What’s Coming?”

Hospital respondents are pessimistic about solutions to the problems associated with prescription drugs. They predict that pharmacy costs will continue to increase as new drugs are developed that are both highly effective and extremely expensive. The majority of respondents see developments in two areas: technology and government involvement.

Drug and information technology. Technology, a major contributor to cost increases at hospitals over the recent past, will continue to drive up drug-related costs in the future, respondents predict. For these hospital administrators, technology includes the development of new generations of pharmaceutical agents as well as new distribution and information systems that continue to evolve.
Developments in next-generation drugs, such as those that have recently been introduced, are sure to continue. In addition, advances in genetics will result in even more expensive clinical agents. More and more of these new agents require a higher level of medical monitoring than can be achieved outside the hospital. Therefore, respondents anticipate an increase in both inpatient and outpatient utilization of new pharmacological products.

Hospital management predicts that investments in information technology will continue to stress budgets for the foreseeable future. For prescription drugs, investments will center around systems to control medication errors and improve coordination of care for patients, such as integrated/electronic medical records, hand-held or bedside ordering tools, and robotic dispensing. While these solutions have been discussed in the past, the growing financial role of prescriptions in the overall clinical picture may accelerate their adoption by hospitals.

Hospitals are also investing in information systems to help them understand the utilization trends that contribute to cost increases. Lack of information is a major problem for many of the institutions, who currently have no integrated medical record and little ability to gather information on outcomes to give back to doctors.

Respondents see integrated patient utilization and cost information as a key component of drug utilization control. These data will be applied to development of more sophisticated formularies and allow for more aggressive adherence to protocols and pathways. Decision-support and reporting systems are improving and will soon replace existing manual or paper systems. External data about drug effectiveness and clinical outcomes will be necessary, and will be integral to P&T committee activities. Respondents predict that contemporary data will be more accessible to decision makers as electronic medical records and other real-time information sources become more commonplace.

More government involvement. Hospital executives see no clear solution to the problem of escalating prescription drug costs. Quite pessimistic about the potential for market forces to curb increases in cost or to provide relief to their institutions, these executives exemplify a common outlook: They reluctantly predict that government intervention is unavoidable and, at the same time, unlikely to result in any significant assistance to hospitals.

“I don’t see relief on the hospital side, but I see the government getting involved. There will be a government plan for prescription drug coverage for Medicare. They want to control it because of the size of the program.”

– Executive vice president/CFO, Los Angeles area hospital

“The state program cost a lot of money. They are going to have to sacrifice programs to offset inflation so they will become more strict with their formulary out of necessity.”

– CFO, northern California public hospital

“If something doesn’t happen, there is going to be rationing. All we can do is keep actively lobbying and pointing out the problem.”

– Vice president and director of finance, northern California medical center
IV. Health Plans and Other Insurers

“Pharmacy costs make me nervous. We need some speed bumps on this pharmacy benefit highway.”
– Clinical pharmacist, northern California health plan

Health plan respondents approached our interview topics, including the rise in prescription drug costs, with caution. Looking back at the past few years, they say they have been battered by price wars. There is universal concern that an active legislature and aggressive regulators are challenging their industry’s reputation. They argue that they were caught in a cycle of change marked by unrealistically low premiums and heavy consolidation of plans and medical groups. The health plan premium is only now beginning to rise again in California, after years of highly competitive pricing.

Plans speak about the need to re-establish a partnership with medical groups to regain control over drug benefits. They describe the need for financial arrangements with pharmaceutical companies to subsidize pharmacy benefit administration. They also predict that the next wave of health care purchasing will be driven by “quality of care”—with disease management and prescription drug coverage a centerpiece of all new efforts.

We met with representatives—four physicians and two clinical pharmacists—from six health plans and traditional insurers. Much has been written about the evolution of health plans in California, and the amount of consolidation that has taken place in the past five years. Our sample reflects these changes. Two health plans are national organizations, two plans cover the entire state of California, and two plans are available only in a region of the state (one northern California, one southern California). At the time of the interviews, plans offered both commercial and Medicare risk products.

We heard about four areas of concern in the discussions with physicians and pharmacists in health plans across California:

1. Rising drug costs have created a crisis for health plans.
2. Health plans are taking back financial risk for prescription drugs.
3. Plans face significant obstacles to pharmacy management.
4. Relationships with medical groups and employers are worrisome.
Rising Drug Costs
Create a Crisis for Health Plans

Health plan respondents report that prescription drugs are critical to their organizational strategy. Pharmacy, its impact and cost, is an issue of very high visibility. All of the stakeholders—employers, members, physicians, and pharmaceutical firms—clamor for favorable treatment in the pharmacy area.

To create differentiation in the highly competitive California health care market, health plans and insurers have mounted a campaign for improved quality of medical care that centers partly on disease management. For the vast majority of conditions being treated in ambulatory care settings, disease management is driven by pharmaceutical intervention. When pharmacy costs spike unexpectedly, the underlying disease management strategy is threatened. On this issue, health plans align with employers and members: Prescription drugs must be accessible and affordable for health care delivery to function efficiently in California’s managed care system.

Cost pressures. Like other stakeholders, health plans see rising prescription drug costs as a crisis for their business. As the following statements attest, plans are concerned about curbing the upward trend in cost and utilization:

“Pharmacy is very high on our radar screen. We lost the most in this area last year—the highest percentage over budget. We’re projecting a 20 percent trend in this part of our premium, unless we can gain better control over it.”

– Chief medical officer,
northern California health plan

“We are in ‘survival mode.’ Everybody’s losing money on drugs. We know the market will win in the end, and we are supporting good economic behavior. It is just a question of who will survive long enough to get there.”

– Medical director,
southern California health plan

The senior risk. Until this year, almost every plan in California offered a senior “risk” product. Because of the penetration of Medicare risk plans, our respondents spoke at length about the importance of Medicare enrollees’ pharmacy experience. Compared to commercial plan members, the pharmacy premium is often three times higher for Medicare enrollees. So the senior population’s use of prescription drugs is of great concern.

“With Medicare risk, members need much more education,” explains a southern California health plan medical director. “Our job has been to deliver access to members, and to help with education. The physicians needed to convince the member to follow their advice, but there isn’t the same bond between the member and doctor. No. So the process didn’t control cost, it didn’t work! Now everybody is going to pay the price for ‘candyland’!”

Health Plans Take Back Financial Risk for Prescription Drugs

For a period in the 1990s, California health plans relinquished some or all financial risk for pharmacy to the medical groups. Medical groups eventually found themselves in the red for pharmacy costs, and began negotiating to return the pharmacy risk to the health plans. This transformation has taken two or three years to complete, but health plans are once more in the position of holding the lion’s share of the financial risk for prescription drugs.
Back to the future. The health plans have moved, in some cases reluctantly, to negotiate arrangements of shared risk for pharmacy. In our interviews, the most commonly described risk arrangement for pharmacy, negotiated separately from all other medical care risk, is 50 percent shared risk with very limited downside risk (typically, a maximum of 10 percent exposure when the medical group exceeds expected costs). These contracts also have a variety of incentives for upside risk (such as equal sharing in the pharmacy budget surplus at the end of the contract year).

Some health plan respondents view the taking back of risk as a precursor to a return to the traditional full-insurance model. Pharmacy coverage for an insurance plan or health plan would be offered as a separate rider and would be fully insured. Says a medical director at a southern California health plan: “The model cannot last, it is going to change. We believed in the delegated model, thought that it would lead to tighter controls on pharmacy cost. Instead, we got ‘fee-for-service’ models. We will end up going all the way back to large pool, indemnity-type coverage for pharmacy.”

The majority of our respondents also have a third-party pharmacy benefits management (PBM) partner involved in the day-to-day administration of utilization management and pre-authorization programs. The PBM firm also pays claims and reports on the prescription drug purchasing programs for rebate management with pharmaceutical firms.

Regulation and legislation. A major stumbling block, say health plan respondents, is the escalating interest of California regulators in pharmacy coverage and consumer satisfaction. Health plans see regulators—the Department of Corporations, and its newest incarnation, the Department of Managed Health Care—as “misguided” and adding to the administrative burden they face. “Regulators in California have good intentions,” remarks a northern California health plan clinical pharmacist. “But the results are difficult for the MCO to implement.”

Legislative involvement is even more of a concern, since respondents, like these two medical directors, view legislators as having inadequate information and basing decisions on political, not clinical, judgments:

“Managed care is the legislators’ number one issue. There is continued legislative furor around drug benefits, strictly for political reasons. Unfortunately, the headlines detract from the real message—that the cost of drug coverage is making prescriptions unavailable to many people.”
– CMO, northern California health plan

“Decisions about pharmacy coverage are being made on the legislative floor—bills are being introduced that are built off of a single case! It’s pitiful.”
– Medical director, southern California health plan

Plans Face Significant Obstacles to Pharmacy Management

When it comes to pharmacy benefit management, health plans say that they will continue to drive behavior change through active investment in educational and data-related activities directed at medical groups and consumers. Since most plans believe that quality will become the next differentiator among the health plans, they will support good prescription drug access and cost management through data, physician education, relationships with pharmaceutical manufacturers, research, and ongoing development of disease state management standards.
Working with pharmaceutical firms. Arrangements with pharmaceutical firms for volume discounts (rebates) have become integral to cost management for health plans. There appears to be no waning of commitment to this economic lever for health plans: “Contracting with the manufacturers is essential to avoid huge premium increases,” explains a clinical pharmacy director at a northern California health plan. “We contract for volume discounts with the lowest AWP [average wholesale price] products in a class. And this is one way of lowering manufacturer costs.”

Adds a medical director of a southern California health plan: “The whole system is driven by politics and marketing! Physicians resent that their autonomy is being taken away—but rebate arrangements are part of the way we can support an affordable pharmacy benefit.”

Health plans view contractual formularies (influenced by clinical choices and economic deals with pharmaceutical firms) as essential to financial survival. The tools they use include closed formularies and tiered benefits. They combine these with pre-authorizations for many high-priced, nonpreferred drugs.

On the other hand, health plans are not thrilled with manufacturer behavior on two other fronts. First, they detest direct-to-consumer advertising as heartily as do the physicians. Health plans go beyond that, though, and object to the pharmaceutical firms’ marketing to the providers. They see the pharmaceutical sales reps as “buying the doctor with cups and trips,” reports one medical director in southern California.

“Pharmaceutical firms have far more power, control, than they should have,” contends a senior executive medical director at a northern California health plan. “The pharmaceutical industry is going to regret their heavy-handed approach when the federal government gets involved (over Medicare drug benefits).”

On balance, respondents in health plans view the pharmaceutical industry as critical to the development of breakthrough therapeutics and argue that some of the new drugs being launched are real clinical stars. They want to center the discussion of pharmacy costs on the question of “Who pays?” as opposed to blaming the developers and marketers of drugs for the cost crisis.

Returning to the status quo. When they originally delegated drug risk to medical groups, most health plans had turned their administrative resources to other priorities. While they actively maintained pharmacy consultation services and continued to make formulary management decisions through the P&T committee structure, any duplicative administrative oversight activities were dismantled. Now health plans are faced with the need to reconstruct basic processes for pharmacy management—a range of activities that have been performed by the medical groups for several years. Plans have far smaller budgets this time around—so they may have trouble taking on this task, and many will use third-party PBMs to maintain pharmacy benefits management. Respondents express little confidence that this return to the status quo will bring relief:

“We’ll lose some of the progress we’ve made. I see providers opting for the easy way out. The easiest way is to reach into the sample closet.”

– CMO, northern California health plan

“Now that we are retaining drug risk, we are having a problem finding upside incentives that work for physicians. Without these, the providers will have no skin in the game. They won’t notice pharmacy costs.”

– Medical director, southern California health plan

“We’re giving the groups data. If they’re not at risk, will they use it? Remember, the M.D. controls what is prescribed. He has the influence.”

– Director of pharmacy services, northern California health plan
Relations with Medical Groups and Employers Are Worrisome

Physicians as partners—“us vs. them”? When it comes to pharmacy benefits management, medical group respondents are suspicious about health plan motives. Plan respondents, in contrast, are somewhat more reluctant to criticize medical groups or physicians.

Tensions are running high, and pharmacy is right at the top of the list of sources of dissen- sion. Plan respondents report that pharmacy budget overruns have made contract discussions highly contentious this year. The overruns are a function of price and volume increases, com- pounded by the medical group experience with “injectables” and their unanticipated impact on medical premium.

The result is a major rift between health plans and medical groups across the state. “Physicians want out of this end-game,” says a northern California health plan director of pharmacy. “There is a groundswell out there—maybe you can’t see or hear it, but if you talk to the doctors you know it is happening. There is more professional antagonism between the health plans and physicians than ever before.”

Health plans, forced to retain pharmacy risk in the most recent contract cycles, now find themselves liable for the expense of pharmacy, while medical groups and individual prescribing physicians influence the behavior of members. The situation does not lend itself to harmonious partnerships:

“In our market, everyone is in conflict—physicians, payers, hospitals, ancillary providers, and retail pharmacies—each plays a role in pharmacy and each wants ultimate control. The only good thing is that everyone is aware of the problem and talking about it. Still, there is no trust relationship.”

— Medical director, southern California health plan

“Working together is a problem. Unfortunately, this is not going to be easy to solve. That’s because the MCOs are cutting cost at the expense of the providers—which is like shooting ourselves in the foot, because the provider is our key link to consumers.”

— CMO, northern California health plan

Expectations for physician compliance with phar- macy management are mixed. Plans echo the concern of medical groups that these two stake- holder groups have conflicting goals. Interviewees describe their difficulty finding a common ground for moving forward. Now that they have drug risk again, they worry that they are just replacing yet another layer of bureaucracy, but will have little impact on physician day-to-day behavior when it comes to pharmacy benefits:

“Providers are so busy with everyday stuff, it’s hard for them to see beyond 5:00 P.M.—much less collaborate with us on a drug management program.”

— Medical director, northern California health plan

“Physicians in California are just like doctors everyday. They have the same dreams and weaknesses of providers any other place. They are just doctors in sunny locations. The only difference for them is that the premiums here are higher, and the reimbursement far lower, compared to anywhere else.”

— Medical director, health plan, southern California

“It’s hard to fault prescribers (I used to be one!)—but, doctors just aren’t as honorable...”

— Medical director, health plan, southern California

Relations with employers strained. Pharmacy is the single largest driver of premium increases with employers in California. It worries employers and is driving a wedge between plans and their customers.
Part of the issue is increased use of existing drugs; part is the proliferation of new, high-priced drugs. Some of these are lifestyle drugs, which are sources of frustration for both plans and employers. According to a northern California health plan director of pharmacy services, “Three-tier benefit designs help with ‘lifestyle drugs,’ but in the long run the only way we’re going to deal with these is as an industry. We need to decide what ‘lifestyle’ is and create coverage that is consistent across plans.”

Without reservation, our respondents see employers as having realized the benefits of California’s highly competitive managed care market in the 1990s. When it comes to rising costs of pharmacy coverage, they report that employers want to contain rising employee expectations without any loss of employee satisfaction or goodwill.

Health plans see drug benefits management as a no-win scenario, since rising prescription drug costs require tighter adherence to formulary, benefits, and utilization management compliance. Tightening up controls will inevitably lead to more employee prescription denials and more conversations with physicians about prescriptions.

Rather than added policing of formularies, health plans promote benefit designs that shift responsibility to employees/members. With the exception of Kaiser Permanente, health plans report more friction with employers over how to best stem rising drug costs. Our respondents are intent upon moving employers to three-tier benefit plans, more general use of NDC (National Drug Code) blocks at the retail pharmacy, and more coverage exclusions for lifestyle drugs.

Reacting to disappointment over pharmacy premiums, employers and their consultants appear to be moving toward third-party carve-outs and greater reliance on group purchasing solutions outside of the health plan arrangement.

Clearly plans and employers are not writing from the same page. “Our large employers want more, not less!” says the medical director of a northern California health plan. “Today, they are excited about electronic linkages to the medical groups, and are demanding more of health plans in this area.”

The medical director of a southern California health plan characterizes the relationship like this: “How have things changed? Look at the response of employers or members to us. When you ask employers or members to speak on behalf of the health plan—their health plan—the answer is ‘No!'”
Kaiser Permanente: A More Seamless Approach to Prescription Drug Cost Increases

Kaiser Permanente is not plagued by some of the same cost and quality trade-offs facing health plans and groups that have contracted to work together. So say interviewees from both Kaiser Permanente and the employers who contract with them. An organization that combines health plan, medical group, and hospital in one entity, Kaiser Permanente is one of the oldest staff-model HMOs in the country (although in recent years it has extended its delivery model to include contracted physicians and institutions).

What makes the difference? For one thing, since physicians work directly for Kaiser Permanente Medical Group (KPMG), it has more than 95 percent compliance with its prescription drug policies: “The physicians set the policies, evaluate all new drugs, and determine what our preferences will be in delivering the highest quality drug therapies,” reports a senior physician on Kaiser’s P&T Committee.

Kaiser’s unique health care delivery model also appears to help spark the impetus to action on quality-of-care measurement. One employer respondent argues that only Kaiser delivers the kind of information needed to fully assess the value of adopting new drugs as they become available: “No one wants to delay adoption of new drugs because they are expensive, not if they will make dramatic difference in the healthy recovery of a patient. But without data and the ability to weigh the trade-offs, too often the decisions are based on the cost of the old drug compared to the new one.”

Employers claim that Kaiser is consistent and applies a standard protocol for evaluating and adopting newly available drugs—even when they are pricier than their older predecessors.

Kaiser also collaborates on outcomes studies with key customers. A benefits manager in northern California notes that “Kaiser does what’s good for them, and good for us. We have a ‘best practices’ project going on. Physician pharmacy ordering is reviewed against Kaiser benchmarks for best practice. Everybody wins. We get improved prescription drug ordering; Kaiser brings their docs up to speed on drug practice using technology to give immediate feedback on quality and to keep it all very current.”

Another northern California employer points out that Kaiser is willing to be tested against a quality standard: “Kaiser is working with large employers to standardize a quality rating that would be used to pay ‘extra credit’ for performance at the end of a contract year.”

Distinguishing characteristics in drug management

In the course of the study, the distinctions in the Kaiser Permanente Medical Group’s pharmacy management model crystallized. There was clear evidence that organizational structure enabled executive policy makers to strongly influence prescribing behavior across medical sites. Through the formulary review process, with active participation by local and regional physician leaders, medical policies related to drug utilization and quality control were effectively adopted and broadly followed. Physicians are employed by Kaiser Permanente Medical Group, and while they are free to use their best medical judgment, their continued exposure to company guidelines and best practice explain the extent of uniformity in prescribing and compliance with P&T Committee policies. We found many examples of this during our interviews:

- Physician leaders conduct on-site medication educational forums.
- KPMG physicians in specialty areas are regularly shown evidence-based data on the effectiveness of specific drugs.
- Physicians at all sites are restricted in their ability to receive special treatment from pharmaceutical sales representatives.
- KPMG distributes physician and site-specific reports on prescribing patterns and compliance with Kaiser P&T standards.
Bringing it together to benefit members

These efforts at impacting physician ordering behavior are coupled with the fact that Kaiser Permanente benefit coverage requires members to fill their prescriptions at Kaiser pharmacies (located at most large medical group sites). The immediate economic effect of Kaiser’s rigorously managed pharmacy program is that Kaiser’s negotiations with pharmaceutical firms— for volume-based discounts or “rebates”—are strengthened by its ability to deliver on commitments to use preferred drugs. Kaiser’s formulary does not contain every possible medication in a therapeutic class. On the contrary, the P&T Committee works arduously to identify and support the use of the drug that is most efficacious, that is clinically as effective as others, but also economical. When volume discounts are calculated, this means that some high-priced drugs demonstrated to be clinically superior become affordable when negotiations assume preferred use across all of Kaiser’s enrolled members.

The unmatched levels of prescribing compliance at KPMG are created by the organizational integration of the health plan, the medical group, and Kaiser’s network of provider facilities. Kaiser’s is the exemplar of the staff-model HMO, in which each of the individual parts works to optimize the economics and clinical effectiveness of the others. In the case of pharmacy management, Kaiser’s commitment to superior clinical outcomes, at the lowest appropriate cost, gives it a unique position among California’s health care delivery system.

What Does the Future Hold?

There are no universal predictions among health plan respondents about the trends or tools for prescription drug management in the future. Health plans recognize the need for partnerships to craft responses, although they doubt such partnerships could be easily formed or would be stable enough to create change. Many health plan predictions center around technology, consumers, and government intervention.

Information and technology essential to health plan success. In the future, respondents say, clinical information will be used to build data reporting consistency across plans. Real-time information will drive disease management strategies with incentives based on the use of current prescription drug data. Health plans will collaborate on raising the standard for quality and completeness of pharmacy data. These respondents voice their hopes and concerns about future technology and collaboration:

“We [providers and health plans] need to work together to plan for costs, risk, or incentive structures that ensure appropriate utilization. We need to get to electronic prescribing.”
– Clinical pharmacy director, northern California health plan

“We see efforts like CALINX—California Links for Quality—as the next big change in information quality and availability. The major stakeholders all participate and it is a joint effort mounted to create consistency and standardization. In pharmaceuticals, we are working on standardizing claims data transmissions from the plans to the medical groups (so they see their experience across all plans and members).”
– Director of pharmacy services, northern California health plan
“We need to partner with employers in order to get information into the hands of members, at the work site.”
— CMO, health plan, northern California

“In the future, we believe that quality will drive purchase decisions for buyers of health plan products. Our concern is the availability of data on benefits, service, and outcomes. Who will monitor in the future? That’s one of the big questions.”
— Senior executive medical director, northern California health plan

Greater consumer choice with accountability. Managed care accomplished revolutionary changes in California health care. Unfortunately, it also raised consumer expectations about the “right” to prescription drugs. Since consumers are shielded, to a large extent, from the retail price for their drugs, they may not be prudent users of their drug benefit. In the future, health plan respondents foresee the continued expansion of tiered-benefit designs for pharmacy that will encourage members to recognize and feel the cost of drug choices.

As one northern California health plan CMO suggests: “The three-tier benefit is helping a lot, even if it isn’t solving the whole problem. It does control cost, and it makes constituencies better consumers! Using this model, if members want more, they will need to pay more, to bear more of the cost for their personal preference. It is sort of ‘the Lexus vs. the Toyota’ idea.”

More government involvement. In California, health plans have a fairly dark view of the immediate future for pharmacy benefits. Part of the pessimism stems from concern about legislative intervention. They believe that government tinkering with drug benefits will complicate the cost picture and add to the tensions between physicians and health plans. Unfunded drug benefit mandates are a concern, particularly given the low level of collaboration among stakeholders today.

“Unfunded mandates for coverage are going to challenge us all. It is worrisome, when you look at the notion that legislators can continue to define what is ‘medical care’ and what belongs in an insurance pool.”
— Senior executive medical director, northern California health plan

“Pharmacy cost increases will slow down, because new drugs will be redundant—more and more ‘me too drugs’—and government will intervene with everything from price controls to mandated benefit designs.”
— Clinical pharmacist, health plan, northern California

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EMPLOYERS IN CALIFORNIA HAVE BEEN HIT with double-digit cost increases in providing coverage for prescription drugs for their employees. Employers report that prescription drug costs are being discussed at the highest level of management at their companies. They are unwilling to continue to absorb the increased costs and are looking at a variety of incremental changes to contain the costs to their organizations without decreasing the levels of coverage provided to their employees and covered dependents. They are also considering more dramatic changes over the next several years that challenge the status quo, address the needs they foresee in the future, and capitalize on the technological developments that will enable innovation.

To understand the impact of rising prescription drug costs on California employers, we spoke with individuals representing five major plan sponsors or purchasing cooperatives across the state. These employers represent a full spectrum of philosophies and approaches to providing benefits in a full-employment environment where they balance the need to attract and retain employees with skyrocketing prescription drug costs.

Four themes emerged from the discussions with employers, plan sponsors, and purchasing groups across California:

1. Employers are ready for major change.
2. Prescription drug benefits are critical to attracting and retaining employees.
3. Relations with other stakeholders are adversarial.
4. Employers are enacting incremental changes in benefit coverage.

“There are big, big changes in benefit design coming.”

– Benefits manager, northern California employer
Employers Are Ready for Major Change

With prescription drugs representing more than 15 percent of benefit expense and increasing at 12 percent to 15 percent per year, this benefit is an immediate focus of benefit managers and senior management at employers in California. In the past, employers have taken a hands-off approach to prescription benefits management. For the most part, they paid the premium and expected the health plans or prescription benefits managers to contain utilization and costs. As utilization increased, employers increased pressure on health plans and PBMs to “take care of the problem.”

Unfortunately, carve-outs not only did not contain costs as anticipated but actually contributed to increasing utilization because they double-buffered employees from costs. Consumers were completely unaware of the impact of their purchasing decisions on the true cost of prescription drug insurance.

Further, PBM incentives were not necessarily aligned with purchaser incentives. For example, new drugs, though expensive for the PBM, may contribute to an earlier return to work—a benefit to the employer but not to the PBM.

The most profound effect of the rise in prescription drug benefit costs is a new willingness among purchasers to assume an active role in cost control. In contrast to medical groups and health plans, employers see themselves as the likeliest drivers of change in the future. They report that they cannot keep absorbing cost increases at the current levels and envision a crisis in funding for prescription drugs that will precipitate major changes in the way prescription drug benefits are administered and financed.

Over the near term, purchasers will continue to make incremental changes but, as one northern California employer puts it, “We’re getting to the point where there’s not much more we can do.”

“\[This upward trend in pharmacy costs represents an unbearable increase to our company,\]” laments another northern California manager. “\[We can’t let it go on indefinitely. For one thing, I don’t think we have the stomach to cut employee choices—but we will look at it. For another, pharmacy adds to a growing liability in our retiree health plan. Our balance sheet can’t take it!\]”

Purchasers are not sure what major changes are coming, but they are preparing for government intervention and/or benefits restructuring. “Restrictions are coming. The pressure is building. In three plus years it’s going to blow! I see it heating up,” exclaims a medical benefits manager for a northern California employer.

Although forward-thinking purchasers welcome a transformation, they believe the current situation, with incremental changes and Band-Aid solutions, will only delay the necessary revolution. “A few years ago, medical costs were spiraling out of control,” reflects the director of insurance services at a northern California purchasing group. “The specter of the Clinton health plan slowed things down for three to five years, but now the effect has worn off and the scare is gone so the speed is picking up. I just wonder if that’s going to have to happen with drugs to get the dramatic kinds of change that needs to happen.”

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Prescription Drug Benefits Are Critical to Attracting and Retaining Employees

Unemployment, at record lows nationally, is particularly low in California with its thriving economy in both old and new economy industries. Competition for employees is fierce, especially in the hot Silicon Valley area. Salaries are high and fringe benefits have become key differentiators in the attraction and retention of qualified staff. As companies re-evaluate and reconstitute their benefit programs, they find it unthinkable to take drugs out of benefit, regardless of the cost:

“Our position is that we are going to continue to offer the most liberal plan possible for as long as possible.”

– Benefits manager, northern California employer

To enable plans to continue at current levels, many companies are subsidizing programs heavily. Others are looking at cost redistribution. For example, some employers are redirecting the focus of their benefits back to their active employees by reducing retiree coverage for prescription drugs.

At the same time, employers are promoting their programs by providing information to employees about the cost to the corporation of the prescription drug benefit. They have asked suppliers to provide reports, either at the point of sale or in summary, detailing the actual price of the drug, the cost to the employee, and the cost to the plan sponsor. Employers are hoping this information will have two outcomes: (1) to remind employees about the richness of the benefit plan, and (2) to increase employees’ understanding of the cost of the drugs so they become better consumers and decision makers.

Continuous review of health benefit programs to see how they compare to competitor businesses is the norm. In the tight labor market, many employers are reluctant to upset workers with bad news about medical benefits. Instead, purchasers target cost management efforts at trouble spots, which may include prescription drugs. Savvy employers survey employees and families for trade-offs among benefit provisions.

Relations with Other Stakeholders Are Adversarial

The purchasers we interviewed expressed frustration with all of the stakeholders for their contributions to high drug costs. Perhaps the most blame is focused on pharmaceutical companies. Employers blame direct-to-consumer advertising for driving up demand and decreasing employee satisfaction. As consumer preferences, influenced by advertising, conflict directly with the cost controls implemented by employers, human resource and benefits managers are seeing an increasing number of complaints and requests for overrides. Moreover, they are disgusted with the amount of money they perceive as going for advertising instead of reducing the cost of drugs.

Purchasers are also out of patience with health plans. Employers look to the plans to either control prescription drugs costs or demonstrate medical offset achieved through increased use of new drugs. Purchasers expect increased premiums to buy them increased quality of care.

This medical benefits manager for a northern California employer doesn’t mince words: “Where is the value in our health plans? What value are we getting for our purchasing dollar? Health care hasn’t improved quality at all (even minutely) in the last five years. Now rates are going back up. We are not getting our money’s worth at all.”
In addition, purchasers have seen health plans cost-shift to provider groups rather than assume responsibility for controlling costs of prescription drugs. One plan sponsor in southern California said that HMOs were “not managed care, just managed dollars.” Purchasers are angry because health plans are not acting like businesses—they are shifting costs rather than reducing costs.

Purchasers also feel that some level of responsibility for runaway costs belongs to medical groups. They had high expectations that medical groups would improve quality of care. Instead, they saw physicians reacting to risk-bearing contracts by compromising the quality of the interaction with their employees as the cost of prescription drugs continued to soar. According to the medical director for a large purchasing group, purchasers have “no empathy for doctors” because “they are not good business people.”

One benefits manager in northern California says, “Doctors are a problem—plans pushed risk to providers, but they’re going broke so they are blaming the health plans in the newspapers.”

Purchasers are concerned about the best way to manage doctors in going back to a fee-for-service system. They are already beginning to see physicians attempting to circumvent cost controls and seek plan limit overrides by telling the patient to “see if you can get this” from the human resource department.

The plan sponsors recognize that adversarial relationships among stakeholders are a serious barrier to the kinds of changes that need to happen. One benefits manager for a large northern California firm describes the situation as dire: “We’re at a stage now where stakeholders have never been more at odds—more ready to cut their own arm off to get the other guy, not just their own nose! Worst I’ve seen in 20 years of California health care.”

**Employers Enact Incremental Changes in Benefit Coverage**

Purchasers faced with exponentially rising prescription drug benefit costs can implement a variety of cost-savings techniques. Proven effective interventions include benefit design changes, tiered copayments, restrictive formularies, retail pharmacy interventions/education, outsourcing risk to PBMs, Internet education, mail order, and disease management. In addition, employers can require health plans to implement coverage restrictions or other cost control mechanisms, such as shared financial incentives with medical groups. However, the issues of attraction and retention significantly hamstring employers attempting to introduce restrictive benefit design schemes or provisions.

As employers experiment, we see specific interventions introduced at some companies at the same time they are being discarded at other companies. The incremental changes discussed below are in place or under consideration at large employers in California.

**Cost sharing.** Employees are being asked to assume more of the cost of their prescription drug benefit. Many benefit designs incorporate large percentage increases in out-of-pocket costs for prescription drugs. In other cost sharing mechanisms, employers are rethinking the methodology they use for calculating the premium cost sharing for employees. Some employers are switching to a “defined contribution” financing methodology in which they contribute a set dollar amount (usually pegged at a percentage of the lowest cost plan offered) and ask employees to pay the difference to get the plan they want.
Benefit limits. Employers are building in financial incentives to use generics or plan formulary through a multi-tier copayment. Most often discussed was a three-tier copayment strategy in which the patient pays a low copayment (such as $5) for a generic drug, a slightly higher copayment (such as $10) for a nongeneric formulary drug, and much higher copayment (such as $25 or $50) for nonformulary prescriptions. Employers have also incorporated limits or excluded coverage for certain new prescription drugs or lifestyle drugs. One employer recently incorporated a plan with mandated mail-order refills required after the second refill (otherwise the enrollee has to pay cash), no physician override for generics, prior authorization for "dispense as written," and a requirement that the enrollee pay the difference for brand-name drugs if generics are available.

Employee consumerism. Employers are trying to educate their employees about the costs of prescription drugs. One human resources manager noted that her role has changed; it is now her responsibility to educate consumers. Employers sponsor health Web sites specifically targeted at employees. Employees and their families are able to access these Web sites through intranet systems at work or at home. Most employers try to send clear messages with incentives aligned to their benefit provisions. "Our goal in transitioning to a three-tier benefit in 2000 is to try to change behavior, not cost-shift. We want to make the employee a better purchaser," maintains a health and welfare plans manager for a northern California employer.

Carve-out programs. Prescription benefits managers have been an important piece of the prescription drug puzzle for a long time. They typically perform an administrative function as well as a drug management function through drug utilization review, formulary management, and rebate management. Many employers do not contract directly with a PBM; instead they rely on the PBM used by the managed care plans they offer. As drug costs continue to rise, however, employers are re-evaluating these relationships. Some employers are taking the benefit away from the health plans and carving out prescription drug coverage to their own PBM. They see two benefits to this strategy. First, it evens out the coverage when plans are putting in different limits and different formularies. Second, it enables them to work closely with the PBM to achieve higher levels of performance than have previously been demonstrated. One way PBMs are being asked to improve performance is through use of technology. Information systems and hand-held devices increase efficiency and cut costs. As one purchaser put it: "People who pay money put a premium on economy and process improvement." PBMs are also being asked to provide physician feedback on utilization and cost, and to perform a "counter-detailing" function for medical groups and patients to combat the effects of direct-to-consumer advertising.

Feeling less confident that the traditional cost-cutting measures will continue to provide the level of relief they need, purchasers are looking to other stakeholders to come up with new interventions that will keep the situation in check, but they are also meeting together to develop solutions and learn from one another.

"Hopefully, we can keep pulling rabbits out of hats," muses the insurance services director of a northern California purchasing group.
The Key to the Future Lies in Innovation

As traditional interventions fail or achieve less than satisfactory results, purchasers are expecting major changes to the way prescription drugs are covered and financed. The desperation they feel is driving some real innovative thinking. The medical director of a purchasing cooperative told us, “Good things are possible through destruction.”

Purchasers predict new solutions will take advantage of technology and consumerism and will feature quality as a keystone. They may grow out of existing models or be developed de novo, driven by the threat of government intervention or by truly “outside the box” thinking in response to market conditions.

Big, big changes in benefit design. Purchasers anticipate major changes in the design of prescription drug benefits that take advantage of the rise in consumerism as well as the growth of technology. Says a benefits manager for a northern California employer: “There are big, big changes in benefit design coming. [Current designs don’t] take into account any of the impact of the Internet—information, ordering, distribution, marketing, education.”

Purchasers have focused on educating their employees about the costs of prescription drugs, increasing their sensitivity to price by enforcing tiered copayments. At the same time, more and better information is becoming available about the relative value of different drugs or treatments. At some point not far away, consumers will be able to evaluate their willingness to pay against the effectiveness of a particular drug, opening the door to new benefit designs. As the information on the relative value of different therapies in a class become quantified, we could start seeing continuously variable copayments, rather than an artificially contrived three-tier limit. Alternatively, a “consumer value plan” could emerge where whichever drug is most cost-effective gets covered for a given condition.

Cancel the middleman. Purchasers are increasingly frustrated with their health plans, beyond the costs of prescription drugs. One option that is surfacing for consideration is direct contracting with providers by employers, essentially cutting out the health plan. How this would work is yet to be defined. It could reintroduce drug risk for physician groups or be combined with one of the information-based benefit options and administered by a PBM. Another option would be the introduction of an insurance rider for pharmacy coverage. With this approach, employees would decide whether to buy pharmacy coverage separately.

Governmental action. Under current U.S. law, American companies are banned from importing pharmaceuticals. However, given the fact that the price for a drug in the United States is often twice as high as the price for the same drug in another country, foreign purchasing has emerged as a means for achieving some savings on prescription drugs. Foreign purchasing could include international mail order or managed prescription tourism. Some employers we interviewed are anticipating legislative reforms that will permit importing of drugs for distribution to American employees.

Other legislation being discussed would cancel some of the dramatic inconsistencies in drug pricing between the United States and other countries. For example, the government could mandate price controls based on drug prices in other countries.

Purchasers also see the potential for federal or state government intervention to control prescription pricing trends. They believe legislation should focus on the pharmaceutical industry, which, between rebates, direct-to-consumer advertising, giving samples to providers, and greed, they see as a root cause of cost increases. Legislation could come in the form of price controls or in elimination of rebates.
This medical benefits manager at a northern California employer doesn’t beat around the bush: “We need to throw the gauntlet down at the pharmaceutical industry or else—direct price controls. They could do price controls on a shorter time frame. The biggest dip in drug trend in the last 20 years was due to the Clinton health care proposal. The reason is they have all the money in the world to solve the public policy problem. They can’t just go on killing the geese that lay those golden eggs.”

The legislature could also intervene by breaking companies up, separating marketing and research and development functions, then prohibiting them from merging back, thereby forcing competition. One interviewee suggests a sunrise law—if industry hasn’t solved the problem within three years, the government will.

*The return to quality.* Throughout our discussion, purchasers bemoaned the loss of quality as a goal for stakeholders in the prescription drug arena. Employers believe that it is essential to bring quality into the cost-benefit equation if costs are to be controlled. “Doctors should be saying ‘we need to improve quality and outcomes.’ Instead they want to go back to the way it was. If we operated on the principle of quality, that’s where the savings could come to doctors and plan sponsors,” insists a health and welfare plans manager for a northern California employer.

Purchasers call for the coming together of all parties—employers, physicians, and health plans—so that outcomes studies, including “best practices” and physician review against benchmarks, can be shared.

“What will it take to get quality back on the table?” asks a northern California benefits manager. “First, partnerships. All successful marriages are based on true partnerships—and having success of the marriage be first and foremost. Partners must have a common interest, both give and get, and recognize that it is in everyone’s interest to come together.”

Purchasers see quality as an issue for health plans that needs immediate attention. They suggest that if plans competed on quality, everyone would benefit. A northern California benefits manager explains: “What is the value of the purchasing dollar? Quality is not going up, but the premium is soaring. Employers are focusing anger on the plans. Plans aren’t acting like businesses, they are shifting the risk rather than reducing costs.”

Purchasers also suggest that they would pay for performance if they could be confident that the money would actually go to improving quality. According to one employer, if physicians “need seed money, employers could pony up if that’s where it’s going to go. [But there’s] no reason to believe that if we raised the premium, the providers or plans would invest it wisely.”

*Technology.* Technology will play a key role in expediting and facilitating benefit changes and quality improvement. Respondents use the term technology to include a wide range of concepts, including information systems, decision support, new devices, and the Internet.

Purchasers expect technology to generate the data that will enable them to manage quality and outcomes. They envision technology’s ability to collect data about the effectiveness of particular drugs, automate prescribing, and provide sophisticated decision support vehicles. They hope that technology will be used to measure quality. Purchasers mentioned the potential of hand-held, “McDonald’s cash register” type of instruments that enable immediate and accurate data capture. They are already beginning to experience the benefits of improved consumer decision support, particularly in provider profiling to support direct contracting.
One benefits manager in northern California believes “the Internet is going to play an important role. Technology can facilitate direct contacting with medical groups—an option we are considering.”

Technology will also have a role in getting quality and outcomes data to consumers. Employers are already instituting communications mechanisms through corporate intranet, for example, to support benefits decision making and retrieve health information. Once outcomes data become available, there are many tools that can be used for dissemination.

The technology purchasers cite most frequently as a significant driver of change, and as having the greatest potential influence in the future, is the Internet. The Internet featured in many interviews as a long-awaited tool to revolutionize communication, education, and supply-chain management as well as applications that have not yet been developed.

Starting from scratch. One employer predicts the need for an entirely new system of covering prescription drugs: “Take out a new piece of cloth whole and design a new system so each component takes a new accountability: purchasers, health plans, consumers, and society.”

Ideally, that would be a market-side solution that would need to rationalize the system, not shifting cost, but really redesigning around four cornerstones: access, choice, quality, sustainable cost.

In such a system, purchasers would not just be concerned about price, but would try to satisfy employees and even be prepared to manage the benefit themselves if health plans falter.

Health plans would need to be a true market for freestanding insurance programs for drugs, offering creative insurance products for a broad range of packages, including life insurance and universal life riders. Plans would use P&T committees to create a closed formulary, which may not include new or “me too” drugs for a couple of years. Plans would offer a tight, well-managed drug rider for a third tier (lifestyle or other off-formulary drugs).

Employees would be recast as consumers. As they assumed more of the costs, the prescription drug benefit would reflect consumer preferences, including alternative medicine and increased accessibility.
VI. Consumers

“I love it when a patient comes to me and says, ‘Take me off of that Prilosec, my co-pay is too high!’ I love that—it makes people stop complaining.”

– Senior medical advisor, southern California medical group

One constant factor in discussions of the issues contributing to the changes in utilization and cost of prescription drugs in California was the changing role of the consumer in health care. Although this study did not gather information from consumers directly, each of the participating stakeholders identified the consumer as a key driver in both the rise and potential reduction of prescription drug costs.

Historically, a patient suffering from a medical condition sought out a physician, who would perform an examination and prescribe an appropriate treatment. The patient would rely on the judgment of the medical professional, bearing only the responsibility for compliance. Over the past several years, however, patients have evolved into consumers, making informed decisions based on their needs, finances, and the best available information. While the rise of consumerism is not unique to health care, its development has had significant implications on the rise in prescription drug costs in California.

Stakeholder groups observe that consumers, particularly the senior population, are extremely concerned about rising prescription drug costs. Medical groups, employers, and health plans across California see both positive and negative implications of this interest. Two themes emerged from our discussions about the new role of the consumer in prescription drug utilization:

1. There are serious gaps in today’s health care consumerism.
2. Consumers are assertive about their preferences and entitlements.
Serious Gaps in Today’s Health Care Consumerism

In the 1980s and early 1990s, the fastest growing health care costs were for inpatient care. Pharmaceutical interventions were encouraged by health plans and employers as inexpensive alternatives to costly inpatient care. Under risk for medical care, physicians recognized drugs as good preventive therapy that minimized their exposure and improved patient health. To facilitate access to drugs and manage utilization, managed care plans incorporated coverage as an integral part of the benefit.

Since the introduction and widespread adoption of the prescription drug card more than a decade ago, respondents report that consumers have been “buffered” from the actual cost of their medications. From the users’ perspective, the prescription “cost” only $5 or $10 (the amount of the copayment), when in fact the true cost of drugs was rising exponentially.

The result? “Both use and cost have been driven by low out-of-pocket costs,” reports the medical director of a northern California medical group. “Utilization increases have been fueled by direct-to-consumer advertising. But with no out-of-pocket cost, demand is high, which raises prices and then costs.”

Cost controls were introduced that focused primarily on medical providers, such as drug utilization review and requirements to write prescriptions for generic substitutes. Tiered copayments for generic drugs were the first incentives for consumers to participate in the cost control measures. Recently, cost controls such as multiple-tiered copayments have focused more directly on the consumers, creating concern among users that they will not be able to afford or have access to the prescription drugs they need.

Our interviews suggest that these efforts have not been effective at controlling costs so far. One of the reasons is that all of the elements required for consumerism to be effective are not yet present. For prescription drug users to behave like consumers, they need to develop price sensitivity and have access to good, if not “perfect,” information.

Price sensitivity. With the exception of seniors, who have borne a direct burden for their prescription drugs, consumers have been largely unaware of the cost of prescription drugs. “Our employees need to understand what prescription drugs cost so they can make appropriate trade-offs. We need to provide them with a statement that shows them what they would have paid for the prescription without our plan,” advises a northern California human resources manager.

Respondents cite three-tier copayments as the first tool that will force consumers to understand the cost of their prescription drug decisions. According to the medical director of a northern California medical group, “New copayment structures only work if there are significant differences between tiers. If there is negligible difference in cost, it makes no difference in behavior. If there is a big difference in cost or they hit their limits, you see the patient say, ‘I need a lower cost drug for this condition.’”

With significant differences in cost between classes of drugs, providers have begun to notice changes in consumer preferences that reduce demand for the newest, most expensive drug without consideration of effectiveness or cost.
“I love it when a patient comes to me and says, “Take me off of that Prilosec, my co-pay is too high!’ I love that—it makes people stop complaining,” says the senior medical advisor at a southern California medical group.

Consumers also respond to price issues under benefit limit situations—although the response may be to change health plans or providers before changing their prescription preferences. One medical director reported that, for the first time in his memory, patients are willing to change medical groups to get a specific drug or avoid prescription drug caps.

**Good information.** There is more and more information available to the consumer through the Internet, news media, and advertising that could support better economic decisions. However, the quality and source of the information is often suspect and it is difficult for consumers to have the confidence to act on what they learn. The most important new sources of information are direct-to-consumer advertising by pharmaceutical manufacturers and the Internet.

In all of the interviews, respondents spoke in highly negative terms about their own feelings about direct-to-consumer advertising. They also universally report that patients “love” DTC advertising. The reason most frequently cited is consumer education; patients feel they learn a lot, not only about the drug but also about their own health conditions. Providers consider much of this learning questionable; they report anecdotes of patients demanding drugs for conditions they don’t have. The provider ends up spending more time with the patient, either disabusing them of information gained on TV or answering questions generated from the patient’s Internet search.

Providers and health plans bemoan the lack of information available to them and their patients about the value of drugs. Is a new drug better than what is currently available? Is it worth the money? Over the next several years, stakeholders suggest, information about quality and value will become more available and will enable better consumer decision making.

Employers realize they have a role to play in helping to promote better consumerism. One employer respondent reflects that human resources personnel are becoming mediators, educating employees in response to direct-to-consumer advertising and increased employee financial responsibility.

“In our benefit design and philosophy,” says a northern California employee benefits manager, “we’re not just in this for the cost shift, we are trying to change employee behavior—we want to make employees better purchasers when there is not much more we can do.”

**Consumers Are Assertive about Their Preferences and Entitlements (“It Isn’t Lifestyle for Me.”)**

Consumers not only have stronger preferences about prescription drugs than they have had in the past, but they are more assertive about getting their needs met. The development of stronger preferences is a direct result of the increase in information available (DTC advertising, medical information as “news,” Internet sources, and the like). The assertiveness comes from the financial stake consumers now hold in their treatment, legislation that has empowered consumers, and a distrust of the motives of health plans in setting medical policy.
Because of the improvements in drug therapies over the past several years, medical groups report that consumers expect a prescription to treat every condition. The patient may present with symptoms that are self-limiting; nevertheless, she or he expects a prescription and will feel cheated without some active treatment. The provider is actually pressured to give the patient a prescription as the required result of a medical visit. “My patients are demanding new, expensive treatments they hear about on TV, even though the old treatment was perfectly effective. And I end up giving it to them,” says a northern California physician.

Consumers have come to expect an intervention at the time of illness rather than seek preventive care. The example most commonly cited is influenza. Patients demand prescriptions for the treatment of flu symptoms, which are likely to be ineffective, but avoid taking a flu shot.

Consumers also demand access to the full spectrum of products available in the market. The plethora of so-called “lifestyle drugs” hitting the market are seriously impacting not only the cost of prescription drug programs but also members’ satisfaction with their plans. In many cases, consumers understand in the aggregate that drugs for baldness, acne, or erectile dysfunction may not be “medically necessary” for everyone; as patients, however, they do not consider such drugs discretionary but vital to their personal well-being. Therefore, they want these drugs available to them under their prescription drug benefit.

There is evidence that consumers are willing to pay higher out-of-pocket costs for lifestyle drugs to ensure that they are included under the plan benefit, even if they are not under the preferred formulary. Many employers are seriously reducing coverage for lifestyle drugs, but some are using differential copayments (for example, 50 percent) as a tool to maintain employee satisfaction with the plan while controlling utilization.

What Will the Consumer of the Future Look Like?

Will today’s aggressive, demanding consumer become tomorrow’s informed, prudent consumer? The answer, according to our respondents, will depend on a host of factors, not just easy access to adequate and objective information about drugs and increased cost awareness, but also the quality of consumer relationships with providers and plans, how the burgeoning senior population responds to rising drug prices, and what the legislature does.

Relationship with providers. Interviews highlighted the growing adversarial relationships between consumers and their physicians and health plans. In the provider’s office the consumer seeks more information and asks for specific treatments. Patients may come to the office armed with questions about their condition as well as alternative therapies. There they meet with a physician who is under enormous pressure to keep the visit as brief as possible and offer treatment plans that are consistent with the practice’s goals as well as the limits and incentives in the patient’s health plan.

“We don’t have the luxury of time when it comes to demanding patients,” explains a Los Angeles physician. “It is easier to write the prescription for a drug that is off-formulary or requires pre-authorization than to take precious time to explain why my preferred drug is as good and less expensive.”

At the same time, physicians are actively involved in establishing new techniques to maintain solid patient relationships. Medical groups report changing their orientation in an attempt to help consumers assume a higher level of responsibility for their health status. “I want to be more of a coach, less of a parent with the patient,” says a northern California medical group respondent. “Rather than being foes, let’s be friends. We really don’t have a choice, so let’s try to make it as pleasant as possible.”
Many practices and hospitals are developing disease management programs and Internet-based educational solutions to provide a higher level of service to consumers. One very large practice is starting a Web site on key diseases to help consumers sift through the volume of information on both diseases and treatments. Their goal is to work with patients to select the appropriate treatment by providing information about the benefit of different drug alternatives.

**Role of seniors.** The “wild card” of the future for the growth of prescription drug costs is the senior population. Seniors represent the largest users of prescription drugs now, and stakeholders believe the utilization will increase astronomically after passage of legislation mandating prescription drug coverage for seniors.

One northern California medical director is pessimistic: “The average age of the seniors in our group is 76. People are living longer and using more drugs, which just increases the demand. Congress’s benefit for seniors will drive up utilization and cost even more.”

Another northern California physician suggests that it might help to stop looking at the senior population as a single indivisible whole: “Half of my seniors use no medications and the others use an enormous amount. We need to establish a different risk pool—partner with commercial insurance to set up risk pools for high users.”

In contrast to the lack of price sensitivity prevalent in employed populations, seniors are extremely aware of the price of their drugs. Even seniors who participate in managed care plans are aware of the costs of their medications because of finite benefits and program limits.

With many health plans abandoning the senior market, more seniors are bearing the direct expense for their medications. Many senior consumers are dealing assertively with their prescription drug expense by looking at alternative purchasing models (such as sources outside of the country) and aggressively lobbying for drug coverage.

Consumers are looking to the legislature in California and at the federal level to grant them further rights in dealing with their health plans. Consumer empowerment and patient rights are key elements in legislation evolving at the state and federal levels. Respondents feel that ultimately consumers will have even more responsibility for treatment decisions, and bear more of the burden for treatment costs. They express hope that insurance and information systems will evolve to enable consumers to make appropriate decisions.