

THE COST OF managed formularies

Before implementing a managed formulary to save on drug plan costs, there are several alternatives plan sponsors can look at. **By Suzanne Lepage**

If there is one thing plan sponsors agree on, it is that drug plan costs continue to rise. Faced with the reality that the costs for their drug plans will continue to grow, plan sponsors are searching for new ways to manage them. Eavesdrop on any meeting between benefits professionals and you're likely to hear someone suggest using a managed formulary to help slow down increasing drug costs. "Excellent suggestion" you might say, "but let's talk about what that really means."

Managed formularies and their alternatives work best with a pay-direct drug plan because the plan member can find out at the pharmacy what's covered—giving them the opportunity to consult with the pharmacist before they make the final purchase. While a managed formulary may reduce drug plan costs for the plan sponsor, formularies often impact them in ways they had not expected.

A managed formulary is much more than just a list of drugs covered under a plan. It is a process of selecting the right drugs to cover. Managing a formulary requires continuing clinical reviews of new drugs entering the market, primarily to determine three things:

1. How these new drugs meet the criteria for being included in the formulary based on the drug's effectiveness in treating the targeted condition.
2. Their safety.
3. The availability of less expensive, equally effective treatments for the same condition.

By controlling the number of costly drugs available on the formulary, drug plan costs may be reduced for the plan sponsor. So then why isn't everyone implementing managed formularies? There are many reasons, involving impacts that pose considerable challenges.

The most significant impact is an obvious one, but worth noting—the cost savings to the plan sponsor comes right out of the plan member's pocket. Almost every dollar saved by the managed formulary is a cost shifted to plan members. Plan sponsors may be saving on their drug plan costs, but they must be able to assess and deal with the potential negative impact on employee relations.

Most estimates of savings after implementation of formulary plans are based on excluding certain drugs. These savings don't forecast possible therapeutic substitution for drugs that are not covered by the formulary. Therapeutic substitution happens when a formulary excludes a drug and substitutes another therapeutically equivalent drug that is covered by the formulary. For example, if a physician prescribes Celebrex to treat a plan member's rheumatoid arthritis, and the plan member discovers it is not covered under the formulary, the pharmacist or plan member may contact the physician to substitute a drug that is covered under the formulary. Naproxen could be substituted for Celebrex and be covered by the formulary.

Although the plan may have saved the \$53.25 monthly cost of Celebrex, it still incurs the \$18.93 monthly cost of Naproxen. Therefore the net annual cost is reduced from \$639 (the annual cost of Celebrex) to \$411.84 (the annual cost of Celebrex minus the annual cost of Naproxen). Naproxen, however, introduces an increased risk over Celebrex for gastrointestinal side effects and ulcer or perforation. These side effects could result in unexpected costs due to lost work time or reduced productivity.

Cutting costs without formularies

Plan sponsors can build other cost savings into their drug plans before implementing a managed formulary.

- **Co-insurance or deductible equal to the dispensing fee.** This encourages the plan member to become a smart shopper for dispensing fees to reduce his portion of the cost.
- **Percentage co-insurance.** This requires the member to contribute proportionally when drug costs increase. A percentage co-insurance is different than a flat dollar co-pay, which does not increase when drug costs do. Recent analysis of Manulife claims data indicates member payment has decreased as a percentage of total claims cost from 10% in 1998 to 9.7% in 1999 and 9% in 2000. This has left a larger portion of the burden of increasing costs per prescription on the plan sponsor.
- **Sliding co-insurance.** This type of co-insurance starts out low and increases the plan member's reimbursement once his or her out-of-pocket costs have reached a catastrophic level. This type of plan design is useful for clients who don't necessarily want to pay for the day-to-day drug expenses of plan members, but do want to provide coverage for catastrophic medical conditions.
- **Limits.** Drug and dispensing fee limits can be used to ensure that pharmacists are charging reasonable amounts to your plan members. Recent analysis of Manulife data indicates that the 10 most expensive drugs

are 5.7% less expensive with a pay direct drug card plan than with a reimbursement plan. The average price per Drug Identification Number was \$89.04 on a reimbursement plan and \$84.27 on a pay direct drug plan.

- **Drug utilization reviews.** Plan sponsors can use drug utilization reviews (DURs) at the point of claim to save on drug plan costs and ensure plan member safety by avoiding duplicate therapies and early refills. DURs are performed by the pharmacist at the pharmacy and look at the past drug usage of the plan member and compares it to the current drug being dispensed. DURs check for things such as drug interactions, duplicate drugs or therapy and whether the plan member is refilling his or her prescription too early. Recent analysis indicates that DURs can save a drug plan 3%.

It's worth noting, however, that both drug and dispensing fee limits and DURs are not available in Quebec. The Association of Quebec Pharmacists has an agreement with pharmacy benefit managers (PBMs) and insurance carriers which specifies that pharmacists do not have to separate drug costs and dispensing fees when submitting a claim electronically. Therefore, a PBM or insurance carrier can't apply drug and dispensing fee limits because they aren't able to separate the two costs when the submission is received from the pharmacist. The agreement also doesn't allow DURs to be applied to claims without permission from the Quebec College of Pharmacists, which has yet to grant permission for DURs to be conducted.

- **Usage.** Another measure plan sponsors

can incorporate into their plan design is one that looks at each plan member's specific usage of acute drugs for a maintenance condition. Once the plan member has stabilized on an acute drug, allow a three-month supply to be dispensed. This will help save on dispensing fee costs, because traditional drug plans only allow acute drugs to be dispensed one month at a time.

- **Administrative options.** Positive enrolment of dependents and the coordination of benefits information can be used to ensure that the plan is only paying for the claims it should. Controlling dependent coverage and coordination of benefits information on a drug plan can realize savings of up to 10%.

Direct enrolment can be used to save on the administrative costs of positive enrolment of dependents. It enrolls the plan member's dependents at the pharmacy at the time of claim and builds in a sophisticated criteria check and matching criteria to validate dependent information being submitted. Direct enrolment saves as much as 10% and also saves on internal administration costs.

- **Incentives.** Ensure that your drug plan only covers drugs that legally require a prescription and includes incentives, such as higher co-insurance, for plan members to use generic drugs. Higher co-insurance, where the plan pays a larger portion of the co-pay than the plan member, can encourage employees to use generic drugs. Your plan can reap a possible savings of 6% for prescription-only drug plans and 3% for generic substitution.

CHALLENGES FOR PLAN SPONSORS

When implementing a managed formulary, plan sponsors have to be clear on their policy for handling individual plan member exceptions. Will plan sponsors deny any exceptions and risk employee dissatisfaction or potential union grievances? Or will they approve drugs that the physician indicates are medically necessary? If this is the case, don't all physicians feel that the drugs they prescribe are medically necessary? The additional employee relations and administration of handling exceptions can also eat away at any expected cost savings.

Removing access to certain drugs by excluding them from the formulary will likely impact employee productivity and absenteeism. The *Aventis 2000 Canadian Consumer Survey* stated that 25% of people are unwilling to

pay for new drugs if their employer doesn't cover all or some of the cost. This means that a quarter of plan members may go without the appropriate drug if it is not at least partially covered by their drug plan.

A study presented in *The Journal of Occupational and Environmental Medicine* in 1997 shows the impact of lost productivity or absenteeism can be far more costly than the price of the drug that is excluded from the formulary. For example, if an employee who suffers migraines goes without an appropriate drug that costs \$44 per month, the cost of lost productivity can be as much as 10 times the cost of the drug treatment.

Every managed formulary is proprietary to the pharmacy benefit manager (PBM) or insurance carrier. Plan members, physicians and pharmacists need a source to

verify which drugs are covered by each different formulary. The list needs to be dynamic because the drugs covered change regularly. Because there are many drugs with similar names, but with different strengths and dosages, the only way to identify a unique drug is by its Drug Identification Number (DIN). In most cases the physician and the plan member will only know the drug name; however the only reliable inquiry tool to determine which drugs are covered by a formulary will be classified by the DIN. As a result, a plan member often only discovers if a drug is covered when the pharmacist inputs the prescription information into their pharmacy software and the DIN dispensed is compared to the list of DINs covered by the formulary. Without a way to easily verify if a drug is covered, a plan member could easily become frustrated at the pharmacy desk when he or she finds out the drug is not covered.

Canadian human rights legislation prohibits discrimination on the basis of disability. If a formulary excludes a drug that a plan member requires to treat his or her medical condition, the plan member may claim that he or she is being discriminated against based on his or her disability.

In addition, collective agreements with unions may be vague about drug coverage. This sometimes makes it difficult to introduce a managed formulary without labour relations issues and potential grievances. One final legal consideration is that benefits are viewed as vested when an employee retires, and it is difficult to implement a managed formulary after retirement unless the retirement plan includes amendment options for the plan sponsor.

So, if managed formularies produce all these challenges, what are the alternatives? Well, if you want to make changes that won't increase administrative and communication costs, create legal risks or impact employee relations, it's time to get back to basics with your plan design. Plan design changes can help control costs, increase cost sharing with plan members and still give plan members access to the drugs they need (see "Cutting costs without formularies," page 53).

To determine which plan design changes will generate the biggest savings for your plan, you have to first understand your drug plan's performance. Pay direct drug plans usually provide excellent reporting that will allow you to analyze who is using your plan, as well as what drugs and treatments are most common and are costing you the most. By comparing your plan data to a benchmark you can work with your plan adviser to develop a customized action plan to manage your drug plan costs.

Often plan sponsors increase premium cost sharing to help keep drug plan costs in check, but the plan member does not directly connect his or her own drug usage to the increased premium, and blames the premium increase on all the other plan members or the plan sponsor. The best kind of plan designs are those that help the plan member understand the impact and the cost of his own family's drug usage at the time of each claim.

Managed formularies are certainly worth considering to reduce drug plan costs, but their impacts must be closely examined to determine the true overall cost savings. Plan sponsors need to explore all types of plan designs to ensure they pick ones that will generate savings with minimal impact on themselves and their plan members.

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