Three-tier Copay Systems and Consumer-centric Care

by Pete Penna

Managed care is changing the practice of pharmacy, sometimes insidiously. Initially slow, the rate of change has been increasing. With the proliferation of technology, increased cost pressures, and exhaustion of efforts directed at other clinicians and services, changes in pharmacy practice have become a managed care focus. Now, we face the challenge of consumer-centric pharmacy practice, that is, practice geared to consumer (customer, member, beneficiary, or patient) needs.

The impact of managed care on pharmacy is clear to pharmacists who practiced before its birth. Pharmacy historians will confirm that the current consumer-centric-care movement has an element of déjà vu. Pharmacists who practiced in community settings before 1970 defined their practice by customer needs. Productivity was a lesser concern. White-jacketed pharmacists knew their customers, their neighborhoods, and the physicians who wrote prescriptions.

It was, of course, a different time in terms of customer needs, financing, and health-team dynamics. Most customers weren't as curious about their medications and, in some cases, physicians limited the amount of information given to their patients. Managed care, by necessity, focused on increasing productivity and reducing costs. Unfortunately, the consumer may have been somewhat forgotten in the process.

Today's consumers want to be involved in their care. They want to know what treatment alternatives exist, and the risks and benefits of each. They frequently seek information on their own, and sometimes, the information on which they rely is either incorrect or misinterpreted. Increasingly, consumers respond to direct-to-consumer (DTC) advertising.

Early managed care organizations (MCOs), before the term managed care even existed, had a simple philosophy about the pharmacy benefit: conventional wisdom dictated that a pharmacy benefit would break any budget. As consumers demanded prescription benefit coverage, various approaches were developed. Some of the earliest MCOs took the formulary concept used in hospitals and applied it to outpatient or ambulatory populations. They structured plans to cover any formulary drug fully, excluded nonformulary drugs, and established exception policies for consumers with unique needs. Forward-thinking organizations also included many over-the-counter medications. Consumers were initially pleased with this type of structure. Since this was applied in staff and group models, management of the benefit was straightforward.

The 1980s brought new financial realities to health care. In particular, the drug benefit caused consternation as drug costs escalated. While some believed that drug costs accounted for larger portions of health care dollars for excellent reasons (e.g., better drugs, more alternatives to hospitalization or surgery, aging populations), managed care executives were concerned. Proof of better outcomes was usually lacking, and therefore new cost-control techniques were introduced, including coinsurance and copayment systems. Coinsurance was never popular with consumers because it was unpredictable. Some coinsurance systems required consumers to pay 30%–50% of a drug's cost; consumers found these too costly. The most acceptable alternative, a fixed and reasonable copayment, didn't reduce costs sufficiently in the long run.

Over time, these systems were modified, changed, and sometimes completely eliminated. Reasons varied. Sometimes, programs were too difficult to administer, or did not reduce costs as much as anticipated. Periodically, studies would demonstrate that certain techniques discouraged consumers from filling prescriptions to the point that adverse events occurred.

As systems became more complex or restrictive, consumer advocates became...

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involved and the consumer-centric health care movement gathered momentum. The closed formulary system in particular was subject to scrutiny and criticism. Although cost containment and quality improved, consumers perceived restricted access and decreased quality, thus decreasing satisfaction. For pharmacy benefits managers, consumer advocacy has meant a return to our earlier model of allowing consumer needs to structure the services and care we deliver. Now, however, consumers have a new set of needs.

Triple-Tier Systems

Managed care looked for new ways to shift or share costs while satisfying the consumer. The most recent permutation of the copayment system, the triple- or three-tier copay, meets this goal, at least in the short term.

Original triple-tier systems were designed as companion pieces to disease-management programs. The concept was simple: drugs designated as first-line agents in guidelines, step care, or protocols were included in the first tier, and required the lowest consumer copayment. Second-line agents were placed in the second, slightly more expensive tier. Agents not included in the guideline or protocol were designated third tier, and required significantly larger consumer copayments. This system's advantage (all drugs were covered to one extent or another) appealed to both consumers and clinicians.

Fairly rapidly, some triple-tier systems moved away from disease management and toward cost management. New terminology developed: the formulary-based triple-tier system emerged. The first tier included preferred drugs, mainly generic entities. The second tier included formulary-approved, preferred brand-name drugs that were considered reasonable in terms of therapy or cost. The third tier included all other drugs, including those designated lifestyle or cosmetic. Some plans refer to third-tier drugs as targeted drugs. The goal was to have consumers help shift drug selection from the expensive third tier to the less-costly lower two tiers.

With improvements in data collection capabilities, some triple-tier trends and concerns have been identified:

- Some consumers tend to like triple-tier benefit designs better than other systems because they perceive better access to all drugs.
- In 1999, 67% of health plans offered a triple-tier option, but only 20% of consumers selected it. Reasons are unclear.
- Most experts suggest that the copayment in each tier must be approximately double that of the tier below to influence consumer choice. The most common structure is copayment of $5.00, $10.00, and $25.00 in the first, second, and third tiers respectively. At the same time, some believe that a $25 copayment will not influence consumers to select a less-expensive alternative.
- It appears that once a drug is assigned to a tier, it rarely moves to a different tier. New and costly drugs have a tendency to be added to the third tier, and remain there despite new indications or research findings that support broader or more frequent use.
- In a closed formulary, medical exception procedures exist so that consumers can obtain nonformulary drugs. In most triple-tier systems, no such system exists. Consumers who need third-tier drugs must pay the higher copayment.
- Lifestyle and cosmetic drugs tend to be placed in the third tier or just excluded by benefit design, regardless of any quality-of-life implications.

The triple-tier system, designed to improve consumer satisfaction, has started to change as all systems do. This tool has enjoyed wide appeal among employers, clinicians, and administrators alike. Over time, certain dissatisfactions can be expected to develop. For consumers, designation of certain drugs as cosmetic or lifestyle may cause concern. For example, some plans designate sexual-dysfunction drugs as lifestyle drugs. Others label smoking cessation aids, antifungal drugs for nail infections, weight-loss aids, and antiwrinkle topical creams as cosmetic or lifestyle. Certainly there can be debate among consumers and clinicians about some of these drugs and whether they treat active disease or improve lifestyle. Increasingly, triple-tier systems are excluding certain drugs. This will surely impact consumer satisfaction.

For clinicians, concern about the process used to determine the tier in which agents are placed is growing. A rational approach to assignment of drugs to tiers can be complex and time-consuming. Clinical expertise is imperative in decision making but is sometimes minimized in light of cost concerns. Clinical misgivings grow when drugs remain in the third tier despite growing utility, or when DTC advertising campaigns create pressure to prescribe third-tier drugs, even when it is therapeutically justifiable to place a drug in the third tier.

For administrators, the inability to predict or control savings secondary to use of a three-tier system is paramount. Over time, as drug cost increases seem to continue unabated, administrators may look for ways to impose greater restrictions. This may include exclusion of certain drugs entirely, or copayment increases for members.

Drug manufacturers have concerns, too. When their products are relegated to the third tier with little chance of movement, they will certainly take action to increase market share. Their tools, including DTC advertising and increased marketing, can create intense pressure.

Implications For Managed Care Pharmacists

Clinical community pharmacy practitioners have a responsibility to make MCOs aware of developing problems with benefit design. In formulary-based three-tier systems, efficient processes to review drug placement when appropriate must be established and communicated to all appropriate parties. Other steps can promote success and sustain consumer satisfaction with the plan.
Consumer education beyond an introduction to the initial benefit package is critical. All consumer education should be easy to use, readily accessible, and updated frequently. Many MCOs have established Web sites for computer-literate consumers. Random telephone interviews and an effective consumer relations department can help plans identify problems early and plan remedial or corrective action. With the advent of electronic communication, plans can broadcast e-mail or fax messages to community pharmacies for distribution to consumers.

Complaint theory should be revisited. Most unhappy consumers will not complain (only 1 in every 20 will), but those who do tend to be extremely vocal and tell many others. A few unhappy consumers can become a public relations nightmare for a plan. Once the dynamics of dissatisfaction are understood, plan administrators will understand the importance of addressing complaints early and well.

Active complaint solicitation is a useful way to improve quality and satisfaction. Customer complaints can be as useful as a costly consultant's review, and may lead to simple improvements with far-reaching impact.

Effective complaint solicitation will vary depending on the size and structure of plans. Random surveys, placement of complaint boxes, and toll-free customer satisfaction phone lines can help.

Continuous reevaluation using quality-management tools should be directed at the formulary structure, all processes related to the pharmacy benefit, educational campaigns, and the impact of DTC advertising. Since change is inevitable, the continuous need for reassessment and circular communication must be understood that clear definitions are needed lest the temptation to exclude drugs progress to categories not traditionally considered lifestyle, like pain relief. Plans must commit adequate time to the formulation process, and might consider including a consumer or an ethicist in the process.

Prior authorization processes should be recognized as a dissatisfier for both consumers and clinicians; if used, they should be modified to be as user-friendly and efficient as possible. Consumer education, physician education, use of technology, and training of prior authorization staff are integral parts of successful prior authorization programs. Such programs should be based on sound clinical criteria.

Interface with other payer plans or provisions must be considered. Plans are dynamic, and change in response to any influences in the marketplace.

A case in point would be what is happening with pharmacy benefits for Medicare plans. Because of increasing cost and competitive pressure, the Medicare benefit is being significantly downsized. In most places, the benefit is now capped, and those caps are decreasing. Member contributions are increasing. In some cases, only generic drugs are being covered. While it might be argued that any benefit is better than no benefit at all, I believe that we have a responsibility to sell programs that provide a worthwhile pharmacy benefit.

Conclusion

The drug benefit must be clinically and financially viable to succeed, but payors and plans must realize that, more and more, health care is being provided with drugs. The precarious balance of an affordable drug benefit, satisfied consumers, and clinically acceptable practices requires constant maintenance efforts by all parties.

References