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# SPECIALTY PHARMACY NEWS

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## Fourth Tiers Could Generate Drug Savings or Increase Medical Spend

A growing number of employers are adding a fourth tier to their formularies in an attempt to rein in spending on high-cost specialty drugs, as well as lifestyle drugs, says a recent report by the Kaiser Family Foundation and Health Research & Educational Trust. But companies should consider the ramifications to employees when firms are simply cost shifting to save themselves money, or the strategy could backfire and, in fact, cost them more in the long run.

According to the *Employer Health Benefits 2010 Annual Survey*, 13% of companies have a prescription drug benefit with four or more tiers — almost a doubling of the total two years ago.

“Specialty drugs generally fall into the fourth tier,” says Tim Heady, CEO of UnitedHealth Pharmaceutical Solutions at UnitedHealth Group. However, he explains that his company is actually “not using the fourth tier for managing the really expensive specialty drugs. But as an example, in our current three-tier design, we look at drugs that perform clinically similarly. We end up with some of these choices in the second and third tiers. We would take some drugs from their tier and put them in the fourth to make the difference between the higher-value choice and lower-value choice more extreme.”

### Higher Copays Can Boost Member Awareness

Heady says some plans’ four-tier use may be motivated by their wanting to “push more cost to employees.” He points out, though, that regardless of how many tiers a formulary may have, “there is an element of cost sharing established in any cost design.”

“Specialty/biotech drugs are very costly, and plan sponsors are realizing that increased copay levels, although not effective at controlling costs, increase member awareness,” says Sean Brandle, vice president, national pharmacy practice, at The Segal Company.

At UnitedHealth Pharmaceutical Solutions, says Heady, “we don’t think of using a fourth tier just to simply increase the cost to the employee, but rather we think of it based on relative value.”

He explains that when a drug is placed on the fourth tier, “it would be viewed as of less value. The

idea of cost shifting versus better decision making is simply a matter of choice. If there are no alternatives, and you simply throw whatever expensive items are onto a fourth tier, that’s clearly cost shifting. If evidence supports a better value for clinical and economic choices, and you throw those on a lower tier, that is to motivate member behavior towards the better value choices. Then, if the individual spends more money, it’s by choice, not need.”

The study also revealed that fourth-tier drugs have an average coinsurance of 36%, up from 31% last year (although down from 43% and 42% in 2005 and 2006, respectively). There are a couple of ways to view this percentage, maintains George Van Antwerp, general manager for the pharmacy business at Silverlink Communications.

If a plan has a 36% coinsurance on a lifestyle drug, “as an employee, that’s great, because the plan covered two-thirds of my costs,” he says. But “if an employee has a life-threatening condition, 36% of a high-cost drug seems overwhelming.”

When drugs have “bad value,” Heady says, “we’ve been excluding them, as opposed to putting them in a fourth tier.” For example, the PBM restricted its prescription drug list to three growth hormones in January 2009, excluding four additional growth hormones that it considered therapeutically equivalent to the three on formulary (*SPN 9/10, p. 9*).

Before the company excluded the four products, it was spending an annual average of \$32,000 per member on these therapies. But following the decision, the UnitedHealth PBM reduced the annual cost by 56%.

There can be a trade-off when members’ out-of-pocket costs are so prohibitive that they forgo necessary medications, Heady contends. “We are concerned about cost, but equally concerned about [members] having access to medicines they need. Having them show up in the ER or hospital would be much more expensive” to the PBM than the drugs are, he points out.

“I would just say that the focus needs to remain on finding the right way to evaluate clinical and economic value of different drug choices and motivate behavior

toward higher-value choices,” Heady says, adding that “there are just a lot of ways to approach that.”

When a formulary is “responsibly managed so that there are clinically sound choices on lower tiers, then the idea here is not cost shifting — it’s responsible cost management,” he maintains.

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