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Vantage Point – Four-tier drug plans thrust affordability into spotlight

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As big pharma and biotech companies alike have targeted highly specialised and more valuable disease areas, a quiet pushback is occurring in the world's largest drug market. US employers and insurers are increasingly imposing drug coverage with four or more "tiers" of coverage, with some of the newest and most expensive drugs assigned to categories requiring the biggest cost-sharing burden for patients.

The increased cost-sharing comes in the context of efforts by US payers to crack down on pharma-sponsored copay assistance programmes to help patients offset the costs of drugs costing tens of thousands of dollars or more a year. With millions more Americans qualifying for health coverage this year, this tug-of-war between insurers and drug companies will only become more fierce, with tiered pharmacy coverage one of the payers' chief weapons.

Nudging toward cheaper options

Tiered drug coverage has existed for some time, driven in part by patent expiries but also to encourage the use of cheaper generic drugs. Growth in the variety of innovative treatments for many diseases has played a role, not to mention the "me-too" therapies that have created multiple options in a single drug class. This latter development has spurred the use of "preferred" and "non-preferred" tiers within branded coverage, to direct patients towards lower cost options.

What is new is this fourth tier, sometimes called a specialty tier, typically saved for the most expensive treatments, These tend to be newly introduced drugs and biologicals that require special administration and handling.

The past year has seen a sizeable increase in the share of four-tier plans in the commercial sphere. According to the annual health benefit survey published by the Kaiser Family Foundation, 23% of US employees are enrolled in four-tier plans in 2013, up from 14% in 2012. In 2004, the first year the foundation collected data on four-tier plans, the share was just 3%.

By comparison, the proportion of employees in a plan that has just a single co-payment for all drugs has halved from 10% in 2004 to 5% today. Three tier plans are still the most common benefit structure, taking in 59% of US employees; however, that share has shrunk from a high of 70% in 2005 according to the survey by Kaiser, a health policy institute.

Lynn Quincy, senior policy analyst with Consumers Union, notes that Kaiser's analysis is of large employer plans, which typically have more generous benefits. The share of small employer plans and individual coverage with four-tier drug coverage is probably greater than the findings of Kaiser survey, Ms Quincy argues.

The trend towards more tiering has been fast enough that New York has banned four tier benefit structures in fully-insured plans licensed by the state, although that has no bearing on the self-funded health plans – typically those run by big multi-state employers – that are regulated by the federal government.

Obamacare design

The increase in multiple tiering has only become more visible with the implementation of the Patient Protection and Affordable Care Act (ACA), commonly referred to as Obamacare. Individual plans offered through state and national health insurance exchanges are making wide use of the cost-control mechanism: 91% of formularies in exchange plans are using four or more tiers, according to an analysis of 600 plans conducted by Avalere Health, a Washington, DC-based health policy consulting firm.

None of the plans in that survey had fewer than three tiers. This mirrors the pattern of Medicare's prescription drug benefit, in which 94% of plans have four or more tiers, although a small slice – 3% – have two or fewer, according to the consultancy's analysis.

The health insurance exchanges are expected to set a precedent for employers, says Eric Gascho, assistant vice-president of government affairs at the National Health Council, an advocacy group for chronically ill

patients. “Like everything, they’ll probably start to follow what the exchanges are doing,” Mr Gascho says.

Price difference

It will come as no surprise that some of the newest drugs for specialised conditions are in the highest tiers. Biogen Idec’s Tecfidera and Pfizer’s Xeljanz are telling examples. The first significant small-molecule oral alternatives in disease areas dominated by injected biologicals, they are thought to offer an advantage from a patient convenience standpoint or efficacy in MS and rheumatoid arthritis, respectively.

Yet, priced as they are at more than $55,000 a year in the case of Tecfidera and $25,000 in the case of Xeljanz, the two pills are often found on the fourth “specialty” tier of prescription drug benefits. It is often down to plan design and employer preferences; the Blue Cross Blue Shield of North Carolina plan, for example, has both drugs on its fourth tier. Other recently approved drugs on that particular fourth tier include Gattex, Pomalyst and Kalydeco.

In that same plan, Tecfidera alternative Copaxone and Xeljanz alternative Humira were both on the third tier, offering a less expensive alternative for the enrolee.

Tier four drugs need not be new drugs. In the North Carolina Blues plan, every growth hormone except for Omnitrope is in tier four, simply because Omnitrope is the cheapest.

At the patient's end, the difference between a drug being on a specialty list and in the typical third "non-preferred" tier is significant. In 2012, the average specialty co-pay for a 30-day supply of a tier four drug purchased at a retail pharmacy was $106, compared with $53 for tier three, according to a survey conducted for the Texas-based Pharmacy Benefit Management Institute (PBMI), an organisation representing pharmacy benefit managers and payers.

One fear that many patient groups have is that, because the ACA made it unlawful for health insurers to refuse to pay for care related to pre-existing conditions, four-tier drug coverage is a technique to achieve the same ends.

“It's against the law to discriminate now based on person's medical condition, and there are consumer groups, particularly those that represent a certain disease like AIDS for example, that are concerned that this is a sort of back-door way to discriminate against certain people, because these drugs in the fourth tier are very expensive," Consumers Union's Ms Quincy says.

Push and pull

A tactic the pharma industry has used to push back on increased cost-sharing – and offset its own high prices – has been discount cards and patient assistance programmes. These have the effect of driving up use - and costs to the payer - and a separate PBMI report cites the use of these schemes as the fifth-biggest specialty drug-related concern of employers who sponsor health insurance plans, out of nine the organisation specifically asked about.

As universal health coverage has rolled out across the US and the plans and insurers push back on discount programmes, their use could decline, as demonstrated by United Healthcare’s recent refusal to honour copay assistance for Humira and the hepatitis C drug Victrelis, amongst others.

“We don’t know if those are going to be allowed in these exchanges,” the National Health Council’s Mr Gascho says.

Mr Gascho acknowledges that dealing with new cost-sharing trends is part of the growing pains of adapting to universal coverage under the ACA. As the programme evolves, policy experts and programme administrators need to consider how to balance affordability against the insurers’ need to show a profit.

“The biggest win we had in the affordable care act is that people with chronic diseases and disabilities can no longer be excluded for pre-existing conditions,” he says. “What that means is that there’s going to be a lot more expensive people who are now being included in these exchanges, and they’re charged the same premium as everyone else. I think the plans are struggling to make this work financially.”

At the same time, Mr Gascho says, “Higher cost-sharing has a huge impact on affordability and access. What we’re really looking for as we move forward with the implementation of ACA is including more robust patient protection which would help make these things more affordable even on a higher cost sharing tier.”

Consumers Union's Ms Quincy adds that, with changing structures of health insurance benefits, pharma companies might need to come up with new economic models that recognise the limits of coverage and personal finances.

"The era of unlimited insurance coverage is over," Ms Quincy says. "Let's not figure out an angle where there's a lot of excess profits in it. It's great that new drugs that help people are being developed. But we've got to think realistically about what we can do to make them affordable.

"It's not just the discount cards that cover the copay amount," she says. "That's spending a little bit of money so you get the insurance payment. It's really, how do you keep the total cost down? Really smart drug companies are going to get out in front and figure out a new model for doing business that isn't dependent on unlimited insurance payments."

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