

## THE TRUE COSTS OF HEALTH PLAN SPECIALTY TIERS

*By David Charles, MD and Mary Ann Chapman, PhD*

An important but rarely asked question is whether it costs more to fill prescriptions for needed medications than to fail to fill these prescriptions. Last year the Congressional Budget Office (CBO) released a memo entitled *Offsetting Effects of Prescription Drug Use on Medicare's Spending for Medical Services*.<sup>1</sup> Not surprisingly, this analysis found that people respond to changes in cost sharing for prescription drugs by changing their use of them. That is, the use of prescription drugs increases in response to price reductions and falls in response to price increases, and this is true across all populations (elderly, nonelderly, privately, and publicly insured).<sup>1</sup>

The CBO memo concludes what common sense tell us—that prescription drugs can reduce overall healthcare costs. When patients get the medications they need, they require fewer physician visits, use fewer emergency medical services, and experience better quality of life. In fact, the CBO projected that a 1% increase in the number of prescriptions filled and taken as prescribed could reduce Medicare's spending by approximately \$35 billion.<sup>1</sup>

This memo marks an important step for the CBO in that the positive impact of therapy compliance is included in their health cost estimates. However, when it comes to the classification of certain medications in a “specialty tier” in public and private health plans, the common sense findings of the CBO are ignored, thereby contributing to higher healthcare costs.

### UNDERSTANDING SPECIALTY TIERS

Physicians are regularly called upon to treat patients with chronic, debilitating diseases for which there are no cures.

In the past, medications for diseases such as cancer, multiple sclerosis, and rheumatoid arthritis were often unable to produce true improvements in patients' lives. This grim situation has changed over the last two decades with the development of new medications and biologics. Many of these new treatments are highly specialized and dramatically reduce symptoms or slow disease progression, leading to improved quality of life.

Not surprisingly, these newer therapies are expensive, reflecting the time, effort, and investment made to develop, manufacture, and test them in clinical trials. Confronted with paying for these higher costs, health plans developed a so-called “specialty tier” that singles out innovative therapies and requires higher co-pays for patients.<sup>2</sup> In some cases the patient's share of the costs may represent a significant percentage of the total, making the therapy inaccessible to those for whom they were developed in the first place.

The tier system included in many prescription benefit plans was designed to encourage the use of less expensive generic medications in the place of name-brands.<sup>3</sup> However, in the case of specialty-tier therapies, generics are not available.



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## Medication Tiers in Benefit Plans

Tier	Types of Drugs	Example
Tier 1	Generic drugs	Proven medication with multiple high-quality manufacturers. Amoxicillin for the common ear infection
Tier 2	Preferred name-brand drugs	Lowest cost option in a class of drugs when generics are not available. Lexapro® (escitalopram) for depression
Tier 3	Non-preferred name-brand drugs	Higher cost name-brand option when lower cost name-brand is available but generics are not available. Cymbalta® (duloxetine) for depression
Specialty Tier	High cost medications such as biologics, cancer treatment, or personalized medication based on diagnostic testing in specific disease states	Highly specialized medication or biologic where no other option exist or where a diagnostic test demonstrates that only one option is appropriate. Humira® (adalimumab) for rheumatoid arthritis. Myozyme® (alglucosidase alfa) for Pompe disease (a rare genetic disease that affects the heart and muscles)

In many instances co-pays for specialty tier therapies are so high that patients cannot afford them. For instance, the Medicare Prescription Drug Program (Medicare Part D) requires beneficiaries to pay between 25% and 33% of the cost for specialty drugs.<sup>3</sup> With an average monthly cost of \$2,000 to \$3,000 (\$24,000 to \$36,000 per year), drugs on the specialty tier require an associated coinsurance of \$500 to \$990 per month.<sup>4</sup> If and when patients on Medicare reach the \$4,750 out-of-pocket limit for their prescriptions (the catastrophic coverage annual qualifying limit for 2013), federal insurance takes over.<sup>5</sup> This naturally raises the question of whether the typical Medicare patient is able to pay \$4,750 out of pocket for prescription drugs in the first place. Those who can't afford this are essentially denied the most effective medications for their condition, forcing them to continue suffering the symptoms of their disease and/or experience irreversible disease progression.

The situation can be just as dire for patients with private health insurance, who may be required to pay between 5% and 50% for medications on the specialty tier.<sup>6</sup> Many private plans do not have an out-of-pocket maximum or maximum dollar limit per prescription, which means that, unlike with Medicare, there is no cap to patients' forced spending on their specialty prescriptions. With these high co-pays, patients can accumulate substantial financial debt trying to pay for sometimes life-saving treatments.<sup>7</sup>

Given the high costs that are passed on to patients, it is not surprising that higher prescription co-pays (especially those exceeding \$100) can lead patients to abandon their treatments.<sup>6</sup> Indeed, the high costs of specialty tier drugs may be so daunting that some patients forgo treatment entirely.<sup>8</sup>

In short, specialty tiers place significant cost burdens on those who suffer from less common diseases, certain chronic diseases, and those living on fixed incomes.<sup>3</sup> Patients who can't afford the out-of-pocket cost are effectively denied their medications.<sup>3</sup>

## ENVISIONING A SOLUTION

The question policymakers struggle with is how to reduce healthcare costs while ensuring that patients have access to the medications they need. One way of doing this is to eliminate the specialty tier categories that place excessive financial burden on patients such that they can't afford to get their prescriptions filled.<sup>9</sup> To reduce the out-of-pocket cost for patients in need of the newest and advance medical therapies, it may be necessary to require a modest increase in the cost sharing for other tier drugs.<sup>9</sup> For instance, the projected increase for a typical Medicare Part D plan would be \$7 per non-preferred brand prescription, \$1 per preferred brand prescription or a \$5 increase in deductible assuming no changes in the population or their patterns.<sup>9</sup>

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Lifting the long-standing federal ban on co-pay offset programs could also help increase access and utilization of these more expensive therapies and potentially reduce overall health care spending. (To help patients afford the high out-of-pocket expenses, manufacturers offer co-pay assistance programs.<sup>10</sup>)

## CONCLUSION

Every day, physicians witness the life-altering benefits of the incredible advanced medications that help patients regain control of their lives. Limiting or eliminating the use of specialty drug tiers would ensure that these benefits are accessible to all patients, regardless of wealth, while also providing long-term savings in healthcare spending. This situation, which requires a big-picture view, is actually a win for all—helping patients and saving money at the same time.

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