Employers, Health Plans, and New Drug Benefit Designs: A Shifting Landscape

Mark Zitter, MBA; Michael Snyder

Payers generally assert that in the face of rising costs they will manage pharmaceuticals more tightly. However, many restrictions that they say they will initiate never become widespread. Why not? Payers may offer a restrictive benefit design, but often employers and other plan sponsors are reluctant to select such designs for their employees. To understand the benefit landscape, we need to look to payers as well as employers.

These findings come from the Zitter Group’s Managed Care Benefit Design Index, which surveys approximately 100 top payer decision makers and 100 self-insured employers and employee benefits consultants. This semiannual, multiclient study explores the trends influencing the creation of benefit design policies. This article is based on findings from the spring 2011 survey.

How Payers and Employers Differ

There are significant differences between payers and employers with regard to which disease areas receive the greatest priority. Payers place the greatest management emphasis on the high-cost, high-prevalence categories of type 2 diabetes and cancer. Employers also prioritize cancer, but they focus much more than payers on lifestyle categories that can impact worker productivity, such as obesity and smoking cessation.

In response to anticipated cost increases resulting from healthcare reform provisions, 55% of payers and 51% of employers planned to increase employee contributions to health insurance premiums for plan year 2011 (Figure 1). However, there was a stark difference between the 2 groups regarding increasing utilization management. A full 59% of payers surveyed reported having plans to increase utilization management, compared with only 15% of employers. Furthermore, although 43% of payers planned to institute a more restrictive formulary, only 13% of employers intended to adopt such a measure.

Looking at specific utilization management changes, 68% of payers increased the number of drugs subject to prior authorization, prior failure, or step edits, and 49% reduced the range of brand-name drugs covered on their most common formulary. By contrast, a large majority of employers made no changes to their utilization management policies for plan year 2011. Only 21% of employers increased the number of drugs subject to prior authorization, prior failure, or step edits, and 14% decreased the range of brand-name drugs covered on their most common formulary.

Some of these differences can be explained by the response samples. Payers represented a cross-section of the market, whereas the employer group was drawn mainly from larger, self-insured employers. Many payers are able to institute more restrictive policies across much

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of their populations (including fully insured members) than large employers are willing to accept. Moreover, many employers see their key responsibility as designing and/or selecting the benefit, thereby leaving management to the payer. For example, few employers see themselves—or want others to see them—as being involved in utilization management.

Cost-Sharing

Although cost-sharing seems to be the most straightforward lever to pull when looking to reduce short-term costs, it is not used as often as might be expected. When payers were asked what factors keep them from increasing cost-sharing, 33% responded that concerns about compliance and healthcare outcomes prevented them from using cost-sharing more liberally. This percentage is double that of employers who share similar concerns.

Payers cited a much wider range of cost-sharing structure changes for plan year 2011 than employers (Figure 2). Of the payers, 78% planned to increase member contribution to health insurance premiums, and 47% planned to increase cost-sharing for prescription drugs.

Increasing member contribution to health insurance premiums was the most frequent selection by employers, although only 39% intended to do so. Despite reported hesitation to increase cost-sharing for physician visits, because of worries that it may have negative ramifications on long-term costs, 30% of payers and 22% of employers still planned to make this change in 2011. For all of these potential interventions, payers said that they were going to be doing more than employers, which emphasizes the increased aggressiveness of payer management relative to what employers indicated they were willing to adopt.

Raising premiums can reduce the cost to the payer or to the employer, leaving employees with more of the burden. Increasing cost-sharing can theoretically also drive

![Figure 1: Cost Control Responses to Healthcare Reform](source: The Zitter Group. Managed Care Benefit Design Index; Spring 2011.)
better health-related behaviors by members, leading them to avoid seeking unnecessary healthcare. The problem with this way of thinking is that research has long shown that increased cost-sharing, although successful in reducing demand for inappropriate care, also tends to reduce the demand for appropriate care. By contrast, premium increases do not impact demand for care, because people pay upfront. Unless premiums increase so much that people drop their healthcare coverage entirely, there is no reason to believe there will be any significant difference in utilization.

When analyzing the potential risk of enacting measures for short-term savings at the possibility of raising long-term costs, there is an overwhelming difference between payers and employers on a few measures. More than twice as many payers as employers said that increasing the employee copayment for physician visits is a bad idea. Although this will save money in the short-term, people who do not go to the doctor when needed will likely cost more in the long-term. Conversely, employers are much more reluctant than payers to increase costs for prescription drugs.

These differences in concerns between payers and employers begin to shed light on why employers do not necessarily buy into some of the benefit designs offered by payers.

**Benefit Design**

The most popular pharmacy benefit design today still incorporates a 3-tier formulary. What has been changing over the past 2 or 3 years is the rise of the fourth tier. Of total payer administrator services–only plans, 23% have 4 tiers on their most representative formulary. However, Medicare Part D plans are now equally likely to have a 3-tier or a 4-tier structure (Figure 3).

When seeking to decrease drug costs, payers first look at increasing cost-sharing for prescription drugs and, second, at switching from copayments to coinsurance for drugs. The third option to consider is offering a benefit strategy for specialty biologic drugs that allows claims to

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**Figure 2: Cost-Sharing Structure Changes: Stakeholder Comparison**

Thinking of your most common commercial plan, please qualify the following possible cost-sharing structure changes with regard to plan year 2011

<table>
<thead>
<tr>
<th>Cost-sharing Structure Changes</th>
<th>Payers: N = 101</th>
<th>Employers: N = 101</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member contribution to health insurance premiums</td>
<td>78%</td>
<td>39%</td>
</tr>
<tr>
<td>Cost-sharing rates for prescription drugs</td>
<td>47%</td>
<td>23%</td>
</tr>
<tr>
<td>HDHP/CDHP/HSA options</td>
<td>44%</td>
<td>14%</td>
</tr>
<tr>
<td>Maximum member out-of-pocket responsibility</td>
<td>44%</td>
<td>20%</td>
</tr>
<tr>
<td>Cost-sharing spread between tier 2 and tier 3</td>
<td>39%</td>
<td>9%</td>
</tr>
<tr>
<td>Cost-sharing rates for inpatient hospital stays</td>
<td>31%</td>
<td>14%</td>
</tr>
<tr>
<td>Cost-sharing spread between tier 1 and tier 2</td>
<td>30%</td>
<td>11%</td>
</tr>
<tr>
<td>Cost-sharing rates for physician visits</td>
<td>30%</td>
<td>22%</td>
</tr>
</tbody>
</table>

CDHP indicates consumer-directed health plan; HDHP, high-deductible health plan; HSA, health savings account. Source: The Zitter Group. Managed Care Benefit Design Index; Spring 2011.
be managed by pharmacy—where payers can exert more control—but is adjudicated back to the medical benefit. However, this cross-benefit management is complex, and many health plans do not have the capability to do so successfully.

One of the most popular future innovation measures that payers intend to use to save on costs is high-deductible benefit design. Although payers and employers are split on the impact of high-deductible benefit design on healthcare outcomes, they agree that there are total pharmacy spending decreases for those commercial lives enrolled in these health plans.

Perhaps more important is that approximately 50% of employers do not have the same entity to manage both their medical and pharmacy benefits. Cross-benefit adjudication is not likely to happen when there are different entities managing each benefit.

With more of the expensive biologic drug categories having multiple drugs with similar safety and efficacy profiles, payers show preference for category management approaches. However, this preference is difficult to achieve if they are only managing one side of that benefit. The plans that cover both benefits are trying to move in the direction of having claims managed by the pharmacy benefit and adjudicated by the medical benefit, but we are a long way from ubiquity.

Looking Ahead

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Employers are slowly moving in the direction of offering more high-deductible plans. Of the employers who offer preferred provider organization, point of service, and/or HMO plan options, only 11% indicated they plan to offer only high-deductible health plans for the 2012 plan year. However, an additional 23% are actively con-
sidering switching to high-deductible health plans for 2012 and beyond.

Value-based benefit design options and adherence programs that include patient–employee communications sound great in theory but have yet to make any substantial impact on cost-savings. All parties involved would like to have improved adherence, but it has not happened significantly in practice.

These 2 management techniques have shown success in pilot programs but have failed to scale effectively. When payers are asked to explain why we do not see more of these innovative strategies in widespread practice, aside from cost, they claim that employers are too concerned with employee dissatisfaction. In fact, employers are concerned about employee morale, but not to the degree that payers perceive. When asked to explain why they decline to implement payers’ proposed management strategies, aside from cost, employers most often say that they are just not convinced the proposed benefit will work.

**Conclusion**

Payers and employers have a lot of similarities, but also many differences. The most common lever used in benefit design is cost-sharing. As seen in response to cost increases stemming from healthcare reform, increased cost-sharing is a quick fix for payers and for employers. Although cost-sharing is able to provide some short-term savings, it will not be the answer in the long-term. Therefore, payers and employers need to better understand each other’s motivations and concerns to successfully create benefit design policies that are beneficial to everyone.

**Author Disclosure Statement**

Mr Zitter and Mr Snyder reported no conflicts of interest.

**Reference**