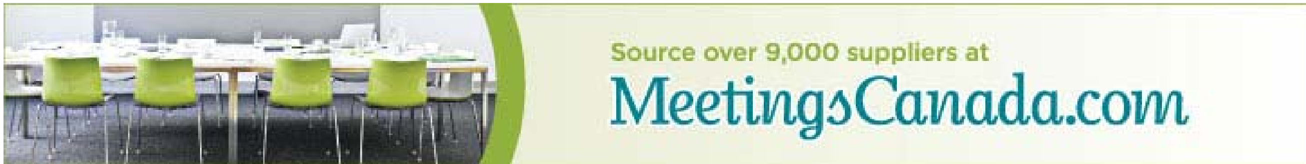

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Plan design: a strategic consideration

Mike Sullivan | January 10, 2011

Plan design as an important strategic plan management tool is back in business. The focus on plan design has been given a big boost by the technological expansion in the marketplace such as flexible, rules-based adjudication platforms and plan-specific design capabilities. There are a number of vendors across the country: some third party administrators (TPA), a handful of mid- to large-size carriers and independent pharmacy benefit managers (PBM) that have brought their own innovations to the market.

Even the large carriers that have outsourced a great deal of their drug plan management to claims processors for decades are now investing their own resources into this area. An example would be the recent job posting for a director, prescription drug management position by Great-West Life.

Plan sponsors are beginning to look beyond simply the lowest cost option when considering their vendor relationships. Armed with a better understanding of the priorities for managing their unique plan experience and containing costs, they are demanding access to more flexible plan adjudication tools. They are also willing to pay for that enhanced service when then can calculate the savings back to the plan.

There remains a significant problem for a vast majority of plan sponsors and their advisors: understanding what they need to be asking for and determining what plan design pieces are required to achieve their goals of cost containment, sustainability and offering of a benefit that is valuable to members. This is where plan sponsors need to start to looking more strategically at their own plan-specific experience, because what is good for one plan sponsor may not necessarily work for another plan of the same size.

Our lingering concern for plan sponsors and their advisors is that “strategic” plan design in the past has often been limited to taking an off–the-shelf product that has been designed for the masses and making it work for a specific group or plan.

More consideration needs to be given to the existing utilization patterns, as well as the demographic and disease state profile of the group’s own experience. Some of plan-specific factors that need to be considered are the following:

- current level of coordination of benefits with other private and public plans, and plan member cost sharing;
- current saturation rate of age-related chronic conditions and specialty drug use based on the demographic and disease state profile (including incidence level) of the plan population;
- current level of generic penetration in the most common drug classes within the plan experience;

- risk factors for future specialty drug use that can be gauged from existing utilization patterns;
- plan utilization and spending metrics by unique claimant and member subtype;
- impact of existing plan design in containing plan costs; and
- evaluation of which disease states are having the most significant impact on drug plan costs, disability experience and member health.

This level of strategic review of the plan experience dictates what priorities exist for optimally managing the plan, and therefore what solutions are needed. The solutions should be determined organically and customized, not with a one-size-fits-all offering like a copy of Microsoft Office.

Plan design needs to be practical and strategic. Consider the focus on generic drug pricing reforms across the country. What does the price of generic drugs matter if your experience is not seeing any growth in this area because the plan is not designed to optimize generic penetrations?

Or consider the growing body of evidence supporting the fact that simply cost-shifting to plan members actually comes back to haunt a plan in other ways.

1. A study by Ellis et al. in the *Journal of General Internal Medicine* showed that members who had a co-payment of $10 to $20 per prescription were 30% more likely to discontinue statin (cholesterol-lowering) therapy when compared to members who had a co-payment of less than $10. The group with a co-payment of $20 or more were 211% more likely to discontinue treatment.
2. A study in the *Journal of Managed Care Pharmacy* by Zhang et al. showed that in two of the most common classes of blood pressure lowering medications, every $1 increment in member cost-sharing led to a 2.8% greater chance of non-persistence with therapy at six months.

The thought for plan sponsors here is, Why invest even a nickel in these therapies for chronic medications for members who stop taking them? Just increasing cost-sharing to members may seem logical as plan costs increase, but strategically, it might result in significantly less return on investment and increase costs elsewhere.

With greater information at their fingertips, this is an exciting time for plan sponsors, advisors and vendors to have strategic plan design conversations. The demand for more sophistication in managing plans is increasing and the industry itself has begun to respond with a greater supply of congruent options.

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