Employer-sponsored prescription drug benefits

Almost all full-time employees with employer-provided medical care benefits had prescription drugs coverage in 1989, but benefits differed for brand name and generic drugs and by type of health care plan

Cathy Baker
and
Natalie Kramer

Medications can come in many forms, from over-the-counter pain killers and stomach soothers, to prescription drugs. As expected, most medical care plans treat medications differently, typically providing no coverage for home remedies, limited coverage for over-the-counter products, and the most comprehensive coverage for most prescription drugs. Typically, prescription drugs (as well as over-the-counter medications) provided to patients in a hospital are covered as part of a medical plan's hospital room and board benefits.[1] Outpatient prescription drugs are also covered by most medical care plans. This article examines outpatient prescription drug coverage available through employer-provided medical care plans.

This article is based on data from the Bureau of Labor Statistics 1989 survey of benefits for full-time employees in medium and large firms. The survey provides data for 32 million employees. Data represent benefit provisions for workers in about 109,000 establishments employing 100 workers or more in private nonfarm industries.[2]

There is considerable interest in medical care plan coverage for outpatient prescription drugs, prompted by increasing drug prices and a variety of new drugs. Data on drug manufacturing and pricing are discussed in the first part of this article, followed by a look at how medical plans cover prescription drug benefits.

Cathy Baker and Natalie Kramer are economists in the Division of Occupational Pay and Employee Benefit Levels, Bureau of Labor Statistics

Prescription drugs

The cost of medical care increased rapidly during the 1980's. Between 1979 and 1989, the price of all medical care rose 119 percent, as measured by the Bureau's Consumer Price Index.[3] During the same period, the Consumer Price Index for all items rose 64 percent. (See chart 1.) While the indexes of all the major components of medical care rose sharply during the 1980's, hospitalization grew at the highest rate, 162 percent, two-and-a-half times the general rate of inflation in the same period; prescription drug costs followed closely behind, with an increase of 151 percent between 1979 and 1989.

In 1989, Americans spent $17.7 billion on outpatient prescription drugs, more than twice the amount spent in 1979.[4] While these figures are staggering, in terms of constant dollars, expenditures on prescription drugs accounted for 3 percent of all health care expenses in 1989, a drop from 5 percent in 1979.[5] This decline reflects the fact that real annual expenditures on prescription drugs fell by 2 percent, while all medical care expenses rose by 44 percent. This difference partly results from the unusually rapid increase in consumption of other types of medical care, including hospitalization, physicians' care, and certain diagnostic tests, during the 1980's. The large increase can be attributed to the rise in the proportion of older Americans and the growing availability and use of some types of health care.[6] The increased availability of generic drugs contributed to the decrease in the growth rate of prescription drug expenditures.

Drug pricing is affected by the complex process of introducing a new drug to market. The Food and Drug Administration employs a drug approval process which is designed to ensure consumer safety. It takes approximately 12 years for drug manufacturers to recoup their outlays for

Table 1. **Prescription drugs: percent of full-time participants by type of medical plan and coverage for brand name drugs, medium and large firms, 1989**

Extent of coverage	All	HMO	Fee-for-service
Total participants	100	100	100
With prescription drug coverage	96	90	97
Full coverage	3	9	1
Limited coverage	94	81	96
Subject to separate limits only[1]	29	79	19
Subject to overall limits only[2]	62	(3)	74
Subject to separate and overall limits	3	2	3
Type of limitations not determinable	(3)	(3)	(3)
Without prescription drug coverage	4	10	3

[1] Separate limitation refers to provisions that apply to individual medical procedures and services. Separate limitations for prescription drugs include: copayment per prescription, per-year deductible, coinsurance, and ceiling on dollar maximum per year.

[2] Overall limitation refers to provisions that apply to multiple medical procedures and services. The three main overall limits are: deductibles, coinsurance provisions, and ceilings on overall plan dollar maximums.

[3] Less than 0.5 percent.

NOTE: Because of rounding, sums of individual items may not equal totals.

product development and testing, averaging about $231 million per drug.[7]

The ability of a pharmaceutical manufacturing firm to secure its share of the market depends not only on its productive capacity but also on its capacity for research and development and its advertisement and promotion. These components account for the comparatively high price of newly manufactured drugs.[8] New drugs may be costly because of the nature of prescription drug patents. The original manufacturer has a relatively short time to recoup expenses and gain a profit. Patents for new prescription drugs are in effect for an average of 10 years,[9] after which other manufacturers may produce and market generic equivalents.

Prescription drug coverage

Ninety-six percent of full-time participants in employer-provided medical care plans were covered for out-of-hospital prescription drugs in 1989.[10] (See table 1.) This widespread coverage continued throughout the 1980's. In addition, the cost of prescription drug coverage increased from 5 percent to 10 percent of an employer's average health care expense.[11]

Coverage differed for out-of-hospital prescription drugs in 1989, based on whether medical care was provided through a traditional fee-for-service plan or a health maintenance organization (HMO).[12] Fee-for-service plans typically pay a share of prescription drug expenses after the individual has met the overall plan deductible. Under HMO's, prescription drugs are usually fully covered after the subscriber has paid a nominal dollar amount (copayment) per prescription. Ten percent of HMO participants were not covered by prescription drug plans. (See table .1.) HMO's sometimes offer prescription drugs as an optional benefit. The percent of HMO participants without prescription drug coverage may be partly traced to employers who do not provide this option.

Types of drug coverage. Not all medications and accessories are covered by prescription drug plans. Most drugs for which a prescription is required by law are covered. Plans with coverage for mental health care and substance abuse treatment usually cover drugs prescribed by psychiatrists for inpatient and outpatient care. Other commonly prescribed drugs, such as compounded dermatological preparations, nitroglycerin, and phenobarbital are usually covered.

However, for special situations, coverage may be limited. For example the majority of plans with prescription drug coverage provide insulin for diabetics, but not all plans provide for diabetic supplies such as syringes, glucose test tablets, and tape used for periodic urine tests. Similarly, some plans cover oral contraceptives but not other contraceptive devices requiring prescriptions.

Nonprescription drugs and medical accessories are usually not covered by most medical plans with prescription drug coverage. Vitamins of all

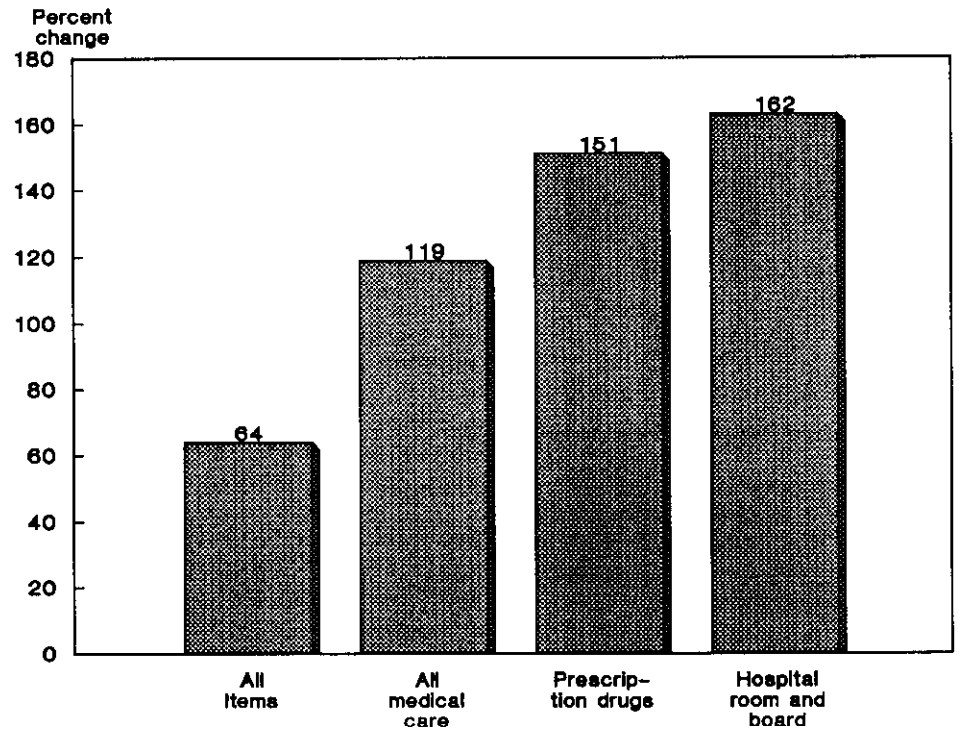
Table 2. **Percent of full-time participants in prescription drug plans with separate coverage limitations by type of limitation, medium and large firms, 1989**

Type of separate limitations	Percent of participants
Total participants[1]	100
Coverage subject to copayment per prescription	92
Less than $2	7
$2–$2.99	15
$3	28
$3.01–$4.99	12
$5	25
More than $5	6
Coverage subject to deductible per year	6
Coverage subject to dollar maximum per year	2
Coverage subject to a coinsurance per prescription	6

[1] The total is less than the sum of individual items because some plans had more than one type of limitation.

NOTE: Because of rounding, sums of individual items may not equal totals.

Chart 1. Increase in the Consumer Price Index for All Items and for selected medical care components, 1979–89



types—multiple, therapeutic, and nontherapeutic—are not covered in most plans. Medical supplies, such as appliances, prosthetic devices, bandages, antiseptics, and dietary supplements, are rarely covered under prescription drug benefits. In addition, blood, blood plasma, and immunization agents are not covered.[13]

The 1987 Employee Benefits Survey data reveal that prescription drug benefits for full-time employees in State and local governments are similar in incidence and types of provisions to those of employees in medium and large establishments in private industry.

Cost containment measures. The very large increases in the costs of prescription drugs during the 1980's led medical plan providers to seek ways to contain costs. Many plans encourage the use of alternatives to hospitalization as a cost containment measure. Preventive medicine is a growing trend, among HMO's in particular. Providing prescription drug benefits for preventive and maintenance medications, for high blood pressure and high cholesterol, can help avoid or minimize potential hospitalization costs.[14]

One measure to counter the spiraling costs of prescription drugs would be to encourage patients to purchase generic drugs, which are less costly alternatives to brand name drugs. The number of subscribers covered by plans with incentives for purchasing generic drugs increased during the 1980's, from 3 percent of medical plan participants in 1985 to 14 percent in 1989.

Another cost containment method is "Maintenance Prescription Drug Programs," an alternative to basic prescription drug coverage. A maintenance prescription drug program incorporates drug utilization review, computerized patient profiles, and electronic claims procedures to reduce the high cost and ease the administrative burden of prescription drug care.[15]

Mail-order prescription drugs are another cost containment measure. Under this method, prescription drugs are filled and mailed by a licensed mail-order pharmacy, which has a contract with a specified medical care plan to dispense prescription drugs to its subscribers. This is a common practice for patients who are participating in maintenance drug programs, such as diabetics, persons with hypertension, or those who use oral birth control. As a rule, the copayment required of the patient and the quantity ordered are inversely related. For example, there may be a $3 copayment per prescription or refill for up to a 30-day supply at participating phar-

Table 3. **Comparison of coverage for generic drugs and brand name drugs, medium and large firms, 1989**

Amount of copayment for brand name drugs	Amount of copayment for generic drugs						
	Total	$0	$1 – $1.99	$2 – $2.99	$3	$4	More than $4
Total	100	14	15	29	32	2	8
$2	2	2	—	—	—	—	—
$3–$3.99	20	(1)	14	6	—	—	—
$4–$4.99	18	—	1	7	10	—	—
$5	47	12	1	15	19	—	—
More than $5	12	—	—	(1)	3	2	8

(1) Less than 0.5 percent.

NOTE: Because of rounding, sums of individual items may not equal totals. Where applicable, dashes indicate no workers in this category.

macies or facilities. However, the mail service programs may specify a $1 copayment per prescription or refill for a 60- or 90-day supply. In 1989, 10 percent of medical care participants were covered by plans with mail-order drug benefits.

Differences in coverage

In 1989, 90 percent of HMO participants and 97 percent of fee-for-service plan participants were in plans that included prescription drug coverage. (See table 1.) HMO's usually covered out-of-hospital prescription drugs subject to a deductible, such as $3 or $5 per prescription. Nine percent of the HMO participants had their coverage provided without any limitations (covered in full).

Overall limitations. Participants in fee-for-service plans generally had prescription drug coverage subject to overall limitations on their medical plan. (Overall limitation refers to provisions that apply to multiple medical procedures and services.) The three main overall limits are: deductibles, coinsurance provisions, and ceilings on overall plan dollar maximums. A deductible is the dollar amount the insured must pay before the policy will begin reimbursing expenses. The deductible most commonly observed in 1989 was $100 or $200 a year, usually with a family limit of two or three times the individual amount. In addition, covered expenses are shared between the individual and the plan (coinsurance), with the insurer generally paying 80 percent of the total and the insured paying 20 percent. Finally, there is often a lifetime dollar maximum on plan payments, most commonly $500,000 or $1,000,000. For example, a typical plan might pay 80 percent of covered expenses up to $1,000,000, after the subscriber has paid a $200 deductible.

Separate limitations. Less than one-third of all medical plan participants were in plans requiring a copayment per prescription. The most common type of copayments were $3 or $5 per prescription. (See table 2.) Other limitations imposed upon prescription drug benefits, such as separate deductibles, coinsurance rates, or dollar maximums, were less common.

Some plans have more than one limitation on coverage of prescription drugs. For example, a plan could require the subscriber to pay a yearly deductible of $100 for prescription drugs, after which the plan would cover all eligible expenses subject to a $3 per prescription copayment. It was unusual for prescription drugs to be subject to a dollar maximum per year.

Generic vs. brand name drugs. As noted earlier, 14 percent of subscribers were in plans with incentives for purchasing generic drugs. The most common way for prescription drug plans to provide these incentives is to cover generics in full or subject to a lower per-prescription copayment than their brand name equivalents. The majority of participants in such plans generally had to pay copayments ranging from $1 to $3 for the generic drug, with $3 being the usual payment. Fourteen percent of the participants had generic drugs covered in full. In contrast, copayments generally ranged from $3 to $5 for brand name drugs. (See table 3.)

It is interesting to compare the copayments imposed on those participants who must pay a different copayment for brand name and generic drugs. For example, the most common copayment for brand name drugs is $5 per prescription. In these plans, the copayment drops to either $2, $3, or zero for generics. Similarly, $4–$4.99 brand name copayments typically drop to $2 or $3 for generic drugs. Reducing the copayment to zero is less common for those plans with $3 and $4 copayments for brand names; this is, perhaps, to prevent unnecessary use by imposing a nominal fee.

IN SUMMARY, between 1979 and 1989, prescription drug costs increased by 151 percent, the rate of growth second only to the costs of hospital room and board. While expenditures on prescription drugs in the United States account for only 3 percent of all medical expenses, there is great interest in prescription drug coverage. □

Footnotes

[1] In-hospital prescription medications are normally covered as a part of hospital miscellaneous charges, which include general nursing care, medical supplies and surgical dressings, and other ancillary charges.

[2] In addition to medical care benefits, the BLS Employee Benefits survey provides data on life and disability insurance, retirement and capital accumulation plans, paid and unpaid leave, and other benefits. The results of the survey are available in *Employee Benefits in Medium and Large Firms, 1989*, Bulletin 2363 (Bureau of Labor Statistics, 1990). Benefits data for State and local governments are available in *Employee Benefits in State and Local Government, 1987*, Bulletin 2309 (Bureau of Labor Statistics, 1988). Data were tabulated for all workers and separately for three occupational groups: professional and administrative, technical and clerical, and production and service workers. Data for this article are not presented for other occupational groups because no significant differences were found.

[3] See *CPI Detailed Report* (Bureau of Labor Statistics, 1990).

[4] U.S. Department of Commerce, Bureau of Economic Analysis, *Personal Consumption Expenditures By Type of Expenditures (millions of dollars), 1978–89*.

[5] U.S. Department of Commerce, Bureau of Economic Analysis, *Personal Consumption Expenditures By Type of Expenditures (millions of 1982 dollars), 1978–89*.

[6] Health Insurance Association of America, *Source Book of Health Insurance Data, 1989*.

[7] See *The Cost of Innovation in the Pharmaceutical Industry: New Drug R&D Cost Estimates* (Medford, MA, Tufts University, The Center for the Study of Drug Development, 1990).

[8] John Egan, Harlow Higinbotham, and J. Fred Weston, *Economics of the Pharmaceutical Industry* (New York, Praeger Publishers, 1982), pp. 40–81.

[9] "Implementation of the Drug Price Competition and Patent Term Restoration Act, 1984: A Progress Report," *Journal of Clinical Research and Drug Development*, Vol. 1, 1987, pp. 263–75.

[10] A plan is employer provided if it is financed, at least in part, by the employer.

[11] David Albertson, "Pharmaceutical Cost Control: A Bitter Pill for Employers?" *Employee Benefit News*, June 1990, pp. 23–26.

[12] A traditional fee-for-service plan reimburses participants for expenses incurred because of illness or injury. Preventive care is rarely covered. Plans usually cover benefits subject to various limitations, and normally impose few, if any, restrictions on choice of providers and facilities. A specialized type of fee-for-service plan is a Preferred Provider Organization (PPO). These plans allow participants to use providers and facilities of their choice, but reimburse at higher rates and with fewer restrictions if treatment is received from designated providers.

A health maintenance organization operates on a prepaid basis, providing a predetermined set of benefits for a fixed cost to its members. The participants' choice of providers and facilities is usually limited to those affiliated with the organization. HMO's both finance and deliver health care services with emphasis on preventive care.

For a more detailed discussion on HMO's and fee-for-service plans, see Thomas P. Burke and Rita S. Jain, "Trends in employer-provided health care benefits," elsewhere in this issue.

[13] Medicare, which provides medical benefit coverage to older Americans, does not cover outpatient prescription drugs. Amendments to the Medicare system, signed into law in 1988, would have provided prescription drug coverage subject to a $600 annual deductible, beginning in 1991. These amendments were repealed, however, in a dispute over plan financing.

[14] Susan Peard, "Mail Order Drug Programs: Where are we now?" *Employee Benefit News*, July 1990, pp. 35–39, 54.

[15] *Employee Benefit Plan Review*, October 1989, p. 11.

A note on communications

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