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PRESCRIPTION DRUG BENEFITS

Impact of Medicare HMOs' Use of Formularies on Beneficiaries

Statement of William J. Scanlon, Director
Health Financing and Public Health Issues
Health, Education, and Human Services Division

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Prescription Drug Benefits: Impact of Medicare HMOs' Use of Formularies on Beneficiaries

Mr. Chairman and Members of the Committee:

I am pleased to be here today to discuss the prescription drug benefits provided by health maintenance organizations (HMO) that participate in the Medicare+Choice program. Currently, about 6.1 million of the 39 million Medicare beneficiaries are enrolled in Medicare+Choice plans, in many cases because they offer prescription drug benefits, which are not covered under fee-for-service Medicare. Medicare+Choice was intended to expand beneficiaries' health plan options. Its success depends on generating quality-based competition among plans so more beneficiaries are attracted to and remain in the program.

Over the past 2 years, this Committee has held several hearings on the information available to Medicare beneficiaries to enable them to make prudent choices about whether to enroll in a Medicare+Choice plan. Our previous work has identified a number of factors that make it difficult for beneficiaries to determine which plan offers the benefits that best meet their needs.[1] In some cases, detailed information about plans' benefits and out-of-pocket fees is provided only after a beneficiary enrolls in a plan. In other cases, detailed information may be available before enrollment from plan sales agents and member literature, but beneficiaries may find it difficult to compare available options because plans present the information in different formats and use different terms to describe covered benefits. Further, plan member literature, a key source of information for beneficiaries, has often contained inaccurate or incomplete benefit information. In our previous work we also noted that some plans described their benefits using terms like "approved" drugs or "preferred" drugs without defining them. In other cases, plans provided little information on the annual dollar limits on prescription drug coverage or how they calculated when a beneficiary had reached the limit. The value of a limit can vary significantly depending on which prices a plan uses to calculate the cost of a prescription. For example, if the annual limit is based on the retail cost of a prescription, the benefit would be worth less than if it was based on the wholesale cost. The lack of comparative information is particularly problematic in evaluating plans' drug benefits because so many different aspects determine the true extent of coverage.

Moreover, making informed choices among health plans is becoming more important for Medicare beneficiaries because the Balanced Budget Act of 1997 specifies that beginning in 2002, beneficiaries will no longer be able

[1]Medicare+Choice: New Standards Could Improve Accuracy and Usefulness of Plan Literature (GAO/HEHS-99-92, Apr. 12, 1999) and Medicare Managed Care: HCFA Missing Opportunities to Provide Consumer Information (GAO/T-HEHS-97-109, Apr. 10, 1997).

to change plans on a monthly basis, as they are permitted to now. If beneficiaries experience problems with a plan or decide that another plan's pharmacy benefits better meet their needs, they will have a limited time period each year to change plans, after which they will be locked in to their decision for the remainder of the year.[2]

While HMOs use various techniques to help control the cost of providing prescription drug benefits, a common technique is to use a formulary—a list of prescription drugs, grouped by therapeutic drug class, which an HMO prefers its physicians to prescribe. HMOs may cover only formulary drugs or provide financial incentives, such as lower copayments, to use formulary rather than nonformulary drugs. HMOs manage their formularies in several ways, including deciding which formulary drugs to add or delete, notifying beneficiaries and physicians about formulary changes, and considering physician requests to cover deleted or nonformulary drugs for specific beneficiaries. As prescription drug costs rise, formularies may become an even more important tool HMOs use to control drug expenditures. Aggressive formulary management may control spending, but beneficiaries need to be aware of how it may affect the value of their drug benefit.

My comments will focus on a report we are issuing to your Committee today that examines how Medicare HMOs manage drug formularies to control drug expenditures and the implications for beneficiaries. We gathered information from 16 HMOs located in three markets—Los Angeles, Miami, and Philadelphia—which account for a significant share of Medicare enrollment. These 16 HMOs represented more than 25 percent of all beneficiaries enrolled in Medicare HMOs. Our findings are based on our analysis of the policies and procedures the HMOs used to make formulary decisions, notify health care providers and beneficiaries about formulary changes, and consider physician requests for nonformulary drugs. We also analyzed how each HMO's formulary changed from November 1997 to January 1999.

In summary, evaluating the prescription drug benefits Medicare HMOs offer is an important but challenging undertaking for prospective enrollees. To determine which plan best meets their needs, beneficiaries need to assess how HMOs' use of formularies can affect their drug benefit. Comparing plans can be difficult because the types of formularies HMOs use and the way in which they are managed differ considerably. The choices

[2]Beneficiaries will have 6 months in 2002 and 3 months in following years to change their enrollment choices.

beneficiaries make can have a significant impact on the value of their drug benefit and their out-of-pocket costs. Plans vary widely in the drugs they cover on their formularies, the copayments they require beneficiaries to make, and the annual limits they set on beneficiaries' coverage. Further, beneficiaries in some plans may not learn about formulary changes until they are at the pharmacy counter. Some plans also make it difficult for physicians to obtain an exception to allow patients to remain on their existing medication at no additional cost if it is dropped from the formulary.

HMOs Use Different Approaches to Manage Formularies

HMOs use formularies to control their drug expenditures by limiting the number of drugs a plan will cover and using financial incentives to encourage the use of formulary drugs. Formularies can be open, incentive-based, or closed. Open formularies are often referred to as "voluntary" because beneficiaries are not penalized financially if their physicians prescribe nonformulary drugs. Incentive-based formularies generally offer beneficiaries lower copayments for preferred formulary or generic drugs. A closed formulary limits coverage to formulary drugs only and requires enrollees to pay the full cost of nonformulary drugs prescribed by their physician.

The HMOs we studied rely extensively on the deliberations of pharmacy and therapeutics (P&T) committees to determine which drugs to add to or delete from their formularies. Typically, P&T committees consider several factors when they assess whether a drug should be added to or deleted from a formulary, including the drug's clinical effectiveness, safety, and whether the drug is therapeutically equivalent to drugs already on the formulary. Most of the P&T committees for the HMOs we studied also consider a drug's cost.

HMOs develop and manage formularies in conjunction with decisions they make concerning the design of their drug benefit. Typically, the design includes such features as (1) the extent to which the plan will pay for nonformulary drugs, if at all; (2) the copayments the plan requires from beneficiaries for formulary or nonformulary prescriptions; and (3) limits or caps on the total dollar amount the plan will pay for outpatient drugs.

Ten of the 16 HMOs in our study use closed formularies, and another is "partially closed" in that the HMO limits coverage to drugs in certain classes but will cover all drugs outside of those classes. Two of the HMOs examined have open formularies in which beneficiaries pay the same

copayment amount for formulary and nonformulary drugs, and the remaining three HMOs use incentive-based formularies that require a higher copayment for nonformulary drugs than for formulary drugs.

The HMOs we studied also manage their prescription drug expenditures by using formulary controls, such as generic substitution and variable copayments. Generic substitution encourages or requires the use of generic drugs when they are available in place of a more expensive brand-name drug. Beneficiaries may also be required as part of the overall benefit design to make different copayments for brand-name, generic, and nonformulary drugs. Twelve of the 16 HMOs in our study require the use of generic drugs when they are available, and 7 of the 16 also use variable copayments.

Twelve of the 16 HMOs we examined deleted drugs from their formularies in four therapeutic classes that are widely used to treat health conditions common to the elderly—hypertension, depression, ulcers, and high cholesterol. These deletions required beneficiaries to switch to alternative formulary drugs or increase their out-of-pocket expenses, in some cases requiring them to pay the full price of the drug. However, 15 of the 16 also added drugs to their formularies in at least one of these classes. Considering all the deletions and additions, 12 of the 16 HMOs covered as many or more drugs in each class in January 1999 as they did in November 1997. With one exception, the HMOs continued to offer several alternatives for physicians to prescribe in each class.

Differences in Formulary Management Have Implications for Beneficiaries

Beneficiaries interested in determining the value of a plan's prescription drug benefit need to consider a number of factors. Differences in the types of formularies, the drugs they include, and formulary controls used by the HMOs can affect whether a beneficiary's drugs are covered and how much they will cost. Beneficiaries may also be affected by differences in the methods the HMOs use to notify them about formulary changes and how they consider physician requests for exceptions from formulary deletions.

The HMOs vary in the methods they routinely use to notify beneficiaries and physicians about formulary changes. For example, while 9 of the 16 HMOs provide copies of formularies on request, the other 7 routinely mail copies of formularies to beneficiaries with information that explains the formulary's purpose and how the beneficiary can use it to review formulary drugs in different classes. Four of these seven HMOs also send letters to beneficiaries notifying them about specific formulary changes

that affect them, as do five of the nine HMOs that send formularies on request. In contrast, four of the nine HMOs do not notify beneficiaries about formulary changes. As a result, beneficiaries may not learn that their drug has been dropped from a formulary and that they will have to pay the full price for the drug until they are standing at the counter of their local drug store.

Beneficiaries are most directly affected by a formulary decision when the drug they have been accustomed to using is deleted from their HMO's formulary and their plan only covers formulary drugs. The change has health care and financial implications for beneficiaries because it requires that they either switch to a new drug that is on the formulary or continue to use the original drug that has become nonformulary and pay for it themselves.

For a beneficiary whose drug is nonformulary, a physician must decide whether an alternate drug on the formulary is appropriate for the beneficiary's care. However, if the physician believes that it is inappropriate for the beneficiary to switch to a formulary drug, the physician must contact plan representatives to request an exception for the beneficiary so that the HMO will continue to cover the beneficiary's original drug.

The HMOs in our study vary considerably in the processes they use to consider exceptions for nonformulary drugs. Beneficiaries enrolled with 2 of the 16 HMOs are not affected by formulary changes because the HMOs use open formularies. At the other 14 HMOs, requests for nonformulary drugs are handled in different ways. Six of the 14 HMOs that use closed or incentive-based formularies require physicians to submit specific medical documentation to demonstrate why formulary alternatives will not be appropriate for a beneficiary. One of these six HMOs also requires the physician to document that the beneficiary tried the formulary alternative during a trial period and that the beneficiary experienced either an adverse reaction to the drug or the drug failed as a treatment alternative.

Three of the 14 HMOs that use closed or incentive-based formularies will grant exceptions for beneficiaries already enrolled in the HMOs from formulary changes—a policy referred to as "grandfathering." Grandfathering allows a physician to keep a beneficiary on the original drug if the physician believes that is the most appropriate care. The physician's prescribing of a nonformulary drug is not an issue as long as the beneficiary remains enrolled in the plan. Although an HMO's use of

grandfathering could enhance the value of a drug benefit to many beneficiaries, this policy was not described in plan materials the HMOs provided beneficiaries.

Conclusions

The success of Medicare+Choice is predicated on quality-based competition. However, Medicare+Choice cannot realize its potential unless beneficiaries are well-informed about their enrollment options. To fully evaluate the prescription drug benefits offered by different plans, beneficiaries need some knowledge of how HMOs use drug formularies in ways that can affect the value of their benefits. This knowledge helps beneficiaries determine which plan best meets their needs by evaluating a combination of factors, including the type of formulary an HMO uses and whether it covers the drugs they use, whether the HMO requires beneficiaries to share in the cost of prescriptions through copayments, and whether the HMO limits the amount of their drug benefit. This knowledge also helps beneficiaries determine how well an HMO keeps them informed about formulary changes and how flexible the HMO is in allowing exceptions to formulary drugs when necessary. Naturally, a beneficiary's preferences and circumstances will affect the importance placed on any one of these factors in evaluating drug benefits.

To help beneficiaries compare Medicare+Choice plans and make informed health care decisions, they need clear and easily understood information that includes the drugs the formularies cover, how formulary changes are handled, and policies and procedures for requesting coverage for nonformulary drugs. While particular formulary changes are not predictable, beneficiaries do enroll in Medicare+Choice plans with the knowledge that Medicare contracts do not allow benefits to be reduced during the course of the contract year. Beneficiaries thus also need a clear understanding of which formulary changes would constitute a reduction of drug benefits and therefore would be unallowable during a contract year.

Previously we recommended that the Health Care Financing Administration (HCFA) require (1) standard formats and terminology for important aspects of managed care organizations' marketing materials, including benefits descriptions, and (2) that literature distributed by organizations follow these standards. While HCFA has made some progress in standardizing important aspects of plans' materials, it has not yet required Medicare+Choice organizations to provide a single standard and comprehensive document that describes plan benefits and beneficiaries' rights and responsibilities as plan members.

Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions you or other Members of the Committee may have.

GAO Contacts and Acknowledgments

For future contacts regarding this testimony, please call William J. Scanlon at (202) 512-7114 or John Hansen at (202) 512-7105. Other individuals who made key contributions include Joel Hamilton and David Michaels.

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