Tier 4 Drugs and the Fraying of the Social Compact

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The growing number of biologic drugs for cancers and other serious conditions is a harbinger of things to come — in more ways than one. These drugs demonstrate that basic research into mechanisms of disease can lead to innovative treatments that turn fatal conditions into chronic disorders. But recent headlines about their high costs — often $50,000 to $100,000 per year — serve as warnings about the financial and ethical challenges we will increasingly encounter throughout medicine.

Because of the rising number of such high-priced medications, some insurers have begun to revise their tiered drug-copayment structures, which have generally delineated three levels of fixed amounts that patients must pay from their own funds when they pick up prescriptions; these amounts have varied depending on the cost of the intervention and whether there are less expensive alternatives. Increasingly, insurers are introducing a fourth tier for particularly expensive drugs, requiring patients to pay what is more appropriately considered “co-insurance” than simply a bigger copayment.

With tiered copayments, patients might pay $5 to $10 per month for a generic medication (tier 1), $20 to $30 for a moderately priced brand-name drug (tier 2), and $50 for a high-priced brand-name drug (tier 3). Health plans use this approach to move “market share” to lower-cost drugs, and some are beginning, in a similar way, to motivate patients to choose lower-cost physicians and hospitals as well.

“Co-insurance” is a different animal. Instead of a fixed amount, patients are charged a percentage — often 20 to 33% — of the overall costs of “tier 4” medications such as biologic agents. Patients who require these drugs are unlucky to begin with, and the out-of-pocket expenses usually far exceed what their budgets can bear.

Co-insurance is not a new idea — Americans who grew up in the era before managed care will remember their parents paying 20% of the costs of office visits, tests, and prescriptions. Indeed, one of the initial attractions of health maintenance organizations was low, fixed copayments for patients. But the costs of health care in general and medications in particular are much higher today. In the 1960s, only the poor...
could not afford coinsurance. Today, only the wealthy can afford it.

Public discussion of the introduction of coinsurance for tier 4 drugs has centered thus far on the sticker shock experienced by individual patients whose costs for essential treatments have skyrocketed. As these cases have emerged, employers and health plans have expressed concern, if not surprise. On April 1, 2008, Kaiser suspended a tier 4 drug program for federal employees for the rest of the year. But tier 4 programs continue for federal employees who are enrolled in other insurance plans, and the expected overall trend is one of growth. Tier 4 systems have now been incorporated into 86% of Medicare drug plans and 10% of private commercial plans that include drug benefits.

The harsh reality is that tier 4 drugs are simply a microcosm of medicine’s future. There is no reason why the tier 4 approach is any less appropriate for medical devices or other expensive interventions than it is for high-cost biologic drugs. The sheer magnitude of the money involved raises fundamental questions about how we will pay for advances in medicine and how we will share financial responsibility for longer, healthier lives.

Like many current cost-containment tactics, tier 4 is a blunt instrument. It focuses on cost, ignoring effectiveness and cost-effectiveness. Consider two tier 4 drugs for breast cancer. Bevacizumab (Avastin) slows the progression of metastatic breast cancer, but studies show it has no effect on overall survival. Conversely, trastuzumab (Herceptin), approved for the adjuvant treatment of breast cancer, can cure 4 to 6 women for every 100 who are treated. Both drugs cost about $55,000 per course of treatment. Does it make clinical, ethical, or economic sense to cover these two drugs in the same way? In a world in which tough choices must be made, society could cover the drug that cures cancer and leave to individual preference the one that does not change survival. Current tier 4 policies sidestep such decisions.

This example raises the larger question of how we will deal with rising health care costs in general. These biologic drugs are expensive, but they currently constitute only about 6.6% of total expenses paid for by health plans. Even for the patients who receive these agents, overall medication expenses are only about half the total hospitalization costs, which are rising because of increasing capital and personnel expenses. Shifting 20 to 33% of the costs of expensive drugs to patients is not going to solve the health care system’s financial challenges.

Why do it, then? These drugs represent a new expense, one that is attributable to a few patients — a small constituency. Shifting a proportion of these costs to a small number of patients is a politically feasible approach to holding down insurance premiums for everyone else — even if it runs counter to the very concept of insurance.

Rather than a long-term solution, however, this transfer of costs is merely kicking the can down the road — and not very far, at that. Insurance plans tried to deal with rising costs in the 1990s by giving the responsibility to providers through capitation and incentives for gatekeeping. Having met with limited success, insurers then tried to engage patients in pursuing efficiency through tiered copayments, insurance plans with high deductibles, and now coinsurance. Because just 10% of patients account for 70% of health care spending, however, there is some limit to how much expense can be shifted to them before concern about costs turns into fear.

The big question raised by the tier 4 phenomenon is this: How generous are we as a society? Data from surveys conducted by Harris Interactive suggest that the willingness of people who are relatively healthy and wealthy to subsidize the care of those who are sick and poor is in decline (see graph). This trend may mean that our society has become less generous or that health care costs have risen beyond what our generosity can bear. In either case, this trend bodes ill for the possibility of spreading to the gen-
The Genetic Information Nondiscrimination Act —
A Half-Step toward Risk Sharing
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Consider three Americans — one with an increased genetic risk for colon cancer, one with a family history of colon cancer, and one with a colonoscopic finding of several large adenomatous polyps. Under the Genetic Information Nondiscrimination Act (GINA), which was recently signed into law by President George W. Bush, health insurance companies may not refuse to cover and may not raise premiums for the first two people, whose genetic information or family history puts them at higher risk for colon cancer.1 Insurers could, however, refuse to sell the third person an individual policy or could quadruple his or her premiums. If the third person is enrolled in an employer-sponsored group health plan, insurers could raise the rates for everyone in the group.

In making such distinctions, GINA is emblematic of this country’s piecemeal and inconsistent approach to health care policy, which makes little sense and leaves many Americans without access to care or in danger of financial ruin if they seek care. Our recent history is replete with examples of similar half-measures in health policy. The Emergency Medical Treatment and Active Labor Act (EMTALA) of 1986 ensures that neither the poor nor the sick can be denied emergency medical treatment, but it leaves those without insurance completely on their own when it comes to fol-