Kaiser Permanente’s Prescription Drug Benefit

A look at how the HMO giant responds to unregulated market pricing of pharmaceuticals.

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Unlike other industrialized nations, the United States maintains no direct controls over prices of patented, brand-name prescription drugs. Although the profitability of brand-name drug manufacturers is largely driven by legislated intellectual property protections enforced by federal agencies and the courts, the pharmaceutical industry has successfully maintained its ability to price its products freely at the levels it considers most profitable without government interference.

As prescription drugs increased in importance in the medical care armamentarium during the 1980s and 1990s, private health insurance plans have expanded coverage of them. For example, even after three years of slight reductions, more than 92 percent of U.S. health maintenance organization (HMO) enrollees have prescription drug benefits. At the same time, traditional fee-for-service Medicare lacks an outpatient drug benefit. As the cost of medicines has increased, it has become clear to policymakers that without a drug benefit Medicare can hardly be considered to deliver comprehensive care.

Drug cost increases, driven by higher prices and higher rates of utilization, continue to escalate. Industry participants observing this trend, particularly insurers and employer-payers, are increasingly questioning the value proposition of prescription drugs—that is, whether the increased spending on pharmaceuticals results in an efficient combination of improved health and reduced spending in other health care sectors. In some clinical areas, such as asthma, the evidence clearly shows drugs’ value in reducing other medical spending and improving quality of life. In most clinical areas, though, the evidence is much less clear.

Despite rising dissatisfaction with drug prices, policymakers seem unlikely to abandon their strong aversion to administered pricing of prescription drugs, accepting the theory that profit stimulates investment in innovative research and development (leading to the development of new drugs). As a result, it is instructive to identify what options are available to balance the economic playing field among those who make and market drugs, those who prescribe them, those who consume them, and those who pay for them.

Purchasers’ options are perhaps best understood by examining the techniques brought to bear by a purchaser facing near monopoly or oligopoly power with an eye toward maximizing its bargaining power with...
suppliers. This paper examines Kaiser Permanente’s approach to managing drug benefits.

**Organizational background.** Kaiser Permanente in California is a group-model HMO providing health care services and coverage to more than six million members. Kaiser Foundation Health Plan Inc. contracts exclusively with the Permanente Medical Group Inc. (in Northern California) and the Southern California Permanente Medical Group to provide medical care services to Kaiser members. Together, the integrated delivery system is known as “Kaiser Permanente.”

Kaiser Permanente in California has long offered prepaid drug benefits as a supplement to its comprehensive health care benefit package. The percentage of members who have outpatient prescription drug coverage has steadily increased over the past twenty-five years. In Southern California, for example, 44 percent of Kaiser Permanente members had prescription drug benefits in 1977; this number had risen to 92 percent in 1998.5

**Market background.** As third-party coverage of prescription drugs has become more commonplace, techniques pioneered in group practices and institutional health care settings—the use of formularies, dissemination of information to physicians, drug utilization review, and organized group or centralized purchasing and distribution—have been adapted to less integrated settings. As a result, approximately three-fourths of all prescriptions filled in 1998 were paid for by some form of third-party coverage.6 Like other health plans, Kaiser Permanente has experienced net drug-cost increases (including changes in utilization and unit price, and factoring in savings resulting from generics programs and other savings strategies) of approximately 12 percent in 1997, 17 percent in 1998, and 16 percent in 1999. This has prompted Kaiser to reexamine its pharmacy benefits management, to determine what can and cannot be improved.

**Drug Information Service.** Kaiser Permanente’s Drug Information Service (DIS) maintains a team of research pharmacists to answer questions from physicians, nurse practitioners, physician assistants, and clinical pharmacists who need research done on cases involving pharmacotherapy for a particular patient or group of patients. This service offers a number of key benefits to clinicians. First, it provides an information source other than pharmaceutical detailers, whose main goal is to facilitate sales of high-margin, single-source products. Second, the service maintains an archive of responses to common questions in a computer database to provide busy clinicians with quick answers. Third, if a Permanente-approved guideline for therapy applies, that information can be quickly provided to the requester. Fourth, peer-reviewed references can be faxed to callers. In the first nine months of 1999, 14,800 queries were received and answered. These requests are compiled into a library of research, available to all Permanente physicians. As of September 1999 more than 97,000 queries had been compiled.

**The Role Of The Formulary**

**Formulary management.** One of the main purposes of a formulary—to create competition among makers of similar drugs when the clinical uses are roughly equal—has been lost in much of the recent debate over formularies’ merits. Without use of formularies (or similar processes) to create competition where it can exist, drug prices would be subject to no market force except the outer limit of what resources are available, either in an individual patient’s bank account or in a health care system’s treasury. Just as a poorly managed formulary process can harm patients by denying access to necessary drugs, so can undue restrictions on formularies harm consumers by reducing competition and raising prices.

Colloquially, formularies are understood to be lists of covered drugs. They are better described as processes to review drugs for clinical appropriateness and need, as well as comparative effectiveness and cost. Ideally, formularies make use of the best-available clinical evidence for drug therapy. The process of creating formularies should include both appropriate clinical information and relative cost information. A formulary’s ap-
Appropriate role is as the first word—not the last word—on preferred drug use. No drug benefit should be defined solely by the formulary; the exception process is critical to ensuring that the unique needs of individual patients can be met while avoiding bureaucratic obstacles for patients and physicians.

As new drugs are developed, physician-specialists within the Permanente Medical Groups acquire pertinent drug information through their own practices, individual reading and educational activities, peer clinical experts, and materials gathered by the DIS. Once a drug is approved by the Food and Drug Administration (FDA), the DIS develops a full analysis that evaluates the peer-reviewed literature, unpublished data, and comparative price information on similar existing therapies. This information is forwarded to physician-specialists and clinical chief specialty groups to make a recommendation on whether a new drug should be added to the Kaiser formulary. These recommendations are ultimately evaluated and voted on by the pharmacy and therapeutics (P&T) committees established within each of the Permanente Medical Groups.

The formulary is maintained with drugs added and deleted at each meeting of the formulary committee. A variety of means are used to convey these decisions to plan physicians. A quarterly newsletter provides therapeutic guidance from experts within the Permanente Medical Group on topics in pharmacotherapy. Periodically, clinical groups review classes of drug within the Kaiser formulary. These reviews focus on eliminating outdated or comparatively hazardous therapies and reevaluating previously excluded drugs.

Additionally, a group of Drug Education Coordinators (DECs), who are trained clinical pharmacists, develop local programs to educate physicians on pharmaceutical therapies. These pharmacists assist physicians in comparing their prescribing patterns with those of their colleagues. Physicians are provided with data to inform them about their own practices (and those of their peers, in aggregate). This encourages physicians to think critically about their own practices while preserving their ability to exercise clinical judgment, patient by patient, in the examination room.

**Formulary exceptions.** The most important formulary element is the Permanente physician’s ability to override and use a nonformulary medication if he or she feels that it is medically necessary for a specific patient. In California this is done without prior authorization and has only required the use of a special nonformulary prescription blank designating that a patient either is a new member (allowed a 100-day transitional supply) or is (or is expected to be) allergic to, intolerant of, or unresponsive to the formulary alternative.

In addition, the prescribing of some medications is limited to certain specialists, and nonformulary status cannot be overridden by the pharmacy unless prescribed by the relevant specialist. For example, human growth hormone can be prescribed only by endocrinologists or infectious disease specialists.

The final adjudication of the prescription benefit is done in the on-site Kaiser pharmacy. When a member arrives at the pharmacy with a prescription, the information is entered into the pharmacy information management system (PIMS). If the prescribed drug is on the formulary, or a Permanente physician has written a formulary override, the patient pays the standard copayment (usually $5–$10). If the patient prefers a nonformulary alternative, although the physician does not consider it medically necessary over available alternatives, then the patient pays full price.

Despite the lack of “command and control” in this process, Kaiser Permanente has formulary compliance of more than 98 percent in California. Perhaps more important, no finan-

“Decisions must be made in the exam room by the treating physician, not in the pharmacy by a computer system.”
cial penalties or rewards are based on a physician’s prescribing. Individual physicians’ prescribing practices are not linked to compensation or financial incentives. Instead, the system relies on education, peer feedback, peer comparison, and involvement of practicing physicians in formulary management.

Considering new drugs for the formulary. The Department of Pharmacy Operations and Strategy at Kaiser tracks pending and new approvals of drugs by the FDA. For clinically important drugs, it may initiate a review even before a drug’s approval as its manufacturer makes data available. In addition, any Permanente Medical Group physician can request that a drug be considered for addition to the formulary. The DIS staff pharmacists assemble the available research and information on a new drug and develop a monograph analyzing the drug’s potential clinical attributes and cost compared with other therapies for the same condition. The monographs form the basic information the P&T committees consider in assessing formulary status of a drug. In 1998 sixty-two different monographs were created.

Between November 1997 and December 1998 the Southern California P&T committee accepted fifty-four drugs to the formulary; did not accept twenty-six drugs; and deleted twenty-three drugs, strengths, or dosage forms of drugs that were previously on the formulary. During that same period the Northern California P&T committee accepted forty-five drugs; did not accept twenty-one drugs; and deleted eighteen drugs, strengths, or dosage forms.

For new drugs considered for inclusion in the formulary in 1998, the average time from approval of a drug to formal consideration was 8.7 months in Northern California and 11.6 months in Southern California. The median time to review, however, was approximately six and seven months, respectively.

Involvement Of Pharmacists In Clinical Care

A major advantage to full integration of medical and pharmaceutical services is the ability not only to use pharmacists in pharmaceutical dispensing and information support to physicians, but also to use their skills in support of patient care. A recent study showed that clinical pharmacist-led anticoagulation clinics have enabled Kaiser Permanente in California to achieve a 59 percent rate of use of warfarin (an anticoagulant) in eligible patients at risk for stroke resulting from atrial fibrillation. Physicians have tended to be reluctant to prescribe this difficult therapy because of the risk of gastrointestinal and intracranial bleeding, if use is not carefully monitored.

The author of the study has pointed out that more than 40 percent of eligible patients are not receiving this therapy. The obvious
challenge is to make this integrated system more accessible to patients.

Secondarily, however, Kaiser Permanente’s experience in operating warfarin clinics enabled it to assess generic warfarin once it became available on the market. In the face of legislative activity by the manufacturer of brand-name warfarin to prohibit generic substitution, studies at Kaiser Permanente in San Diego and the Department of Veterans Affairs (VA) were able to put the controversy to rest, assuring access to generic warfarin.8

Organized Purchasing

While each Kaiser Permanente region operates its own pharmacy units, as well as its own P&T committees, national pharmacy purchasing is consolidated in California. As a result, when there is general agreement among the P&T committees around the country with regard to a particular therapeutic class, a single negotiator represents Kaiser Permanente’s 8.5 million nationwide enrollees in price discussions with drug manufacturers. Manufacturers can no longer play one Kaiser Permanente region against another, and Kaiser members benefit economically.

Kaiser Permanente is a particularly powerful negotiator in part because it is a direct purchaser—it operates its own pharmacies and warehouses. Most other health plans operate their pharmacy function through pharmacy benefits managers (PBMs), as third-party payment intermediaries. Thus, Kaiser is negotiating directly on the price of drugs, not merely for rebates off the reimbursed amount to an independent pharmacy. Buying in bulk and repackaging internally also allows Kaiser Permanente to maximize economic benefit to its members in cases where, for accounting and other reasons, a manufacturer may wish to make a bulk sale at a discount.

Kaiser Permanente is generally only able to negotiate on price in cases where it has the ability to shift market share in a therapeutic class among competing agents. For example, in the selective serotonin reuptake inhibitor (SSRI) class of antidepressants, four drugs potentially compete with each other as first-line therapies for a majority of patients. In other words, while clinical appropriateness may vary based on side-effect profile, the P&T committee determined that most patients could start on any of the four drugs. If treatment fails, a different drug must be tried. If an organization can, however, convince its physicians to prescribe one of the four drugs as the first therapy for, say, 90 percent of the patients, the one or two preferred drugs can be bid out to competing manufacturers for inclusion on the formulary. In an unrestricted market, this should drive price competition; in fact, Kaiser Permanente negotiates discounts on this basis.

Unfortunately, purchasers are limited in their ability to use competition to lower drug costs. Most significantly, the government interferes in the form of a favored status claimed by the state Medicaid programs under federal Medicaid law.9 Under this law manufacturers must provide the state with the same level of discount realized by the most effective private purchaser. This constrains the seller’s incentive to compete on price, because the seller will have to provide the lowest negotiated price to a much larger purchaser that does not create competition. (Generally, state Medicaid programs collect rebates on all drugs in a given class from all competitors, rather than working to move market share to one bidder.) This compromises prudent purchasers’ ability to realize (for their patients) the full benefit of the competition they have created. Market anomalies, such as “Medicaid best price,” that pose barriers to open competition among

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drug manufacturers should be reexamined. To the extent that Congress elects not to pursue price regulation of prescription drugs, it should encourage, and not interfere with, purchasers’ efforts to make competition more effective, to make the market work for consumers, and to enhance the quality of pharmaceutical care.

Concluding Comments

The elements of its integrated delivery system—a mutually exclusive relationship between a group practice of self-governed physicians and a facility-based health plan that buys, warehouses, and dispenses drugs—allow Kaiser Permanente to optimize value purchasing without sacrificing quality of care. Kaiser integrates drug benefits into the delivery of medical services by Permanente physicians. Practicing physicians participate in and receive detailed clinical information about formulary decisions. Physicians can override the formulary when they believe it is medically necessary and appropriate for a particular patient. These systems allow effective drug utilization management where similar, competing drugs in the same therapeutic class exist. This provides an ability to drive market share, in a clinically sound fashion, from one competing drug to another.

What these techniques cannot effectively do, however, is assess whether new therapies for conditions that previously had been untreated or undertreated should or should not be covered. The formulary is generally less effective at managing broad issues of whether health plan coverage of any particular class of therapy is desirable. These are social insurance decisions to be made by those who pay for care—employer-payers, individual premium payers, and taxpayers. While formulary committees harbor much of the information that can inform these decisions, such committees engaged in social insurance policy determinations risk undermining the primary principle on which they should be founded: seeking the most appropriate clinical use, based on quality, safety, efficacy, and relative cost-effectiveness.

Finally, while there are few solid data yet on drug spending that is offset by resulting forgone medical or hospital spending, integrating the pharmacy and medical benefits in one organization means that financial offsets can be captured and translated into benefit for the member population. In theory, an integrated structure avoids less integrated systems’ tendency to view pharmacy and medical costs in separate budget “silos.” Nevertheless, much more work needs to be done to assess the value of pharmaceuticals, because drug spending is more easily quantified than long-term quality-of-life and economic medical benefits are. Integrated delivery systems like Kaiser Permanente need to do better at measuring these economic costs and health benefits. On closer inspection, many pharmaceuticals will likely prove their value. Many others will not.

NOTES

5. Based on internal Kaiser Permanente records.