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COST CONTROL FOR PRESCRIPTION DRUGS

by David H. Shnayer

Physicians usually treat hypertension, arthritis, ulcers and other chronic diseases by prescribing the same drug or drugs for long periods of time. These "maintenance" drugs absorb 75 to 80 percent of claim dollars in the average prescription drug plan. Such drugs are used for months or years, they are often very expensive and the benefit fund pays multiple professional fees for repeated refills.

Adding a maintenance drug mail order option can produce substantial savings for the benefit fund on its regular prescription drug benefit. This option provides a central fill pharmacy from which maintenance drugs can be ordered by mail. A covered person who needs a prescription drug over a long period of time asks his or her physician to write a long term (up to six months) prescription, and mails the prescription to the central fill pharmacy with one co-payment. The central fill pharmacy checks eligibility, dispenses the drug and sends it to the patient by first class mail or UPS within 24 to 48 hours.

The fund pays a professional dispensing fee of about $2.50 each time a prescription is filled. A one-month prescription refilled 12 times a year costs the fund $30.00 (12 × $2.50) in professional fees each year. With a maintenance drug option the prescription is refilled twice a year at a cost to the fund of $5.00 (2 × $2.50) in fees. The fund saves $25.00 in professional dispensing fees for one maintenance drug for one person for one year. About 60 to 70 percent of participants use maintenance drugs, and they often use more than one, so savings mount up quickly.

Unlike some other cost control techniques, a maintenance drug option is popular with participants. It is not a restriction of benefits, but an added choice of ways to use an existing prescription drug benefit. Participants can save money with one co-payment every six months instead of one every month, and they can enjoy added convenience by ordering their maintenance drugs by mail rather than travelling to a

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HOSPITAL RATE DISCOUNTS FOR SELF-INSURED FUNDS WILL CONTINUE THROUGH 1987

Self-insured funds will be able to continue negotiated discount rates with New York hospitals through 1987. This is the result of a combination of legal action and effective lobbying by the labor movement.

The legal action was initiated in 1983 by the Optical Workers Insurance Fund in *Rebaldo v. Cuomo,* when New York forbid hospitals to negotiate discount rate agreements with "groups" that self-insured after May 1983. The only groups with such agreements are ERISA funds. The Optical Workers Fund sued New York Governor Cuomo and others in the Federal courts, maintaining that the State has no right to regulate ERISA funds. *Rebaldo v. Cuomo* was followed closely and, in some instances, supported financially by other self-insured funds. While the case was pending, the State agreed not to penalize hospitals for continuing discount rates with any self-insured funds.

The Second Circuit Court eventually ruled against the Fund and in June of this year the U.S. Supreme Court refused to hear the Fund's appeal, allowing the Second Circuit ruling to stand. Although the Supreme Court never explains why a writ of certiorari is denied, it apparently gave great weight to the State's argument that negotiated discounts for self-insured funds jeopardized New York's waiver from Medicare regulations. That waiver expires on January 1, 1986.

Meanwhile, the New York State Legislature was preparing a renewal through 1987 of NYPHRM, the hospital rate regulation system that contained the disputed prohibition. The New York State AFL-CIO and numerous labor leaders lobbied hard for the absolute right of self-insured funds to negotiate with hospitals for discount rates. In response, the Legislature expanded NYPHRM's "grandfather" category of groups that could continue existing discount agreements to include all funds that self-insured and entered the agreements before May 1985.

The NYPHRM renewal extends through 1987, so that virtually all groups that have been enjoying discount rates can rest assured that those rates will continue for at least two years. The effort continues to establish that any and all self-insured funds have a right to negotiate with hospitals for discount rates.

A BENEFITS NEWSLETTER TO WATCH

We recommend to our readers the newsletter published by the Research Department of the Amalgamated Life Insurance Company. "Benefits Brief" is a service for ALICO's management and technical staff that periodically and clearly condenses news about health care and health benefits. Here are excerpts from recent issues:

American hospitals posted their highest profits in 20 years in 1984, according to the American Hospital Association. Industry profits were $8.3 billion last year, up from $6.5 billion in 1983. This is attributable to a substantial decrease in the average length of stay among Medicare patients; if a hospital can discharge a patient within the guidelines of the applicable diagnostic related group (DRG), or earlier, the remainder of the Medicare reimbursement becomes clear profit. As a result of shorter stays, many hospitals have been able to cut supplies and staff and increase profits even more.

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Total costs per patient for home care hospices are much lower than those for hospital-based hospices, according to the National Hospice Study Final Report. Costs for home hospices average $76 a day and $5,492 for the length of a terminal illness, while costs for hospital-based hospices average $99 a day and $6,148 total.

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The U.S. Supreme Court has ruled that there is nothing in Section 409(a) of ERISA to support the claim that a delay in the processing of benefits "gives rise to a private right of action for compensatory or punitive damages." The Supreme Court decision strikes down a lower court ruling which had said that participants could recover damages if it was shown that a fiduciary had "acted with actual malice or wanton indifference to the rights of a participant or beneficiary." If the Supreme Court had not overturned the earlier decision there was the possibility that fiduciaries would have been held liable to plan participants as well as to the plan itself.

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Mandatory preauthorization for hospitalization and/or surgery is lawful provided that the policy is administered consistently and does not violate any specific federal law, according to a U.S. Court of Appeals. In a test involving a severely obese woman who was denied surgical benefits because she failed to seek approval from her husband's health care plan prior to undergoing surgery for her condition, a lower court ruled that the woman's condition made surgery necessary. However, the appellate court ruled that federal courts have no authority to modify health care plan provisions where eligibility conditions do not violate ERISA or any other applicable federal law.

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More than 25% of women in the primary childbearing age range of 18-24, who account for 40% of all the births in the U.S., have no health care coverage and as a result they are unlikely to receive adequate medical attention. Date from the 1984 Current Population Survey conducted by the U.S. Census Bureau indicates that all told, 17% of women 15 to 44 years old have no form of health insurance; the young, the poor, minorities, unmarried women and those employed in job areas such as household services and retail industries are those most likely to be without coverage. The cost of giving birth in the U.S. averages $3,200 for a normal delivery.

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Alcohol is implicated in 20% to 50% of all hospital admissions, yet a diagnosis of alcoholism is made in fewer than 5% of these cases, according to *Science* magazine. This report confirms the long held belief that most physicians are notoriously deficient in the areas of diagnosis and intervention with alcoholic patients. In fact, a 1982 poll by the American Medical Association indicated that only 27% of the physicians surveyed felt competent to deal with alcoholic patients. However, a trend towards education in this neglected area of medical training is occurring slowly as medical schools begin to experiment with various ways of introducing addictive disorders to the curriculum. The Johns Hopkins School of Medicine has recently introduced a program which will acquaint every medical student and clinician at the institution with the early signs of alcoholism and make them competent to recommend appropriate treatment for the disorder.

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Prescription drug prices have jumped 56% in the past four years, a rate that far exceeds the Consumer Price Index for the same period, according to the House Subcommittee on Health and Environment. A report by the subcommittee indicates that hormones, diabetic drugs and biologicals showed the greatest increase, up 102%, with tranquilizers and sedatives following closely with an increase of 96%.

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An incentive program in effect at Paracelsus Corporation hospitals in California, which offers cash awards to physicians who keep services to Medicare patients to a minimum, has been denounced by the American Medical Association. The A.M.A. has charged that cash awards are nothing but kickbacks that "encourage physicians to act out of selfish, economic interests rather than their primary concern for patient care" and has asked the Department of Health and Human Services (HHS) to investigate. The Inspector General of HHS has responded by saying that nothing can be done in situations where statutes do not specifically prohibit discounts or kickbacks, since an important element of the prospective payment system is that hospitals are supposed to be able to do what they want with the money they earn under the system.

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At least 60% of 2,800 pre-surgery tests studied by a group of researchers were done on patients who showed no conditions indicating a test should be done, according to a recent study published by the *Journal of the American Medical Association.* Medical tests in the U.S. amount to over $600 annually for every man, woman and child and add up to about half the charges on the average hospital bill.

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At least 75% of the health care providers surveyed by Price Waterhouse report a decrease in total hospital admissions since the advent of Medicare's prospective payment system (PPS), while 57% report a decrease in Medicare admissions. About 75% indicate a decrease in overall average lengths of stay and 92% report a decrease in average lengths of stay for Medicare recipients. Meanwhile, critics of PPS, which include Congressmen and some health care providers, continue to charge that there is substantial evidence indicating that quality of care has suffered under the system.

HYSTERECTOMY

by Arthur A. Levin, M.P.H.

One of the ways that the ever-increasing costs of medical care can be controlled is to eliminate services that cannot be shown to improve health. A major criticism of medicine has been that much elective surgery may be medically unnecessary. There are perhaps a dozen elective procedures that comprise a substantial portion of the total amount of surgery performed annually, and whose medical appropriateness is often doubtful. Our last column dealt with one such procedure—hemorrhoidectomy. Now we begin a two-part series on hysterectomy.

Although the incidence is dropping from peak levels reached in the mid-1970's hysterectomy is still the most frequently performed major surgery in the United States. At present almost two-thirds of all adult women will have had their uterus removed by age 70. What is perhaps most alarming is the fact that incidence of hysterectomy performed on younger women of child-bearing age is increasing. Of the 650,000 hysterectomies performed in 1980, half were on women under 45 years of age. Hysterectomy is frequently, almost routinely, combined with oophorectomy (removal of the ovaries). The great majority of these procedures are performed on an elective basis; that is, there is no medical emergency or even urgency.

Critics of the quality of women's health care often point to the substantial amount of surgery performed that is medically unnecessary. Hysterectomy is often used as a prime example of a procedure whose benefit to providers may be clearer than its benefit to patients. There is considerable evidence that lends credence to the criticism.

First, the rate of hysterectomy in the U.S. is double that of England and Wales—but it cannot be shown that women in those countries are any less healthy. What is known is that the U.S. has twice the number of surgeons as do those countries.

Second, studies in the U.S. show great variations in hysterectomy rates by region, and no population or disease patterns that would explain them. Other studies find that the incidence of such surgery declines when hospitals develop standards for medical necessity, often combined with physician education.

Women's health activists have asked for years why so many medically unnecessary hysterectomies and oophorectomies are performed. Many believe that at least a part of the problem is the sexism prevalent among gynecologists and surgeons, most of them male. One often cited advocate of elective hysterectomy is a Dr. Ralph C. Wright, who says:

"...The uterus has but one function: reproduction. After the last planned pregnancy, the uterus becomes a useless, bleeding and symptom-producing, potentially cancer-bearing organ and therefore should be removed..."

Activists in women's health issues have wondered aloud whether, if testicular cancer occurred in older rather than very young men, the same philosophy would be applied to routine surgical castration.

Standing against the enthusiasm of Dr. Wright is a review by researchers at the Centers for Disease Control of 3.5 million hysterectomies performed between 1970 and 1979. They found that one out of every seven (15%) were "questionable" and cited this as a conservative estimate. In addition, other CDC researchers reported on findings that half of those with abdominal hysterectomy and one-quarter of those with vaginal procedures had at least one complication requiring further care.

Many risks, both physiological and psychological, are poorly understood and frequently not discussed with women by those recommending the procedure. As a result, women often express a willingness (or even desire) to have the surgery because they have not had the benefit of a fully informed discussion. A 1977 Harvard School of Public Health study looked at hundreds of 35-year-old women who had elective hysterectomy and could find an overall gain in life expectancy of only 0.2 years. The researchers concluded: "Cancer prophylaxis cannot justify elective hysterectomy; we cannot assess whether quality-of-life considerations do."

The cost of a hysterectomy in Manhattan can range from $5,000 to $15,000 for surgeons' fees and hospitalization. Reducing the rate of unnecessary hysterectomy could help reduce health care costs. More important, tens of thousands of women can be spared exposure to the risks inherent in the surgery, as well as the risks of physical and psychological aftereffects.

Understanding the agreed upon indications for hysterectomy, the so-called "grey areas" and a discussion of the risks of the surgery will be the subject of our next column.

Arthur A. Levin is director of The Center for Medical Consumers and Health Care Information, Inc.

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Prescription Drugs

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pharmacy each time they need a refill. Fewer visits to a physician for new prescriptions are needed, and the related costs of those visits are also reduced.

A maintenance drug option also produces savings by increasing the number of prescriptions filled generically. Most drugs have two names. The generic name is its chemical name. The brand name is a trade name by which the drug is advertised. Generic drugs often cost as much as 70 percent less than their brand name equivalents and they must meet the same federal standards of safety, strength, purity and effectiveness as their brand name equivalents. The central fill pharmacy always dispenses generics where possible. The patient gets equal medical value and the fund pays a lower price.

Here is a list of some chronic conditions and some drugs often used to treat them. Except for insulin, all these are brand name drugs and are among the medications most often prescribed in the U.S.:

Arthritis:	Clinoril, Feldene, Indocin, Motrin, Naprosyn
Diabetes:	Diabinese, insulin, Orinase, Tolinase
Epilepsy:	Dilantin
Heart conditions:	Corgard, Coumadin, Digoxin, Inderal, Isordil, Lanoxin, Quinidine
Hypertension:	Aldomet, Aldoril, Dyazide, Hydrodiuril, Hygroton, Inderal, Lasix, Lopressor, Ser-Ap-Es, Slow-K
Menopause:	Premarin, Provera
Nervous disorders:	Librium, Valium
Thyroid disorders:	Proloid, Synthroid
Ulcers:	Tagamet, Zantac

If a high proportion of your fund's prescription drug claims are for these drugs, a maintenance drug option will help control costs.

David H. Shnayer is president of Nationwide Prescription Services, Inc., Valley Stream, N.Y.

CHOOSING AND BUYING A MAIL ORDER OPTION

Several companies in the New York metropolitan area offer mail order prescription drug service. As when purchasing any service, trustees should ask for competitive bids based on a complete description of the covered group and the proposed structure of the benefit. Mail order can stand alone as the only kind of prescription drug benefit available, or can be added to an existing program.

SELF-ADMINISTERED PROGRAMS

A mail order option can be particularly useful for a fund that offers a self-insured prescription drug benefit. With a self-insured benefit, participants are reimbursed for their prescription drugs at 80% of retail price. By adding a mail order option, any prescriptions dispensed through the central fill pharmacy are charged to the fund at average wholesale price, which can be as much as 35% below retail.

The greatest savings for any prescription drug program come from the price difference between generic drugs and brand names. A self-insured fund can cash in on these savings by training its claims staff to identify maintenance drug users who are using brand name drugs. The fund can then educate these people about the advantages of generic drugs, and encourage them to ask their physicians to prescribe generically.

THIRD PARTY ADMINISTRATION

If the fund already purchases prescription drug services from a third party administrator, a mail order option can easily be added. The trustees rather than the TPA should choose a company to supply the mail order program. Their choice should be based on the quality and service distinctions among the possible suppliers. The program can be integrated into the administrative procedures of any plastic card system.

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