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ScienceDirect
Research in Social and Administrative Pharmacy 11 (2015) 459–467
RESEARCH IN SOCIAL & ADMINISTRATIVE PHARMACY

Commentary

The Affordable Care Act, health care reform, prescription drug formularies and utilization management tools

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Summary

The U.S. Patient Protection and Affordable Care Act (hence, Affordable Care Act, or ACA) was signed into law on March 23, 2010. Goals of the ACA include decreasing the number of uninsured people, controlling cost and spending on health care, increasing the quality of care provided, and increasing insurance coverage benefits. This manuscript focuses on how the ACA affects pharmacy benefit managers and consumers when they have prescriptions dispensed. PBMs use formularies and utilization control tools to steer drug usage toward cost-effective and efficacious agents. A logic model was developed to explain the effects of the new legislation. The model draws from peer-reviewed and gray literature commentary about current and future U.S. healthcare reform. Outcomes were identified as desired and undesired effects, and expected unintended consequences. The ACA extends health insurance benefits to almost 32 million people and provides financial assistance to those up to 400% of the poverty level. Increased access to care leads to a similar increase in overall health care demand and usage. This short-term increase is projected to decrease downstream spending on disease treatment and stunt the continued growth of health care costs, but may unintentionally exacerbate the current primary care physician shortage. The ACA eliminates limitations on insurance and increases the scope of benefits. Online health care insurance exchanges give patients a central location with multiple insurance options. Problems with prescription drug affordability and control utilization tools used by PBMs were not addressed by the ACA. Improving communication within the U.S. healthcare system either by innovative health care delivery models or increased usage of health information technology will help alleviate problems of health care spending and affordability.

Keywords: Health care reform; Affordable Care Act; United States healthcare issues; Control utilization tools

Competing interests: The authors declare no potential conflicts of interest, competing interests, or funding sources associated with this manuscript.

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http://dx.doi.org/10.1016/j.sapharm.2014.08.004

Introduction

Health care reform under the ACA will impact millions of Americans, yet the ripple effects beyond the intended impact are unclear. The ACA is arguably the most comprehensive change to the U.S. health system since the inception of Medicare and Medicaid in 1965. Decreasing the number of uninsured, controlling costs, and increasing the amount of coverage provided by insurance plans are goals of the ACA. Under the ACA, nearly all aspects of the U.S. healthcare system will be affected including the way in which prescription drug coverage benefits are structured for new and currently insured individuals. The ACA will require insurance plans for individuals and small groups to comply with mandated minimum coverage standards set by the state benchmark plan. This formulary requirement is to ensure patient access to care and to increase affordability of medication. However, government mandated formulary requirements in the U.S. have been linked to excess spending, opening the door for increases in the cost of health care for all patients, including those currently with insurance.[1]

Background

The objective of this paper is to examine the impact the ACA may have on health care consumers in the United States when they have prescriptions dispensed. Two key areas that are examined include prescription drug formularies and utilization control measures commonly used by pharmacy benefit managers. The overarching effects that the ACA will have on the U.S. healthcare system will be examined. This paper also analyzes how these changes could lead to an increase in access to care barriers for patients requiring medication. Expected ramifications for both the newly and currently insured and potential solutions that could alleviate these issues will also be discussed.

PBMs and control utilization tools

The increasing usage and administrative costs associated with the management and payment of prescription drugs has led to health plans in the United States "carving out" this section of benefits to pharmacy benefit managers (PBMs). PBMs negotiate drug prices with both the pharmaceutical industry and pharmacies and act as the middleman between the payer and the rest of the health care system. PBMs utilize formularies to encourage the usage of medications that have been proven to be safe, effective and affordable.[2–4]

Table 1 illustrates four common utilization control and formulary exception features that patients have to directly deal with when they are getting prescriptions dispensed.

There is evidence that these formulary features are effective at controlling drug spending, ensuring safe usage of medications, and shifting prescribing patterns toward the usage of preferred medications, especially those in the elderly and chronic disease population.[2–4,6]

Patient issues with control utilization tools

Although the utilization control techniques used by PBMs have good intentions and attempt to help patients, they come with unintentional barriers to access of care.[6–9] The primary argument against the prior authorization process is that the process not only requires the involvement of the PBM, pharmacy, and prescriber but also takes

Table 1
Examples of four common utilization control measures used by United States PBMs[2–5]

Type of utilization control measure	Prescriber contact	Length of process	Notes
Prior authorization	Yes	Ranges from instant to a few business days (more common)	Requires approval of PBM before medication is covered
Step therapy	Dependent on patient history	Usually instant, dependent on need of prescriber contact	Requires attempt of preferred therapy
Tiered copayment	No	Instant	Determines cost sharing responsibility of patient
Quantity limits	Yes, if change in directions required	Dependent on responsiveness of prescriber	Sets day supply and medication quantity restrictions