OPTIMIZING THE HEALTH CARE INVESTMENT: STRATEGIES FOR EMPLOYER HEALTH BENEFIT DESIGN – WHAT EMPLOYERS NEED TO KNOW TO BETTER MANAGE SPECIALTY PHARMACY

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Sponsored by:
OPTIMIZING THE HEALTH CARE INVESTMENT:

STRATEGIES FOR EMPLOYEE HEALTH BENEFIT DESIGN

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THE CHALLENGE

Bend the cost trend and continue investing in specialty care in an uncertain health care world

THE STRATEGY

Ensure employee access to specialty pharmaceuticals while managing health care costs

THE MISSION

Put the optimal benefit design strategies in place
THE CHALLENGE

BEND THE COST TREND AND CONTINUE INVESTING IN SPECIALTY CARE IN AN UNCERTAIN HEALTH CARE WORLD
**ANNA’S STORY**

THE EXPERIENCE OF A VITAL EMPLOYEE WITH UNDIAGNOSED INFLAMMATORY BOWEL DISEASE (IBD)

**WHO**

Anna is a 29-year-old employee

**HOW DOES SHE FEEL?**

- Anna started to feel sick about 4 years ago with stomach cramps, diarrhea, tiredness, and frequent trips to the bathroom. She thought it was food poisoning and dismissed her symptoms.

- A couple of weeks later, her symptoms worsened. She assumed it was stress and pushed through.

- She made an appointment with her primary care physician, who was unable to give her a definitive diagnosis without further tests and monitoring.

- It was an unpleasant experience — she struggled between bathroom trips and fighting the fatigue.
ANNA’S STORY

1 YEAR LATER

HOW DOES SHE FEEL?

- Anna continued to experience flare-ups of symptoms, such as diarrhea many times a day
- She has also experienced a loss of appetite and has lost weight, which added to her being tired and fatigued
- She tried dietary changes like removing gluten and processed foods, and even thought about consulting a nutritionist
- She tried mind-body practices such as meditation and yoga, but she continued to experience symptoms
- Anna’s symptoms were affecting her daily life
ANNA’S STORY

3 YEARS LATER

HOW DOES SHE FEEL?

- Anna’s primary care physician tried multiple treatments, but her abdominal cramps and diarrhea were still very active and she has experienced substantial weight loss.

- She worked with her primary care physician to be referred to a gastroenterologist, a specialist in the digestive system.
ANNA’S STORY

CURRENT STATUS

HOW DOES SHE FEEL?

• After being referred to a gastroenterologist, it took Anna about a month to schedule an appointment

• After multiple visits and multiple tests, she was diagnosed with moderate to severe Crohn’s disease

• She was put on an oral immunosuppressive therapy
  – Her immunosuppressant therapy initially worked; however, over time, she continued to experience very active symptoms, even while on treatment
  – Given the severity of her symptoms, after running additional tests, reviewing her medical history, and discussing the risks and benefits of treatment, the gastroenterologist determined that Anna was an appropriate candidate for biologic therapy, a type of specialty pharmaceutical
CONDITIONS LIKE THESE MAY BE IMPACTING YOUR EMPLOYEES

INFLAMMATORY BOWEL DISEASE (IBD) (ULCERATIVE COLITIS [UC]/CROHN’S DISEASE [CD])
• An estimated 1.4 MILLION American adults are affected by UC or CD (2012)¹
• Based on a national health survey in 1999, SYMPTOMATIC IBD PATIENTS WERE ASSOCIATED with a 12.3% NET REDUCTION in WORKFORCE PARTICIPATION in a one-year period, incurring an excess cost of an estimated $5,228 per patient²
• In a retrospective claims analysis, IBD patients in the employee population had HIGHER UTILIZATION of SHORT-TERM DISABILITY³

RHEUMATOID ARTHRITIS (RA)
• Affects approximately 1.3 MILLION Americans (2005)⁴
• Patients with RA have a HIGH RISK OF DISABILITY AND MORTALITY⁵
• RA is the FOURTH MOST COSTLY CONDITION PER EMPLOYEE in comparison to other chronic conditions (2003 dollars)⁶

MULTIPLE SCLEROSIS (MS)
• More than 200 PEOPLE ARE DIAGNOSED WITH MS EACH WEEK IN THE US,⁷ with an age of onset between 20 AND 50 YEARS⁷,⁸
• Employees with MS are 4 TIMES MORE LIKELY TO HAVE DISABILITY CLAIMS, resulting in an ADDITIONAL COST OF APPROXIMATELY $3,500 PER EMPLOYEE due to disability (2006 dollars)⁹

Specialty Medications are only one type of medication used to treat these conditions. Not all patients with these conditions utilize specialty medications to manage their condition.

*Comparison of disability costs/claims for IBD patients versus controls in a retrospective claims analysis.

SPECIALTY PHARMACEUTICALS
MAY BE NEEDED TO MANAGE CERTAIN
AUTOIMMUNE CONDITIONS\textsuperscript{1,2}

Typically large, complex molecules with a special biotechnology production process.

Dosage form is typically by injection, not solid tablets, capsules, inhalers, or topical agents.

Specialty pharmaceuticals may require complex monitoring and handling processes.

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ONLY A PORTION OF HEALTH CARE COSTS COMES FROM SPECIALTY PHARMACEUTICALS

<table>
<thead>
<tr>
<th>Medical Costs</th>
<th>Prescription Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>43%</td>
<td>20%</td>
</tr>
<tr>
<td>All Other Medical Costs</td>
<td>13%</td>
</tr>
<tr>
<td>Specialty Drug Cost Under Specialty Medication Benefit</td>
<td>17%</td>
</tr>
<tr>
<td>Costs for specialty medications are found in both the medical and pharmacy benefit, making it important to look at costs broadly.</td>
<td>7%</td>
</tr>
<tr>
<td>Specialty Drug Cost Under Medical Benefit</td>
<td></td>
</tr>
<tr>
<td>Nonspecialty Drug Cost Under Pharmacy Benefit</td>
<td></td>
</tr>
</tbody>
</table>
THE STRATEGY

ENSURE EMPLOYEE ACCESS TO SPECIALTY PHARMACEUTICALS WHILE MANAGING HEALTH CARE COSTS
EMPLOYERS NEED OPTIONS THAT ARE BOTH COST-CONSCIOUS AND EMPLOYEE-CENTRIC

Many current strategies to manage costs are based on benefit design elements, such as:

- Increasing Employee Out-of-Pocket Cost Sharing
- Increasing Prior Authorization for Physicians to Prescribe

EMPLOYERS NEED A LONG-TERM, HOLISTIC SET OF STRATEGIES WHEN DEVELOPING BENEFIT PLAN DESIGN
INCREASING EMPLOYEE COST SHARE MAY HAVE UNINTENDED CONSEQUENCES

FOR SEVERELY ILL EMPLOYEES, OUT-OF-POCKET EXPENSES CAN EXCEED 7.5% OF THEIR GROSS FAMILY INCOME\(^1\)*

APPROXIMATELY 25\% OF PATIENTS WITH COST SHARING OVER $500 ABANDONED DRUG\(^2\)

HIGHER PATIENT COSTS WERE ASSOCIATED WITH FEWER DAYS OF THERAPY (REFILL ADHERENCE)\(^3\)

AS AN EMPLOYER, IT IS IMPORTANT TO KEEP IN MIND THAT SOME EMPLOYEES, LIKE ANNA, NEED ACCESS TO SPECIALTY MEDICATIONS.

\(^*\)For severely ill employees in 2004.

OPTIMIZE YOUR BENEFIT DESIGN

1. EMPLOYEE HEALTH STRATEGIES: Rx STRATEGIES ON THE PHARMACY SIDE
   - Check: Limit employee out-of-pocket costs to improve cost access
   - Check: Mandate specialty pharmacy use to leverage the services and support specialty pharmacies can provide
   - Check: Prevent nonmedical switching* of medically stable patients on a specialty medication to limit disruption

2. EMPLOYER STRATEGIES: MANAGING STRATEGIES ACROSS MEDICAL AND PHARMACY
   - Check: Understand the difference and impact of:
     - Spending across medical and pharmacy benefit
     - Managing a drug across medical or pharmacy benefit
   - Check: Ensure consistent employee cost sharing across medical and pharmacy benefit
   - Check: Consider site-of-care optimization

*Nonmedical switching: changing medications for nonmedical reasons, due to changes in formulary coverage.
1 EMPLOYEE HEALTH STRATEGIES: Rx STRATEGIES ON THE PHARMACY SIDE

• LIMIT EMPLOYEE OUT-OF-POCKET COSTS TO IMPROVE COST ACCESS
  
  • Mandate specialty pharmacy use to leverage the services and support specialty pharmacies can provide
  
  • Prevent nonmedical switching of specialty medications to limit disruption
HIGH OOP COSTS WERE ASSOCIATED WITH HIGHER RX-FILL ABANDONMENT

6% of cancer patients with co-pays of ≤$100 abandoned initial prescriptions for oral anti-cancer drugs
25% of those with cost sharing >$500 abandoned drug

n=1053
*Abandonment was defined as reversal of an adjudicated pharmacy claim without a subsequent paid claim for any oncolytic (oral or intravenous) within the ensuing 90 days.

Study Design

OOP=out-of-pocket.

REDUCED PATIENT COSTS (OUT-OF-POCKET) LED TO LOWER RX-FILL ABANDONMENT*

Reducing patient out-of-pocket costs helped more patients fill their prescribed drug therapy

COMMERCIAL PATIENT ABANDONMENT BY CO-PAY COHORT (2012)¹

<table>
<thead>
<tr>
<th>Condition</th>
<th>Patient Pays Less Than $30</th>
<th>Patient Pays More Than $75</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>2%</td>
<td>41%</td>
</tr>
<tr>
<td>TRT</td>
<td>2%</td>
<td>40%</td>
</tr>
<tr>
<td>Anti-Depressant</td>
<td>4%</td>
<td>41%</td>
</tr>
<tr>
<td>Statins</td>
<td>4%</td>
<td>57%</td>
</tr>
<tr>
<td>Immunology</td>
<td>4%</td>
<td>68%</td>
</tr>
<tr>
<td>MS</td>
<td>0%</td>
<td>23%</td>
</tr>
</tbody>
</table>

*Abandonment is defined as the proportion of patients who do not fill the drug of interest within 90 days of their first approval (covered [not rejected] by payor) for that drug.

Study Design

MS=multiple sclerosis; TRT=testosterone replacement therapy.

Source: SHA PTD dataset (2012); IMS FIA dataset (2012); Amundsen Group analysis.

1. Data on file, AbbVie Inc.
REDUCED PATIENT COSTS WERE ASSOCIATED WITH MORE DAYS OF THERAPY POSSESSION

NEW START COMMERCIAL REFILL ADHERENCE* BY CO-PAY COHORT (2011-2012)¹

*Adherence is defined in retrospective assessments as the number of doses dispensed in relation to the dispensing period. Compliance with the prescription is assumed, but unknown, when the medication is dispensed. Retrospective prescription claims database analyses lack the details of daily dosing with respect to timing, dosage, and frequency of medication taking.

Study Design

MS = multiple sclerosis; TRT = testosterone replacement therapy.

Source: SHAPA PTD dataset (2012); IMS FIA dataset (2012); Amundsen Group analysis.
1. Data on file, AbbVie Inc.
CHRONIC VASCULAR DISEASE: IN A RETROSPECTIVE CLAIMS ANALYSIS

HIGHER MEDICATION POSSESSION RATIO WAS ASSOCIATED WITH LOWER TOTAL HEALTH CARE SPENDING

IMPACT OF MEDICATION ADHERENCE* IN CHRONIC VASCULAR DISEASE ON HEALTH SERVICES SPENDING, 2005-2008

FOR ADHERENT* PATIENTS PHARMACY COSTS WERE HIGHER WHILE OTHER HEALTH CARE COSTS WERE LOWER

*Adherence was measured using the medication possession ratio (MPR). MPR is the number of days during the year when the patient had medication, divided by the number of days in the year. Condition-level adherence for each patient-year observation was calculated as the average of MPRs for all therapeutic classes for each chronic disease, weighted by the days’ supply in each therapeutic class. A condition-level MPR below 0.80 was considered nonadherent, and a ratio of 0.80 or greater was considered to be adherent.

Source

1. **EMPLOYEE HEALTH STRATEGIES: Rx STRATEGIES ON THE PHARMACY SIDE**

- Limit employee out-of-pocket costs to improve cost access

- MANDATE SPECIALTY PHARMACY USE TO LEVERAGE THE SERVICES AND SUPPORT SPECIALTY PHARMACIES CAN PROVIDE

- Prevent nonmedical switching of specialty medications to limit disruption
SPECIALTY PHARMACIES PROVIDE AN ADDITIONAL LEVEL OF PATIENT SUPPORT

- Specialty pharmacies **COORDINATE** many aspects of patient care and disease management. They also have **PATIENT SUPPORT TEAMS** who have specific training in various diseases/conditions.
- Specialty pharmacies are designed to **EFFICIENTLY** deliver medications with special requirements.
- Drugs dispensed by a specialty pharmacy **OFTEN REQUIRE MORE COMPLEX ROUTES OF ADMINISTRATION** such as injection or infusion, requiring a higher level of patient training and counseling.

PATIENTS USING A SPECIALTY PHARMACY HAD GREATER MEDICATION REFILL ADHERENCE THAN THOSE USING A RETAIL PHARMACY

**Mean Medication Refill Adherence**

- **Retail Pharmacy**
  - (n=25,953)
  - 73% (±26%)

- **Specialty Pharmacy**
  - (n=60,126)
  - 89% (±18%)

**Study Design:** A retrospective analysis of a Wolters Kluwer database representing 86,079 US patients who were prescribed a biologic for autoimmune conditions from January 11, 2003, to August 13, 2009. Patients were included if they used only one pharmacy and one mechanism of reimbursement. Percentages shown represent the mean MRA of all patients within each group.

*Medication refill adherence (MRA) was defined as the total days of supply divided by the number of days evaluated multiplied by 100, which is a percentage and is capped at 100.

NOT ALL SPECIALTY PHARMACIES ARE THE SAME
CHOOSE A SPECIALTY PHARMACY TO MEET YOUR NEEDS

- Customer service—24/7 clinical and financial assistance
- Specialty medication therapy management—programs and services to promote adherence
- Proper storage and handling of product
- Quality—provides check points from treatment initiation

- Waste reduction—policies and procedures to manage waste
- Data management/reporting—information technology capabilities
- Cost containment—competitive pricing and flexibility
- Internal resources—prior authorization services, account management, formulary management

Specialty pharmacy core services can vary but additional services are often offered for an added cost.

EMPLOYEE HEALTH STRATEGIES: Rx STRATEGIES ON THE PHARMACY SIDE

• Limit employee out-of-pocket costs to improve cost access

• Mandate specialty pharmacy use to leverage the services and support specialty pharmacies can provide

• PREVENT NONMEDICAL SWITCHING OF SPECIALTY MEDICATIONS TO LIMIT DISRUPTION
PRESERVE THE DECISION
MADE BY THE PHYSICIAN AND PATIENT

CAREFULLY CONSIDER INSURANCE-DRIVEN NONMEDICAL SWITCHING

- The patient journey leading up to biologic therapy can be difficult and complicated
- Patients with certain autoimmune diseases are often treated with multiple therapies before being prescribed a biologic therapy
- The efficacy and safety of switching medically stable patients who tolerated and adequately responded to biologic therapy has not been assessed in adequate and well-controlled clinical studies

Once patients are adequately responding to and tolerating a specific biologic therapy, they should not be switched without careful consideration
HEALTH CARE COSTS WERE HIGHER FOR PATIENTS WHO SWITCHED A BIOLOGIC

A retrospective claims database analysis using Clinformatics DataMart data compared medical and total costs of medically stable patients on one biologic who were switched to a step-1 agent versus patients who were maintained on that original biologic during a 6-month follow-up period.

Source: Clinformatics Data Mart.

*Patients were required to have no hospitalizations, ER visits, or a substantial increase in biologic dose in the 6 months prior to the switch.

Results showed a difference of $547 more in medical costs and $4,013 more in total costs for patients who switched to a step-1 agent versus those who were maintained on the original biologic.

Switchers and maintainers did not differ in age, gender, region, or health plan type at baseline; switchers had a significantly higher Charlson comorbidity index at baseline than maintainers and when this was adjusted for in the multivariable regression analysis, the cost differences between the groups were still observed (P<0.0001).

1. Data on file, AbbVie Inc.
ANNA’S STORY:
WHAT COULD HAPPEN TO ANNA IF HER EMPLOYER CHANGES HER SPECIALTY HEALTH BENEFIT DESIGN?

WHAT IF ANNA...

Discovers her medication costs go from a $50 co-pay to 30% co-insurance?

OR

Picks up a prescription while traveling from a pharmacy that does not know how to process her discount card?

OR

Finds out from her pharmacy her medication no longer has preferred formulary status?

NOW ANNA...

May not be able to afford her medication

May have to go back to her physician for tests or switch to new medications
EMPLOYER STRATEGIES:
MANAGING STRATEGIES ACROSS MEDICAL AND PHARMACY

- UNDERSTAND THE DIFFERENCE AND IMPACT OF:
  - SPENDING ACROSS MEDICAL AND PHARMACY BENEFIT
  - MANAGING A DRUG ACROSS MEDICAL OR PHARMACY BENEFIT

- Ensure consistent employee cost sharing across medical and pharmacy benefit

- Consider site-of-care optimization
PHARMACY VS MEDICAL BENEFIT
FOR SPECIALTY PHARMACEUTICALS CAN CREATE CHALLENGES

- Some specialty drugs are **COVERED UNDER BOTH** the pharmacy and medical benefit, **INCREASING POTENTIAL FOR CONFUSION TO EMPLOYERS**\(^1\)

- Medical benefits often have an out-of-pocket maximum, in contrast to pharmacy benefits, which often do not have a maximum. This can lead to **DISPARITY IN TERMS OF EMPLOYEES’ COST BURDEN**\(^1\)

- **TRACKING** and managing total costs of drugs covered under the medical benefit can be a **DIFFICULT PROCESS** for employers\(^1\)

- Having two different benefit structures translates into **DIFFERENT LEVELS OF EMPLOYEE COST SHARING**

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Based on a survey of pharmacy and medical directors representing 102 health plans and more than 108 million covered lives.

ROUTE OF ADMINISTRATION
CAN INFLUENCE MEDICAL VS PHARMACY COVERAGE

Based on a survey of pharmacy and medical directors representing 102 health plans and more than 106 million covered lives.

COST SHARE OFTEN DIFFERS
UNDER THE PHARMACY VS MEDICAL BENEFIT

MEAN COMMERCIAL CO-PAY COST SHARE

<table>
<thead>
<tr>
<th>Pharmacy (single specialty tier; n=24)</th>
<th>Medical (n=73)</th>
</tr>
</thead>
<tbody>
<tr>
<td>$103 ($40–$250)</td>
<td>$68 ($10–$250)</td>
</tr>
</tbody>
</table>

MEAN COMMERCIAL CO-INSURANCE COST SHARE

<table>
<thead>
<tr>
<th>Pharmacy (single specialty tier; n=24)</th>
<th>Medical (n=73)</th>
</tr>
</thead>
<tbody>
<tr>
<td>23% (10%–50%)</td>
<td>19% (10%–30%)</td>
</tr>
</tbody>
</table>

Based on a survey of pharmacy and medical directors representing 102 health plans and more than 106 million covered lives.

SHIFTING BENEFIT COVERAGE CASE STUDY

OBJECTIVE:
- To manage specialty spending by phasing in a specialty drug benefit over 12 months

METHODOLOGY:
- Designated specialty therapies — both self- and physician-administered — were covered under a member’s pharmacy benefit
- Providers who treated members with the specialty benefit were required to obtain drugs through the specialty pharmacy network; BCBSRI denied provider buy-and-bill claims
- 12 months of data from members who had the new specialty pharmacy benefit were compared with data from the 12 months prior to the program’s start

RESULTS:
- Per-member per-month (PMPM) increased only 0.8% for groups with the benefit compared with an 18.7% rise in PMPM costs for groups without it

*An Independent Licensee of the Blue Cross and Blue Shield Association.
Results of this strategy do not guarantee any particular savings or other result.

EMPLOYER STRATEGIES: MANAGING STRATEGIES ACROSS MEDICAL AND PHARMACY

- Understand the difference and impact of:
  - Spending across medical and pharmacy benefit
  - Managing a drug across medical or pharmacy benefit

- ENSURE CONSISTENT EMPLOYEE COST SHARING ACROSS MEDICAL AND PHARMACY BENEFIT

- Consider site-of-care optimization
ENSURE CONSISTENT EMPLOYEE COST SHARING ACROSS MEDICAL AND PHARMACY BENEFIT

Determine which drugs covered under the medical benefit can be moved under the pharmacy benefit¹:

- Easier to track
- Not subject to as much price variation
- Use an out-of-pocket maximum to ensure that taking the medication does not become a heavy burden

Consider moving specialty drugs into a separate drug benefit to achieve²:

- Same patient cost sharing
- Same price paid for drug
- Same utilization review policies and procedures
- Real-time integration of medical and pharmacy data

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2 EMPLOYER STRATEGIES:
MANAGING STRATEGIES ACROSS MEDICAL AND PHARMACY

• Understand the difference and impact of:
  – Spending across medical and pharmacy benefit
  – Managing a drug across medical or pharmacy benefit

• Ensure consistent employee cost sharing across medical and pharmacy benefit

• CONSIDER SITE-OF-CARE OPTIMIZATION
SITE OF CARE COSTS CAN DIFFER

Case Study: A Medical Benefit Average Specialty Drug Cost-per-Unit by Site of Care

$70/UNIT Administered in HCP office

$111/UNIT = ~60% more expensive Administered in hospital outpatient department

Despite the low number of claims per year, the cost difference between delivery sites may have a significant impact on drug spend

<table>
<thead>
<tr>
<th>Site of Care</th>
<th>Cost per Unit</th>
<th>Units</th>
<th>Cost per Claim</th>
<th>Claims per Year</th>
<th>Annual Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCP office or home infusion</td>
<td>$70</td>
<td>50</td>
<td>$3,500</td>
<td>7</td>
<td>$24,500</td>
</tr>
<tr>
<td>Hospital outpatient department (average health plan cost-per-unit)</td>
<td>$111</td>
<td>50</td>
<td>$5,500</td>
<td>7</td>
<td>$38,850</td>
</tr>
<tr>
<td>Hospital outpatient department (highest cost hospital)</td>
<td>$360</td>
<td>50</td>
<td>$18,000</td>
<td>7</td>
<td>$126,000</td>
</tr>
</tbody>
</table>

THE MISSION

PUT THE OPTIMAL BENEFIT DESIGN STRATEGIES IN PLACE
WHAT SHOULD AN EMPLOYER DO TO PROVIDE ANNA WITH ACCESS TO SPECIALTY MEDICATIONS AND STILL CONTAIN COSTS?
LOOK COMPREHENSIVELY TO ASSESS CURRENT COSTS AND UNDERSTAND COST COMPONENTS

Integrate and track data for specialty medications\(^1\):

- ✔ Analyze costs of treatment in terms of total medical and pharmacy costs
- ✔ Combine data to better understand the value and cost of specialty medications
- ✔ Use data to establish a baseline for future comparisons

THE LEVEL OF DATA COLLECTION AND ASSESSMENT WILL DETERMINE THE SUCCESS OF MANAGING SPECIALTY PHARMACY INTERVENTIONS\(^2\)

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START NOW WITH HOLISTIC
EMPLOYEE-FOCUSED BENEFIT DESIGN STRATEGIES

LIMIT EMPLOYEE OUT-OF-POCKET COSTS
✓ Ensure employees are not burdened with high out-of-pocket expenses that may lead them to not start or discontinue treatment\(^1,2\)

MANDATE SPECIALTY PHARMACY USE
✓ Contract with specialty pharmacy/leverage specialty pharmacy services of a pharmacy benefit manager for employee services and support\(^1\)

PREVENT NONMEDICAL SWITCHING
✓ Ensure employees continue on the specialty treatments their physicians prescribe

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EMPLOYER COST MANAGEMENT STRATEGIES

- Determine what specialty medications in the medical benefit can move to the pharmacy benefit\(^1,2\)

- Aim to ensure consistent employee cost sharing across pharmacy and medical benefits where appropriate\(^2\)

- Re-examine plan design to ensure that the site of specialty medication administration is managed\(^1\)

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GET STARTED TODAY

✓ Work with your partners to understand your benefits design

✓ Determine where to make benefit changes – look at what is being offered for your medical vs pharmacy benefits

Ensure that your employees have access to the care they need
HIGH OOP COSTS WERE ASSOCIATED WITH HIGHER RX-FILL ABANDONMENT*

**Study Design:** Cross-sectional cohort study utilizing administrative claims data to calculate the abandonment rate of oral oncolytic medications and identify factors that may affect the likelihood of abandonment. The study included 10,508 patients with Medicare and commercial insurance for whom oral oncolytic therapy was initiated between 2007 and 2009.

*Abandonment was defined as reversal of an adjudicated pharmacy claim without a subsequent paid claim for any oncolytic (oral or intravenous) within the ensuing 90 days.

REDUCED PATIENT COSTS (OUT-OF-POCKET) LED TO LOWER RX-FILL ABANDONMENT*

**Study Design:** Commercial patients were selected by their first approved attempt to fill a product of interest between January 2012 and December 2012. A 12-month eligibility lookback and a 6-month eligibility follow-up was performed to ensure patients were visible in the dataset. Patients were grouped by their final out-of-pocket cost (after any secondary payer payments) on their first attempt to fill. SHA longitudinal claims data were used for specialty drugs (immunology and MS). IMS FIA longitudinal data were used for nonspecialty drugs (diabetes, TRT, statins, and anti-depressants). Longitudinal claims include payer channel, patient co-pay information, and lifecycle status.

*Abandonment is defined as the proportion of patients who do not fill the drug of interest within 90 days of their first approval (covered [not rejected] by payor) for that drug.

1. Data on File, AbbVie Inc.
REDUCED PATIENT COSTS WERE ASSOCIATED WITH MORE DAYS OF THERAPY POSSESSION

Study Design: Included commercial patients initiating a new product of interest between September 2011 and October 2012. A 12-month eligibility lookback and a 15-month eligibility follow-up was performed to ensure patients were visible in the dataset. Patients were grouped by their most common final out-of-pocket cost (after any secondary payer payments) during the year they are tracked. SHA longitudinal claims data were used for specialty drugs (immunology and MS). IMS FIA longitudinal data were used for nonspecialty drugs (diabetes, TRT, statins and anti-depressants). Longitudinal claims include payer channel, patient co-pay information, and lifecycle status.

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HIGHER MEDICATION POSSESSION RATIO WAS ASSOCIATED WITH LOWER TOTAL HEALTH CARE SPENDING

*Medication Possession Ratio (MPR) is the number of days during the year when the patient had medication, divided by the number of days in the year. Condition-level adherence for each patient-year observation was calculated as the average of MPRs for all therapeutic classes for each chronic disease, weighted by the days’ supply in each therapeutic class. A condition-level MPR below 0.80 was considered nonadherent, and a ratio of 0.80 or greater was considered to be adherent.

Source: CVS Caremark integrated pharmacy and medical administrative claims data, January 1, 2005–June 30, 2008. Presented are marginal effect estimates from linear fixed-effects models of health services cost. All models included a weighted Charlson Comorbidity Index; two-year indicator variables; dummy variables for age 65 or older, male, and adherent; and interaction terms for age 65 or older, male, and adherent.

HEALTH CARE COSTS WERE HIGHER FOR PATIENTS WHO SWITCHED A BIOLOGIC¹

Study Design: Patients aged 18-64 years; patients who were switched were medically stable on one biologic before switching (usage greater than or equal to 90 days before switching to step-1 agents; no hospitalizations, ER visits, or dosage escalation during the baseline period); patients who were maintainers had continuous original biologic usage (i.e., at least Month 1 and Month 6 use of original biologic) in the follow-up period; 1-year study period between January 2011 and December 2012. Switching had to occur in 2012. Step-1 agents were other biologics.

*Patients were required to have no hospitalizations, ER visits, or a substantial increase in biologic dose in the 6 months prior to the switch.

A retrospective claims database analysis using Clininformatics DataMart data compared medical and total costs of medically stable patients on one biologic who were switched to a step-1 agent versus patients who were maintained on the original biologic during a 6-month follow-up period.

Results showed a difference of $547 more in medical costs and $4,013 more in total costs for patients who switched to a step-1 agent versus those who were maintained on the original biologic.

1. Data on File, AbbVie Inc.
HEALTH CARE COSTS WERE HIGHER FOR PATIENTS WHO SWITCHED A BIOLOGIC

Limitations: Claims data imply a standard set of limitations, including that disease severity and other clinical variables are absent from the data. Key among the omitted variables is reason for switch, which must be inferred from the data. In addition, the paid amounts included in the data are standardized to account for differences across health plans and provider contracts, and may not reflect actual costs incurred by the patient and third-party payer. Additionally, these analyses were based on a privately insured patient population, perhaps not representative of the entire US population. Lastly, observed claims data could include coding errors or omissions, although the occurrence of this is low.

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A retrospective claims database analysis using Clinformatics DataMart data compared medical and total costs of medically stable patients on one biologic who were switched to a step-1 agent versus patients who were maintained on the original biologic during a 6-month follow-up period.

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1. Data on File, AbbVie Inc.
National Employer Initiative on Specialty Pharmacy

Developed by employers for employers
Midwest Business Group on Health

- Founded in 1980 as a 501(c) (3) not-for-profit employer coalition by a group of large Midwest employers
- Members consist of over 120 large self-insured public and private employers – Boeing, Ford, Kraft, OfficeMax, Procter & Gamble, State of Illinois
- Members are represented by senior human resources/health benefits professionals
- Members annually spend more than $4 billion on health care for over 4 million lives
- Founding member of the National Business Coalition on Health
Specialty drug trends

• U.S. spending on specialty drugs is projected to increase 40% to 70% in the near future
• 3 of the 4 costliest prescription therapy classes will be for specialty conditions
• At least 50% of all drugs in late-stage development are in the specialty drug category
• Currently, there are over 900 of specialty drugs already approved by the FDA
• 50%-60% of specialty drugs are represented by the oncology category
Specialty drug trends

- About half of specialty drug costs are funding through the pharmacy benefits – the other half through medical – *this makes it difficult to track where the money is spent*

- Top 3 highest selling drug categories – Cancer, RA and MS

- Many challenge exist...
  - Lack of PBM transparency – e.g. rebates/contracting
  - Abuse and misuse by providers – e.g. site of care
  - Lack of innovation in benefit plan design
Midwest Business Group on Health

National Employer Initiative on Specialty Pharmacy
Employer Initiative on Specialty Pharmacy
2011 to 2015

- Employer Advisory Council
- Annual Employer Surveys on Specialty Pharmacy – 4th year
- Online Employer Toolkit – [www.specialtyrxtoolkit.com](http://www.specialtyrxtoolkit.com)
  - **Section I**: Understand the specialty pharmacy landscape, emerging issues and related stakeholders
  - **Section II**: Address key challenges and identify innovative approaches to benefit plan design and vendor contracting
  - **Section III**: Support at-risk population through communications and resources
Employer Initiative on Specialty Pharmacy
2011 to 2015

- Annual Multi-Stakeholder Collaboration
- National Educational Outreach
- Employer Demonstration Pilots – Partner with 6 sister coalitions
2014 MBGH Annual Employer Member Survey

- Reducing costs: 8% low priority, 28% medium priority, 64% high priority
- Managing specialty drugs: 5% low priority, 28% medium priority, 45% high priority
- Avoiding 2018 excise tax: 5% low priority, 28% medium priority, 59% high priority
- Creating effective benefits communications: 4% low priority, 28% medium priority, 59% high priority
- Creating a culture of health: 4% low priority, 28% medium priority, 56% high priority
- Offering more targeted wellness programs: 3% low priority, 20% medium priority, 45% high priority
- Integrating vendor data to manage health: 13% low priority, 23% medium priority, 38% high priority

High priority
Medium priority
Low priority
No priority
4th Annual Employer Survey

- Survey respondents: 81 employers
- Represent over 1.5M employees
- Average employer size: 19,800
- Primary industries
  - 22% - Manufacturing
  - 10% - Technology and Science
  - 9% each - Financial Services; Government; Health Care
Employer level of understanding of biologic drugs and specialty pharmacy benefits

<table>
<thead>
<tr>
<th>Year</th>
<th>Medium</th>
<th>High</th>
<th>Low</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>53%</td>
<td>22%</td>
<td>25%</td>
</tr>
<tr>
<td>2012</td>
<td>48%</td>
<td>36%</td>
<td>10%</td>
</tr>
<tr>
<td>2013</td>
<td>56%</td>
<td>22%</td>
<td>17%</td>
</tr>
<tr>
<td>2014</td>
<td>45%</td>
<td>32%</td>
<td>17%</td>
</tr>
</tbody>
</table>
## Level of employer understanding ...

<table>
<thead>
<tr>
<th></th>
<th>High</th>
<th>Above Avg</th>
<th>Average</th>
<th>Below Avg</th>
<th>Low</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>How to effectively manage SP drug benefits</strong></td>
<td>10%</td>
<td>32%</td>
<td>44%</td>
<td>14%</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Criteria for coverage of SP through pharmacy vs medical benefits</strong></td>
<td>15%</td>
<td>31%</td>
<td>40%</td>
<td>12%</td>
<td>2%</td>
</tr>
<tr>
<td><strong>3 year cost trend for SP drugs</strong></td>
<td>27%</td>
<td>33%</td>
<td>31%</td>
<td>7%</td>
<td>2%</td>
</tr>
<tr>
<td><strong>Difference in cost trends between coverage through pharmacy vs medical benefit</strong></td>
<td>21%</td>
<td>33%</td>
<td>25%</td>
<td>19%</td>
<td>2%</td>
</tr>
</tbody>
</table>
### Level of employer agreement ...

<table>
<thead>
<tr>
<th>Concern</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Somewhat Agree</th>
<th>Don’t Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Concerned about increasing SP costs</td>
<td>78%</td>
<td>18%</td>
<td>4%</td>
<td>0%</td>
</tr>
<tr>
<td>Concerned about number of SP drugs in pipeline</td>
<td>60%</td>
<td>35%</td>
<td>3%</td>
<td>2%</td>
</tr>
<tr>
<td>Plan to shift more of rising costs to employees</td>
<td>2%</td>
<td>24%</td>
<td>32%</td>
<td>42%</td>
</tr>
<tr>
<td>High cost of SP drugs are acceptable if they offer improved outcomes</td>
<td>3%</td>
<td>15%</td>
<td>62%</td>
<td>20%</td>
</tr>
</tbody>
</table>
### Level of employer agreement...

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Somewhat Agree</th>
<th>Don’t Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SP drugs are cheaper than medical treatments and hospital stays that may occur</strong></td>
<td>8%</td>
<td>45%</td>
<td>43%</td>
<td>4%</td>
</tr>
<tr>
<td><strong>New and innovative solutions are needed to manage SP</strong></td>
<td>56%</td>
<td>34%</td>
<td>10%</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Our PBM does a good job managing SP costs</strong></td>
<td>12%</td>
<td>39%</td>
<td>41%</td>
<td>8%</td>
</tr>
<tr>
<td><strong>Our Specialty Pharmacy does a good job managing SP costs</strong></td>
<td>10%</td>
<td>31%</td>
<td>47%</td>
<td>12%</td>
</tr>
</tbody>
</table>
Plan design strategies

- Same as traditional drug plan design (88%)
- Include vendor performance guarantees (51%)
- Offer single integrated benefit that incorporates drugs into medical care (42%)
- Shift more cost to employees (55%)
- SP as carve-out (63%)
- Narrow network that assumes risk (68%)
- No drug formulary—costs based on lifestyle, business preserving, etc. (46%)

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Most effective cost management strategies

1. Coordinated information on disease therapies
2. Defined contracting terms/coverage for claims reimbursement
3. Day’s supply/limitations messaging
4. Site of care strategies driving patients to lower cost options
5. Formulary explanations
6. Incorporation of wellness across the continuum of care
Most effective patient outcome strategies

1. Alternative risk financing/actuarial design
2. Restricted coverage under the medical benefit
3. Exclusive or limited networks by setting of care
4. Defined contracting terms/coverage for claims reimbursement
5. Day’s supply/limitations messaging
Oncology plan design strategy

- Integrated PBM manages benefits (HP PBM) - 37%
- Required use of specialty pharmacy to get Rx - 25%
- Physician-based model using PA from list - 21%
- Independent PBM receives reports from health plan on integrated use - 17%
- Oncology carve-out - 0%
- Narrow formulary to include preferred oncology drugs - 0%

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Plan design elements to drive people to lowest cost site of care

- Don't know about this
- Very effective
- Need more info
- Effective
- Somewhat effective
- Don't offer
Incentives offered to covered population for use of ...

- **Specialty pharmacy**: 11% Offered/Effective, 35% Offered/Not Effective, 48% Don't Offer, 6% Don't Know
- **Care/case mgmt**: 10% Offered/Effective, 42% Offered/Not Effective, 40% Don't Offer, 8% Don't Know
- **Step therapy for oral Rx at retail**: 5% Offered/Effective, 32% Offered/Not Effective, 54% Don't Offer, 9% Don't Know
- **Compliance to drug**: 5% Offered/Effective, 18% Offered/Not Effective, 60% Don't Offer, 17% Don't Know
- **Site of care**: 7% Offered/Effective, 15% Offered/Not Effective, 72% Don't Offer, 6% Don't Know
- **Compliance to treatment**: 5% Offered/Effective, 18% Offered/Not Effective, 61% Don't Offer, 16% Don't Know

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## Cost-share increases over past 3 years

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 10%</td>
<td>28%</td>
<td>15%</td>
<td>46%</td>
<td>10%</td>
</tr>
<tr>
<td>11-20%</td>
<td>18%</td>
<td>24%</td>
<td>29%</td>
<td>29%</td>
</tr>
<tr>
<td>21-30%</td>
<td>17%</td>
<td>0%</td>
<td>33%</td>
<td>50%</td>
</tr>
<tr>
<td>31-40%</td>
<td>0%</td>
<td>0%</td>
<td>20%</td>
<td>80%</td>
</tr>
<tr>
<td>41-50%</td>
<td>17%</td>
<td>0%</td>
<td>17%</td>
<td>67%</td>
</tr>
<tr>
<td>Over 50%</td>
<td>0%</td>
<td>0%</td>
<td>43%</td>
<td>57%</td>
</tr>
<tr>
<td>No increases</td>
<td>13%</td>
<td>11%</td>
<td>67%</td>
<td>9%</td>
</tr>
</tbody>
</table>
Impact of cost-share increases

- Reduced compliance: 37%
- Reduced Rx fill rate: 29%
- Increased requests for $ assistance or mfg coupons: 17%
- Employee complaints about costs: 9%
- Increased compliance to treatment: 1%
- No impact: 5%
- Don't know: 1%

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Value of specialty drugs in significantly improving chronic or life-threatening disease outcomes

- Valuable: 46%
- Highly Valuable: 36%
- Somewhat Valuable: 8%
- Need more info: 8%
- Don't know: 2%

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Value of specialty drugs in improving workforce productivity

- Somewhat valuable: 11%
- Valuable: 29%
- Need more information to evaluate: 16%
- Highly valuable: 27%
- Don't know: 13%

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Value of specialty drugs in improving workforce productivity

- Somewhat valuable: 4%
- Valuable: 27%
- Need more information to evaluate: 16%
- Highly valuable: 29%
- Don't know: 13%
Online Employer Toolkit

www.specialtyrxtoolkit.com
National Employer Initiative on Specialty Pharmacy

Specialty Pharmacy 101  
Managing Specialty Benefits  
Supporting At-Risk Populations

Employer Toolkit

With the significant growth of specialty pharmacy, employers must seek effective solutions to manage increasing pharmacy and medical plan costs. This toolkit will help employers to:

- Address key challenges in managing specialty pharmacy benefits and provide tools for the C-Suite
- Identify innovative approaches to benefit plan design and service partner contracting
- Support at-risk population through communications and resources

Click for Employer Journey in Pharmacy Benefits

In the News

- 05/24/2013  
  Health Law Policies that Offer Low Premiums C...
- 05/14/2013  
  How to Manage Pharmacy Benefit Plans in a Rag...
- 07/4/2013  
  Current Trends in Specialty Drug Utilization...
Employer Demonstration Pilots
National Coalition/Employer Pilots

- Employers’ Health Coalition – Arkansas
- Employers Health Coalition – Ohio
- Florida Healthcare Coalition – Florida
- Healthcare 21 – Tennessee
- Mid-America Coalition on Health Care – Kansas
- Midwest Business Group on Health – Midwest
Employer Pilots: Benefit Coverage Approaches (based on Multi-Stakeholder meeting)

1. Ensuring High-Quality Case/Care Management and Coordination with Medical and Pharmacy Plan Vendors
2. Improving Treatment Adherence
3. Using Value-Based Benefit Design: Higher Value Medications At Lower Cost Share (e.g. lowest cost for best outcome)
4. Incentivizing Patients to Use Specialty Pharmacy
5. Using Limited Fill Supply Plan Design Options (e.g. 7-10 day first fill on new prescription)
6. Using Step-Therapy Strategy to Improve Clinical Outcomes and Medication Compliance

All pilots to include consumer communications effort
Employer Initiative on Specialty Pharmacy
2015 to 2016

• Consumer Communications Strategy
  – Broadening the understanding and awareness for the average consumer of what specialty/biologic drugs are, how they are different and other key messages

• PBM Assessment/Audit
  – Supportive content or tools for employers in identifying gaps in program and plan design offerings and recommended strategies

• Site of Care Assessment
  – Identifying and assessing effective strategies in site of care management as one tactical aspect
Midwest Business Group on Health

What Can You Do Now?
Benefit Plan Design Elements

- Identify those with high-cost chronic conditions who have poor drug adherence – ensure PBM/vendor programs address this

- Include clinical coverage rules, such as prior authorization and step therapy to ensure appropriate utilization (e.g. conditions such as MS and RA)

- Ensure case/care management is coordinated or integrated

- Conduct aggressive negotiation of financial and non-financial contract terms with PBM to capitalize on today’s buyer’s market – remember, they work for you!
Benefit Plan Design Elements

- Include proactive clinical management programs to ensure optimal pricing, appropriate use and avoidance of high-cost hospitalizations

- Integrate drug channel management strategies that ensure specialty drugs are dispensed through the most cost-effective and efficient pharmacy delivery channel
  - Retail, mail order or specialty pharmacy

- Determine options and utilization for sites of care – determine drug use by site of care to determine if other factors are impacting plan design performance
Benefit Plan Design Elements

• Implement a comprehensive utilization control strategy
  • Site of care prior authorization
  • Dose and quantity edits
  • Prior authorization
  • Step therapy

• Manage Provider Reimbursement – Costs for hospital-owned practices have increased significantly – link physician practices with their parent organization to evaluate plan design outcomes and determine more consistent reimbursement practices
PBM Contracting
A few “Pearls”

• Ensure you know “who gets the rebate” in your contract

• Avoid boilerplate contracting language which is often designed to benefit the PBM

• Ensure consistency of coverage through the all sections of the contract

• Consider the value of carving out for certain specialty conditions – e.g. oncology
Thank you!

Cheryl Larson
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clarson@mbgh.org

MBGH Employer Toolkit:
National Employer Initiative on Specialty Pharmacy
www.specialtyrxtoolkit.com
OPTIMIZING THE HEALTH CARE INVESTMENT: STRATEGIES FOR EMPLOYER HEALTH BENEFIT DESIGN – WHAT EMPLOYERS NEED TO KNOW TO BETTER MANAGE SPECIALTY PHARMACY

Kim Foerster
Vice President, Lockton Companies
Cheryl Larson
Vice President, Midwest Business Group on Health

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