NBCH action brief

Value-based Purchasing:
Pharmaceutical Management

In 2012, health care spending in the United States reached $2.8 trillion, with pharmaceutical costs representing more than $263 billion or 9% of overall costs.[1] Given the rise in medical expenditures, purchasers—employers, unions, and governmental entities—are seeking strategies to optimize employee health while managing health care costs, including drug spend. Purchasers can apply the strategies of value-based purchasing to add quality to what has been a price-only focus, thus allowing a measure of value—the amount of health gained per health care dollar spent.[2] This Action Brief outlines the scope of value-based purchasing for pharmaceuticals as well as how health plans are addressing the issues based on data from eValue8™, a purchaser resource for tracking health plan performance to improve health outcomes and control costs for purchasers and consumers. Lastly, the brief highlights the merits and potential risks of current and emerging pharmaceutical purchasing strategies for purchasers and consumers.

WHAT'S THE ISSUE?

PRESCRIPTION DRUGS ARE THE THIRD LARGEST HEALTH CARE EXPENSE IN THE U.S., BEHIND HOSPITAL CARE AND PHYSICIAN/CLINICAL SERVICES[3], YET COST CONTROL STRATEGIES MAY NOT ALWAYS USE A VALUE-BASED APPROACH.

An Overview of Value-based Purchasing (VBP)

VBP is a purchaser strategy that leverages market clout to enhance the value of health care products and services, taking into consideration both cost and quality.[4]

WHY SHOULD EMPLOYERS CARE?

Employers should consider how their pharmaceutical management strategies, as part of their broader health benefits, help them achieve the best value for their health benefit dollar. Are the approaches they select taking value—both cost and quality—into account? What are the clinical and financial benefits and risks of these strategies?

- Given the rise in medical and drug expenditures, employers want to maximize their investments in health benefits.
- According to a 2009 National Pharmaceutical Council survey, 89% of employers acknowledge medication compliance as a top health management objective.[5]
- VBP can help realign incentives for health care delivery and improve population health and productivity (and ultimately an employer's bottom line). When purchasers buy on quality, service, and cost, rather than on cost alone, they drive the health care system toward achievement of higher quality care at the lowest possible cost.[6]

VBP STRATEGIES FOR PHARMACEUTICAL MANAGEMENT

A few major areas for value-based pharmaceutical purchasing innovation include: generic substitution, therapeutic substitution, incentive-based formularies, and value-based insurance design (V-BID).[7]

- **Generic Substitution —** Replacement of a brand name product with an unbranded version of the drug that uses the same active ingredient in the same way and amount. Generic drugs are typically less expensive than their brand name equivalents.[8]
- **Therapeutic Substitution —** Replacement of a drug with one that is chemically different but has similar efficacy and results. Substituted drugs may be used because they are more convenient for patients to use, have fewer side effects, provide improved control of the condition, have lower out-of-pocket costs, or lead to lower overall health care costs.[9]
- **Incentive-based Formularies —** Use of financial incentives (lower copayments) to encourage utilization of drugs preferred by the payer. Ideally, the criteria used to create drug tiers are based on clinical outcomes rather than on the cost of ingredients and manufacturer rebates.[10] In using a value-based approach to tiering, branded drugs wouldn't automatically be excluded from and a generic drug wouldn't automatically be placed on a lower tier based on price alone.

- **Value-based Insurance Design -** V-BID utilizes incentives to encourage enrollee adoption of healthy behaviors, high-performing providers, and evidence-based services. This can include certain prescription drugs that are often covered at lower copays to encourage appropriate use.[11]

EMERGING APPROACH: EXCLUSIONARY FORMULARIES

- In recent years, some of the largest pharmacy benefit managers (PBMs) have proposed cost savings to purchasers by excluding coverage for certain drug therapies. Some stated reasons for the exclusions include: the availability of interchangeable drugs; rapid drug price increases; patient and payer willingness to have fewer drug choices in exchange for cost savings; and the belief that the availability of drug manufacturer co-pay cards encourages consumers to take the higher-cost branded drug instead of a lower-cost competitor.[12] As with any new approach, purchasers should consider this strategy with caution and consideration of the risks and benefits.
- Proponents of the approach predict that there will be savings, (e.g., one PBM estimates that exclusions will lead to 2-3% savings of prescription drug spend for subscribers).[13] However, according to a major benefits consulting group who has reviewed this strategy and its data over the past two years, there has not yet been independent third party validation of the impact on pharmacy spend. At this time, employer groups with and without exclusion strategies do not exhibit discernible differences in per member per month costs, nor trend. Further, the resulting impact on the larger medical spend is also unknown.
- The clinical consequences also remain unclear. Preliminary data shared from one large employer with over 60,000 covered lives showed that in the first few months since implementation of exclusions, nearly 50% of the more than 500 rejected refill requests remained unfilled with an alternative. Past research shows that restrictive formularies may limit access and increase barriers to patient adherence.[14] Further, non-adherence has been shown to lead to poorer outcomes, which can lead to greater health care (medical plan) use and higher overall health care costs.[15] Research also indicates that increasing patients' share of medication costs beyond a certain threshold is associated with decreased adherence.[16]
- Additional research is needed to determine the financial and clinical effects of this strategy before it can be decided if this approach is value-based. Questions for consideration include:
  - How is value (both quality and cost) built into the design?
  - What is the impact of drug exclusions on patient adherence and overall health outcomes?
  - What is the impact on lower income employees?
  - What approaches to "grandfathering" existing patient therapies can be developed to avoid costly medical plan consequences, yet still encourage rational drug pricing?

"At present, the exclusion strategy does not appear to meet the criteria of V-BID. The basic premise of V-BID is to reduce cost-sharing to encourage consumers to take medications for which the benefits—both clinically and economically—are high.[17] Exclusionary formularies reflect a contrary perspective on the relationship between benefit design and access to high-value pharmaceuticals."

—A. Mark Fendrick, MD, Director, Univ. of MI Center for Value-Based Insurance Design

Case Study: Value-based Formulary

After growing member dissatisfaction with traditional PBM models that produced skyrocketing pharmacy costs, the Montana Association of Health Care Purchasers developed a pharmacy benefit program, URx, implemented and administered by MedImpact Healthcare Systems. It allowed self-funded employer members to manage an evidence-based, multi-tiered formulary and encourage use of clinically- and cost-effective drugs. The value-based strategy included a modified 8-tier formulary with 5 non-specialty and 3 specialty tiers that adjusts with member behavioral changes (e.g., pharmacy adherence and healthy lifestyle choices) and promotes effective, lower-cost medications. Placement on non-specialty tiers is based first on how well a medication treats disease and then on its overall value (efficacy plus cost). Products with better value are placed on lower tiers with lower out-of-pocket costs. Consequently, even the lowest tiers include both generic and branded products. The result has been a $31 per member per month reduction in drug costs (primarily due to a more optimal drug mix and greater use of lower cost, clinically appropriate medications) and a 12.5% increase in use of generics. Total medication costs decreased by 16% as a result of the increase in generic utilization. The program has also led to a 20-25% savings relative to traditional PBM approaches and no increase in employee contribution.[18] This approach also led to improved member health outcomes.

MEASURING UP

EVALUE8 RESULTS FROM 2013 SHOW THAT PLANS ARE SUCCESSFULLY EMPLOYING A VARIETY OF STRATEGIES TO SUPPORT VALUE-BASED PURCHASING OF PHARMACEUTICALS.

- Generic dispensing rates increased for both HMOs and PPOs from 2011 to 2012. The average HMO generic dispensing rate was higher at 81% than the PPO rate of 77%. Generic dispensing rates ranged from a low of 75.4% to a high of 93.8%.
- Across the important therapeutic drug classes, the average rate of generic dispensing was highest for antidepressants (93%) and lowest for metformin (diabetes) (57%). The four most common cost management and utilization strategies reported by surveyed plans are dose optimization (100%), prior authorization (98%), therapeutic interchange (97%), and step therapy (95%). The surveyed plans were least likely to use therapeutic class reference pricing (44%).
- Common strategies used by surveyed plans to ensure the appropriate utilization of specialty drugs were step therapy, quantity limits, and channel management, with nearly all surveyed plans employing them. Other widely used strategies to ensure appropriate utilization of specialty pharmaceuticals included requiring prior authorization (97% of surveyed plans), utilizing reimbursement reductions (95%), and using formulary tiers or placed limits on off-label use (93%).
- 90% of surveyed plans report fully implementing incentive-based formularies, and 81% report using or piloting rankings that are tied to variable copay designs in their incentive-based formularies.

TAKE ACTION

Action Item #1: Implement a value-based approach to managing pharmaceuticals

- Base selection criteria for formularies on clinical outcomes to ensure that pharmaceutical costs do not decrease at the expense of rising medical costs.[19]
- Contract with pharmacy vendor(s) that have the capacity to offer and support value-based strategies like V-BID with enrollee incentives for the utilization of high value services and providers, adherence to drugs, and adoption of healthy behaviors.[20]

Action Item #2: Support appropriate medication use and adherence

- Conduct an independent review of your pharmacy vendor(s)' formulary and the adequacy of the medications on it. Ask your vendor(s) how formulary changes / exclusions and requests for formulary exceptions are handled. How does your vendor(s) monitor and encourage patients to start and remain on their medications?
- When evaluating formulary shifts/exclusions, consider approaches to "grandfathering" stabilized patients with clinically-sensitive conditions to protect against clinical and economic exacerbations for the member and the medical plan.
- Work with your pharmacy vendor(s)—your plan and/or PBM—to analyze health data and implement/maintain medication compliance and patient support programs.
- Provide employees with resources, such as the drug-related articles in the *Choosing Wisely*® Employer Toolkit, to help them make informed decisions about medications.

Action Item #3: Incorporate pharmaceutical management into a broader value-based benefit strategy

- Incorporate medication services into integrated care models like patient-centered medical homes and accountable care organizations.
- When partnering with your vendor(s) to implement value-based approaches like V-BID, coordinate the program with your disease management, wellness vendors, and/or PBM, and work with them to develop and implement a multi-faceted communication plan that emphasizes the benefit of the program to all enrollees and brings providers into the communication loop.[21]
- Verify that pharmacy and medical benefits are aligned, and link data between the two in order to evaluate cost and outcomes across both types of benefits and the entire health-care spectrum, not just through the lens of pharmacy.[22]
- Use decision support tools such as NBCH's ValuePort™ to identify opportunities to improve pharmaceutical management strategies, including benefit and incentive designs, vendor partnerships, and employee education.

Action Item #4: Join your local employer-based health coalition

- Coalitions can serve as vehicles for improving workforce and community health at the local level and achieving the most value for health care expenditures. These collaborations leverage the voice and power of purchaser members in improving health and health care.

Endnotes

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