Specialty Drug Management Across the Medical and Pharmacy Benefits

Tuesday, November 13, 2012

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About the Speakers

GARY OWENS, M.D., has been president of Gary Owens Associates, a consulting organization in southeastern Pennsylvania, since 2007. He has almost 30 years of experience in medical and pharmacy management. Prior to founding Gary Owens Associates, Dr. Owens was at Independence Blue Cross (IBC) as vice president of medical management and policy for 22 years with responsibilities for medical and pharmacy management, technology evaluation and medical policy. Dr. Owens has presented extensively on managed care and related medical management topics, including at conferences of the Academy of Managed Care Pharmacy (AMCP), the National Association of Managed Care Physicians (NAMCP), the Association for Value-Based Cancer Care and AdvaMed. He has written more than 60 articles on managed care, pharmacy and biotechnology, which have been published in American Health and Drug Benefits, The Journal of Managed Care Medicine, The American Journal of Managed Care, Journal of Managed Care Pharmacy, Value Based Cancer Care and Disease Management. Contact Dr. Owens at gowens99@comcast.net.

DONNA PAINE, Pharm.D., is the clinical pharmacy specialist with Blue Cross & Blue Shield of Rhode Island (BCBSRI). In this role she has responsibility for developing cost management and quality of care initiatives provided through the pharmacy program and supporting physician-directed pharmacy education and performance incentive programs. Dr. Paine oversees the specialty pharmacy program that she implemented in 2008. Program components include use of select specialty pharmacy providers, adoption of clinical and utilization management services, and application of appropriate cost share design to support the benefit. This program has served as a model for other health plans in optimizing the use of high-cost biologics. Dr. Paine is presently involved with initiatives to enhance the patient experience and improve cost of care provided through the specialty pharmacy program. Dr. Paine received her Bachelor of Science degree in Pharmacy from the University of Rhode Island as well as her Master’s in Business Administration. She later received her Pharm.D. degree from the Massachusetts College of Pharmacy. Contact Dr. Paine at Donna.Paine@bcbsri.org.

Moderator: Angela Maas, managing editor of AIS’s Specialty Pharmacy News and Drug Benefit News

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(1) E-mail your question(s) to moderator Angela Maas at amaas@aishealth.com or

During the Webinar

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WEBINAR PROGRAM

- Introductions/Administrative Reminders
- Speaker Presentations
- 30-Minute Q&A Session

WEBINAR MATERIALS

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WEBINAR OUTLINE

Part 1: Gary Owens, M.D., Gary Owens Associates
- Benefit design history
- Emerging issues for benefit management
- Medical vs. pharmacy benefit
- A practical framework for benefit decisions
- Working with stakeholders in the future

Part 2: Donna Paine, Pharm.D., Blue Cross & Blue Shield of Rhode Island
- BCBSRI considerations for specialty strategy
- BCBSRI key specialty program features
- BCBSRI specialty program performance
- BCBSRI specialty program enhancements
- Medical drug management

Part 3: Questions and Answers
Specialty Drug Management Across the Medical And Pharmacy Benefits

Gary M. Owens, MD
Gary Owens Associates
November 13, 2012
AIS webinar
Overview

- The pharmacy benefit is evolving
- Benefit design history
- What are current “Crossover” benefits—some examples and why they exist
- Emerging Issues for benefit management
- Medical vs. Pharmacy benefit—
  - How is the landscape changing?
  - Who are the stakeholders?
- A practical framework for benefit decisions
- Working with the stakeholders in the future—it may not be business as usual
Some Background

More Than 2000 Drugs in Development Pipeline

- Cancer: 630
- Central Nervous System: 325
- Infections: 212
- Cardiovascular: 211
- Diabetes/Metabolism: 141
- Respiratory disorders: 122
- Pain/Inflammation: 119
- Blood disorders: 88
- Gastrointestinal: 85
- Dermatological: 67

- 35 - 40% of new pipeline drugs through 2009 are Specialty
- 25% of Specialty pipeline is infusion-based administration
Some estimates indicate that up to 50% of cancer drugs in pipeline will be oral by 2015

A significant number of these will have a genetic biomarker*

Benefit Design History

- Original pharmacy benefits were part of “major medical” benefit in the early 80’s and before and therefore part of an integrated medical/pharmacy benefit
- Late 80’s saw the emergence of the pharmacy card programs
- This allowed the creation of a separate benefit category for agents obtained in retail pharmacies
Evolution of the Pharmacy Benefit

- The emergence of tiers and differential out-of-pocket costs made management of utilization possible.
- Formularies became the norm.
- Ability to shift utilization and management of drug cost were independent of the medical benefit.
- Real time claims information became one of the major sources of information on populations and a critical link to chronic care management.
- Therefore, over time, issues have arisen that make the benefit distinction less clear.
- Some examples...
“Crossover Benefits”

- It is already common practice to cover selected medical benefit items under the pharmacy benefit
  - Diabetic testing supplies
  - Spacers for inhaled pulmonary medications
  - Diabetic needles and syringes
- Medicare covers most vaccines under the Part D benefit.
- This was done to facilitate access, create patient convenience and to allow contracting for best price in selected categories.
Benefit Management: The Changing Landscape

- The continued growth of injectables for patient self injection
- Office-based injectables and infusions
- Companion diagnostic testing
- Patient self-administered testing for many conditions
Emerging Issues to Consider

- The development of cancer vaccines: Will they be handled as drugs?
- Genetic testing for many cancer treatments (e.g. KRAS, BRAF, ALK)
- Many more to follow in the next 3–5 years
Where do you draw the line?

- The “dividing line” for which benefit is most appropriate is less clear with some of the newer agents, treatments and diagnostics.
- Multiple stakeholders, each with a unique point of view which must be considered within the context of the benefit decision framework.
Applying an objective framework for benefit decisions
Step 1

- Define your desired outcome in the selected category or for the selected agent
  - Improved clinical outcomes
  - Managing costs
  - Enhanced patient experience
  - Ability to manage the agent or category
  - Alignment with your overall healthcare management strategy
Step 2

- Identify your stakeholders and understand their perspective
  - Patients:
    - Need for access
    - Overall care experience
    - Out-of-pocket cost
    - Maintaining physician / patient relationship
  - Benefit administrators (MCOs & PBMs)
    - Access
    - Quality of care
    - Ability to manage the class/category
    - Ability to get real-time data
    - Population management strategies
Step 2 (continued)

- Identify your stakeholders and understand their perspective
  - Employers:
    - Patient satisfaction
    - Optimum clinical outcomes
    - Cost management
    - Data requirements
  - Providers:
    - Single point of access for care
    - Ability to manage dosing and side-effects
    - Need for real-time information for clinical decision-making
    - Reimbursement issues
Step 3

- Understand the continuum (concepts)

- Pharmacy benefit
  - Multiple points of access
  - Real-time data management capabilities
  - Cost management capability
  - Real-time care coordination

- Medical benefit
  - Single point of access
  - Delayed data capture
  - Cost management capability
  - Need for case management
Step 4

- Score the criteria
  - Site of care
  - Ease of administration
  - Level of oversight required
  - Variability in dosing
  - Triggers therapy decisions
  - Ability to systematically record and respond
  - Cost to payer

- Access
  - Data collection
  - Cost management

- Physician oversight & management

- Pharmacy benefit

- Medical benefit
Understand the continuum (examples)

Pharmacy benefit
- Oral Oncology agents
- Oncology support agents
- Patient self-diagnostics
- Home infusion agents

Medical benefit
- Complex infusions
- Agents with REM program
- Requirement and physician oversight
- Genetic testing
- Companion Diagnostics
Step 5

- Identify challenges and mitigating strategies
  - What are the current benefit structures and definitions of coverage? Can the changes be made without benefit design change?
  - What changes may need to be made in benefit designs?
  - What are the regulatory requirements (if any) to make these changes?
  - What are the notification requirements?
  - How will these changes be coordinated across multiple organizations?
  - Provider response and changes needed in provider infrastructure?
  - IT/claim system issues?
  - Others…
Step 6

- Develop your change management plan
  - Define the “driving-need” for choice of benefit assignment
  - Weigh the different aspects of care: balancing Cost, Quality and Access issues
  - Carefully review the technical requirements, consequences and outcomes of changing benefit assignment
  - Careful coordination and communication with all stakeholders are required
  - Monitor results and revise strategy as needed over time
  - Keep an open mind to changes in the landscape and re-think benefit issues on a continuing basis
  - Make sure benefit designs continue to offer the flexibility needed to act quickly as the landscape changes
Blue Cross & Blue Shield of Rhode Island

Specialty Drug Management

Donna Paine, PharmD, MBA
November 13, 2012
AIS webinar
BCBSRI Considerations for Specialty Strategy

• Competitive Landscape
  – Mostly regional, dominant payer
  – 3 payer market

• Drug Management Tools
  – Less restrictions on use of drugs through medical benefit

• Rx vs. Medical benefit comparisons
  – Medical typically more favorable than pharmacy

• Plan System Capabilities
  – Outdated medical claims processing system
BCBSRI Specialty Pharmacy Addresses many Pharmacy and Medical Benefit Challenges

- Program maximizes opportunities to reduce the unit cost of drugs
- Removes inconsistencies between pharmacy and medical benefit specialty drugs
- Enhances the clinical management of specialty drugs
- Ensures appropriate utilization of specialty drugs
- Maintains member access through reasonable member cost sharing and convenient distribution
BCBSRI Key Program Features

- Designated specialty drugs (both SA and OA) are covered under a member’s **pharmacy** benefit
- Member’s cost share is the highest tier or co-insurance for their drug benefit
- There is a limited specialty pharmacy network. For purposes of this benefit, retail pharmacies are NOT part of the specialty pharmacy network
- Providers are required to use the Specialty Pharmacy Network to obtain the drug
BCBSRI Specialty Program Performance

- Reflects 65% of plan specialty drugs
- Drug expenditures- 6% PMPM savings
  - Severe asthma: 7.5% cost/claim differential
  - Osteoporosis: 19.6% cost/claim differential
- Utilization review program: 10% denial rate
BCBSRI Specialty Program Enhancements

• Administered by specialty pharmacy
  – Partial Fill Program
  – Dose Optimization Program
  – Therapy Management
BCBSRI Program Enhancements

• Partial Fill Program

  – Program Goals:
    • Reduce rate of unused medication.
    • Early patient identification for disease support

  – Targets cancer drugs with tolerability and adverse event risks
    • Patients receive 2 week supplies for first 2 months
    • Specialty pharmacy evaluates tolerability and dispenses accordingly
    • MD receives patient assessment after 1 month of treatment
BCBSRI Program Enhancements

• **Dose Optimization Program**

  – Program Goal: Minimize waste through use of most cost effective package

    • Weight based therapies have inherent partial vial waste

    • Responses to therapy are often subjective assessments so exact dose may not be critical

  – Dose calculation, recommendation for closest vial amount made to prescriber and appropriate package size dispensed

    • Remicade, Immune Globulin, Synagis

    • 10% reduction in quantity dispensed, 16% savings
BCBSRI Program Enhancements

• Therapy Management

  – Program Goal: Improve patient outcomes and enhance coordination of care

  • Hepatitis C-adherence, side effect mgt
    – 40% required care coordinator intervention

  • Oncology- early patient identification for Care Coordinator resources
    – 20% of referrals from Specialty Rx enrolled in Care Coordination

  • Multiple Sclerosis- exacerbation assessment, disease progression, Care Coordination referral
    – 5% referral rate to BCBSRI Care Coordinators
Medical Drug Management

• Applicable to 35% of specialty drug expenditures
  – Majority are oncology related therapies

• Challenges
  – Medical claims system limitations
  – Resource limitations to expanded utilization review (UR)
  – Variable relationships with provider network (physicians, hospitals, out-of-area)
Medical Drug Management

- Approach includes claims edits, fee schedule changes, enhanced utilization review & P4P

- Claims edits- separate from utilization review
  - Dosing limits, claims frequency, diagnosis and other medical service edits
  - Implemented Q2, 2012
  - Projected 1% savings
Medical Drug Management

- Comprehensive provider drug reimbursement strategy
  - Reimbursement methodology evaluation
    - Hospitals transitioning to ASP
    - AWP basis used for physicians
    - Differential reimbursement based on preferred products
  - Specialty pharmacy serves as alternate source for drug if provider unable to purchase
Medical Drug Management

- Pre-authorization process to be re-engineered

  - Goal: consolidated, web based process that provides streamlined, consistent decisions
    - Integrate medical and pharmacy processes
    - Web portal provides single access point for all drug pre-authorization requests
      - Improved provider satisfaction
      - Expand utilization review for drugs under the medical benefit
        - Establish medical drug preferred products
Medical Drug Management

- P4P Opportunities
  - Initial focus is Oncology
    - Scope of practice settings
    - Identification of cancer types
    - Assess variations in practice
    - Metrics-who and how to measure
BCBSRI Specialty Program

Questions?
Plans Are Increasing Their Clinical Focus on Specialty Management

Reprinted from the May 2012 issue of AIS’s monthly newsletter Specialty Pharmacy News. Call (800) 521-4323 for more information.

Although some specialty drug management tactics that health plans have been using over the past few years such as increasing patient cost share still are in use, plans also seem to be turning to strategies with more clinically focused outcomes than in the past, according to the eighth edition of the EMD Serono Specialty Digest.

For example, the top goals of a specialty pharmacy program remain the same as reported the previous year: reduce inappropriate utilization and lessen drug acquisition costs. But more plan respondents this year said they wanted to make formulary decisions based on comparative effectiveness data, and improving patient adherence and persistence still garners a high ranking. However, “some of these more clinical elements are harder to come by,” points out Debbie Stern, vice president at managed care consulting firm Rxperts, Inc. and author of the report.

Data in the digest on 2011 health plan management of specialty pharmaceuticals were gathered in December 2011 from 102 health plans across the U.S. that represented more than 122 million lives: about 84 million commercial lives, 13 million Medicare Advantage Prescription Drug Plan lives, 20 million managed Medicaid lives and 6 million other lives. Health plan pharmacy directors and medical directors whose primary responsibility was overseeing specialty drugs and specialty pharmacy-related services at their plans responded to the online survey.

Managing oncology also was important to plan respondents, and many reported putting tactics in place to do so.

Oncology Management Is Increasing

“Last year compared to this year, there has been a significant amount of change in the number of plans that implemented or expect to implement” strategies to manage oncology, including requiring companion diagnostic tests before certain therapies are approved, restricting drug use based on those test results and implementing quantity limits, says Stern.

She points out that in last year’s digest, 40% of plans required companion diagnostic tests before approving certain therapies, a number that has risen to 53% this year. And 32% of plan respondents last year said they restrict drug use based on those test results, compared with 47% this year.

While it may seem that there is somewhat of a gap here in that payers may require that a test be given but not that a patient has a certain response, Stern says that “some payers would say, ‘We don’t really want to be practicing medicine…We’ll let the physician make the final decision.’ But others say they will be very black and white about it. But companion diagnostics can be not only black and white in terms of patient response but also gray.”

She points to the “big gap between 40% and 32%” in these two responses last year, a difference that narrowed to 53% and 47% this year. “From last year to this year, we see payers becoming more aggressive in managing that,” she says. Management in this area “is changing and growing.”
More than half (52%) of health plan respondents say they have programs to educate providers on palliative care, with 24% saying they plan to implement such strategies within the next 12 months. And 45% say they educate patients on advance care or end-of-life planning, with another 20% reporting that they will set up tactics to do so within the next year. Health plans, says Stern, are focused on “what’s going to make the patient most comfortable, not cause excessive costs to the system and [how to] treat patients in a more holistic manner.”

This year’s digest asked about the importance of outcomes in four different therapeutic categories — hepatitis C, multiple sclerosis, rheumatoid arthritis and oncology — to determine what plans think “is most important from an outcomes perspective. Is it all about managing costs or more clinical measures?” says Stern. In hepatitis C, for example, the top two were clinical: achieving a sustained viral response and stopping therapy in nonrespondents after response-guided therapy. In multiple sclerosis, the top two responses were reducing the rate of relapse and reducing the progression of disability.

“This isn’t rocket science, but it’s nice to see the degree, the element of interest in true clinical outcomes,” Stern says. Specialty pharmacies, she says, can take these lists of measures to their clients to determine what is most important to them. And pharma companies can see what data are really of most interest to plans.

In this year’s digest, 82% of plan respondents cover self-administered agents under the pharmacy benefit, a number that’s up from 73% in 2010 and 76% in 2009. Likewise, 76% said in 2011 they covered office-administered agents under the medical benefit, up from 62% in 2010 and 73% in 2009. Only 8% of current respondents said they had a separate specialty benefit for self-administered agents, while 4% said they had one for physician-administered drugs.

“I am surprised that there is still a big gap between self-administered and office-administered agents and [their coverage under the] pharmacy benefit and the medical benefit,” says Stern. “There have not been any major steps to overcome the challenges” of specialty drugs being adjudicated in both benefits. “I expected to see more of a carve-out specialty benefit....Equalizing cost share has not been a huge goal.”

In fact, only 6% of respondents cited equal cost share for specialty drugs across both benefits as a strategy to manage these medications. “This is not something payers are looking at doing,” she says, acknowledging that it “is difficult; it’s not an easy thing to do.”

And although 62% of plan respondents said that having the pharmacy department manage specialty drugs across both the pharmacy and the medical benefit was a strategy their plan had implemented, another chart showed some discrepancy in this. Among nononcology specialty drugs in the pharmacy benefit, 78% of plans managed them through their pharmacy department. Seventy percent of plans managed oral oncology drugs through pharmacy, while only 49% did so for nononcology drugs in the medical benefit, 41% did for oncology drugs in the medical benefit, and 19% managed companion diagnostics through the pharmacy department.

“There is still a divide in integrating this type of stuff,” points out Stern.

Asked about changes in their specialty pharmacy management that they expect over the next 12 months, the most common response among commercial health plans, at 39%, was increased patient cost share. “That’s a problem because it impacts adherence,” contends Stern.
And while that has been a common approach over the past few years, other responses are really in contrast to ones from a few years ago. For example, commercial plans anticipate implementing pathways in not only oncology (29%) but also other specialty therapeutic classes (27%), tactics that show a “focus on bringing physicians into the mix.” And the negotiation of risk contracts with pharma manufacturers (23%) shows “a desire for the pharmaceutical industry to put a little skin in the game.” Nineteen percent of commercial plans anticipate mandating use of a specialty pharmacy provider for some or all office-administered agents.

Such responses, Stern says, are “very sophisticated compared to a few years ago, when prior authorization and preferred products were the standard block and tackle for specialty pharmacy programs. This shows a more strategic approach rather than ‘let’s just manage drug costs’…There are opportunities for all the stakeholders to be engaged or at least be aware that there is the need for engagement.”

The responses may indicate some potential changes in benefit design and utilization management, contends Stern. For example, “if there are more molecular diagnostics to treat individuals, then the concept of preferred and nonpreferred drugs [within a therapeutic class] doesn’t make sense if some drugs work for one person and not another…The typical way to manage drugs may not apply to specialty drugs as we have more targeted therapies.”

Other questions flagged for further review based on the responses include the following:

♦ **What do value-based benefit design and consumer-directed health care mean for specialty drug coverage?**
♦ **“Will payers become more aggressive at monitoring patients’ response to therapy?”**
♦ **“A lot of departments are touching the patient….Is this effectively coordinated, or is it a pain in the neck for patients?”**
♦ **With pathways programs, “what does that actually mean as far as how they are measured? Do plans need a third party to manage them?”**

Contact Stern at dstern@rxperts.net. Download the digest at http://specialtydigest.emdserono.com.

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**Integrating Pharmacy, Medical Can Help Cut Specialty Costs Overall**

Reprinted from the April 2012 issue of AIS’s monthly newsletter Specialty Pharmacy News. Call (800) 521-4323 for more information.

Many payers have a difficult time really understanding what specialty drugs cost in general, as well as what they are specifically spending on these therapies. But they know they want to reduce those costs, cut down on inappropriate use and improve adherence to specialty medications, according to the Pharmacy Benefit Management Institute’s *Specialty Drug Benefit Report*.

“The survey showed that 88.3% of employers surveyed weren’t sure about the average cost of a specialty medication, and 86.9% didn’t know what percent of total specialty drug spend is reimbursed under the medical benefit,” points out Claire Marie Burchill, vice president of strategy, product & marketing at Cigna Corp. “However, these same employers
indicate a moderate (68%) or high (18.9%) level of understanding of specialty pharmacy benefit management.”

This gap, she says, “creates an opportunity for companies like Cigna because we want to talk about more than just drug costs.” Cigna, she says, has been undergoing a “major initiative the last couple of years” to make sure its “clients understand the data we’re giving them” about specialty management.

With specialty pharmaceuticals covered under both the medical and the pharmacy benefit, it can be hard to have insight into the spend on the medical side. “In most situations, PBM’s are really focused on drugs covered under the pharmacy benefit,” explains Burchill, which can result in “silod benefits.”

**Medical Costs Outweigh Pharmacy**

According to Thom Stambaugh, vice president at Cigna Specialty Pharmacy, “3.8% of our members are driving 26% of the total medical costs.” Of the 26%, “one-quarter of that is related to the cost of the drug, half of which is in the medical benefit and half in the pharmacy benefit. But three-quarters of that cost is associated with medical costs of treating a condition,” such as emergency room visits, hospitalizations and lab testing.

Based on Cigna’s 2011 book of business, 200,000 members in an integrated population of 5 million medical and pharmacy members were taking specialty drugs. That entire population spent $22 billion on pharmacy and medical costs. And of those members on specialty therapies, 43,000 “had at least one hospitalization in a one-year visit, and 60,000 had to go to the ER,” says Stambaugh.

“The drug piece of it, while it seems very high, is the tip of the iceberg” when it comes to total specialty costs, he says.

One solution to impact these costs is to “drive deeper discounts in the medical benefit because of the class-of-trade acquisition costs physicians can get,” Stambaugh says. “When you carve the drug portion out of medical,” this can result in “discoordination of care, which makes for a difficult physician experience and a difficult patient experience.”

In addition to keeping drugs with physicians, “appropriate medication use and site of administration” can help reduce costs, he says. And “therapy management and health advocacy can help avoid emergency room visits and hospitalizations.”

**Cigna Saved $13M in Growth Hormone Costs**

Cigna, for example, leveraged its physician network to get the most out of its growth hormone management and make the product less expensive for clients and customers.

“Most physicians would say these products are essentially the same except the method of administration — the needle — is different,” Burchill tells SPN. When the plan makes benefit changes, “we usually send communications to our customers. The difference here is we recognized that with specialty drugs, patients were taking their physician’s advice even if the drug costs were higher.”

The health plan had Saizen (somatropin [rDNA origin]) and Humatrope (somatropin [rDNA origin]) as its preferred products. So Cigna went through its data and identified every growth hormone product that was not one of the preferred ones and who the physician prescribing it was. “We contacted their offices and worked with nurse practitioners” to shift their patients to the preferred agents.
Through these efforts, “we moved more than 90% of the people.” The average cost of the therapy went from $40,000 down to $25,000 and resulted in a “total cost savings of $13 million across our book of business,” says Burchill.


Ensuring Appropriate Drug Use and Site of Service Could Be Improved

Reprinted from the January 2012 issue of AIS’s monthly newsletter Specialty Pharmacy News. Call (800) 521-4323 for more information.

Health plans definitely have made strides in their management of drugs under the medical benefit. However, opportunities still exist to provide more efficient and effective care, according to data in ICORE Healthcare’s second edition of the Medical Pharmacy & Oncology Trend Report.

One section of the report is based on responses from commercial health plan medical directors and pharmacy directors of 60 health plans managing more than 153.2 million lives, up from the 146.3 million managed in the 2010 report. The survey was conducted in June and July and includes information on current and future benefit trends.

The second section of the report is based on data from paid medical and pharmacy claims for full-year 2009 and 2010 based on a proprietary data set from multiple regional and national health plans. The claims were across all lines of business, sites of service, and medical and pharmacy benefits.

ICORE President Michael Waterbury tells SPN that one interesting finding in the report is the continuing trend of hospital-based administration of specialty drugs and treatment of conditions such as cancer and rheumatoid arthritis. “Community oncologists are going out of business and selling their practices to hospitals because the margins aren’t where they need them to be,” he explains.

### Spend by Key Therapeutic Class (Medical and Pharmacy)

<table>
<thead>
<tr>
<th>Therapy</th>
<th>2009</th>
<th>% of Spend</th>
<th>2010</th>
<th>% of Spend</th>
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<td>IV chemotherapy</td>
<td>$89,181,960</td>
<td>33%</td>
<td>$81,881,838</td>
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<td>Rheumatology</td>
<td>$32,666,943</td>
<td>12%</td>
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<td>Granulocyte colony-stimulating factor</td>
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</tr>
<tr>
<td>Antiretrovirals</td>
<td>$5,545,859</td>
<td>2%</td>
<td>$4,846,520</td>
<td>2%</td>
</tr>
<tr>
<td>Other</td>
<td>$57,434,542</td>
<td>21%</td>
<td>$63,147,583</td>
<td>24%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$267,497,351</strong></td>
<td><strong>100%</strong></td>
<td><strong>$267,222,020</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

SOURCE/METHODOLOGY: ICORE Healthcare, Medical Pharmacy & Oncology Trend Report, second edition, released Dec. 2011. Data are from paid medical and pharmacy claims for full year 2009 and 2010 based on a proprietary data set from multiple regional and national health plans. Claims were across all lines of business, sites of service, and medical and pharmacy benefits.
Physician offices represented almost half of the medical injectable billed claims in 2011 (45%, up from 44% in 2010), but the outpatient and inpatient settings in total weren’t far behind. The percentage of medical injectable claims from the hospital outpatient setting dropped slightly from last year’s report, from 27% to 25%, but inpatient claims rose from 10% to 12%. The home health setting saw a decrease as well, from 18% to 15%.

Patients, Waterbury contends, will receive better care when they are continually evaluated by the same physician. But when those patients are receiving drugs through the outpatient setting, “that continuity is fragmented, and there is not an improvement in the quality of care.” And with patients with compromised immune systems being exposed to nosocomial infections in the hospital setting, those people “may walk in, but they may not walk out.”

Health plans “should focus on driving cost and quality of care.” Community oncologists “spend a fair amount of time” with patients and represent “the highest quality and the lowest cost” of care, he says.

The survey notes that the majority of plan members were with payers that have put in place programs to try to curtail shifts in the site of service to hospitals, “although the success of these programs is generally not known.”

The report shows that overall medical and pharmacy spend among oncology and certain therapeutic injectable classes in 2010 was almost $270 million per million lives — “almost one-quarter of $1 billion,” notes Kjel Johnson, Ph.D., senior vice president with Magellan Pharmacy Solutions (see table, p. 43), an operating unit of Magellan Health Services, Inc., which purchased ICORE in 2006 (SPN 7/06, p. 1). Still, the year-over-year trend was flat, due to (1) a couple of top drugs, including Taxotere (docetaxel) and Eloxatin (oxaliplatin) — No. 7 and No. 10 among the highest-cost medical benefit injectables/infusibles, respectively — facing generic competition, and (2) effective plan management of these costs, he says.

A medical claims analysis compared the classified and unclassified codes — including so-called “dump” codes such as J3490 — paid by commercial payers. For 2010, more than $227 million in classified codes were allowed per 1 million lives, while only $882,851 in unclassified codes were paid, representing 0.4% of medical benefit claims analyzed.

Johnson points out that there are “whole initiatives focused on [determining what nonspecific codes are for], but it is a miniscule spend.”

Still, says Waterbury, “I’m shocked at how many high-cost nonspecific diagnosis codes are used,” including codes for $8,000 and $10,000. “It’s amazing how low the bar is,” he says. And while some of the codes may be for drugs just approved that don’t yet have a Healthcare Common Procedure Coding System (HCPCS) code, Waterbury wonders if some of the other use is “intentional [nonspecific coding] because people don’t want to be managed.”

He maintains that “it’s so much work to make sure drugs are used appropriately and paid appropriately.” Prior authorization is one tool that can help in this area, as is “bridging the communication gap” between payers and providers.

Off-label use for the top 25 medical injectables compared with use consistent with FDA approval and inclusion in National Comprehensive Cancer Network guidelines was fairly similar across all lines of business, representing about 7% of the total spend per 1 million lives across commercial, Medicare and Medicaid plans.

“There are still a substantial amount of drugs used for what they shouldn’t be,” Waterbury says. For example, the report took a close look at paid claims for Aloxi (palonosetron HCl), Kytril (granisetron HCl) and Zofran (ondansetron HCl), drugs used to treat
chemotherapy-induced nausea and vomiting, to see what type of regimens they were used with. Aloxi is indicated for use with moderately and highly emetogenic chemotherapies, but claims showed that 37% of its use was with low emetogenic chemotherapies. “There’s not one clinic in this country or manufacturer that would say that’s appropriate use,” he contends.

And although payers and providers have not necessarily been on the same page with health care services over the years, that divide seems to be getting smaller. “Oncologists are realizing that it’s an unsustainable model to do anything, anywhere, using any drug they want,” says Johnson. There “is some effort” on their part; they “want to be reasonable.”

But that effort needs to come from both sides, he says, noting that for health plans, “it’s not reasonable to prior auth all [specialty] drugs, but it’s reasonable to prior auth the top 10 drugs.”

According to Waterbury, “Everyone is looking to ACOs [i.e., accountable care organizations]...and the government to see if they can create a model that works.” He asserts that “Physicians have had a long history of not executing on ideas.” And while “physicians are strong clinically and in interacting with patients” and coming up with good ideas, the follow-through effort, as well as determining how to measure and report outcomes and handle contracts, often has left a little to be desired.

**Coinsurance Rise May Seem Small, but...**

Almost half of plan respondents (43%, up from 41% in the previous report) say they require neither coinsurance nor a copay for medical injectables. The number requiring only coinsurance rose from 21% in the last report to 27%, while copay-only plans rose from 18% to 20%. The percentage of plans that require both coinsurance and a copay, though, dropped from 20% to 10%.

In the first edition of the report, all plans reported they require an average 17% coinsurance, which rose to 20% in the latest edition. Respondents say they expect that percentage will rise to 22% in 2012. And while these may seem like only slight increases, Johnson points out that some injectable/infusible drugs may have annual price tags of $80,000 — which means a 2% coinsurance increase is another $1,600 for which members will be responsible.

The pharmacy benefit traditionally has been easier than the medical benefit when it comes to payer implementation of management strategies. However, the report shows that health plans with about 65% of the total lives represented in the survey have some formulary management of injectables/infusibles on the medical side. That percentage is actually down from 75% in the prior report, a fact that Waterbury says is “surprising to me...I wasn’t necessarily expecting to see a decrease.”

This could be due to the fact that when a sophisticated health care person hears the term “formulary,” he or she probably thinks of tiers, copayments and pharmacy cards, he says. Waterbury, however, says that more plans are “saying they are putting in more controls on the medical side” — although not necessarily a formulary — to try to emulate the management tactics on the pharmacy side. “I do believe plans have been working hard” on this, he says.

Download the trend report at http://icorehealthcare.com. Contact Waterbury and Johnson through Christopher Pearsall at CMPearsall@magellanhealth.com. ✦