Pharmacy 101 Training
Prescription Drug Trends
Trends Impacting Pharmacy Costs

• Increased Utilization
• Increasing Drug Prices
• Shift Toward More Costly Medications
• Exploding Pipelines
  – Specialty
  – “Me-too” drugs
• Generic Drugs
The Number of Prescription Drugs Dispensed Keeps Rising

Number of Prescriptions Dispensed in the U.S.

1992: 2.0B
1997: 2.6B
1998: 2.7B
1999: 3.0B
2004: 4.0B*

* projection

Drug Utilization
Increased Utilization

- More attention on disease prevention leading to increased medication use
- Increased focus on evidence-based medicine leading to individual treatment that relies on drugs
- Incidence and prevalence of chronic conditions is increasing among an aging population
Pricing Dynamics

- **Price:** the cost per prescription
- **Average price per prescription is rising 4-7% per year**
- **Brand:** consistently above-average cost increases probably due to the anticipated generic introductions
- **Generic:** prices decline as additional manufacturers begin selling the same generic
Shift Toward More Costly Medications

• Newer brand name drugs being used more frequently than older generic drugs
• Influenced by direct-to-consumer (DTC) advertising
  – Hypnotics had one of the biggest trends and the most DTC advertising
  – UPMC already had utilization management strategy in place in July 2006
• Patients seeking medical attention for conditions not previously treated
• “Me-too” Drugs
• Specialty Drugs
“Me too” drugs

- Modified mimics of existing medications

- Extending a patent while typically offering little benefit to patients
Specialty medications

• Fastest growing segment of the pharmaceutical market
  – About 20% increase in drug spend in 2006
  – 2.5 times trend for traditional drug
  – 15% total drug spend, 23% by 2010

• Average cost per month is $1,500 for one prescription

• Exploding pipeline
  – Oral
  – Traditional diseases

• Spend to reach $90B by 2009 from $40B in 2006
Biopharmaceutical Pipeline Continues To Grow

- **Biotech Drugs on the Market**
- **Biotech Drugs in Development**

<table>
<thead>
<tr>
<th>Year</th>
<th>Biotech Drugs on the Market</th>
<th>Biotech Drugs in Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>10</td>
<td>100</td>
</tr>
<tr>
<td>1995</td>
<td>29</td>
<td>240</td>
</tr>
<tr>
<td>2000</td>
<td>92</td>
<td>369</td>
</tr>
<tr>
<td>2005</td>
<td>197</td>
<td>600</td>
</tr>
</tbody>
</table>

Source: PhRMA, International Federation of Pharmaceutical Wholesalers & Biotech Industry Organization
Most of the Specialty Pipeline Is for Common Illnesses

- Psoriasis
- Multiple Sclerosis
- Hepatitis C
- Crohn's Disease
- Rheumatoid Arthritis
- Oncology

Number of Drugs

- Phase 2
- Phase 3
- Applications Submitted

©2007 UPMC Health Plan
Other Trends - Generics

• Crucial Point in Time
  – Approximately $10B brand drugs going generic each year until 2010

• Generic Dispensing Rate
  – Today’s most important trend management metric

• Therapeutic Substitution
Brand Drugs Going Generic Soon
More than $50 billion within the next five years
Overview of Managed Care
What is Managed Care?

• Managed Care
  – Balances medical decisions with economic factors to achieve cost-efficient health outcomes
  – Applies standard business practices to the delivery of healthcare
  – Emphasis on the coordination of services and reduction in fragmentation
  – Gatekeeping concept
### Evolution of Managed Care

<table>
<thead>
<tr>
<th>Fee For Service</th>
<th>Indemnity Insurance</th>
<th>Service Insurance</th>
<th>Managed Care Today</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early 20th Century</td>
<td>Created to protect beneficiary against financially catastrophic illness</td>
<td>Developed in response to uncontrolled healthcare costs</td>
<td>1973 – Federal HMO Act passed, more managed care organizations (MCOs) entered marketplace</td>
</tr>
<tr>
<td>“Pay as you go”</td>
<td>Premiums collected in advance to ensure funds were available</td>
<td>Organizations/employers contracted with physicians</td>
<td>For-profit organizations began changing the face of managed care</td>
</tr>
<tr>
<td>Patients paid usual &amp; customary (U&amp;C) charges on a fee for service basis</td>
<td>Provided reimbursement to individuals/providers at the U&amp;C fee</td>
<td>More restricted choices</td>
<td>Today managed care is a variety of types of models that combine features of indemnity insurance and service insurance</td>
</tr>
</tbody>
</table>
Evolution of Managed Care

• Continuum of cost-sharing versus freedom-of-choice

• Managed care penetration into Medicare and Medicaid markets
Pharmacy’s Role in a Health Benefit

• Members in health plans have access to many health benefits
  – Doctor visits
  – Physical Therapy
  – Hospital stays
• Of all the covered benefits a health plan offers, the member uses the pharmacy benefit the most
• Member uses the pharmacy benefit on average 15-18 times annually
• About 10% of all health care costs are directly related to pharmacy
Typical Pharmacy Benefit Management Components

• Claims Processing
• Product Development
  – Benefit Design Recommendations
• Clinical Pharmacy Services
  – DUR
  – Utilization Management
• Network Management
• Formulary Management
• Rebate Negotiation
Typical Pharmacy Benefit Management Components (cont)

• Mail Service
• Specialty Pharmacy Services
• Customer Service Call Center
• Data Collection and Reporting
• Annual Review
Claims Processing
Interactions in Managed Care

Rx Card → Pharmacy

Managed Care Organization → Claims Processor

UPMC Health Plan
Where you belong.

©2007 UPMC Health Plan
Claims Processing

**Member**
- Member takes prescription and ID card to pharmacy

**Pharmacy**
- Submit online claim to PBM
  - Fill Prescription
  - Collect Copay

**PBM**
- Eligibility Verification
- Benefit Determination
- Drug Utilization Review
- Utilization Management
- On-line Response
- Data Capture
Claims Processing

• Electronic claims processing system stores data in a host computer system
• Basic adjudication functions occur in real time:
  – Checking eligibility
  – Claims submission
  – Calculating member copay
  – Determining pharmacy reimbursement
  – Checking formulary status
  – Conducting prospective/concurrent drug utilization review
Point of Sale Edits

• May be utilized to incorporate prior authorizations, formularies and quantity limitations with messages sent back to dispensing pharmacists

• Advanced systems may conduct prior authorizations electronically based on the member’s claim history
  – This is a more member friendly approach to utilization management

• Drug Utilization Review edits
Pharmacy Benefit Design
Components of Benefit Design

- **Cost Management**
  - Copayment/Co-insurance
  - Benefit Maximums/Deductibles/Out of pocket maximums
  - Retail / Mail Service
  - Generic Options
  - Specialty Pharmacy

- **Utilization Management**
  - Formulary
  - Quantity Limitations
  - Prior Authorization/Step Therapies
  - Exclusions
Pharmacy Benefit Design

• Copayment Structure
  – Flat copay
  – Tiered copay
    • Brand – Generic copay spread

• Coinsurance
  – Percentage copay
  – Minimum and maximum amounts
  – Members share more of the cost of medications
  – Easily adapts to yearly drug cost increases

• Alternative designs
  – Copay Waivers
  – Pitney Bowes model
Benefit Structure Options

• Benefit Caps
  – Limitation on financial value provided under pharmacy benefit plan for a set period of time

• Deductibles
  – Minimum threshold payment required on an annual basis before benefit plan begins to make payments on a shared or total basis

• Out of Pocket Maximum
  – Maximum amount member contributes before plan makes payments for a member’s healthcare
Formulary Management
Formulary Management

• Formulary – a list of medications which are covered by a health plan
• Can also be referred to as the PDL (preferred drug list)
• Decision of which drugs to cover
• Periodic review and modification by the Pharmacy and Therapeutics (P&T) Committee
• Goal: To provide the safest, most clinically effective drugs to produce the best patient care at the most reasonable cost to all of the health care stakeholders
Tasks of the P&T Committee

• Create the formulary
• Determine exclusions from the formulary
• Review clinical criteria recommended for prior authorizations and step therapy
• Review quantity limits for drugs
Members of the P&T Committee

• Physicians within the local community
  – Chief Medical Officer Chairman
  – Medical Directors of the Health Plan
  – Active community and academic-based practices
  – Variety of specialists: Geriatrics, pediatrics, psychiatry, infectious disease, cardiology, internal medicine, and family practice

• Pharmacists not affiliated with the Health Plan
  – UPMC Outpatient, Retail Pharmacy, Hospital Pharmacy

• UPMC Health Plan Clinical Pharmacy Department (no voting privileges)
Decision Making Process

- UPMC Health plan pharmacy department determines the agenda
  - Based on new drugs, new indications for drugs, prior authorizations being requested, recommendations from the P&T committee
- Analyze clinical information and trials for safety and efficacy
- Research current drug utilization to determine disruption, trends, and the financial impact the change would make
- Propose utilization strategies and recommendations with drug monographs, new policies, and class reviews
- Clinical sophistication enhanced by our relationship with UPMC Health System
  - Physicians and thought leaders in the health system provide feedback on new drugs and help to develop our clinical criteria for utilization management
- P&T committee votes on the recommendations
Maximizing Value in Formulary Decisions

Value: A Quality/Cost Balance

Value is a function of a balance of Quality (Q) and Cost (C)

- Quality increases while cost stays the same = greater value
- Cost increases while quality stays the same = lesser value

©2007 UPMC Health Plan
Where you belong.
Timeline of Formulary Changes for UPMC HP

- P&T committee meets quarterly to discuss recommendations.
- Negative changes are made two times a year:
  - April and July P&T drive January changes for the following year.
  - October and January P&T drive changes for the following July.
- Positive changes are made throughout the year.
- If an urgent issue arises between P&T meetings, there will be a fax vote to determine a resolution.
Communication of Formulary Changes for UPMC HP

- Send letters directly to members who will be impacted by negative formulary changes
- Member newsletter explains formulary changes
- Send letters to clients and providers giving a brief overview of the changes
- Targeted physician letters are sent indicating which patients will be affected by any negative formulary changes
- Notify network pharmacies in the local area of the changes
- Update the website
Components of Formulary Management

• Formulary Philosophy and Design
• Maximizing Generic Utilization
• Utilization Management
  – Prior Authorizations
  – Step Therapies
  – Quantity Limits
UPMC HP Formulary Philosophy

• ‘Lowest Net Cost’ Strategy without compromising care quality while balancing access
  – Goal: Drive utilization to generics and preferred brands
  – Works in conjunction with copay designs
  – Hybrid three-tier incentive / closed categories
    • Best of both worlds formulary design
    • Allows for rebates on non-preferred products
    • Prevents ‘lazy 3\textsuperscript{rd} tier syndrome’
    • Therapeutic class-focused
  – Generic Programs
    • Member, provider, and employer awareness campaigns
    • MedVantx generic sampling service
Factors Influencing Formulary Philosophy

Decision

- Politics and Public Image
- Discounts and Rebates
- Effectiveness
- Acquisition Cost
- Cost-Effectiveness
- NCQA
- Disease Management Programs
- Regulatory Issues
- Efficacy
- Consumer Expectations
- DTC Advertising
- Productivity, Satisfaction and QOL
- Physician Support
- Safety
- Budget Impact
- PBM, Physician, and Pharmacy Contracts
Formulary Design

• Open
  – Payer provides coverage for all medications regardless of whether or not they are listed on the formulary
  – Some drugs still may be excluded based on plan design

• Closed
  – Non-formulary drugs are not reimbursed by the payer

• Multi-tiered
  – Different levels of copayment for covered drugs
Formulary Design

• UPMC HP offers 2 commercial formularies
  – Your Choice
  – First Choice
Your Choice

- Hybrid three tier incentive formulary with closed categories
  - Tier 1: Generics
  - Tier 2: Preferred Brand-Name Drugs
  - Tier 3: Non-preferred Brand-Name Drugs
  - Tier 4: Specialty Medications (have the third tier copayment)
- Covers most medications, but some drugs are considered non-covered
- Incentive to pick a 1\textsuperscript{st} or 2\textsuperscript{nd} tier medication due to lower cost sharing by the member
First Choice

- Two tier formulary with a step therapy option to get to the “Non-First Choice” alternatives
  - Tier 1: Generics
  - Tier 2: Preferred Brand-Name Drugs and Specialty Medications
  - Non-First Choice (NFC): Not typically covered by First Choice; if the member has claims history for a First Choice drug that was ineffective, then the NFC drug will pay

- NFC drugs are mostly the same as the third tier drugs on the Your Choice formulary
Medications Not Covered on UPMC HP Formularies

• Non-Covered Medications with Covered Alternatives
  – Considered non-formulary
  – Can submit a medical necessity review if the member has tried ALL the formulary alternatives
  – Select medications are chosen for this category based on safety and financial considerations
UPMC HP Designer Narcotics

<table>
<thead>
<tr>
<th>Available Branded Drugs (cost per Rx)</th>
<th>Available Generic Drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avinza $230.00</td>
<td>Hydrocone/APAP $6.48</td>
</tr>
<tr>
<td>Kadian $325.00</td>
<td>Oxycodone/acetaminophen $12.84</td>
</tr>
<tr>
<td>Magnacet $645.00</td>
<td>Propoxyphene $6.67</td>
</tr>
<tr>
<td>Liquicet $1,161.00</td>
<td>Tramadol HCL $11.12</td>
</tr>
</tbody>
</table>

- Branded products have same active ingredients but differ in:
  - Dosage form (Kadian, Avinza - once a day Morphine)
  - Delivery system (Liquicet – liquid hydrocodone/acetaminophen)
  - Strength of components (Magnacet has 400mg of APAP instead of 325mg)

- All non-formulary status at UPMC HP
- All LOB 2007 – 21 unique members
- Utilization is significantly lower than national benchmarks
UPMC HP Sleep Agents

- Highest trending category - 36% trend (ESI)
- Heavily DTC advertised
  - Lunesta’s advertisements
    - “are the most memorable among adults”
    - “is the most recognized prescription drug brand advertised on broadcast primetime TV”
- Sedative/Hypnotics – Many new branded agents
  - Lunesta - $98.99
  - Rozerem - $82.50
  - Ambien CR - $123.90
  - Sonata - $85.27
- Intelligent Formulary Design - Leverage impending Ambien generic
  - UPMC HP Ambien market share 80% versus national market share 43%
  - Ambien generic is now available at $15 per Rx - savings of $100 per Rx
UPMC HP - Non-sedating antihistamines

• Cover:
  – Fexofenadine (generic Allegra)
  – Loratadine OTC (generic Claritin OTC)

• Do not cover:
  – Zyrtec, Clarinex, Allegra-D, Claritin-D, Loratadine-D, Zyrtec-D

• “D” = decongestant = pseudoephedrine
  – Pseudoephedrine is available in generic or as Sudafed behind the pharmacy counter for less than $5 for a box of 24 tablets
Plan Exclusions

- Purpose of the pharmacy benefit plan is to provide coverage for drugs that are medically necessary
UPMC HP Standard Plan
Exclusions

- Anabolic steroids
- Antiobesity medications
- Drugs for investigational use
- Drugs for cosmetic purposes or hair growth
- Fertility agents
- Impotency drugs
- Most OTC medications
- Needles/syringes (other than insulin)
- Nutrition and dietary supplements
- Ostomy supplies
- Smoking deterents
- Urine strips

©2007 UPMC Health Plan
Brand vs. Generic

What is a generic drug?

• When a new drug is discovered and patented by a pharmaceutical company, the company is typically awarded a 17-20 year patent on the active chemical.

• When the patent expires, anyone can make the chemical. Manufacturing standards are still required.

• Typical drop in price of a brand drug in 6 to 12 months after the patent expires is: 80%
Generic Medications

- Cost-effective alternatives that offer the same level of safety and quality as their brand-name equivalent
- Have the same active ingredient
- Cost less due to lower research costs and little advertising
- Food and Drug Administration (FDA) regulates generic drugs to ensure the drug’s active ingredients, drug strength, and dosage form are identical to the corresponding brand-name drug
UPMC HP DAW 1 versus DAW 2

• DAW 1: Physician requests the brand
  – Must be written on the prescription
  – UPMC Medical Necessity Review: the physician must submit chart documentation to show that the member has tried 2 different generic manufacturers of the same generic drug
  – Examples: Simvastatin, the generic for Zocor, is made by Teva, Mallinckrodt, Sandoz, Ranbaxy, etc.
  – If approved, covered at tier 3

• DAW 2: Member requests the brand
  – Automatically pays at tier 2 plus the retail cost difference between the brand and the generic
Utilization Management

- Prior Authorizations
- Step Therapy
- Quantity Limitations
Prior Authorizations (PA)

• Certain medications require a closer review to support their coverage
• Control costs and ensure proper utilization and safety of the patient
• Physician must submit a request for review by clinical staff
• Criteria based on therapeutic guidelines, FDA approved indications, medical and clinical literature, and provider recommendations
UPMC HP – Prior Authorizations

• Currently ~50 prior authorization policies exist
• Typical PA categories include:
  – Specialty Medications for inflammatory conditions, blood cell deficiency, growth deficiency, hepatitis C
  – PPI
  – COX II selective inhibitors (Celebrex)
  – Medications that could be used commonly for off-label indications (Topamax, Lyrica)
  – Medications that have safety concerns (Tysabri)
UPMC HP – Prior Authorizations

- Consistent across the medical and pharmacy benefit
  - Expanded reach of pharmacy clinical policies
  - PA policies also apply to medical claims
  - Utilize efficient technology for review of the prior authorization requests
Narcotic 'Lollipop' Becomes Big Seller Despite FDA Curbs

- Narcotic painkiller Actiq, is only FDA-approved for use in treating cancer pain
- Despite labeling, according to The Wall Street Journal, oncologists accounted for only 1 percent of the 187,076 Actiq prescriptions filled at retail pharmacies in the U.S. during the first six months of 2006
- FDA regulators are investigating whether Cephalon marketers have targeted non-oncologists
- In order to control and monitor Actiq, UPMC Health Plan requires clinician approval for all prescriptions across all lines of business (Prior Authorization)

- **23 unique UPMC members prescribed Actiq - 78% have a cancer diagnosis.**
Step Therapy

- Process to ensure that a preferred medication is used as the first course of treatment
- Rules for each “step” therapy medication are built into the pharmacy computer system
- Medications are automatically approved if there is a record that you have already tried the first line agent in your medication history
- Member and provider friendly
- If no claims history of the first line medication can be found, clinical information submitted from the physician is required
UPMC HP List of Step Therapy Medications

- Altace
- Byetta
- Lunesta
- Nexium
- Prevacid
- Protonix
- Ranexa
- Singulair
- Symlin
- Vytorin
UPMC HP Prilosec OTC Initiative

![Graph showing PPI PMPM costs]

- ESI CM HMO BENCHMARK: $4.90
- CM
- MA
- MC

©2007 UPMC Health Plan
Quantity Limits

- To promote the appropriate utilization, prevent stockpiling, and to control costs
- Defined as a set number of days supply provided for a prescription or a dosage limitation for a prescription
- Determined by manufacturer dosing and FDA guidelines, as well as clinical literature
UPMC HP Days Supply of Medications

• Limited to a 30-day supply
  – Specialty Medications
  – Controlled Substances
  – Prescriptions filled at a retail pharmacy

• 90 day supply of maintenance medications
  – Express Scripts mail order
Clinical Programs
Drug Utilization Review (DUR)

- Identify prescription related problems
- Review of physician prescribing, pharmacist dispensing, and patient use of medications
- Review the medical appropriateness of drug therapy
- Opportunities for cost reduction
- Goal: Interventions to improve the utilization of medications
Drug Utilization Review

• Prospective DUR / Concurrent DUR
  – Occurs before the patient has received the medication
  – Potential problems identified and resolved before dispensing or at the time of prescription dispensing (at the point of sale)
Concurrent DUR edits

- Abuse/misuse
- Refill too soon
- Drug-age
- Drug-gender
- Drug-pregnancy
- Drug-allergy interactions
- Drug-disease interactions
- Drug-drug interactions
- Inappropriate duration of treatment
- Incorrect dosage
- Therapeutic duplication
Drug Utilization Review

• Retrospective DUR
  – Occurs after the patient received drug therapy to determine whether or not therapy was appropriate or met criteria
  – Often considered a screening process for identifying potential problems requiring increased intervention
Retrospective DUR

• Review periods can be performed:
  – Weekly
  – Monthly
  – Quarterly
  – Biannually

• Reviews may be conducted by:
  – Automated Data Mining Programs
  – Pharmacist Intervention Programs
Retrospective DUR

• Clinical opportunities commonly identified
  – Abuse/misuse
  – Drug-drug interactions
  – Incorrect dosage
  – Over and under-utilization
  – Therapeutic appropriateness
  – Therapeutic duplication
  – Compliance
UPMC HP Retrospective DUR

• Pregnancy DUR
  – Category D and X drugs – MD letter
  – Asthma, diabetes, mental health drugs – maternity program case manager

• > 20 medications DUR

• > 6 narcotic medications DUR

• Other ad hoc retrospective DUR
UPMC HP Integration of Care

- Emphasis on integrating all aspects of health care
- Clinical pharmacists work closely with care managers to maximize the value of the prescription benefit
- Integration with medical management team at the Health Plan – work together to address member health issues and to design innovative care management programs
Care Management

• Characteristics of medical conditions appropriate for targeting for an integrated program:
  – Chronic diseases
  – High prevalence & high cost
  – High rate of patient noncompliance
  – Existing or easily developed treatment practice guidelines
  – Consensus on treatment quality and outcomes
Care Management

• Compliance & Adherence Programs
  – Asymptomatic patients treated for chronic diseases have higher rates of drug nonadherence, with elderly patients at highest risk
  – Reasons for noncompliance
    • High cost of medications
    • Adverse effects experienced
    • Difficulty understanding the purpose of drug therapy & dosing
    • Forgetfulness
Care Management

• Implementation of Compliance & Adherence Programs
  – Medication Possession Ratio (MPR)
    • Estimates adherence information utilizing information in a claims database
    • Calculated by dividing days supply of drug by days between refills
    • MPR < 0.8 roughly equivalent to 1 week late on a 30 day supply
Medication Therapy Management

• Referred to as MTM programs
• High risk members identified through sophisticated integration of medical and pharmacy claims
• Intended to optimize therapeutic outcomes and improve the overall health of our members
• Developed and maintained in-house
UPMC HP Medication Therapy Management (MTM) Programs

- Systematic Logic and Programming Developed and Maintained in-house
- Integration of medical & pharmacy claims
- Program administered by UPMC HP Multi-Disciplinary Team including Clinical Pharmacists and Medical Management
  - Diseases Managed: Diabetes, Infectious Disease (HIV/AIDS), Asthma, Transplant, Cardiac
  - Components:
    - Drug-disease states
    - Drug-drug
    - Compliance with therapy for chronic disease
    - Overuse, underuse, therapy duplication
    - Labs for thyroid, statin, diabetes, anticonvulsant
  - Interventions include either a physician letter or referral to medical management for a communication intervention
MTM example

• Therapeutic Duplication
  – Patient JR visits his cardiologist on August 1st, fills a prescription for simvastatin (generic Zocor) at Pharmacy A
  – Patient JR visits his PCP on August 9th, fills a prescription for Lipitor at Pharmacy B
  – Duplication of therapy is identified by the UPMC HP pharmacist
  – Pharmacist intervenes by sending a letter to the PCP
  – PCP discontinues the Lipitor
  – Cost savings and appropriate care associated with the discontinuation of Lipitor
MTM example

• Compliance
  – Patient JR fills a 30-day supply of his simvastatin on August 1\textsuperscript{st} and September 1\textsuperscript{st}, but then doesn’t fill it again until November 15\textsuperscript{th}
  – UPMC HP pharmacist identifies compliance problem and forwards the case to a nurse on our medical management team
  – Nurse calls the member to determine the reason for non-compliance
  – Since the member is forgetful, the nurse suggests that the member put a note on the refrigerator to help him remember to take his medication
  – Member is compliant going forward
  – Potential cost savings associated with decreased medical costs for a member who is compliant
DUR / MTM

• Issues and patterns identified in these programs can be helpful for:

  – Provider education

  – Developing member programs
Provider Education

• Education on appropriate drug selection and use
• Detailing based on the best scientific and clinical knowledge
• Drugs to be detailed chosen based on:
  – Results of DUR and MTM programs
  – General market trends
Provider Education

• MD profiling: target physicians who are, for example, not using generics, using high cost medications, over-prescribing
• Educate the physician: Visit the office and/or send a letter
• Show the physician: Peer comparisons, savings opportunities, clinical rationale
• Education of network pharmacists on benefit design
Member Communications

• Health Related:
  – Preventative Care
    • Make member aware of preventative measures to remain healthy (such as vaccines)
  – Disease Focused Messages
    • Educate members on general information about common diseases (such as high cholesterol)

• Medication Related:
  – Encourage members to use generics
UPMC HP Examples of Member Programs

• Osteoporosis Program
  – Identify members over the age of 65 recently suffering from a fracture
  – Make sure the members are receiving appropriate drug therapy
  – Send out information on osteoporosis to members

• Cough and Cold Program
  – Deliver cough and cold kits to physicians office during the flu season containing samples of OTC cough and/or cold medications
  – Promote appropriate antibiotic use
  – Physician can give the member something when they leave the office besides an Rx for an antibiotic
Quality Management

- National Committee on Quality Assurance (NCQA)
  - Private, nonprofit organization developed in 1990 to improve health care
    - Provides information on the quality of care and services delivered
  - Goals of NCQA
    - Change how clients and individuals choose health care
    - Change how health care is provided
  - Review cycle depends on accreditation status
    - 3 year cycle with the highest level of accreditation (Excellent)
    - Otherwise review is annually
Quality Management

• Healthcare Effectiveness Data & Information Set (HEDIS) Measurements
  – NCQA’s set of managed care quality indicators
  – Developed to provide employers with standardized performance measures to compare managed care organizations
  – Focuses on specific quality of care issues
HEDIS

• Areas of focus are:
  – Effectiveness of care
  – Access and availability of care
  – Satisfaction with care
  – Health plan stability
  – Use of services
  – Cost of care
  – Informed health care choices
  – Plan descriptive information
HEDIS

• Specific pharmacy indicators focus on chronic conditions:
  – Appropriate drug therapy for treatment of asthma
  – Controlling hypertension
  – Persistence of beta-blocker treatment after a heart attack (180 day course)
  – Cholesterol management after an acute cardiovascular event
  – Comprehensive diabetes care
  – Antidepressant medication management
  – Systemic corticosteroid within 14 days and bronchodilator within 30 days after COPD exacerbation
Quality Management

• Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS)
  – Annual member satisfaction survey
Quality Management

Accreditation = NCQA Scores + HEDIS Scores + CAHPS Scores
UPMC HP NCQA Accreditation

• UPMC Health Plan Commercial, Medicaid, and Medicare all received an excellent rating

• “NCQA's highest accreditation outcome is granted only to those plans that demonstrate levels of service and clinical quality that meet or exceed NCQA's rigorous requirements for consumer protection and quality improvement. Plans earning this accreditation level must also achieve HEDIS® results that are in the highest range of national or regional performance.”

http://web.ncqa.org/
Specialty Pharmacy Services
Specialty Medications

• Specialty Products Include:
  – High cost injectable or oral
  – High cost disease
  – High touch disease
  – Medications with unique storage and/or dispensing requirements
  – Coverage through the medical and pharmacy benefit
Specialty Medications

• Small patient populations with chronic, often complex diseases
• Average cost per month is over $1,500
• Cost drivers
  – New Products
  – New Indications
  – Rich Pipeline
• Often difficult to discover and manufacture (genetically engineered)
Specialty Medications – Follow-On Biologics

• Difficult to make a generic equivalent product since biologics are derived from living beings
  – Small changes can make them ineffective or potentially harmful
  – Won’t be exact copies
• Some of the oldest biotech patents have already expired
  – Insulin, Growth Hormone
• FDA currently lacks a regulatory framework to quickly approve follow-on biologics or biosimilars
• Working on a bill for framework for biotech generic FDA approvals
  – June 2007 – US Senate approved a bill allowing generic versions of biotech drugs after 12 years of exclusive marketing rights
• Biosimilars may only be about 30% lower in cost
Each Specialty Patient Has Large Annual Costs

- Well
- Acute condition
- Low-grade chronic

- Chronic conditions and/or procedures
- Rare Diseases, Acute Complex, Multiple co-morbidities

Medical Care 41:1153, 2003
Specialty Growth Continues to Outpace Traditional Drug Market

- ‘Specialty’ pharmacy transcends both the medical and pharmacy benefit
- Traditional pharmacy utilization management methods cannot always be applied to the medical benefit
- Reimbursement for the same drug can vary significantly between medical claims and pharmacy claims

Source: Express Scripts analysis of IMS data.
UPMC HP Specialty Pharmacy Management

- Multi-Pronged Approach
  - Channel Management
    - Exclusive Specialty Provider – CuraScript
      - Aggressive rates with comprehensive patient management
      - Robust utilization and opportunity reporting
    - J CODE blocks
  - Utilization Management
    - Prior Authorizations, Quantity Limits
      - Medical and Pharmacy Benefit aligned
    - Clinical Pathway Strategies
    - Formulary Management
Network Management
Pharmacy Network Management

• Pharmacy Network: All pharmacies who have contracted with a managed care organization to provide pharmacy services for members
• Goal is to balance access and cost
• Networks consist of chain & independent pharmacies
• Reimbursement rates are written into the network contract
Pricing Terms

• AWP (Average Wholesale Price)
  – Most commonly used price index – typically set through wholesaler surveys
  – Commonly referred to as the sticker price
  – Used to calculate the reimbursement payments to retail pharmacies
  – Specific to drug strength, dosage form, package size, and manufacturer
Pricing Terms

• MAC (Maximum Allowable Cost)
  – MAC lists are used as cost containment tools
  – Used to calculate the reimbursement payments to retail pharmacies for GENERIC medications to mitigate variability in AWP
    • Usually based on the average of several generic medications from multiple manufacturers
  – Typically negotiated between PBMs and the managed care organization
Pricing Terms

• WAC (Wholesale Acquisition Cost)
  – Price paid by wholesalers to manufacturers

• AAC (Actual Acquisition Cost)
  – Price actually paid by pharmacies to wholesaler for a drug product

• U&C (Usual and Customary) or Retail
  – Pharmacy’s everyday selling price to individual customers paying without insurance
  – Includes mark-up (rent, utilities, wages, etc.)
Typical Reimbursement

• Payments made to pharmacies for providing drug products to members
• Typical brand medication reimbursement
  The lower of…..
  – AWP - % discount + dispensing fee (contractual discount)
  – U&C
• Typical generic medication reimbursement
  The lower of……
  – AWP - % discount + dispensing fee (contractual discount)
  – U&C
  – MAC + dispensing fee
Network Components

• Retail

• Mail Order

• Specialty Pharmacy
Retail Pharmacy Network Functions

• Negotiate Discounts
  – Pass-Through or Lock-In
  – Rate Guarantees
• Credential
• Monitor and Audit
• Reimbursement
• Help Desk
UPMC HP Retail Pharmacy Network

- Enhanced Network
  - Giant Eagle
  - Eckerd
  - Wal-Mart
  - Sam’s Club
  - Target
  - Walgreens
  - Kmart
  - Rite Aid
Mail Service

- 90-day supply of medications
- Used for maintenance medications for chronic conditions
- Deeper discounts with no dispense fees
- Improved safety and efficacy through automation
- Convenient home delivery
- Efficient automated member tools
- Awareness and Marketing Programs
Specialty Pharmacy Provider

• High touch for chronic, complex diseases
• Convenient mail order delivery to the member or the physician
• Improved access to drugs as many retail pharmacies do not carry these types of medications
• Provide education to members and access to professionals trained in the proper use of these specialty medications
• Medication management and compliance programs
Delivering High Touch Care

Rheumatoid Arthritis Data

Better Educated
- Retail: 75%
- CuraScript: 86%

Rate staff as extremely skillful
- Retail: 72%
- CuraScript: 83%

More Satisfied
- Retail: 74%
- CuraScript: 82%
CuraScript Patients Are More Adherent With Therapy

- Rheumatoid Arthritis: 79% (Retail), 87% (CuraScript)
- Multiple Sclerosis: 82% (Retail), 92% (CuraScript)
- Hepatitis C: 84% (Retail), 92% (CuraScript)
Rebate Negotiation
Rebates

• Rebate: A monetary amount returned to a payer from a prescription drug manufacturer

• Rebate agreements help drive down the cost of prescription drugs
Rebates

• Types

  – Formulary-Access Rebate

  – Market Share Rebate (Performance)
Formulary-Access Rebates

- Offered for preferential tier placement of a drug
- Higher rebates are offered if competing drugs are:
  - Kept off the formulary
  - Placed in a non-preferred status
  - Covered with utilization management (PA, ST, QL)
- Any change of formulary status or utilization management typically can affect rebates
Market Share Rebates

- Used when the manufacturer wants to increase % market share of a product versus competitors products
- Market share = Manufacturer’s sales / Total market sales
- Offer a variable percentage of rebate dollars based on market share level a drug achieves
- Manufacturer gives larger rebates if market share increases significantly
Rebates

• Payment and Sharing Arrangements
  – Percentage arrangements
  – Per claim (per Rx, per Brand, per Brand formulary)

• Transparency
# The Net Cost Equation

Average Wholesale Prices

- less Network Discount
- plus Dispensing Fee
- plus Sales tax

---

Ingredient Cost

- less Benefit Copay
- plus Plan Paid Cost

---

Plan Net Cost

- less Manufacturer Rebate
UPMC HP Pharma Rebate Contracting

- UPMC Health Plan performs:
  - Direct pharma contract negotiations
  - Rebate administration functions
- Over 35 manufacturer contracts
- Multi disciplinary rebate work group includes:
  - Clinical Oversight
  - Financial Evaluation
  - Market Assessment
  - Pipeline Impact
- Dedicated Analytics Team
UPMC HP Rebate Strategy

• Lowest ‘Net Cost’ Strategy
  – Drives utilization to generics and preferred brands
  – Preferred product positioning philosophy creates leverage
  – High cost category tier placements/exclusions drive generic and OTC utilization
Operational Services
UPMC HP Operational Services

• Pharmacy Services Customer Service Call Center
  – Clinical and administrative prior authorizations
  – Dedicated pharmacists and call center representatives
  – Specialized resource unit
  – Specialized mail order and specialty drug teams
  – Escalated member issues (complaints and grievances)

• Benefits Configuration Team
  – Reporting, compliance, and performance monitoring
Pharmacy Related Calls

• Calls from the physician
  – Go to the Pharmacy Call Center

• Calls from the pharmacy
  – Go to ESI Pharmacy Help Desk
  – Go to the Pharmacy Call Center if ESI cannot address the issue

• Calls from the member
  – Go to the Member Services Call Center
  – Go to the Pharmacy Resource Desk if it is a complex member issue
Quality Measurements

• Average speed to answer
• Average abandonment rate
• Service level
  – % of calls answered in 30 seconds or less
• Quality of the phone call
  – Listen to and rate the phone calls
UPMC HP Website Capabilities

• Pricing quotes for prescriptions
• Formulary information
  – Personalized member formulary
• Drug savings for using generic
  – Sensitive to the member’s benefit design
• Drug savings for using certain pharmacies
  – Mail order
• Common side effects
• Drug-drug interactions
• Order mail order refills online
Typical Pharmacy Benefit Management Components

• Claims Processing
• Product Development
  – Benefit Design Recommendations
• Clinical Pharmacy Services
  – DUR
  – Utilization Management
• Network Management
• Formulary Management
• Rebate Negotiation
Typical Pharmacy Benefit Management Components (cont)

- Mail Service
- Specialty Pharmacy Services
- Customer Service Call Center
- Data Collection and Reporting
- Annual Review
Health Plans vs. Pharmacy Benefits Management (PBM)

- **Health Plan**
  - PBM component is included in services
  - Access to medical claims, diagnosis codes, and Rx claims
  - Utilize PBMs for some services

- **PBM**
  - Carved out from medical benefits
  - Access to Rx claims only
ESI Relationship
Best of Both Worlds Capability

• ESI provides:
  – Superior technical platform
  – Leading mail order and specialty capabilities
  – Vast resource infrastructure
  – Reporting capabilities for clients

• UPMC Health Plan provides:
  – UPMC physician- and pharmacist-led clinical and formulary development, management, and maintenance
  – Comprehensive care and health management programs integrating medical and pharmacy claims
  – Flexible and dynamic formulary and benefit designs
  – Aggressive, in-house manufacturer drug contracting
The UPMC Health Plan
*Pharmacy Advantage*

- **Comprehensive Financial Offering**
  - Aggressive retail network rates coupled with ‘member friendly’ 30 K network size
  - Full service, national mail service and specialty capability (ESI) with aggressive rates
  - All inclusive administrative fee providing Eligibility, Claims Processing, Clinical Formulary management and Care management components and reporting

- **Extensive Clinical, Formulary, Specialty, and Trend Management**
  - Dedicated team of clinical pharmacists for proactive benefit, drug pipeline, utilization and trend management consultation
  - Cutting edge clinical programs and formulary developed and maintained by leading UPMC physicians and pharmacists
  - Clinical sophistication enhanced by our relationship with UPMC Health System
  - Formulary rebate management ‘in house’ to maximize discount opportunities
The UPMC Health Plan
Pharmacy Advantage

• Integrated Pharmacy Services
  – Single PBM platform allows for efficient pharmacy benefit administration and enhanced member service
  – Allows for integration of pharmacy and medical claims for enhanced, holistic member management
  – Multi-disciplinary, organizational team engagement provides quality, holistic care model
  – Robust reporting includes pharmacy and medical

• Administrative Efficiency
  – One point of contact for eligibility, member, and client services
  – Robust web capability, including price-check, pharmacy locator, and formulary information