FEATURE

Weeding Out Waste

RX FORMULARY EXCLUDES LOW-VALUE DRUGS IN FAVOR OF THOSE WITH PROVEN EFFICACY AND LOW-COST ALTERNATIVES AS PART OF MORE THOUGHTFUL APPROACH THAT RETHINKS PBM MODEL

Written By Bruce Shutan

An estimated 30% of all health care spending is deemed wasteful. And with pharmaceuticals long representing the fastest-growing portion of self-insured health plan costs, it's not surprising that a waste-free formulary was finally developed to manage that soaring tab.

Industry observers consider this novel approach a great way to prune low-hanging fruit and save on costs but also a means to rethink relations with traditional pharmacy benefit managers.

Indeed, PBMs have become a lightning rod for criticism over rebates on inflated scripts, opaque spread-pricing arrangements and conflicts of interest with drug manufacturers. They also have been taken to task for a lack of accountability on adequately reining in an employer's drug spend.

These gripes have seen the creation of "transparent" or "fiduciary" PBMs that only charge a modest administrative fee per script. They have been lauded for being far better stewards of prescription drug benefit plans.

Many formulary drugs cost more than they should because large PBMs are making money on them, explains Lauren Vela, senior director of member value for the Pacific Business Group on Health.

Lauren Vela

'A NO-BRAINER'

More than two years ago, PBGH researched the impact of contracts that 15 self-insured employers had with the nation's three largest PBMs, which are Express Scripts, CVS Caremark and OptumRx. The results were eye opening.

An August 2019 PBGH Issue Brief on wasteful spending in pharmacy benefit plans noted that $63 million in annual savings were possible among those plan sponsors it examined just by reducing the use of high-cost, low-value drugs. Under this calculation, which represented anywhere from 3% to 24% of overall pharmacy spending, 6% of claims analyzed were deemed wasteful. They included 868 scripts from 71 drug groups.

Until that study financed by the Commonwealth Fund was done in conjunction with Integrity Pharmaceutical Advisors, Vela didn't fully understand just how badly the traditional PBM business model was affecting drug spend. While ridding formularies of wasteful drugs doesn't necessarily have the biggest impact relative to other Rx solutions, Vela says it might be the easiest of all steps, adding "it's sort of a no-brainer."

But that transition may not always be a smooth one. In adopting a waste-free formulary, she cautions that there could be some pushback from health plan members who are unhappy if drugs they've been prescribed are no longer covered. Another scenario is fear of smaller rebates.

Moreover, many PBGH members have been told by their PBM or consultant not to worry about the formulary misspending dollars. When this happens, she advises them to request in writing which of the drugs with a questionable track record are actually on their formulary and how much they're being charged for them.

As a result of these efforts, some PBGH members are interested in replacing their PBM entirely, while others are pressing their PBM to be more accountable. There's also resistance to change because of longstanding relationships with big-three players, fearing that such a move would be too risky. Vela found it interesting that PBMs now offer low net cost formularies, but even so, she'd like to see more of her members give fiduciary PBMs a try.

As part of its quest to root out formulary waste in favor of drugs with proven clinical utility as well as low-cost alternatives, PBGH incorporated recommendations from the Institute for Clinical and Economic Review. Several algorithms also were used to evaluate medications.

Drugs that were excluded from PBGH's waste-free formulary include Absorica, a vitamin A derivative to treat acne; Dexilant, a proton-pump inhibitor, and Glumetza, an extended-release formulation of metformin.

All were considered wasteful or low-value and fell into four categories. They included so-called me-too scripts involving immaterial tweaking of a particular ingredient, combination drugs that fuse two active ingredients into one pill, over-the-counter equivalents

and brand names that are used when generics are available.

Combo drugs may be particularly hard to swallow for some health plan sponsors and members alike. Terry Killilea, Pharm. D., SVP of clinical/fiscal integration at USI Insurance Services, recalls how a large client in Texas saw the cost of a product used to treat a variety of skin conditions skyrocket out of the blue from $700 per month to about $50,000 to $60,000 a month. "The only unique thing about it was it was a combination of two OTC products," he says.

In crafting a vigilant drug list, Killilea explains that some PBMs may recommend that new products not be covered for six months until safety is proven and there's an evidence-based assessment of their clinical value. While describing the waste-free formulary as a catchy moniker and nice marketing term, he says it's not a new practice and, in fact, dates back 30 years into his own career. "Any good PBM operation or prescription plan will pretty much have that addressed already," he adds, noting that it's not as much Rx performance as avoidance of certain scripts.

Saying he's a biochemist at heart, Killilea requires a fiscal regiment on pricing alongside "some validation that there's clinical assessment... We don't make the decisions, but we certainly push the PBMs to apply rigor."

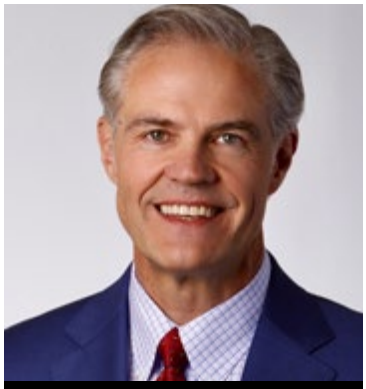
KEEPING COPAYS MANAGEABLE

A similar Golden State success story has been unfolding for several years. The Self-Insured Schools of California (SISC) implemented a waste-free formulary in partnership with Navitus Health Solutions, a transparent PBM, and Integrity Pharmaceutical Advisors. Featuring lowest net cost scripts and transparent pricing to reduce wasteful spending, it achieved a significant reduction in cost trend and per-employee-per-month savings with minimal member disruption.

With the Rx portion of renewals growing an average of 11.7% annually between 2010 and 2014, SISC decided to lower net pharmacy cost instead of maximizing rebate income. It also sought a PBM committed to transparency vs. being focused on driving use of its own mail-order pharmacy.

The waste-free formulary it adopted rooted out 600 drugs, including Treximet, a migraine medication composed of two old drugs. Although that script's individual ingredients prescribed separately cost just $7.31, the after-rebate cost was about $219.

"By removing waste, we are able to maintain low member cost-sharing, which gives members affordable access to the therapies they need," explains John Stenerson, SISC's deputy executive officer. "Our copays average $4.30 for generics and $26.54 for brands."



John Stenerson

He says the formulary's drugs are safe and just as effective as the ones that have coverage restrictions and also help improve lives. In the face of government inaction on this issue, Stenerson believes "it's up to us to stay vigilant and diligent about promoting value and attacking the waste in the system."

SISC, which was established in 1979, pools resources across school districts to secure affordable and sustainable health benefits coverage for 330,000 employees and their families at more than 400 school districts in 43 counties in California.

Suzanne Delbanco, Ph.D., executive director of Catalyst for Payment Reform, lauds SISC for the way it communicated the waste-free formulary in advance and built in a transition period. "They were very sensitive to how this can be perceived by plan members and really thoughtful about how much time they each might need to adapt to the new set of prescriptions," she says. Catalyst for Payment Reform's website touts a May 2019 case study on SISC's experience, which can serve as a model for other self-insured entities.

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Mike Case Haub

APPROPRIATE MEDS AND DOSAGES

Better formulary management not only makes drugs more affordable, it also can improve adherence and health outcomes. "There's mounting evidence that people refrain from seeking care when they perceive it to be too expensive, especially for people who are on drugs for chronic conditions," Delbanco reports.

But a closer look at longstanding practices may reveal unintended consequences. "Everybody's really focused on medication adherence," says Mike Case Haub, PharmD, CEO of CHC Health. "But the research has shown that we're spending or wasting about $528 billion a year on non-optimized drug therapy. That means that it's not necessarily an adherence issue."

The real problem, he explains, is with patients not being on correct medication or dosage. Physicians might prescribe a particular script because the patient is having an adverse reaction to another medication, which can become a house of cards. For every Rx dollar spent in the U.S., about $1.15 is spent to reverse the effects of medication, Case Haub reports, resulting in a negative return on investment on drug therapy.

More than half of patients are readmitted to hospitals within 30 days because of a medication-related issue, he notes, and oftentimes no one is managing their prescriptions. "They might come into the hospital on 15 meds; they go home on 15 new meds, and then they get home and wonder if they take all 30 of these meds," he says.


Jim Lewis

The solution is having clinical pharmacists becoming actively involved from an education standpoint and helping manage coordination of care, explains Case Haub, whose firm on average finds at least three significant issues with a patient's medication. His approach involves unbundling pharmacists from pharmacies. "Our pharmacists are in a telehealth or virtualized situation," he says. "We're not in a pharmacy filling prescriptions and distributing product."

Over-prescribing medication has precipitated the need for more judicious formularies, according to Jim Lewis, founder and CEO of Predictive Health Partners whose firm recently formed a strategic partnership with CHC Health to provide medication management services. Considering how some patients seek multiple scripts from several different doctors or pharmacies in any given year, he's deeply concerned about the effect on adverse drug events (ADE).

Cutting the number of ADEs in half would not only prevent about 2.3 million hospitalizations nationwide, but also save 74,000 lives and $30 billion. That conclusion was drawn in an April 2019 Lown Institute report that also noted it would reduce the number of outpatient visits for ADEs by 37 million in the coming decade.

"We can literally go out, engage individuals who are at high risk of having an adverse drug event, and the reason that they would want to talk to us is that they're wasting money," he says. "They don't need to be on six, eight or ten prescriptions."

Another point to consider about the waste-free formulary concept is that with new drugs constantly in development or coming off patent, the list of approved scripts will change on a regular basis. "It's something that you have to remain vigilant about and continually search for opportunities to make those decisions about the formulary," Delbanco says.

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Given the focus of her organization, she believes the best opportunity to reform Rx payment is to package together pharmacy and medical costs with incentives for providers to spend as efficiently as possible. "If a group of providers is being given responsibility to adhere to a budget for a given population," she suggests, "they will make judicious decisions about when to use pharmacy and medical care, and how to keep the costs as low as possible by using the best combination." ■

Bruce Shutan is a Portland, Oregon-based freelance writer who has closely covered the employee benefits industry for more than 30 years.