State Employee Benefits Committee
Group Health FY17 Planning
January 22, 2016
Objectives for Today’s Discussion

• Safeguard Rx - Express Scripts Efforts to Control Rising Costs

• Medical Channel Management

• Advanced Utilization Management

• Formulary Drugs with Over the Counter Equivalents

• Medicare Part D & Part B Coordination
Express Scripts SafeGuard Rx
Protecting Clients from Inflation
Industry first inflation protection guarantee

Brand Drug Inflation

Clinical Utilization Management
Hepatitis Cure Value
Cholesterol Care Value
National Preferred Formulary
Indication-Based Management

Inflation Protection Guarantee
State of Delaware
Medical Channel Management
# Medical Channel Management (MCM)

<table>
<thead>
<tr>
<th>Program</th>
<th>Capability</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Covers specific specialty drug categories exclusively under pharmacy benefit</em>&lt;br&gt;<em>Addresses significant drug spend hidden under medical benefit</em>&lt;br&gt;<em>Positions clients for substantial new drug pipeline</em></td>
<td><em>Dedicated resources to manage patient transitions</em>&lt;br&gt;<em>Experienced physician management to provide smooth transfer</em>&lt;br&gt;<em>Robust data analytics to support customizable program configurations for clients</em>&lt;br&gt;<em>Savings reporting available</em></td>
<td><em>Client savings average 8-12%</em>&lt;br&gt;<em>Visibility of specialty spending</em>&lt;br&gt;<em>Managed spending, trend, and utilization</em>&lt;br&gt;<em>Consistent application of clinical protocols</em></td>
</tr>
</tbody>
</table>

*Based on report prepared by Medco’s Performance Solutions group, measuring therapy and coverage management savings for clients enrolled in the MCM program. These savings assume no coverage management programs were being utilized on the medical benefit. Bases for savings percentages is 2013 MCM case studies of 6 clients and 377 impacted patients. All savings reported are estimated and are not guaranteed.*
# Medical Channel Management Opportunities

<table>
<thead>
<tr>
<th>Primary therapies</th>
<th>Self-administered</th>
<th>Rare Disease</th>
<th>Clinician-administered</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>GH, MS, non-infused RA, Anemia, Oral oncology</td>
<td>GH, MS, non-infused RA, Anemia, Oral oncology</td>
<td>Hemophilia, IVIG, enzyme deficiency, Alpha-1, PAH</td>
<td>RSV, allergic asthma, infused RA, osteoarthritis, opthalmics</td>
<td>NA</td>
</tr>
<tr>
<td>Implementation complexity</td>
<td>Low</td>
<td>Low/medium</td>
<td>Low/medium: RSV, allergic asthma High: infused RA</td>
<td>Low/medium</td>
</tr>
</tbody>
</table>

GH=growth hormone; PAH=pulmonary arterial hypertension; IVIG=intravenous immune globulin; RA=rheumatoid arthritis; MS=multiple sclerosis; RSV=respiratory syncytial virus
## Patient-Level Savings Examples

| Movement from infused therapy to self-injected (coverage management) | Patient received *Remicade*® at physician’s office through the medical benefit.  
• Due to a prior authorization (PA) rule, MCM drove movement to a lower-cost, self-administered drug (i.e., *Enbrel*®, *Humira*®)  
• Self-administration removes infusion expense |
| --- | --- |
| End off-label use (coverage management) | Patient received intravenous Immune globulin (IVIG) at physician’s office through the medical benefit to treat multiple sclerosis.  
• Off-label use of extremely expensive drug ceased |
| Uniform plan rule enforcement (coverage management) | Adult patient received growth hormone at physician’s office through the medical benefit.  
• Adult-use rule triggered and the order was canceled |
| Improved dose management (therapy management) | Patient received *Procrit*® at physician’s office through the medical benefit.  
• Movement to Accredo® yielded improved vial optimization and dispensing of smaller quantity of drug  
• Continued clinical evaluation for appropriate use |
MCM Program Flow

1. Newly diagnosed/existing patient* obtains medication or prescription from prescriber.
2. Prescriber submits claim to medical claims processor.
3. EOB message directs patient or provider to Accredo® for next fill or claim will not be paid.
4. Provider or member initiates prescription, and Accredo gathers appropriate authorization information for next refill.
5. Accredo adjudicates refill under pharmacy benefit and initiates ongoing patient care and specialty pharmacy support.

1. Claim denied on first fill
2. Claims processor educates claimant
3. Upon appeal, benefit makes a one-time exception payment (when applicable)

MCM = Medical Channel Management
EOB = Explanation of Benefits
*One-time notification mailing sent to existing patients triggered by medical carrier mail file.
Next Steps

1. Analyze specialty utilization under Highmark and Aetna medical plans  Underway

2. Review utilization and identify opportunities  February 2016

3. Discuss recommendations with SEBC.  March 2016
Advanced Utilization Management
Progressive solution to enhance safety and savings through integrated, rules-driven programs.
# Utilization Management Philosophy

## 1
Do you want your members to take **medications** for only those conditions that are **approved**?

## 2
Do you want your members to take medications that achieve **meaningful clinical outcomes** and **cost less money** for the member and the plan?

## 3
Do you want your members to take medications in the **proper approved quantity**?

> Protect your plan from future unknowns
Advanced Utilization Management
comprehensive trend management solution

<table>
<thead>
<tr>
<th>PRIOR AUTHORIZATION</th>
<th>STEP THERAPY</th>
<th>DRUG QUANTITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Right Patient</td>
<td>2 Right Drug</td>
<td>3 Right Amount</td>
</tr>
</tbody>
</table>

PROACTIVE, HOLISTIC APPROACH
1. Actively monitor changing landscape
2. Automatically update clinical rules
3. Implement marketplace changes as they occur

Strategically developed packages to improve trend and align philosophy across plan
A Stepwise Approach

Advanced UM Package Options

- **Limited**
- **Advantage**
- **Advantage Plus**
- **Unlimited**

Client savings

Utilization Management

Better Decisions  |  Healthier Outcomes

Client tolerance for member impact and targeting under-managed disease states
## Limited Package: Programs in place today

### Prior Auth
- Pulmonary Hypertension
- Respiratory Conditions
- Multiple Sclerosis
- Blood Cell Deficiency
- Endocrine Disorders
- Growth Deficiency
- Sleep-Wake Disorder
- Osteoarthritis
- Enzyme Deficiencies
- Skeletal Muscle Relaxant
- Inflammatory Conditions
- GI Disorders
- Hereditary Angioedema
- Gout
- Macular Degeneration
- Hormonal Supplementation
- Mental/Neuro Disorders

### Step Therapy
- Pain and Inflammation
- Sleep Disorders
- Allergies
- Ulcer Disease
- Acne
- Skin Conditions

### DQM
- Allergies
- Anaphylaxis
- Anti-infective
- Anti-influenza
- Antifungal
- Asthma/COPD
- Contraceptives
- Eye Conditions
- Hormone Supplementation
- Impotence
- Inflammatory Conditions
- Migraine Headaches
- Nausea/Vomiting
- Sleep Disorder
- Ulcer
# Advantage Package: Programs in place today

## Prior Auth
- Bone Conditions
- Allergy Desensitization
- Pain
- High Blood Cholesterol
- Skin Conditions
- Asthma
- Impotence
- Diabetes
- Glaucoma
- Eye Conditions
- Weight loss
- Seizures

## Step Therapy
- High Blood Pressure/Heart Disease
- Urinary Disorders
- Osteoporosis/Bone Conditions
- High Blood Cholesterol
- Asthma
- Diabetes

## DQM
- Anti-infective - Specialty
- Asthma - Specialty
- Blood Cell Deficiency
- Bone Conditions
- Diabetes
- Endocrine Disorder
- Fertility
- Hepatitis C
- High Blood Cholesterol
- High Blood Pressure
- Inflammatory Conditions - Specialty
- Multiple Sclerosis
- Overactive Bladder
- Pain
- Pulmonary Hypertension
- Wound Care

*Also inclusive of Limited Package targets.*
### Advantage Plus Package: New Opportunity

**Prior Auth**
- Anticoagulant
- Chemical Dependence
- Acne
- Hepatitis
- Viral Infections
- Cancer
- Pharmacogenomic testing

**Step Therapy**
- Attention Disorders
- Alzheimer's Disease
- Seizures
- Neuro Disorders
- Pain
- Depression
- Migraine Headaches
- Gout

**DQM**
- Depression
- Mental/Neurological Disorders
- Oncology

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**Designed to target most comprehensive traditional and specialty medications for optimal client and member savings. Includes medication classes that are traditionally under-managed with significant savings.**

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*Also inclusive of Advantage Package targets.*
### Unlimited Option: New Opportunity

**Prior Auth**
- Autonomic disorders
- Immune Serums
- Bone Conditions
- RSV Prevention
- Bacterial Infections

**Step Therapy**
- Contraception

*Designed to be an all-inclusive offering. New rules and lists created can be added under the Unlimited option for no additional charge.*

Also inclusive of Advantage Plus Package targets.
## Advanced Utilization Management
### Savings Detail
### Advantage Plus Package

<table>
<thead>
<tr>
<th>STRATEGY</th>
<th>ANNUAL SAVINGS</th>
<th>PMPM SAVINGS</th>
<th>MEMBER IMPACT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step Therapy</td>
<td>$218,410</td>
<td>$0.18</td>
<td>2,968</td>
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<tr>
<td>Prior Authorization</td>
<td>$0</td>
<td>$0.00</td>
<td>-</td>
</tr>
<tr>
<td>Drug Quantity Management</td>
<td>$307,879</td>
<td>$0.26</td>
<td>1,484</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$526,289</strong></td>
<td><strong>$0.44</strong></td>
<td><strong>4,452</strong></td>
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<th>MEMBER IMPACT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step Therapy</td>
<td>($1,395,548)</td>
<td>($1.18)</td>
<td>1,280</td>
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<tr>
<td>With grandfathering</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Prior Authorization</td>
<td>$0</td>
<td>$0.00</td>
<td>-</td>
</tr>
<tr>
<td>With grandfathering</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug Quantity Management</td>
<td>$307,879</td>
<td>$0.26</td>
<td>1,484</td>
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<td><strong>Total</strong></td>
<td>($1,087,669)</td>
<td>($0.92)</td>
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Savings are net of program cost and rebate impact.
Packages include Step Therapy, Prior Authorization, and Drug Quantity Management.
## Advanced Utilization Management

### Savings Detail

**Unlimited Option**

<table>
<thead>
<tr>
<th>STRATEGY</th>
<th>ANNUAL SAVINGS</th>
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<th>MEMBER IMPACT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step Therapy</td>
<td>$1,455,487</td>
<td>$1.23</td>
<td>5,706</td>
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<tr>
<td>Prior Authorization</td>
<td>$1,196,243</td>
<td>$1.01</td>
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<tr>
<td>Drug Quantity Management</td>
<td>$307,879</td>
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<td>1,484</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>$2,959,609</strong></td>
<td><strong>$2.50</strong></td>
<td><strong>12,645</strong></td>
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<table>
<thead>
<tr>
<th>STRATEGY</th>
<th>ANNUAL SAVINGS</th>
<th>PMPM SAVINGS</th>
<th>MEMBER IMPACT</th>
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</thead>
<tbody>
<tr>
<td>Step Therapy</td>
<td>($1,054,509)</td>
<td>($0.89)</td>
<td>2,511</td>
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<tr>
<td><strong>With grandfathering</strong></td>
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<tr>
<td>Prior Authorization</td>
<td>$135,145</td>
<td>$0.11</td>
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<tr>
<td><strong>With grandfathering</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug Quantity Management</td>
<td>$307,879</td>
<td>$0.26</td>
<td>1,484</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>($611,485)</td>
<td>($0.52)</td>
<td>6,015</td>
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</table>

Savings are net of program cost and rebate impact. Packages include Step Therapy, Prior Authorization, and Drug Quantity Management.
### Advanced Utilization Management Implementation Timeline

- **-3 Months**
  - Approved addendum provided to account team for implementation

- **-1 month**
  - Letters sent to impacted members

- **Go Live**
  - Program edits begin

- **Ongoing**
  - Step Therapy Rapid Response letters are sent to members and physicians as needed
Member Communication Process

Auto updates allow new-to-market drug utilization changes to be added *before* it impacts members

**Prenotification Letters**  
Sent 30 days prior to implementation

- **Coverage Authorization Prenotification**  
  *(Prior Authorization, Drug Quantity Management)*

- **Preferred Step Therapy Prenotification**  
  *(Implementation of step edits without grandfathering)*

**Step Therapy Rapid Response**

- Letters to members with dropped claim after step therapy reject at retail or mail
- Program sends both member and physician letters
- Letters provide alternative medications and explain step therapy process
Formulary Drugs with OTC Equivalents – Savings Opportunity
Over the Counter Equivalent Medications

- 14 medications currently covered under the Commercial plan (active employees & non Medicare retirees) where an Over the Counter equivalent is available.
- Exclusion of these Over the Counter equivalent medications would reduce plan costs.
- Member would purchase equivalent outside of prescription benefit.
- Member Impacts: 3,529 members purchased one or more of these 14 medications under the commercial plan in FY2015.

Total Estimated Annualized Savings Opportunity

$44,000

Savings are based on State of De. Utilization and are not guaranteed.
Over the Counter Equivalent Medications

- Ranitidine HCL
- Polyethylene Glycol 3350
- Cetirizine HCL
- Meclizine HCL
- Ammonium Lactate
- Clotrimazole
- Famotidine
- Lansoprazole
- Hydrocortisone
- Loperamide
- Diphenhydramine HCL
- Omeprazole-Sodium Bicarb
- Mentax
- Cimetidine
EXCLUDING OVER THE COUNTER EQUIVALENT MEDICATIONS

Implementation Steps

• Identify members with recent prescription history of use of prescription medications that have exact over the counter equivalents (same strength and dosage form)

• Send pre-notification letters 30 days prior to advise them that these medications will no longer be covered through the State’s prescription benefit
Medicare Part D and Part B Coordination
EGWP Part B/D Current Process

• CMS requires that plans subject a subset of medication to a Medicare Part B vs. Medicare Part D determination. What this means is that there are medications that can either pay as Medicare Part B or Medicare Part D. The way in which they pay is based on the indication for which the medication is being used and can also be dependent on the route of administration or dosage.

• Plans can decide how they would like to pay for the Medicare Part B medications.

• State of DE currently covers as the primary payor, Part B medications filled at the pharmacy through the non Medicare (enhanced benefit) portion of the Medicare Part D EGWP benefit.

• State of DE Medicare members who fill a Part B drug at a hospital or doctor’s office, the medication will process as Part B. Part B pays 80% of the cost of the medication. The member is responsible for submitting a COB request to ESI to pick up the remaining 20% (member pays the copay and the State of DE non Medicare (enhanced benefit) pays the difference).
Medicare Part B- limited drug and supplies coverage*

Examples of drugs and supplies that may be covered under Medicare Part B

- Drugs used with Durable Medical Equipment- infusion pumps, nebulizers
- Injectable Osteoporosis Drugs
- Some antigens
- Blood clotting Factors
- Diabetic Testing Supplies
- Vaccines: Flu, Pneumonia and Hepatitis B
- Injectable and infused medications administered by a licensed medical provider
- Oral cancer medications
- Oral Anti Nausea medications

*this is not an inclusive list of covered products and services
Achieving Medicare Part B Savings at Retail Pharmacy

• At Retail – Identification of drugs and supplies that may meet criteria to be billed to Medicare Part B as primary.
• Express Scripts solution prospectively facilitates billing Medicare Part B as the primary payor for eligible drugs/supplies.
• State of DE non Medicare (enhanced benefit) pays the remaining balance AFTER member pays prescription copay.
• Impact on the Patient
  • Minimal or no disruption to the patient
  • Patients may experience reduced out of pocket expense depending on their co-payment structure and secondary coverage

Total Estimated Annualized Savings Opportunity

$650,000

Savings are based on State of De. Utilization and are not guaranteed.
PATIENT COMMUNICATION & EXPERIENCE

Patient Experience At Retail

**Primary Claim**
- Patient provides red, white & blue Medicare Card & Express Scripts Card
- Pharmacist confirms Medicare Part B eligibility (may need to reach out to prescriber)
- Requests patient signature on an Authorization of Billing Form & submits Med Part B claim

**COB**
- Pharmacist does not wait for Medicare Part B response
- Submits COB claim to Express Scripts with anticipated Med Part B payment amounts (80%)
- Obtains Express Scripts response with Plan & Patient Pay amounts

**Patient Pays**
- Patient pays their copayment/coinsurance calculated based upon the plan’s chosen Med B COB formula
- Patient can leave the pharmacy with their filled prescription
ACHIEVING MEDICARE PART B SAVINGS

Implementation Steps

• 90-day lead time required for standard implementations
• Program implementations start on the 1st of the month

<table>
<thead>
<tr>
<th>Program Action</th>
<th>State of Delaware</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligibility</td>
<td>Confirm Medicare Part B or Medicare Part D indicators are sent to Express Scripts</td>
</tr>
<tr>
<td>Communications</td>
<td>Review standard announcement letters &amp; mailing pull criteria</td>
</tr>
<tr>
<td>Establish COB Options</td>
<td>Confirm how to handle 20% balance after Medicare pays primary</td>
</tr>
<tr>
<td>Contract Amendment</td>
<td>Sign Med B Solution Contract Addendum or Add to Current Contract</td>
</tr>
</tbody>
</table>
Next Steps:

• Continue discussions on Medical Channel Management and Advanced Utilization Management.

• Approve exclusion of OTC equivalents from Commercial (active/non-Medicare retirees) plan effective on or before July 1, 2016.

• Approve implementation of Medicare Part B Coordination for Medicare Part D EGWP plan effective July 1, 2016.
Supplemental Slides
Prior Authorization: The Right Patient

Prior Authorization ensures the clinically appropriate use of medications.

Prior Authorization ensures that medications are used safely.

Prior Authorization asks the question: “Is this the right medication for this patient?”
How Prior Authorization Works

• Drives savings and patient safety through monitoring:
  • Targeted, high-cost medications
  • Medications with the highest potential for inappropriate use

Physician Visit → Rx written → RPh

Prior authorization required; call physician

QUICKER PROCESS IF SUBMITTED ELECTRONICALLY

If an active prior authorization exists, claim pays

System checks existing prior authorization

If no active prior authorization exists, claim rejects

• Physician contacts PA department
• If clinical criteria is met, then an override is issued, and the claim will pay
• If criteria is not met, then claim will reject
About Step Therapy
Reduce prescription waste

Step therapy reduces waste by promoting the use of generics

### Chemical equivalence
Two drugs with active ingredients that are identical at the molecular level

- **Ambien®** → zolpidem

  Occurs 95%+ of the time with little intervention

### Therapeutic equivalence
Two drugs with active ingredients that are similar at the clinical level

- **Silenor®** → zolpidem

  Occurs infrequently without intervention
Step Therapy: The Right Drug

**Step Therapy** encourages members and physicians to try clinically effective, front-line medications (usually generics) before trying second-line (usually brand name) medications.

Step Therapy asks the question “What other medications has this patient taken for this condition?”
How Step Therapy Works

- Step therapy reduces waste by promoting the use of generics

  - Prior authorization required; call physician; must try step 1 drug first
  - After 4 days, if claim for front line or back-up drug(s) is not in system, send letter to member and physician explaining process
Drug Quantity Management aligns the quantity dispensed with FDA-approved dosage guidelines and other supportive evidence.

Drug Quantity Management asks “Is this the correct quantity (tablets/capsules) of this medication?”
How Drug Quantity Management Works

• Aligns the dispensed quantity of prescription medication with FDA-approved dosage guidelines
• Ensures that the most cost-effective product strength is dispensed
• Helps reduce waste in the pharmacy benefit

- Physician Visit
- Rx written
- RPh
- System checks for appropriate quantity
- If quantity is less than or equal to program limit, the claim pays
- If quantity exceeds the program limit, the claim rejects

- Messaging to pharmacy with maximum quantity allowed
- RPh can submit for allowed amount or ask physician to request an exception
How Preferred Specialty Management Works

- Creates a competitive environment steering toward preferred products
- Reins in inflation with improved market leverage and price protection
- Drives improved discounts
- Manages specialty in a comparable manner to traditional

<table>
<thead>
<tr>
<th>Diabetes (Traditional)</th>
<th>Multiple Sclerosis (Specialty)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 in 12 members</td>
<td>1 in 1,000 members</td>
</tr>
<tr>
<td>$13,000 annual cost per treated member</td>
<td>$34,000 annual cost per treated member</td>
</tr>
<tr>
<td>Oral and injectable therapy</td>
<td>Oral and injectable therapy</td>
</tr>
</tbody>
</table>