



## **Agenda Item 9**

April 15, 2014

**ITEM NAME:** Potential Prescription Drug Plan Changes for 2015

**PROGRAM:** Health Benefits

**ITEM TYPE:** Information

### **EXECUTIVE SUMMARY**

In an effort to encourage appropriate use of cost effective drug therapies while ensuring appropriate use and availability of care, staff are exploring cost mitigation strategies for 2015 for health plans whose outpatient prescription drug benefit is managed by pharmacy benefit manager (PBM) CVS Caremark. Two possible strategies involving only the PBM include High Performance Generic Step Therapy and Targeted Brand Fourth Tier Copay. Two possible strategies that would involve both the PBM and the health plan focus on site of care alignment and medical pharmacy precertification under Anthem Blue Cross.

### **STRATEGIC PLAN**

This agenda item supports Goal A, Improve long-term pension and health benefit sustainability, by ensuring cost effective prescription drug utilization.

### **BACKGROUND**

#### **Outpatient Prescription Drug Benefits Managed by CVS Caremark**

Prescription utilization management programs are an important tool used by PBMs to promote the safe, effective, and evidence-based use of medications. In 2012, the average ingredient cost per script was \$33 for generics and \$216 for single source brands. The average cost of a brand name prescription has increased 27% since 2007. As of May 2013, 22% of CalPERS prescriptions are filled with a single source brand drug. In anticipation of the 2015 rate renewal, staff will be examining High Performance Generic Step Therapy and Targeted Brand Fourth Tier Copay.

#### **Outpatient Specialty Drugs Administered Under the Medical Benefit**

As reported to the Pension and Health Benefits Committee in October 2013, specialty drug costs increased from \$146 million in 2009 to \$254 million in 2012. There is a need for the implementation of strategies designed to control cost while maintaining clinical appropriateness.

For our Preferred Provider Organization population, members can currently obtain most specialty drugs either from CVS Caremark Specialty Pharmacy (i.e., the PBM) or from physicians (medical benefit). Specialty drug claims obtained through the PBM are adjudicated and paid through CVS Caremark. Specialty drug claims obtained through the medical benefit that are administered in prescribers' offices, infusion centers, or other outpatient settings are paid by Anthem Blue Cross. In anticipation of the 2015 rate renewal, staff has examined two sets of methods to reduce specialty drug costs under medical benefit: Site of Care Alignment under Coram (a CVS Caremark subsidiary) and Medical Pharmacy Precertification under Anthem Blue Cross.

## **ANALYSIS**

### **Prescription Benefit Design Proposals - for Preferred Provider Organization (PPO) Basic Plans and Health Maintenance Organization (HMO) Basic Plans with Pharmacy under CVS Caremark**

Two Pharmacy Benefit Design options, High Performance Generic Step Therapy and Targeted Brand Fourth Tier Copay, are described below. If either of these mutually exclusive options is implemented, a comprehensive communication plan will be developed and include direct member and prescriber mailings and use of Castlight<sup>1</sup> to inform members about the change and options.

#### **1. High Performance Generic Step Therapy (HPGST, a CVS Caremark standard program)**

- Program description: As reported to the Pension and Health Benefits Committee in December 2013, step therapy programs have been widely implemented throughout the United States. Approximately 60 percent of commercial payers reported having one or more step therapy programs in 2010. Step therapy programs require that a generic alternative is tried before brands are covered.

CVS Caremark's High Performance Generic Step Therapy encourages clinically appropriate prescribing at the lowest cost, without sacrificing clinical outcomes, by steering members to more cost effective first-line generics, and

---

<sup>1</sup> As reported to the Pension and Health Benefits Committee in Feb 2014, Castlight Health, Anthem Blue Cross, and CalPERS are developing a two-year pilot project to integrate an online tool with our PPO product data. This integration will provide quality and cost information for various health procedures and services. The goal of this pilot is to help our PPO members make informed choices when selecting medical and pharmaceutical services. By making health care quality and cost information more transparent, members and their dependents will be empowered to take greater accountability for their health care choices. The Castlight Health Pilot will be used to guide and inform members of the new benefit design(s). For approximately 18,000 HMO members who will not have access to Castlight, CVS Caremark will customize an education campaign.

provides coverage for one preferred select brand in some classes. The preferred select brand is determined by clinical effectiveness based on FDA approved indications, lowest net cost and/or shortest remaining patent life. It is important to note that the targeted brands in HPGST have generic alternatives within therapeutic classes and the dispensing of generic alternative requires a new prescription from the prescriber. As opposed to the Member Pays the Difference where brands have generic equivalent and the dispensing of generic equivalent is automatic. For some classes, such as the Proton Pump Inhibitors class where sufficient generics are available, a generic(s) trial is required before any single source brand is covered. CVS Caremark currently administers the High Performance Generic Step Therapy to 4.6 million lives. See Table 1 of Attachment 1 for drug classes involved.

- Member experience: At a retail pharmacy, when a prescription for a targeted single-source brand is transmitted to CVS Caremark, the CVS Caremark claims adjudication system will check for previous generic(s) use. If the history shows generic(s) use, the single source brand claim will be paid. If the patient's record shows no history of a generic(s) trial, the claim is rejected and the retail pharmacist receives an electronic message with the generic-first criteria and a toll-free Prior Authorization number for the prescriber to call for more information.
- Similarly at CVS Caremark Mail Service, the rejected claim for a patient with no generic history triggers a fax to the prescriber explaining the alternative first-line medication requirement and requesting a new prescription for a generic alternative, along with a toll-free Prior Authorization telephone number.
- In the event the prescriber determines that a generic alternative is not right for the member, the prescriber can call the toll-free Prior Authorization Department to request medical necessity clinical exception review for the targeted brand coverage at the lower applicable brand copay. If no generic claim is processed within 72 hours of the brand claim rejection, a communication will be sent to the member by letter and the prescriber by fax informing them of the program, the alternatives and options available. The targeted brand is not covered if the patient didn't have history of generic use or medical necessity clinical exception.
- Pros: Generic dispensing rates will increase with improved cost savings to CalPERS and members. There will be minimal disruption with proactive communication plan to members and prescribers (both pre-implementation and post reject). The member will be guided to generic alternative with the reject message to the pharmacy (for retail) or prescriber (for mail service) and a new prescription for the generic alternative is needed.

- Cons: There is a potential for member to leave the pharmacy with no prescription if they refuse to accept the generic alternative. There may be increased member complaints when medication is not covered because member did not meet coverage or medical necessity criteria.
- Estimated Annual Net Savings: \$6 million.

## **2. Targeted Brand Fourth Tier Copay (a CalPERS customized program)**

- Program description: Targeted Brand Fourth Tier Copay focuses on the same 15 drug classes as High Performance Generic Step Therapy. However, targeted brand medications will incur a fourth tier copay (i.e., a generic trial is not required). The proposed fourth tier copay is \$125 for up to 30 day supply at retail and \$250 for up to 90 day supply at mail.

This program would help guide members using targeted brand medications that have generic or preferred brand alternatives but are not captured in the Member Pays the Difference (MPD) program. The MPD program applies to brand medications with a generic equivalent and the dispensing of the generic equivalent is automatic. In contrast, these targeted brand medications have generic or preferred brand alternatives within therapeutic classes and the dispensing of generic or preferred brand alternative requires a new prescription from the prescriber. The cost for the Fourth Tier Copay cost share percent is similar to Member Pays the Difference member cost share percent.

- Member experience: At both retail and CVS Caremark Mail Service pharmacy, when a prescription for a targeted brand is presented the prescription will fill with the higher copay. In addition, at retail pharmacy, there will be a message attached to the paid claim that a lower cost generic alternative is available (this may or may not be seen or provided to the member). The member can choose to pay the higher copay or have the pharmacist contact their prescriber for a new prescription for a lower cost generic alternative.
- In the event the prescriber determines that a generic alternative is not right for the member, the prescriber can call the Prior Authorization Department to request medical necessity clinical exception review for the targeted brand coverage at the lower applicable brand copay.
- To ensure successful implementation and decreased member dissatisfaction, CVS Caremark will send out pre-implementation member and prescriber notifications via mail for impacted members. This provides the opportunity for

member and prescriber to proactively change a prescription to a lower cost alternative or request medical necessity clinical exception review for the targeted brand coverage. Additionally, customized generic alternative mailings can be sent on a periodic basis for members who pay for a high cost targeted brand informing them of their low cost generic alternatives.

- Pros: There is no hard stop at the pharmacy and member is able to continue taking the targeted brand if they choose to pay the higher cost share. The member will be provided with an easy to understand list of medications and alternatives. The benefit design promotes increased generic dispensing with improved cost savings to CalPERS and members. There will be minimal disruption with proactive communication plan to members and prescribers, transition fill, and medical necessity clinical exception review.
- Cons: Member is not redirected to lower cost alternatives at the point of filling the prescription. Members may not be aware of lower cost alternatives. Member may leave a pharmacy with no prescription if they refuse to pay a higher copayment. There may be increased member complaints due to the higher cost share.
- Estimated Annual Net Savings: \$6 million.

### **Prescription under Medical Benefit Management Proposals - for PPO Basic Plans**

Staff has examined two sets of clinical designs to reduce specialty drug costs, improve drug cost transparency, and increase consistency of clinical utilization management under the medical benefit:

#### **1. Site of Care Alignment (Home Infusion versus Medical Office versus Infusion Center)**

- Program Description: Site of Care Alignment targets clinician infused drugs that are billed and paid for under the medical and/or pharmacy benefit and re-directs the member to a lower cost, clinically-appropriate site of care and or channel of dispensing. For example, costs are generally lowest for home infusion with a visiting nurse and highest at an outpatient hospital setting. Rates through physician offices under the medical benefit can be highly variable depending on the provider fee schedule.

The drug can continue to be billed and paid under the medical benefit. For example, oncology drug infusions might remain on the medical side with physician offices, hospital, or infusion centers as sites of care, and the

oncology supportive agents such as anti-emetics, hormonal drugs, IVIG, and steroids, infused in the home under nurse supervision. If home infusion is not an option for the supportive oncology therapies, directing patients to infusion centers might be more beneficial, safer and convenient for the patient and less costly for the health plan. Many physicians may not be aware that home infusion is an option, and the site of care clinical design provides the opportunity for physician education.

CVS Caremark recently acquired Coram Specialty Infusion Services. Coram serves 165,000 patients nationwide and does 90% of infusions in home settings. There are currently nine Coram ambulatory infusion suites in California in addition to the network of nurses who provide skilled infusion care in the home setting. The program offers opportunity to educate physicians on home infusion for the patient, obtain greater cost and quality transparency for high cost specialty drugs, and continue to look at future value based purchasing designs beneficial to our members. This comprehensive approach helps to circumvent manufacturer coupon assistance programs which undercut copay differentials due to the current lack of checks and balances under Medical Benefit and it effectively deals with providers who object to the change due to loss of buy and bill revenue.

- Member experience: If the Site of Care benefit is implemented, 390 current CalPERS members would be impacted. The members and prescribers will be directed to CVS Caremark where they will work with a nurse who will assess the appropriateness of home care. That information will be utilized to determine the care plan for the member in conjunction with the physician. The care plan may include a change in site of care and/or dispensing entity.
- Pros: This alignment provides consistent pricing and enables application of other trend management programs such as utilization management and specialty preferred drug programs. As well as consistent, high touch clinical management. The program ensures that the site of care is not only clinically appropriate, but also cost effective. In many circumstances the member may not be aware that home care is an option; and transition to home infusion may be viewed as a positive change by many members. Physicians may also see this as a benefit because of high inventory costs associated with specialty drugs and uncertainty of medical carrier reimbursement. It also promotes greater coordination of patient care and physician education between Anthem and CVS Caremark physicians and pharmacists.
- Cons: The program introduces change in the provider of some specialty drugs; some members may not want to change their site of care as they have developed a relationship with the staff that provides for the infusion of their drug.

- Estimated Annual Net Savings: \$1.6 million.

## **2. Medical Pharmacy Precertification under Anthem Blue Cross**

- Program Description: This program potentially expands Anthem's list of specialty drugs requiring appropriate precertification prior to physician prescribing. Under the current program, the Provider contacts Anthem Blue Cross for precertification of a targeted specialty drug billed under the medical benefit to ensure that specialty drugs are appropriately used, safe, and align to evidence-based medicine.
- Member experience: Minimal member impact as this program is directed at the provider. Member may experience denials for drugs not supported by evidence-based medicine.
- Pros: This program helps ensure safe, effective and appropriate use with initial, ongoing and retrospective clinical evaluation. The process expands Utilization Management policies and protocols and provides consultative guidance for future management, thus resulting in increased cost transparency.
- Cons: Requires joint efforts with the Provider(s). There may be some member disruption if their care is not supported by evidence-based medicine.
- Estimated Annual Net Savings: To be determined during 2015 rate setting process.

### **NEXT STEPS:**

- Obtain Board direction on High Performance Generic Step Therapy versus Targeted Brand Fourth Tier Copay.
- Meet with Anthem and Caremark physicians and pharmacists to discuss prescription under medical benefit management proposals in order to assess cost saving opportunities, physician education, increased transparency and patient safety issues.

### **BUDGET AND FISCAL IMPACTS**

These programs are designed to reduce medical and pharmacy spend in the health benefit program beginning in 2015. Minor cost reductions are projected at this time

but we believe these are important steps to improving long-term cost containment.  
We will continue to evaluate cost savings.

**ATTACHMENTS**

Attachment 1: Table

- Member Impact for Proposed High Performance Generic Step Therapy and Proposed Targeted Brand Fourth Tier Copay, by Drug Class

---

KATHLEEN DONNISON  
Chief  
Health Plan Administration Division

---

ANN BOYNTON  
Deputy Executive Officer  
Benefit Programs Policy and Planning