



Agenda Item 10

May 20, 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, staff further explored two utilization management strategies for 2015 for the Preferred Provider Organization (PPO) Basic Plans and Health Maintenance Organization (HMO) Basic Plans whose outpatient prescription drug benefit is managed by pharmacy benefit manager (PBM) CVS Caremark. Medicare health plans are excluded as are Kaiser and Blue Shield of California as they do not use CVS Caremark. These two strategies are High Performance Generic Step Therapy and Targeted Brand Fourth Tier Copay. Both strategies ensure evidence-based use of medications, counter manufacturer couponing, and manage future costly new Food and Drug Administration (FDA) approved medications.

STRATEGIC PLAN

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

BACKGROUND

As reported to the Pension and Health Benefits Committee on April 15, 2014, prescription utilization management programs are an important tool used by PBMs to promote the safe, effective, and evidence-based use of medications. The CalPERS CVS Caremark average ingredient cost per script and dispensing rate for 2012 and 2013 are shown in table below.

	2012	2013
Average Ingredient Cost/Script for Generics	\$ 30.13	\$ 29.99
Average Ingredient Cost/Script for Multi-Source Brand	\$ 115.26	\$ 107.26
Average Ingredient Cost/Script for Single Source Brand	\$ 371.47	\$ 419.34
Generic Dispensing Rate	75.3%	77.5%
Multi-Source Brand Dispensing Rate	1.5%	1.4%
Single Source Brand Dispensing Rate	22.8%	21.1%

As reported to the Pension and Health Benefits Committee on December 17, 2013, the independent speaker from Pharmacy Benefit Management Institute reported the evaluation of 14 published step therapy programs covering 5 therapy classes (antidepressants, antihypertensives, antipsychotics, nonsteroidal anti-inflammatory drugs and proton pump inhibitors). The research demonstrated that step therapy programs increased the use of generics and provides financial savings for members and sponsors. The research further demonstrated that step therapy programs had no effect on long-term adherence or other medical expenditure for all classes studied except for antipsychotics in the Medicaid population. Lastly, the speaker stressed the importance of pre and post implementation member and prescriber communication to maximize member satisfaction with a step therapy program.

The High Performance Generic Step Therapy is developed and managed through the activities of the CVS Caremark National Pharmacy and Therapeutics (P&T) Committee.^A The P&T Committee is an external advisory body of experts from across the United States, composed of 19 independent health care professionals including 16 physicians, one of whom is also a medical ethicist and three pharmacists, all of whom have broad clinical backgrounds and/or academic expertise regarding prescription drugs. The regular voting members on the committee are not employees of CVS Caremark. The P&T Committee is charged with reviewing all drugs, including generics, that are represented on the CVS Caremark approved drug lists. The committee establishes that the selections made are non-biased, quality driven and evidence-based. The clinical merit of the drug, not cost, is the primary consideration. The P&T Committee also reviews and approves all utilization management tools such as prior authorization, step therapy and quantity limits associated with CVS Caremark's approved drug lists.

ANALYSIS

The 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 proactive communication plan will be developed to include direct member and prescriber mailings and use of Castlight¹ to inform members about the change and options.

¹ 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.

1. High Performance Generic Step Therapy (HPGST, a CVS Caremark/CalPERS customized standard program)

Program description: As reported to the Pension and Health Benefits Committee on April 15, 2014, 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 except for circumstances of approved medical necessity clinical exception. For most classes, a one-step generic trial is required before single a source brand is covered. Four of the 15 drug classes (Proton Pump Inhibitors, Nonsteroidal Anti-inflammatory Drugs, Angiotensin II Receptor Blockers, and Urinary Antispasmodics) have 2-step criteria. See Table 1 of Attachment 1 for drug classes involved. Similar utilization management programs are currently in place for Blue Shield of California and Kaiser CalPERS health plans.

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. In some cases, one preferred select brand is covered. 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. In the Member Pays the Difference (MPD) program, brands that have a generic equivalent are automatically filled with the generic drug.

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 (PA) number for the prescriber to call for more information. CVS Caremark has claim history data for our PPO members dating back to January 1, 2012. The claim look back period is 180 to 365 days depending on the drug class. In the event where the generic trial was older than the look back period, the generic trial history may be provided by the prescriber via the PA process described below.

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 PA telephone number.

In the event the prescriber determines that a generic alternative is not right for the member (for example, member has a documented generic trial history older than the look back period), the prescriber can call the toll-free PA Department to request a medical necessity clinical exception review for the targeted brand coverage at the applicable brand copay. Prior Authorizations are typically approved for 2 years. A targeted letter is also sent to prescriber prior to the 2 year approval expiration for re-authorization or a trial of generic alternative. The re-authorization process is important due to constant changes in medical knowledge and member's clinical condition. The PA turnaround time for a standard request is 72 hours and for an urgent request is 24 hours. In 2013, CVS Caremark processed 99% of CalPERS PA in less than 1 day. Most of the drug classes in HPGST are for chronic conditions where the immediate initiation of therapy is not required. In the event the member needs immediate therapy for non-chronic conditions, the pharmacist may assist member with selection of an Over-the-Counter medication(s) for interim use as many drug classes in HPGST have Over-the-Counter options. In general, medications within a therapeutic class in HPGST can be switched safely because the medications use standard dosing and do not require additional office visit or blood test. The targeted brand will not be covered if the patient does not have a history of generic use or a medical necessity clinical exception.

To ensure successful implementation and increase member satisfaction, a comprehensive proactive communication plan will be developed and implemented. The goal is to get members switched to generic alternatives or have medical necessity clinical exception approval in place prior to HPGST implementation. In addition to the comprehensive proactive communication, a one-time transition fill with a 30 day supply of the targeted brand will be provided during the transition in the event member has not switched to generic alternatives and does not have a medical necessity clinical exception approval. This occurs at the time member arrives at the pharmacy or submits prescription to mail order for their refill.

Proposed Member Communications:

1. Pre-implementation general communication – member mailing, top prescriber² mailing, website update and newsletter article 3 to 6 months prior to implementation. These communications will inform member and prescriber of the upcoming changes, where to direct questions, and how to access the HPGST drug list.

² Defined as top 20% of prescribers for CalPERS members

2. Pre-implementation targeted communication for current targeted brand users and prescribers – customized impacted member and prescriber³ mailing 3-6 months prior to implementation to inform the upcoming changes and allow time for member to obtain prescription for generic alternative or to work with prescriber to request medical necessity clinical exception review.
3. Post-implementation targeted communication for new targeted brand and previously targeted users and prescribers – additional customized impacted member and prescriber mailing after implementation to inform the changes and remind member and prescriber of the change, the alternatives, and options available.
4. Retrospective post-rejection communications - if no generic claim is processed within 72 hours of the brand claim rejection, a communication will be sent to the member by mail and the prescriber by fax informing them of the change, the alternatives and options available.

Statistics on the CVS Caremark members experience with the HPGST program and proposed communication plan are provided in Attachment 2.

Pros: HPGST encourages evidence-based use of medications, counters manufacturer couponing, and manages future costly new FDA approved medications by steering members and prescribers to generics first. Generic dispensing rates will increase with improved cost savings to CalPERS and members. Member disruption will be minimized with the comprehensive proactive communication plan to members and prescribers (pre-implementation, post-implementation and post claim rejection). 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. A one-time transition fill will be provided during the transition in the event member has not switched to generic alternatives and does not have a medical necessity clinical exception approval. CalPERS staff conducted a survey of two CVS Caremark clients⁴ that have implemented Generic Step Therapy Program. On a scale of 1 to 5, with 1 being rarely and 5 being often, both plans rated 1 for how often the plan hears about patient not being able to receive medications. Both plans were happy with their implementation and stated pre-implementation communication and planning are crucial.

Cons: There is potential for member to leave the pharmacy with no prescription if they need to switch to generic alternative or request medical

³ For example, if a prescriber has 10 CalPERS members on targeted brands, he/she will receive 10 letters

⁴ City of Charlotte North Carolina (14,000 active PPO lives) and State of New Hampshire (110,000 mostly active HMO lives)

necessity clinical exception review. 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 and 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. If the Targeted Brand costs less than the 4th tier copay, the member pays the lower Targeted Brand cost.

Member experience: At both retail and the 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. However, this may or may not be seen or provided to the member because the claim automatically pays. 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 increase member satisfaction, a comprehensive proactive communication plan will be developed and implemented. The goal is to get members switched to generic alternatives or have medical necessity clinical exception approval in place prior to Targeted Brand Fourth Tier implementation.

Proposed Member Communications:

1. Pre-implementation general communication – member mailing, top prescriber mailing, website update and newsletter article 3 to 6 months prior to implementation. These communications will inform member and prescriber of the upcoming changes, where to direct questions, and how to access the Targeted Brand 4th Tier drug list.
2. Pre-implementation targeted communication for current targeted brand users and prescribers – customized impacted member and prescriber mailing 3-6 months prior to implementation to inform upcoming changes and allow time for member to obtain prescription for generic alternative or to work with prescriber to request medical necessity clinical exception review.
3. Post-implementation targeted communication for new targeted brand and previously targeted users and prescribers – additional customized impacted member and prescriber mailing after implementation to remind member and prescriber of the change, the alternatives, and options available.
4. Post-implementation quarterly communications - customized generic alternative mailings to members who paid Fourth Tier copay for a targeted brand to inform them of low cost generic alternatives.

Pros: Targeted Brand Fourth Tier encourages evidence-based use of medications, counters manufacturer couponing, and manages future costly new approved medications. Generic dispensing rates will increase with improved cost savings to CalPERS and members. 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. Member disruption will be minimized with the comprehensive proactive communication plan to members and prescribers (pre-implementation, post-implementation and quarterly post claim low cost generic alternatives mailing).

Cons: Member is not redirected to lower cost alternatives at the point of filling the prescription because the claim was paid and message for lower cost generic alternative may or may not be provided to member. Therefore, members may not be aware of lower cost alternatives. Member may leave the 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.

BUDGET AND FISCAL IMPACTS

Adopting either of these strategies will help reduce pharmacy costs for members and plans using CVS Caremark.

ATTACHMENTS

Attachment 1: Table

- Drug Classes and Member Impact for High Performance Generic Step Therapy and Targeted Brand Fourth Tier Copay

Attachment 2: Power Point

- Potential Prescription Drug Plan Changes for 2015

KATHLEEN DONNISON
Chief
Health Plan Administration Division

ANN BOYNTON
Deputy Executive Officer
Benefit Programs Policy and Planning

References

- A. CVS Caremark. Formulary Development and Management. Available at: <http://www.caremark.com/portal/asset/FormDevMgmt.pdf>. Accessed May 5, 2014.