Pharmacy Programs: Achieving Value and Affordability

January 17, 2018
Agenda

• BriovaRx and OptumRx Approaches to Value and Affordability
  – Michael Zeglinski, BriovaRx and OptumRx

• PBGH Waste Free Formulary
  – Lauren Vela, Pacific Business Group on Health

• Options for Value and Affordability
  – Kathy Donneson, CalPERS

• Reference Pricing as a Purchaser Strategy for Managing Drug Prices
  – James C. Robinson, UC-Berkeley
BriovaRx and OptumRx Approaches to Value and Affordability

Michael Zeglinski, RPh
Senior Vice President of Specialty Pharmacy, OptumRx
Chief Executive Officer, BriovaRx

January 17, 2018
A complex and costly challenge

A Growing Concern

Specialty accounts for 40-50% of pharmacy spend across medical and pharmacy benefits.¹

Skyrocketing Costs

Specialty drugs cost approximately 50x times more than traditional medications.²

Fragmented Care

Poor health care coordination nearly doubles the cost of patient care.³

Climbing Trends

Specialty pharmacy industry trends averaged >21% over the last 3 years.⁴


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Going beyond the traditional specialty approach

Traditional Specialty Management
- Formulary and drug cost management
- High touch
- Open and preferred pharmacy alternatives
- Adherence focused condition management
- Dispensing and delivery

BriovaRx Complete Care

Capabilities
Driving down overall healthcare costs, not just specialty trend

Care
Taking care of the whole person, not just the specialty prescription

Connections
Synchronizing care to improve overall health outcomes, not just adherence
Capabilities to drive down total health care

Price and Contract Innovation
Price protection and value-based approaches that deliver the lowest net cost

13.2%
industry leading specialty pharmacy trend

Site of Care Optimization
Site of care and medical management solutions that address total cost picture

$6.8M
site of care savings in 2016 for inflammatory patients

Total Cost Management
Synchronized care that lowers per patient per month medical costs

$17,500 / $14,900
avoidance savings per hospital readmission – oral oncology / Transplant
Medical benefit management

Analyse

Customized Evaluation
Review cross-benefit claims to compare client’s data to leading industry benchmarks and identify gaps in care and cost-control opportunities

Assess

Tailored Recommendations
Leverage usage and cost patterns to recommend a client-specific strategy focused on trend drivers and cost

Act!

Improved Benefit Plan
Implement solution, including site of care redirection and HUB-model soft outreach for key conditions
### Care focused on the whole person

<table>
<thead>
<tr>
<th>Taking care of the patient, not just the prescription</th>
<th>Driving better care through our condition-specific expertise</th>
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<tbody>
<tr>
<td>Keeping patients on track through a 360° view and smart engagement</td>
<td>Making life easier through flexible delivery and affordability options</td>
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- **7% more adherent patients with BriovaLive video consultations**
- **10% higher adherence with BriovaCommunity personalized video service**
- **100% of patients would recommend BriovaCommunity**

*Harvoni patients*
## Value Based Agreements - How We Get There

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<th>Concept</th>
<th>Status</th>
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<td><strong>1. Value-Based Contracting</strong> – A formulary contracting effort aimed at linking drug prices with metrics (adherence or total cost of care). The objective is to change the dialogue between OptumRx and pharma that focuses on how drugs perform in a member population.</td>
<td>In progress; four agreements in the area of obesity, MS, diabetes and CV-related disease have been executed with additional contracts in respiratory disease pending. Targeting implementation of multiple agreements with CalPERS in Q1 2018.</td>
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<td><strong>2. Value-Based Formulary</strong> – The ultimate outcome of this effort is the development of a new product that will be a mix of traditional benefit-design controls and select therapy categories that focus on the most cost-efficient therapies which emphasize the optimal clinical outcomes.</td>
<td>The goal of this initial phase is to create a proof-of-concept to take to CalPERS for consideration of a pilot program to evaluate commercial application to a membership population.</td>
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PBGH Waste Free Formulary

Lauren Vela, MBA
Senior Director, Member Value
Pacific Business Group on Health

January 17, 2018
Why is there waste in a formulary?

• PBM-driven
  – Rebate guarantees, Spread
• Pharma-driven
  – Me Too Drugs, Combo drugs, OTC equivalents,
  – Pay for Delay
• Purchaser-driven
  – Rebate habit
  – Member experience rules
• Doctor-driven
  – Prescribing without the information, authority, or incentive to prescribe highest value
The Project

- Purchasers collaborate to develop a waste-free formulary and instruct their PBMs to administer the new customized formulary.
- Doctors are engaged to prescribe to this COMMON formulary.
- Patients are happier, doctors are more satisfied, and purchasers save money!
Feasibility Study: Three Work Streams

?1 Data Analysis

Use employer data to unpack pricing, model different formulary choices, estimate savings

?2 Will physicians recognize it?

Use partnerships with trusted provider associations to engage physicians. Use focus groups to fully understand all issues.

?3 Will employers use it?
PBGH Waste Free Formulary in Context

FIRST LEVEL

Medical Channel
- NDC Coding on all claims
- Removal of prescribing impact on physician earnings

Medical and PBM Channel
- EMRs & e-Prescribing supports
- POS UM; step therapy, value prescribing, genomic testing, indication compliance
- PA is ultimately the providers’ responsibility; initially supported by external clinical advisors

PBM Channel
- Purchasers “insource” formulary design for rebate transparency for “no rebate” goal
Arm providers with the information, authority, and incentive to prescribe the right thing to the right patient at the right time for the right price!
The Bigger Story

- Purchasers MUST convene for a better healthcare system
- Changing what we pay for will change what is manufactured
- Changing how we pay PBMs will change the way they do business (and align our interests)
- Discontinuing our wasteful spending will allow more responsible spending on high value health
- Arming doctors with information, authorit incentives will result in better care
Options for Value and Affordability

Kathy Donneson
Chief, Health Plan Administration Division
CalPERS

January 17, 2018
Challenges to Value and Affordability

- Complicated Pricing Models
- Open-Customized-Closed-Excluded
- Numerical Tiers-Parsing Further
- New Drugs to Market & Direct to Consumer Ads
- No common codes, wide variation in cost by site

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Non-Transparent Supply Chains

- Cost Strategies
- Access Strategies
- Manufacturer Strategies
- Market Strategies

May Not Address Root Causes
Potential Strategies for 2019 and Beyond

- Implement Reference Pricing for Rx Therapeutic Classes: Lowest cost therapeutically equivalent drug
- Evaluate Value-Based Insurance Designs for Pharmacy: Value-Based Contracting – payment based on drug performance or outcome metric
- Modify Prescription Drug Copayment Structure: • Redefine tiers to numerical tiers • Reduce administrative and formulary complexity

Source: https://www.calpers.ca.gov/docs/board-agendas/201705/pension/item7-01.pdf, minus "carve-out..." bullet
Importance of Partnerships - Example of Opioids

Source: Kelly Pfeifer, MD, at https://www.calpers.ca.gov/docs/board-agendas/201711/pension/item-7-attach-1.pdf
Importance of National Strategies

Modified from https://www.calpers.ca.gov/docs/board-agendas/201711/pension/item-7-attach-1.pdf
Should CalPERS Adopt ICER Approach to Value?

The value framework of the Institute for Clinical and Economic Review (ICER) "seeks to inform decisions that are aimed at achieving sustainable access to high-value care for all patients."

Reference Pricing as a Purchaser Strategy for Managing Drug Prices

James C. Robinson
Leonard D. Schaeffer Professor of Health Economics
Director, Berkeley Center for Health Technology
University of California

January 17, 2018
What is Reference Pricing?

• Sponsor (employer, insurer) establishes a *maximum contribution* (reference price) it will make towards paying for a particular service or product
  – This limit is set at some point along the observed price range (e.g., minimum, median)
  – Patient must pay the full difference between this limit and the actual price charged
  – Patient may reduce cost sharing by switching to low-priced product or provider

• Patient chooses his/her cost sharing by choosing his/her product or provider
  – Patient has good coverage for low priced options but *full responsibility* for choice
Impact of Drug Reference Pricing

• RETA Trust, an association of Catholic dioceses with 22,000 lives, implemented reference pricing July 2013
• For this study, RETA drug claims from July 2010 to December 2014 (N=573,456) were compared to claims from a labor union trust (N=549,285)
• Multivariable (difference-in-difference) analyses indicate that reference pricing was associated with:
  – 11.3% growth in probability that a RETA patient selects the low-priced drug within its class
  – 13.9% reduction in average price paid
  – 5.2% increase in employee cost sharing

Increased Share for Low-Price Drug Within Each Therapeutic Class

Vertical dashed line indicates date of reference pricing implementation.
Reduced Prices Paid and Increased Consumer Cost Sharing
Can Reference Pricing Be Applied to Specialty Drugs?

- Much of the price increases and variability have been for specialty drugs, which are more complex and expensive than traditional medications.
- There is great potential for price competition among specialty drugs: innovation is producing large numbers of therapeutic equivalents.
- However, specialty drugs differ amongst themselves in efficacy, toxicity, mode of administration.
- To be effective, reference pricing will need to incorporate comparative effectiveness analysis.
- A better term would be ‘value-based pricing’.
Applications of ICER Benchmark Prices

• Sanofi/Regeneron faced stringent UM for their PCSK9 drug Praluent, due to charging a price, even after rebates, far above ICER benchmark

• For new drug on atopic dermatitis, Dupixient, it conferred with ICER and chose a launch price near the benchmark ($37K)

• Favorable response from payers, though not all promised to forgo UM. Drug firm still negotiated rebates with PBMs, resulting in post-rebate price of $30K

• IMHO, payers should eliminate onerous UM and cost sharing for drugs charging benchmark prices

Walker (WSJ) 2017