Pharmacy Cost Trends and System Impacts: Plan Management

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This is the fourth installment of the Pharmacy Cost Trends and System Impacts fact sheet series. Pharmacy plan management has the potential to improve health outcomes while limiting cost increases for health plans and consumers. This fact sheet includes information about pharmacy plan management strategies and potential policy issues associated with these strategies. Previous fact sheets in this series have explored pharmaceutical cost trends,[1] the role of drug supply and pharmacy payments,[2] and specialty drugs.[3]

Opportunities for Improvement

As more citizens gain access to healthcare coverage, cost-effective delivery of healthcare services including pharmaceuticals is critical. Pharmaceuticals are an increasing driver of costs,[4] and employers and health plan administrators have emphasized the need for management of prescription drug benefits. The primary goals for pharmacy management programs and strategies are to support better health outcomes and control pharmacy-related costs.

Pharmacy management strategies may be integrated with existing primary care management models such as patient-centered medical homes (PCMHs) and other value-oriented population-based strategies. This kind of integration with physicians and patients can lead to more timely identification of high-risk individuals, increased appropriate use of drugs or alternative therapies, and improved health outcomes.

Pharmacy Plan Management in Action

The Arkansas Employee Benefits Division (EBD) is the administrator of the self-funded health insurance plan offered to state and public school employees. Since 2008, EBD has worked with the UAMS College of Pharmacy to make coverage recommendations to the decision-making board. The pharmacy benefit is a part of the overall healthcare benefit, and the potential effects of any proposed changes are compared for both pharmacy and medical outcomes. Implementing a reference pricing strategy in 2014 saved the plan an estimated $20 million by deferring coverage to the lowest-cost options for identical prescriptions.

Pharmacy Plan Management Overview

Traditional methods of managing pharmacy costs include price negotiation, the substitution of generic drugs in place of higher-cost alternatives, rebates from manufacturers, beneficiary cost sharing, formulary or drug list restrictions, disease management, mail service prescriptions, and drug utilization review.[5] Both disease management and population-level management tactics are increasing in popularity in an effort to improve patient outcomes and contain cost growth. Disease management typically involves identifying high-risk patients with chronic or special conditions for whom intensive medical care and pharmaceutical management is beneficial. This concept is appealing to purchasers seeking to improve outcomes and reduce costs associated with their higher-risk plan members.

In 2016, Arkansas's Health Reform Legislative Task Force meetings highlighted the potential benefit of targeting pharmacy costs to reduce costs for the state's entire Medicaid program. Irrespective of the method for reforming the delivery and financing model for the Medicaid program, the Task Force recognized the need for targeted management of prescription drug cost and utilization within Medicaid programs.[6]

Pharmacy management programs can generally be categorized as integrated or unintegrated. An integrated management program is tied into overall health benefit design and likely managed by the same entity. A program that is unintegrated may be offered to individuals as a separate benefit from the medical benefit plan. Without proper coordination, it is possible the same drug could be priced differently depending on whether it is administered within separate health and pharmacy benefits.

Tiered Formularies and Reference-based Pricing

A common approach among plans to reduce overall costs is to utilize tiered formularies or reference pricing policies. Within a tiered formulary framework, patients are given options for treatments and drug choices. Lower-tier co-payments are less costly and typically associated with generic options or drugs for which the purchaser has negotiated a lower price. Higher-tier options require a more expensive co-pay in exchange for brand or specialty drugs. Almost all publicly and privately insured individuals in the U.S. receive coverage through plans with tiered formularies. Nationally in 2015, eighty-one percent of covered workers were in plans with three or more tiers of cost sharing. Twenty-three percent of covered workers were enrolled in a plan with four or more cost sharing tiers compared to 13

percent in 2010.[7] While tiered formularies are aimed at reducing drug spending for payers, increased member cost sharing may lead to patient non-adherence or adverse outcomes.[8]

Formulary drug lists are usually developed by health plans as well as pharmacy and therapeutic (P&T) committees composed of pharmacists and physicians from various medical specialties to guide appropriate use. Formularies are typically updated annually but may be changed more frequently if new drugs enter the market or if the Food & Drug Administration (FDA) deems an existing drug to be unsafe. Health plan administrators often choose to tailor their drug benefits design by using formularies developed by pharmacy benefit management groups. Figure 1 below displays the formulary development process used by a prominent national pharmacy benefit management organization.[9]

Figure 1: Formulary Development and Review Process

Under reference-based pricing strategies, plans typically provide a lower-cost option within a drug category and require plan members to pay for any cost-differences should they choose a more expensive alternative. Reference pricing has been used widely abroad but has not been as widely adopted domestically. Reference pricing is meant to limit the amount paid by the purchaser while incentivizing patients to select the preferred lower cost drug, which could ultimately conserve resources and provide lower-cost options for plan members. While implementing reference pricing may increase complexity of plan design, the strategy may incentivize patient choice of higher-value treatments and is consistent with national efforts to increase healthcare value.[10]

Value-based Alternative Payment Model Impacts

By participating in alternative payment models (APMs), health plans may incentivize providers to better manage their prescribing patterns. Arkansas's primary value-based APMs are the PCMH and episodes of care (EOC) components of the Arkansas Healthcare Payment Improvement Initiative (AHCPII). Since pharmacy costs represent a substantial amount of total-cost-of-care, AHCPII participating providers are incentivized to work more closely with pharmacists and patients and to utilize electronic health records to track and assess pharmaceutical utilization. While these efforts have shown promise, the sustainability of AHCPII is contingent on participation of public and private payers and self-insured employer purchasers.

As part of their PCMH strategy, Little Rock Family Practice hired a full-time pharmacist to serve patients within the clinic.

The EOC model incentivizes providers to provide better quality care inclusive of appropriate prescribing patterns for conditions such as upper respiratory infections, for which unnecessary antibiotic use has been reduced by 28 percent from 2012 to 2015 as a result of the model. Figure 2 below displays the yearly rate of antibiotic prescribing within Arkansas Medicaid's non-specific upper respiratory infection episodes for which antibiotics may not be indicated, beginning in 2011 with the baseline year.[11]

Figure 2: Arkansas Medicaid Upper Respiratory Infection Episode: Antibiotic Prescribing Rate

Quality Measure	Oct. '11–Sep. '12	Oct. '12–Sep. '13	Oct. '13–Sep. '14	Oct. '14–Sep. '15
At least one antibiotic filled	44.6%	37.2%	34.0%	32.2%
Multiple courses of antibiotics filled	3.2%	2.4%	2.1%	1.8%

Population-level management strategies such as PCMH usually involve incentivizing provider responsibility for their entire patient panel's service utilization, health outcomes, and associated total cost of care. They financially incentivize use of generic drugs when available and appropriate, medication management, and patient education aimed at improved adherence. Some PCMH clinics, such as Little Rock Family Practice, have used the model to enhance pharmacist integration into their primary care team.[12]

Pharmacy Benefit Managers

As explored in a previous fact sheet, pharmacy benefit managers (PBMs) fill a plan management niche by negotiating pharmacy benefits on behalf of health plans. PBMs manage drug formularies, which determine drug coverage, copayments, and other cost measures for health plans. PBMs may allow plans to leverage their relationships with drug manufacturers to allow for rebates in exchange for listing certain drugs in a plans formulary. While PBMs are designed to slow cost growth and plan spending, recent financial disputes between large health plans and PBMs, coupled with continued growth in overall drug costs, have increased concern around transparency of PBM arrangements with manufacturers.

State Strategies

In both fee-for-service (FFS) and managed care organization (MCO) settings, states have enacted varying degrees of pharmacy benefits management (PBM) strategies. Figure 3 below displays examples of state strategies for PBM in both MCO and FFS settings.

Figure 3: State Examples of Pharmacy Management Strategies

	Primary Strategies	Outcomes or Projected Goals
Iowa	Pharmacy management is carved out of the state's MCO program. The state implemented the Medicaid pharmaceutical care management program, as well as a similar program for state employees.	In 2014, 31 percent of 3,037 Medicaid-eligible patients met with pharmacists; reporting 2.6 medication-related problems per patient, 52 percent recommended new medication and 31 percent recommended discontinuing a medication.[13]
New York	This state has an MCO environment; it recently transitioned to include a managed pharmacy benefit in 2012. Pharmacy benefits are now included under the scope of the state MCO services.	The state saved an estimated $425 million in 2012, and pharmacy dispensing fees have been reduced from $3.50 to an average of $1.75.[14]
Alabama	In a largely rural FFS environment, this state created a commission to address pharmacy management and is currently working with local pharmacies and providers to create regional managed drug benefit programs.	The state improved fairness and accuracy of drug payments by shifting from average wholesale price (AWP), to average acquisition cost (AAC) and statistical survey-based dispensing fee.[15]

Pharmacy benefits are optional for Medicaid programs, but many states including Arkansas offer pharmacy benefits. Efficient pharmacy benefit management may reduce the growth in overall medical utilization and costs. While increased prescribing of drugs for management of chronic diseases such as asthma, diabetes, and hypertension, coupled with efforts to improve patient adherence may increase pharmacy utilization and spending, recent studies have shown that these activities are directly linked to reduced overall medical utilization and costs.[16]

CONCLUSION

While the issue of increasing drug costs is complex, several options exist for public and private payers to improve patient outcomes while controlling the cost of pharmacy spending and overall health care costs. Pharmacy management can contribute to a more efficient plan and healthier population by streamlining the prescription process and promoting coordination of care across settings and providers. While there is a great deal to gain from proper pharmacy management, policymakers must weigh the need to maintain appropriate access, available resources, and any unintended adverse effects of pharmacy-related policy decisions.

It is possible that cost savings for health plans or care facilities may result in increased costs for consumers, which may lead to reduced patient adherence and in turn poorer health outcomes. Consumers may also face challenges understanding changes to prescriptions to which they previously have had access. As policymakers and key stakeholders consider options for transforming the state's healthcare system, pharmacy management options should be considered that are aimed at improving access while incentivizing providers and patients to make informed decisions about the need, intended use, and cost of their pharmaceutical resources.

(See reverse for references.)

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