

Will Value-Based Pharmacy Design Take Off?

Pioneering Benefit System Has Few Takers So Far

By Chris Lewis

Key Developments

- ▶ A new trend in pharmacy benefits is value-based benefit design, which prices pharmaceuticals according to healthcare value.
- ▶ A common approach is for plans to put medications such as asthma inhalers, statins and beta blockers on a low-cost or free tier.
- ▶ Early pioneers in VBID are large self-insured employers such as Marriott International Inc., Pitney Bowes Inc., the University of Michigan and the city of Asheville, N.C.
- ▶ As plans delve into VBID, expect them to start with diseases more easily controlled by medications, such as diabetes, asthma and hypertension.
- ▶ Health plans may move increasingly into tiering based on drugs geared to prevention. CIGNA Pharmacy Management has a drug plan option that allows employers to waive the plan deductible for more than 700 standard preventive prescription drugs.
- ▶ Aetna is planning a controlled clinical study of the impact of a value-based formulary on medication compliance, health outcomes and cost of care.
- ▶ Marriott and a subsidiary of Aetna are working on a copay structure that can be customized to provide the most copay relief to members who will derive the most benefit (such as those with diabetes and heart disease).

If a consumer is covered by health insurance and needs a colonoscopy, chances are she won't be charged if she's over 50, the age at which the

chance for colon cancer increases. It's become accepted practice in the insurance industry to provide cost incentives to encourage preventive care in the medical setting.

So why not transfer the same logic to prescription drugs and make them free for those who need them the most? Some companies are doing just that, leading the way in adopting a radical, new formulary design that's creating one of the biggest ripples of interest in the pharmacy benefit management industry today.

Value-based insurance design (VBID) also referred to as value-based benefit design, substitutes the standard tiered system based on the underlying cost of the drug with one that prices pharmaceuticals according to healthcare value. For instance, a life-saving diabetes drug might be on the free tier, while a lifestyle drug, such as Viagra, might be in the most expensive category.

Businesses are increasingly looking to this design as a way to control more expensive treatments or hospitalizations down the line by encouraging

Doubling Copays Decreases Medication Usage*

Therapeutic Class	Reduction in Days Supplied When Copayments Double
Antihistamines	44%
NSAIDs [†]	45%
Antidiabetics	25%
Antiasthmatics	32%
Antiulcerants	33%
Antihyperlipidemics	34%
Antihypertensives	26%
Antidepressants	26%

Reduction In Days Supplied When Copayments Double

*Reflects the percentage decrease in per-member annual days supplied for prescribed drugs when copayments were increased 100 percent.

[†]Nonsteroidal anti-inflammatory drugs.

Source: RAND study published in the May 19, 2004 edition of the Journal of American Medical Association.

compliance with essential medication regimens. A 2004 Rand study showed that when the amount patients pay for prescription drugs doubles, patients cut their use of common drugs for chronic diseases—such as diabetes, asthma and gastric acid ailments—by as much as 23 percent.

Health plans are beginning to experiment with VBID and are rolling out design choices for their clients.

"Everybody's interested in it because it's intuitively appealing," said Dana Felthouse, president of the Pharmacy Benefit Management Institute, an organization that represents plan sponsors. "I think employers are really searching to maximize their investment in benefits. If you have members who are more compliant, you're going to experience both a greater clinical and economic return on your investment in both the medical and drug care that you're subsidizing for them."

Self-Insurers Are Pioneers

That's the theory, but many businesses are still waiting to see hard data on the economics of such a switch. There are some observational studies on compliance and cost savings, but a significant controlled study has yet to be done, although at least one major study is on the horizon.

In the meantime, mostly self-insured companies and health plan sponsors with large bases of employees and rising healthcare costs are willing to make the investment to influence consumer behavior. Some of the early pioneers of VBID are Marriott International Inc., Pitney Bowes Inc., the University of Michigan and the city of Asheville, N.C.

To get control of double-digit increases in its healthcare costs, Stamford, Conn.-based Pitney Bowes, with more than 35,000 employees, in 2001 restructured its pharmacy benefits to move diabetes, hypertension and asthma medications to the lowest copay tier. It has since reduced copays for

Value-Based Drug Strategies of Leading Edge Versus Other Employers

How many surveyed would set copays on most effective drug for the condition?

Leading edge: 24%
Other: 10%

How many surveyed would waive copays to use generics?

Leading edge: 34%
Other: 13%

How many surveyed would waive employee cost sharing for chronic disease drugs?

Leading edge: 38%
Other: 16%

How many surveyed would waive copays to participate in disease management?

Leading edge: 45%
Other: 23%

How many surveyed would mandate generics?

Leading edge: 72%
Other: 37%

Source: Midwest Business Group on Health 2007 survey on employers' readiness to adopt value-based benefit strategies. Survey sent to over 400 employers in various parts of the country; results received by 163 employers. Leading edge employers—about 21 percent of respondents—are defined as employers willing to try new benefit strategies based on their perceived, yet untested, value. They see a link between health and productivity and see benefits as an investment in human capital.

seven other drugs, including anti-seizure drugs, statins and drugs to treat osteoporosis and cancer. It also has set up medical clinics at work sites that offer regular screenings for diseases as well as routine medical care.

The company has seen a return on investment of \$2 to \$3 for every \$1 spent on its wellness program, through reduced emergency room visits, reduced workers' compensation claims and other savings, said company spokeswoman Colette Cote.

Companies that are most likely to adopt this strategy consider them-

selves leading-edge businesses—about 21 percent of employers—according to the results of a recent survey of 163 employers around the country by the Midwest Business Group on Health. Those businesses have a strategy, or plan to adopt one, to waive copays to encourage employees to participate in disease management programs, use generics and/or improve adherence with chronic disease treatments.

While 72 percent said they were in favor of mandating generics, only 38 percent were willing to waive employee cost-sharing for chronic disease drugs. The percentages were much smaller for non-leading edge employers.

"The vast majority of employers are sitting on the sidelines—what we call conservative—and they're just putting their toe in the water and saying, what are the leaders doing and is it making much sense, and is that something that we really want to get into?" said Larry Boress, the group's president and CEO.

The Money Jitters

Smaller businesses are understandably hesitant. In the short term, their costs will mount if they decide to absorb the cost of waiving copays and coinsurance without increasing employee cost-sharing in other areas. They also face the prospect of investing in the long-term health of employees who may be out the door in five years.

Also, many industry watchers are unclear about what level of copay change will alter consumer behavior. Most employers surveyed by the Midwest Business Group said they didn't consider copays to be barriers to optimal care.

While they're not willing to leap on board just yet, many businesses are starting to take notice and inquire with their pharmacy benefit managers (PBMs) and insurance carriers.

"There's a lot more attention, and it is sort of the new idea on the block. Although it's been around, I think it's getting some prominence," said

Andrew Webber, president and CEO of the National Business Coalition on Health and an advocate for VBID.

Although some plans and employers have been experimenting with VBID since the early part of the decade, interest spiked in January when professors associated with the University of Michigan's Center for Value-Based Insurance Design, which was established in 2005, published a *Journal of Health Affairs* article touting the improvements in care and cost gained from switching to a clinically sensitive formulary design. One of the authors, Mark Fendrick, M.D., a professor of internal medicine at U-M's School of Medicine, is one of the leading proponents of VBID.

"By leaving behind the archaic principle that patients should pay the same amount for all services and encouraging high valued services and discouraging medical services of low value or unproven value or benefit, we can markedly improve the efficiency of our healthcare system," Fendrick said in an interview with HealthLeaders-InterStudy.

Various Approaches

The value-based insurance designs take various forms. Most plan sponsors are starting with one or a few categories of diseases more easily controlled by medications, such as diabetes, asthma and hypertension. High-cost specialty drugs are currently not a part of VBID, although discussions are under way, Fendrick said.

The most common approach so far is to put medications, such as asthma inhalers, statins and beta blockers, on a low-cost or free tier, available to everyone without regard to a patient's medical status.

CIGNA Pharmacy Management started offering in July 2006 a prescription drug plan option that allows employers to waive the plan deductible for over 700 standard preventive prescription drugs.

UnitedHealthcare announced in April it was putting chlorofluorocarbon-free

Aetna To Study Value-Based Formulary Approach

Value-based insurance design—basing drug formulary cost tiers on the clinical value of drugs rather than their underlying cost—is generating buzz among plan sponsors and pharmacy benefit managers, but many trend watchers are waiting for the hard evidence. They may get their first taste of it in three years.

Aetna, working with Harvard University researchers, is planning what's believed to be the first major controlled clinical study of the impact of a value-based formulary on medication compliance, health outcomes and costs of care.

While industry professionals are looking forward to it, a select group of unsuspecting Aetna members are in for a pleasant surprise—they will be getting heart medications for free for a few years. The three-year study, which begins in the fall of 2007, will examine the effects of giving away statins, beta blockers and specific anti-hypertension medications to patients who have suffered a heart attack.

"Demonstrating adherence [to medication regimens] is pretty easy, but demonstrating the [improved] outcomes and lower costs gets to be much more difficult, and you need many more patients enrolled in the study," said Troy Brennan, M.D., Aetna chief medical officer.

To that end, Aetna is trying to involve its 2,200 plan sponsors in the study. Although the insurer can implement the study with its fully insured book of business, the company is working to get self-insured clients on board, as well.

The study will identify, through claims data, patients who have been released from the hospital after a heart attack, and expects to follow an estimated 4,000 to 5,000 Aetna members, Brennan said. The study team will randomly choose patients to get the free medications and inform them of the waiver of their copays.

Using a control group, researchers will track clinical outcomes, such as the incidence of repeat heart attacks and the occurrence of stroke and cardiovascular-related deaths. The resulting medical costs will be tracked, as well as lost productivity, to see if those with free medicines show better outcomes.

Study sponsors estimate that for every \$600 of lost copay revenue per patient, the savings generated from improved outcomes will be around \$5,000—that's without raising cost-sharing to other patients, Brennan said.

He said the study is starting with the cardiovascular conditions because outcomes can be tracked in a relatively short time frame, within 18 months of a hospital discharge. "We think that once we demonstrate findings in this particular disease, it'll be applicable to a lot of other diseases," he said.

Hopefully, the results will be definitive enough to demonstrate the value of the concept, Brennan said.

"There are a lot of people who are jumping on board with this concept because they think it makes good sense and it does," he said. "In medicine we've done a lot of other good things we thought made good sense and when we actually subjected them to more rigorous analysis, it turned out they didn't work out. We want to find out in a clinical study if this really works."

asthma inhalers on its lowest copay tier (at a price of between \$5 and \$10) to encourage their use despite the high cost and short supply.

One health plan that has been an early adopter of the VBID is Humana Inc., which offers plan sponsors a value-based plan design, called RxImpact, in addition to its traditional three- and four-tier drug lists.

"We were one of the first health plans to actually look at medications and try to group them according to their ability to prevent a serious medical episode and according to the time frame in which they impact medical expenses," said Troy Koch, PharmD, director of pharmacy sales and segment support for Humana.

Instead of tiers, RxImpact relegates

its medications to one of four groups ranked by the seriousness of the medical condition. Instead of being charged varying copays, members are given an allowance to spend per prescription: for instance, \$10, \$20 and \$30, depending on the group their medication is in.

"By grouping medications by therapeutic class within the same group and applying an allowance, it lets individuals understand the true costs of those medications. It gives them a set amount of money to spend and drives people to look for the lower-cost options," Koch said. "It also educates them on whether it's a short term or a long term medication to affect overall conditions."

He said probably fewer than 5 percent of employer groups have opted for RxImpact, and they tend to be smaller companies with Web-savvy employees. These adopters are seeing cost benefits.

"We do see that there is a decrease in the net paid per member, per month as well as an increase in generic dispense rates with RxImpact plan over our traditional Rx 4 plan," he said.

The Holy Grail

While programs like the one Humana is doing are a welcome start in the VBID movement, Fendrick said the preferred approach—the one more truly aligned with the value-driven theory—targets individual plan members who will benefit the most from financial incentives to stay the course on medications. The University of Michigan, in cooperation with its PBM, SXC, is offering prescription copay relief for covered employees diagnosed with diabetes.

In addition, Marriott—having reduced copayments for patients with heart disease, diabetes and asthma—is working with ActiveHealth Management, a subsidiary of Aetna, to match benefit design to medical need. The formulary's copay structure is customizable to provide the most copay relief

to members who will derive the most benefit from it.

It's a more complicated approach that requires a sophisticated data system, but Fendrick said it's worth it.

"We feel that real savings and trends are more likely to occur when copay relief is carefully targeted to those high-risk groups most likely to have a high-cost adverse event that may be prevented by the increased use of effective therapies," Fendrick said.

Steering The Ship

Employer coalition leaders say businesses in a position to purchase their own prescription drugs are leading the charge to a value-based system, which they say runs counter to the traditional formulary design focused on reducing upfront expenditures on expensive brand name drugs.

Webber said fully insured employers should take a leadership role in challenging their PBMs and health plans to put these programs in place where it makes sense. Aside from the limited programs put forth by some of the national insurers, value-based design is far from being a widespread practice in the prescription drug benefits industry.

"The PBM world has been told by the employers—and I fault ourselves on this—just control drug spend, and we're going to assess your performance on how well you keep drugs down," Webber said. "We are saying to employers that you have to look at total costs. Sometimes there's a unique advantage to a drug intervention in terms of chronic care management that will save you dollars over time."

The PBM Response

PBMs are willing to put VBID systems in place for clients, but their role is to evaluate the transition on a case-by-case basis to ensure it makes sense for them, said Bob Craig, PharmD, executive director of strategic benefit services for Medco Health Solutions Inc.

Medco, one of the nation's largest PBMs, has clients using different varieties of a value-based design.

"We're very interested in the value-based benefits approach, and we're doing it today. There's a high level of interest and curiosity among some segments of our customers," Craig said. "I personally have visited with customers to discuss it further and determine whether it's right for them. Some say 'no' and others want to know more."

He said such a formulary design is completely compatible with the traditional purchasing programs that use manufacturer discounts and rebates to leverage purchasing power.

But he said it's difficult to sell the concept to employers and other health plan sponsors under onerous financial burdens to sustain healthcare benefits for their employees.

Factoring in the lack of long-term clinical outcome studies and cost analyses, much of the healthcare marketplace remains skeptical, Craig said.

"People rarely buy on intuition in the healthcare market. They want robust proof statements," he said. "The proponents of this benefit design need to present more compelling evidence, in part because some clients need actuarial modeling to set premiums. They want predictability in costs."

Studies Under Way

Craig added, "Right now the evidence is limited, it's somewhat controversial, depending on who you ask, but we're building a body of evidence I think will tell us a lot more about the future of this concept. Employers want to know the ROI as well as the time required for the healthcare payment on the investment.

"This approach may prove to be less well suited for employers with younger workforces or higher turnover. It depends on the quality of published evidence, the investment horizon of each employer, and their underlying benefit philosophy and expectations."

A Sample Value-Based Formulary: Humana's RxImpact

	Drug	Quantity	Member Pays
Group A: Drugs with greatest ability to prevent a serious medical episode in the near future	Amoxicillin (generic)	30	\$0
	Zithromax	6	\$14
	Levaquin	7	\$32
Group B: Drugs for the control of long-term conditions such as cancer, heart disease and multiple sclerosis	Cholesterol:		
	Lipitor	30	\$50
	Lovastatin (generic)	30	\$11
	Zocor	30	\$100
	Hypertension:		
	Hydrochlorothiazide (generic)	30	\$0
	Lisinopril (generic)	30	\$5
Zestril	30	\$16	
Group C: Drugs that may reduce symptoms and improve day-to-day functioning.	Heartburn:		
	Ranitidine (generic)	60	\$59
	Omeprazole	30	\$75
	Prevacid	30	\$100
	Pain (non-narcotic):		
	Ibuprofen (generic)	90	\$10
	Naproxen (generic)	60	\$45
Celebrex	30	\$75	
Group D: Drugs that may improve psychological, emotional or physical well-being. Allowance: 0.	Specific medications not listed. (Examples include drugs that treat obesity, sexual dysfunction and acne.)	N/A	N/A

Source: Humana Inc.

Leaders in value-based design are looking forward to a controlled study that Aetna plans to do with Harvard University in the second half of 2007 to study over three years the effect of reducing copays for heart attack victims on both health outcomes and medical costs. (See related article.)

But some companies aren't waiting for those studies to make the upfront investment toward changing consumers' behavior toward healthcare, said Felthouse of the PBMI. The economic modeling they do and the return-on-investment they report will guide the followers.

"I do think employers are now comfortable with a longer return on investment, especially companies that have large retiree populations where they're going to have those retirees on the books for a long time and they really need to manage the long-term investment, as well as the long-term health," she said.

Raising Prices For Others

To maintain cost neutrality, plan sponsors have the option of increasing cost-sharing for other members. It is the cornerstone of the VBID approach being promoted by Fendrick and other leading proponents: that is, lowering copays to people in most need of low-cost interventions and raising prices for medications that are more lifestyle-oriented, such as sleep aids and sexual performance aids.

"These cost offsets are likely to take time and it is our belief that short-term expenditures may rise to some extent," Fendrick said. "Payors should get some reassurance to know that these added expenditures are going not to some unexplained black hole, but to those medical services that are deemed to be most important to improve the beneficiaries' health."

That raises the uncomfortable question of who decides the value of one

person's condition over another. How do you explain to an employee that her indigestion problem or chronic sleep problem isn't taken as seriously as a colleague with diabetes?

It's a good discussion to have, Craig said, because it goes to the heart of the question about the role of a health plan in society.

"If you lower copayments for drugs we think are high value because we want to manage your health and then conversely we say to pay for that, maybe we'll raise the copays on other drugs that are less valued, you're leading up to the question that health plan sponsors have avoided all along, and that is, what should be covered and what is healthcare?"

"A lot of these are value judgments," Craig added. "The reason 'value' is in the term value-based insurance design is that the company is making a value judgment about you, your condition,

and your benefit plan. That is not something that a PBM can do.”

Fendrick bristles when the subject of cost savings comes up in the VBID discussion. As a physician, he believes the ultimate goal should be to encourage the use of high-value services and not to discourage them by putting up financial barriers.

“I don’t think at least in the short term that providing better healthcare and better health is going to save money. I know that’s going to disappoint some of you,” he told conference goers recently at a PBMI conference in Phoenix.

Ultimately, he said, businesses that provide healthcare will have to figure out what they’re willing to consider in terms of costs. “Some may want to maximize health with little discussion of costs, others might be strictly attentive to expenditures alone—which, in my opinion, is currently the status quo,” he said. “And the third, and most desired, option is to carefully assess the amount of health that’s being achieved for the dollar spent, which is similar to the approach that businesses use to evaluate those expenditures in every other sector of the economy.”

Outlook—Value-based insurance design is generating a lot of interest among plan sponsors looking for a way to control their long-term drug spend, but it’s largely a movement being led by a few leading-edge, self-insured companies that are able to drive their own pharmacy benefit trends. Other businesses watching on the sidelines are looking to the leaders for cost-benefit analysis and will likely jump on board as more substantial studies show that this is a way to not only control costs, but invest in the long-term health of their employees. ■