National Alliance
of Healthcare Purchaser Coalitions
Driving Health, Equity and Value

ACHIEVING VALUE
MEDICAL SIDE OF DRUG BENEFITS

A Deep Dive Powered by eValue8™

AUGUST 2021

Dear Healthcare Purchaser:

For years, experts have known that a significant part of drug spending occurs through the medical benefit. With the emergence of specialty drugs, the cost of drugs delivered through medical channels has increased substantially. To date, however, little has been known about how drugs delivered through the medical benefit are managed.

Since 2016, the National Alliance of Healthcare Purchaser Coalitions has conducted an analysis of drug management in the pharmacy benefit manager (PBM) setting, seeking better understanding of how PBMs address adherence, safety, transparency, and other important factors. The National Alliance used the same approach with health plans for this report.

Healthcare purchasers play a major role in crafting benefit design that supports effective drug management. Will purchasers adopt policies that move patients to higher-value sites of care? Are purchasers willing to push for greater transparency with regard to rebates under the medical benefit? As more biosimilars become available, will purchasers take responsibility for ensuring their use? In their drive for more effective medical drug management, purchasers must be willing to answer "yes" to these and other questions.

As you read this report, consider how you can contribute to better management of drugs under your medical benefit.

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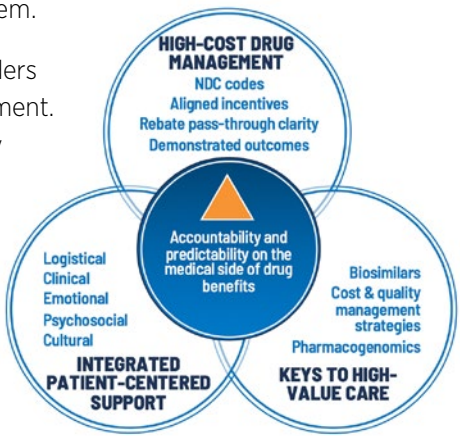
EXECUTIVE SUMMARY

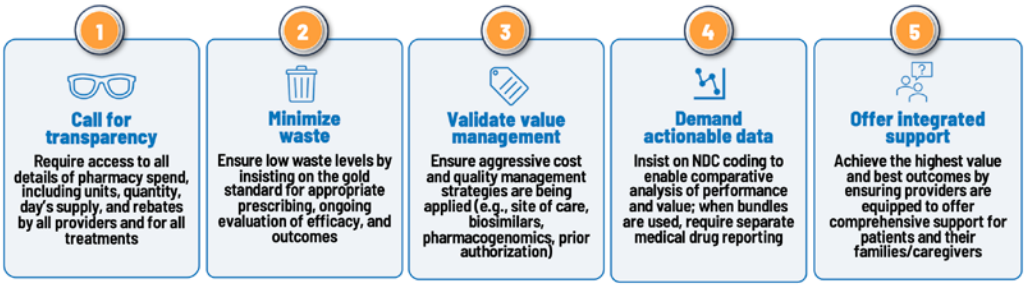
As the exorbitant cost of specialty drugs continues to dominate healthcare news headlines, most employers are closely scrutinizing their pharmacy benefit manager (PBM) practices. **Still, many purchasers are surprised to learn that nearly 50% of a plan's total drug spend comes from specialty medications and about 35% of those are currently bill through the medical benefit, according to the 2020 Express Scripts Drug Trend Report**. This matters because drugs reimbursed through the medical benefit include unhelpful J codes, which are much less specific than NDC codes, obscuring the true cost of specialty drugs and healthcare associated with administering them.

The health plans that submitted information for this report deserve special recognition:

Participation is voluntary and the plans devoted significant resources to submitting this data.

To address this issue, the National Alliance assembled a team of thought leaders in pharmacy management to outline best practices in medical drug management. These experts offered five key recommendations for achieving accountability and predictability on the MEDICAL SIDE of drug benefits, as described in our recent infographic. These recommendations are designed to counteract the markups and misalignment of incentives that have created unstructured pricing, leaving employers and other purchasers in the dark about what they are paying for and whether they have access to the highest-value care.





Images from the National Alliance infographic depict the employer expectations and interconnectivity needed to improve high-cost drug value. View the full infographic here.

Our 2020 eValue8® plan performance evaluation includes detailed questions to solicit objective information on what health plans are doing to manage drug spending under the medical benefit. The online assessment was completed by eight national and regional health plans. These plans are to be highly commended for answering questions about the policies and procedures they use to manage medical benefit drug expenditures in these five categories:

- **ACHIEVING CLAIMS TRANSPARENCY**
  No respondents offer auditors open-book access to pharmacy network, sites of care (inpatient and outpatient, including infusion centers, doctor's office, home…), or pharmaceutical industry contracts, receivables, distributions, and reconciliations.

MINIMIZING WASTE

Almost all plans require genetic testing to determine drug eligibility when applicable (though the number of drugs ranged from 20 to 150). Only half have policies in place requiring that medications to be dispensed utilizing appropriate vial sizes to minimize waste.

MANAGING VALUE

The plans are generally working to direct treatment to the most cost-effective sites of care. Plans are actively reviewing biosimilar options, even given the relatively slow biosimilar uptake in the US.

PRODUCING ACTIONABLE DATA

Only half of the plans require that providers submit itemized bills for a select set of medications administered in the inpatient and outpatient settings. There are many payment mechanisms used for infusions in both settings; the method of payment drives the level of detail in the data available to the employer and ability to control the price. Understanding the payment process will help employers request and obtain actionable data. For example:

- How are expensive drugs billed during an inpatient stay? Are they included in the per diem, case rates, billed separately, or other?
- How are expensive drugs billed for outpatient cancer care? Case rates, buy/bill, provided by the plan, other?

SOCIAL SUPPORT FOR PATIENTS

The plans all have traditional patient outreach processes for adherence to treatment, but few have patient-centered approaches, such as patient chat rooms or trained peer support. Directing patients to community and advocacy organizations can also be an important part of their journey (e.g., American Cancer Society, Arthritis Foundation, Genetic Disease Foundation, Musular Dystrophy Association, National Hemophilia Foundation, Neurologic Disease Foundation…)

National Alliance Resources

The National Alliance has a long-standing focus on pharmacy management through our Pharmacy & Medical Drugs Initiative. As part of that initiative, nearly 50 diverse stakeholders created a framework of Five Rights, which can structure thinking about how best to address drugs delivered through any channel. That framework complements our findings in this report. For comprehensive information on PBM drug management, see our 2020 PBM Report.

PROVIDING TRANSPARENCY

The top 10 most expensive drugs in the US range from $633,000 to well over $2.1 million annually, making specialty drugs the fastest-growing area of spending for employers (and contributing to the 66.5% of personal bankruptcies tied to medical costs). Since a significant percent of specialty spending is currently billed under the medical benefit, it's important for purchasers to understand how that money is flowing, so they can analyze these costs. We asked whether plans are receiving, revealing and sharing rebates, and what level of auditability purchasers can expect.

Rebates

Purchasers are scrutinizing rebates in the PBM setting closely, but not much is known about corresponding rebate practices under the medical benefit. What types of rebates exist? Are penalties being passed back to purchasers? As differentiated from volume-based rebates, we learned that almost all plans have outcomes-based contracts in place in which manufacturers are financially penalized if clinical, financial or utilization expectations are not met. Few plans include either rebate arrangement in their episodes of care and few pass either volume-based or outcomes-based payments back to purchasers.

It should be noted that medical drugs are an emerging area for rebates, and plans are not yet exerting the same level of influence in the medical setting that they do with PBMs. Plans reported that only 19 medications, and less than 5% of specialty drugs, earned rebates. Nonetheless, this is an area that should be monitored, as small numbers of drugs could translate into significant dollars.

Rebate Policies	Number of Plans Out of Eight
Plans that pass manufacturer rebates back to employers	
Plans with outcomes-based and/or value-based contracts with manufacturers	
Plans with targeted pricing or an outcome warranty in existing episode of care bundles	
Plans that pass back to employers the outcomes-related penalties received from manufacturers	

 The number of colored slices (out of 8 slices) represent the # of plans. The absence of a "pie" indicates no plans offer service or have a program.

Audits

Routine auditing is fundamental to fiscal management and is part of an employer's fiduciary responsibility. The results of this evaluation indicate the level of audits available to employers and other purchasers is very low and, therefore, checking with consultants and health plans to ensure routine auditing takes place is advised.

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Claim Audits	Number of Plans Out of Eight
No external audit allowed	
A limited number of claims allowed	
All claims processed over the life of the contract	
Contracts Audits	
Selected access to all types of pharmacy network contracts, payments and reconciliations	
Open-book access to all types of pharmacy network contracts, payments and reconciliations	
Selected access to sites of care contracts, payments and reconciliations	
Open book access to sites of care contracts, payments and reconciliations	
Selected access to pharmaceutical industry contracts, receivables, distributions and reconciliations	
Open-book access to pharmaceutical industry contracts (e.g., manufacturer, wholesaler, specialty pharmacy…), receivables, distributions and reconciliations	

MINIMIZING WASTE

Employers have found ways to manage health care costs but need to step up their efforts to tackle a more vexing problem — eliminating wasteful medical care spending.

A recent *Journal of the American Medical Association* study found that 20% to 25% of medical spending is unnecessary.

"As long as we are in a fee-for-service world we will get services whether we need them or not," said Michael Thompson, president and CEO of the National Alliance of Healthcare Purchaser Coalitions. "We need to shift from paying for volume to paying for value, and employers need to put pressure on providers to get this right. Part of the reason vendors don't offer this information is because they're responsible for getting rid of it. Employers should be asking for spending reports from vendors and need to make them accountable for identifying and eliminating waste."

The estimated waste hovers between $760 billion and $935 billion, with administrative costs such as claims processing, billing, and transferring medical records making up the largest share at $266 billion annually, according to the JAMA study.

Yet, more than half of employers aren't actively doing anything about it, according to a 2018 report by the National Alliance. While the first step for employers should be identifying the problem, nearly two-thirds of businesses surveyed don't collect or analyze data to track waste.

Given the magnitude of drug costs, any waste in medical drugs may have a particularly high impact. Waste can happen in several ways:

- The drug is unnecessarily prescribed.
- The effect of the drug is not monitored and based on the patient's response.
- The amount of drug prescribed is different from the amount ultimately dispensed.
- The drug is improperly stored and handled.

Implementing strategies like those below yielded savings among self-insured employers.

Confirm that drug dosages match clinical criteria.	Number of Plans Out of Eight
Require **genetic testing** to determine applicability as indicated by guidelines (number of drugs ranged from 20 to 150 in this assessment).	
Ensure that the **drug dosage prescribed** meets clinical criteria.	
Evaluate continuation of therapy with respect to **disease progression.**	
Evaluate continuation of therapy vis-a-vis **adverse effects.**	
Implement **quantity limits** for self-injectables.	
Require that amount administered matches the prescribed amount.	
Have policies in place requiring that **vial sizes** match prescribed amount.	
Have policies in place requiring **rounding to nearest vial size** when appropriate to minimize waste.	
Have policies in place requiring the scheduling of multiple patients on the same day to accommodate single-dose **vial sharing**, when safety is ensured.	
Work with manufacturers to tailor vial size	
Have policies requiring specialty **"assay management"** (see definition, below) at the pharmacy level (especially for treatments for cancer and hemophilia).	
Incorporate digital or **pharmacokinetic tools** to ensure the proper dosage is administered and maintained.	

The number of colored slices (out of 8 slices) represent the # of plans. The absence of a "pie" indicates no plans offer service or have a program.

Ensure that drugs are handled properly.	
Ensure that drugs are administered by entities **accredited** by URAC, JCAHO, or other comparable third-party organization.	

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Progressive Approaches to Waste Management

Assay management is the process of filling a prescription as closely to the prescribed target dose as possible, particularly for extremely expensive drugs such as those for hemophilia. It's important to be as accurate as possible (max+/- 3%) to avoid waste.

For a comprehensive example of how to mitigate high-cost claims, view this June 2021 National Alliance Action Brief which takes a closer look at hemophilia. For extremely expensive drugs, such as those for hemophilia, it's important to be as accurate as possible to avoid waste.

Pharmaco-"what?"

- Pharmacokinetics takes into account patient characteristics such as body weight, excretory and metabolic functions, and the presence of other therapies. For example, concentrations of drugs eliminated mostly by the kidney are usually greater over time in patients suffering from renal failure than they are in patients with normal renal function who receive the same drug dosage.
- Pharmacogenetics addresses drug response due to heredity or, frequently, how a single gene affects drug metabolism and effects. Pharmacogenomics is a broader term for how all of a patient's genes (the genome) can influence drug response. The terms genetics and genomics are frequently used interchangeably.

MANAGE OVERALL VALUE

Health plans should employ aggressive cost- and quality-management strategies by striving to provide care in the highest-value settings, adopting strategies to increase use of less expensive biosimilars, and making best use of third-party drug value analytics. We found that most health plans are applying traditional drug management strategies in the medical setting, but strategies for moving patients to higher-value sites of care and promoting biosimilars were lacking. Use of third-party analytics was variable.

Sites of Care

Health plans should be contracting with providers to ensure that specialized care is delivered at high-value sites with proven optimal outcomes. Costs at different sites of care can vary widely; for example, hospitals mark up drug prices by 250% on average, with some as high as 700% on certain specialty drugs are not uncommon. Plans using a site-of-service management strategy have saved more than 20%.

Site-of-care Policies	Number of Plans Out of Eight
Require the use of specific sites of care as part of **contracts** with specialists such as oncologists and rheumatologists.	
Incorporate the use of designated sites of care into the **prior authorization** process.	
Use **patient incentives** like lower cost-sharing arrangements for existing or new patients to use higher-value sites of care.	

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Biosimilars

Biosimilars represent an opportunity for savings now and, more important, in the future, as more biosimilars are developed. Establishing the right strategies now will contain costs tomorrow.

A recent National Alliance Action Brief outlines purchaser opportunities and strategies for using biosimilars to help control overall healthcare costs. A Johns Hopkins study for the ERISA Industry Committee reports that if all employers who self-insure health coverage had achieved full biosimilar substitution for just the first two biologics to have biosimilars in the US, savings could have been between $407 million and $1.4 billion in 2018, not including the impact of undisclosed confidential rebates. Yet, for most marketed biosimilars, market share is lagging behind expectations.

Reasons often cited for the lack of biosimilar uptake include 1) health plan *drug policy* decisions, 2) the extent of *prescriber* confidence in the evidence of biosimilar equivalence, and 3) strategies to promote biosimilars *to patients*. Accordingly, we asked the health plans what actions they were taking in those three areas to promote biosimilar uptake.

We learned that plans generally have internal policies that position biosimilars advantageously. However, strategies like formulary positioning appear to have less impact in the medical setting. Also, plans could do more to educate prescribers and patients about the effectiveness of biosimilars.

Medical Drug Management Policies	**Number of Plans Out of Eight**
Biosimilar is positioned as preferred in formulary.	
Biosimilar is used before original biologic in step therapy.	
Biosimilar is used before original biologic in prior authorization.	
Provider Promotion	
Partnering with credible external organizations to educate prescribers on the benefits of biosimilars.	
Biosimilar is positioned as preferred in formulary contracts in place, incentivizing use of biosimilars.	
Working with individual physicians on use of biosimilars with new patients.	
Working with individual physicians on switching patients already on the original biologic to its biosimilar.	

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Patient Promotion	Number of Plans Out of Eight
Biosimilar is positioned as preferred in formulary contracts in place, encouraging use of biosimilars through such incentives as lower- or no-cost sharing.	
Education/outreach to new patients to use biosimilar instead of original biologic.	
Education/outreach to patients on biologic to switch to biosimilar.	

Biosimilars Under the Pharmacy Benefit

There are also opportunities for biosimilar savings through the drug/PBM channel. The National Alliance 2020 PBM Report, showed that the opportunity for biosimilars adoption and savings is far greater than employers have experienced to date. The table below shows that only two of the PBMs covered in the report achieved biosimilar market share of equal to or over 50% for any of the most used biosimilars.

Biosimilar Drug	PBMs with More than 50% Patients on Biosimilar Out of Five Participating PBMs
Zarxio®	
Inflectra®	
Renflexis®	
Retacrit®	

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Use of Third-party Value Analyses

The industry's ongoing transition from fee-for-service to value-based healthcare has created more value analysis than ever before. We asked participating plans how they incorporate analyses from organizations like the Institute for Clinical and Economic Review (ICER) in their decision-making. Though plans use the analyses for coverage decisions, few base pricing and reimbursement levels on their findings.

How is third-party data like ICER used?	Number of Plans Out of Eight
Coverage	
Coverage decision under medical benefit	
Cost/Pricing	
Negotiation with manufacturer	
Pricing decision	
Provider reimbursement level	
Facility reimbursement level	
Site-of-care decision	
Drug Promotion/Education	
Patient education	
Physician education	

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Why Does Third-party Value Review Matter?

With so many financial conflicts of interest throughout the pharmaceutical supply chain, purchasers often lack insight into where they are getting good value from their drug spending and where they are overpaying. However, independent value assessments can help. ICER is a nonprofit research organization that 1) analyzes the safety and efficacy evidence of treatments nearing FDA approval; 2) calculates how much a new drug is likely to improve patients' lives and/or avoid other health care costs in comparison to the previous standard of care; and 3) recommends a price benchmark that aligns fairly with the treatment's clinical and economic benefits. While ICER has found approximately 30% of the drugs it has reviewed to be cost effective, it also revealed that many others would require significant discounts—sometimes as much as 90%—for their pricing to match their benefit to patients.

—**Sarah K. Emond**, MPP, Executive Vice President and Chief Operating Officer, Institute for Clinical and Economic Review

For more information on value frameworks, see the National Alliance Employer RX Value framework report.

SUPPLYING ACTIONABLE DATA

The first step in acquiring accurate medical drug data is requiring that claims include itemized bills from providers. Surprisingly, only half of the plans reported requiring that providers supply such bills.

Step two is assigning the right code to the drug and, for expensive specialty products administered in a hospital or physician's office, this matters even more than usual. Employers should demand that their plans require NDC codes, which provide an essential level of transparency. In the past, drugs reimbursed through the medical benefit were frequently identified using unhelpful J codes, which are much less specific and mask the true cost of specialty drugs. Unlike J Codes, NDC numbers identify the labeler (manufacturer, re-packager or distributer), product code (strength, dosage form), formulation of a drug for a specific company, and package code.

Surprisingly, only half of the respondents require itemized bills.

How are plans clarifying drug data?	Number of Plans Out of Eight
Require that providers submit itemized bills for select set of medications in inpatient setting.	
NDC required for payment.	

The number of colored slices (out of 8 slices) represent the # of plans. The absence of a "pie" indicates no plans offer service or have a program.

SUPPORTING PATIENTS TO ACHIEVE OPTIMAL HEALTH OUTCOMES

The bottom line: Patients need to receive their drugs and take them as prescribed. Patients should have access to all available financial support, a full range of integrated clinical support, personalized social support, and community resources like transportation assistance. While the plans earned high marks for traditional pharmacy support (like compliance outreach), they were less likely to offer patient-centered social support (like peer-to-peer interaction).

Financial Support	**Number of Plans Out of Eight**
Patient assistance programs	
Compliance and Clinical Support	
Proactive outreach to assess the member's compliance to prescribed regimen	
Scheduled outbound nurse calls to member	
24/7 nurse on-call line for incoming calls	
24/7 pharmacist on-call line for incoming calls	
24/7 behavioral health clinician	
24/7 master of social work (MSW) or above	
24/7 non-clinical staff on-call line for incoming calls	
Nutritionist	

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Digital Support	
Online chat support or similar interactive feature.	
Outbound emails to member on a fixed schedule.	
Mobile application inbound text messaging support.	
Mobile application outbound text messaging.	
Group chat room, group text messaging, community health workers, peer-support trained specialists.	
Group text messaging, community health workers, peer-support trained specialists.	
Community Support	
Transportation	
Community health workers	
Peer support trained specialists	

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EMPLOYER CHECKLIST

Recommended Areas for Discussion with Your Health Plan

- ☐ Plan has outcomes-based contracts and/or value-based contracts with manufacturers.
- ☐ Plan sponsor receives the outcomes-related penalties from manufacturers.
- ☐ Contract allows open-book access to:
  - ☐ Pharmacy network contracts, payments and reconciliations.
  - ☐ Pharmaceutical industry contracts, receivables, distributions and reconciliations.
  - ☐ Site-of-care contracts, payments and reconciliations.
- ☐ Plan manages waste:
  - ☐ Evaluates continuation of therapy with respect to disease progression and adverse effects.
  - ☐ Has quantity limits for self-injectables.
  - ☐ Has policies in place requiring that vial sizes closely match the prescribed amount, and that the plan requires specialty "assay management" at the pharmacy level (especially for treatments for cancer and hemophilia).
  - ☐ Incorporates digital or pharmacokinetic tools to ensure that proper dosage is administered.
  - ☐ Ensures that drugs are administered by entities accredited by URAC, JCAHO, or other comparable third-party organization.
- ☐ Plan manages biosimilars:
  - ☐ Biosimilars are positioned as preferred in the medical drug formulary or payment policy.
  - ☐ Plan has provider contracts in place incentivizing use of biosimilars.
  - ☐ Benefit design encourages the use of biosimilars with features such as lower cost or no cost-sharing.
- ☐ Plan provides actionable data:
  - ☐ Plan requires that providers submit itemized bills for a select set of medications in inpatient settings.
  - ☐ Plan requires use of NDC codes for the medical drug benefit payment.
- ☐ Patient support:
  - ☐ Plan provides patients with digital peer-to-peer support, such as group chat room, group text messaging.
  - ☐ Plan supports interaction with community health workers and peer-support trained specialists.

National Alliance
of Healthcare Purchaser Coalitions
Driving Health, Equity and Value

The National Alliance of Healthcare Purchaser Coalitions (National Alliance) is the only nonprofit, purchaser-led organization with a national and regional structure dedicated to driving health and healthcare value across the country. Its members represent private and public sector, nonprofit, and Taft-Hartley organizations, and more than 45 million Americans spending over $300 billion annually on healthcare. Visit nationalalliancehealth.org, and connect with us on Twitter.

eValue8
HEALTH CARE

eValue8™ is a resource that assesses health plan performance and highlights key areas of improvement as well as areas of excellence. Performance reports allow participants to evaluate health plans on a local, regional and national level.

Plans and purchasers receive objective scores enabling comparison of plans against regional and national benchmarks and a roadmap for improvement. Plans learn what they need to do to align their strategies with purchaser expectations to maximize the value of the health care investment and ultimately improve health and quality of care.

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