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Practical Research for Multiemployer Plans

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Managing the High and Rising Cost of Prescription Drug Coverage

Segal's Research Finds Wide Variance in Pharmacy Benefit Managers' Prior Authorization Denial Rates for Specialty Drugs

Specialty drug spending continues to grow through the introduction of new, innovative medications, increased utilization and price inflation for existing specialty medications. One of the most frequently prescribed specialty medications, Humira® Pen, which is used to treat certain types of arthritis and Crohn's disease, has an average retail price of $5,249 per month for the most common dosage.[1] Humira has increased in price more than 68 percent between 2013 and 2016.[2] Spinraza™, a new treatment for spinal muscular atrophy, costs an astounding $750,000 for the first year of treatment. These are just a couple of examples of drugs that are expected to drive total annual spending on specialty medications to $402 billion by 2020, accounting for 47 percent of overall prescription drug spending.[3]

Specialty drugs represent a disproportionally large share of prescription drug spending. They accounted for more than one-third of total spending in 2016.[4] With specialty drug trend continuing to increase by double-digits annually, that share is expected to increase dramatically over the next few years, as illustrated on the next page.

> "Specialty drugs represent a disproportionally large share of prescription drug spending."

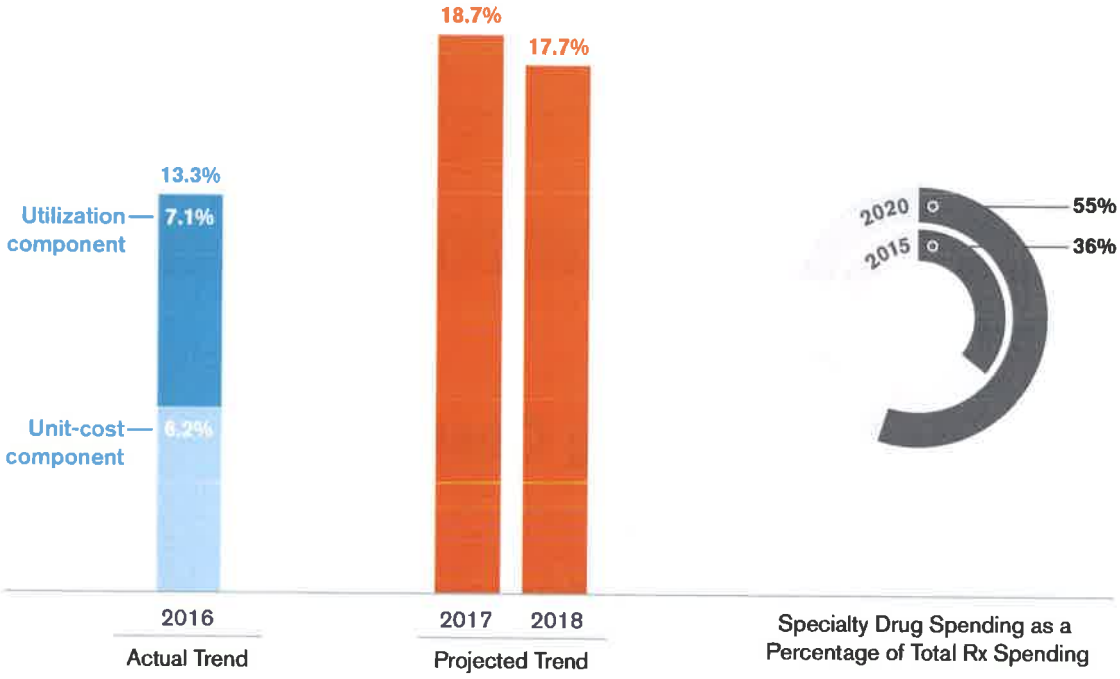
[1] HealthPocket, September 5, 2017 InfoStat

[2] Alliance of Community Health Plans infographic, The Spike in Drug Costs: Rheumatoid Arthritis (March 2016).

[3] IMS Institute for Healthcare Informatics, *Medicines Use and Spending in the U.S.: A Review of 2015 and Outlook to 2020* (April 2016).

[4] Express Scripts *2016 Drug Trend Report.*

Specialty Drug Trend Is High, Is Projected to Rise and Accounts for a Large — and Growing — Share of Overall Prescription Drug Spending



Sources: Actual trend is from Express Scripts' *2016 Drug Trend Report*. Projected trend is from the 2018 *Segal Health Plan Cost Trend Survey*. The data on drug spending is from Medicines Use and Spending in the U.S. IMS, April 2016. NHE, Artemetrx, CVS Health Internal Analysis, 2016, as reported in CVS Health's Executive Briefing Insights (Issue 22, 2017).

To manage prescription plan spending, many plan sponsors rely on strategies offered by pharmacy benefit managers (PBMs). Utilization-management programs are among the most common strategies PBMs use to target cost management of high-cost specialty drugs.

Types of Prescription Drug Utilization-Management Programs

As the name suggests, utilization-management (UM) programs aim to ensure that prescriptions are for the right people, are at the right dose and are at the right cost. There are three different types of UM programs commonly employed by PBMs:

- **Prior Authorization** — When a PBM flags a drug for prior authorization, the prescription is not filled at the point of sale. First, the PBM's staff will conduct a coverage review that consists of contacting the prescribing physician to review the reason for and dose of the drug in light of the patient's clinical situation and other options available to treat the condition. This type of UM program helps ensure appropriate use of selected drugs. It is designed to prevent improper use of drugs and to guide the use of drugs that work best for a particular indication.
- **Step Therapy** — This UM program promotes taking lower-cost therapeutically equivalent medications first to treat a certain condition before stepping up to more expensive medications. Generic drugs, which are typically less costly than brand-name drugs, are commonly prescribed as the first step. For example, the Proton Pump Inhibitor drug class (gastrointestinal drugs) is an example of a group of drugs where there are multiple generic options. Similar to prior authorization, with step therapy, the PBM flags a drug for step therapy review which means the pharmacist will be restricted from filling the drug until the PBM's clinical staff contacts the prescribing physician to review the reason for prescribing an advanced step drug instead of starting with a lower-step drug.
- **Quantity Duration** — With this type of program, a specified amount of medication will be filled within a specified time period. These quantities are established by the PBM's clinical staff to ensure an appropriate amount of the drug is used to treat the condition and are based on prescribing guidelines approved by the U.S. Food and Drug Administration (FDA) and/or other federal agencies like the Centers for Disease Control and Prevention.

Plan sponsors will need to give approval to their PBM to initiate one or more of the above utilization controls and should also evaluate the cost the PBM charges to perform any or all of these UM services.

> "Prior authorization ... is designed to prevent improper use of drugs and to guide the use of drugs that work best for a particular indication."

Research on Prior Authorization

Segal Consulting chose to conduct research on prior authorization because it is one of the most frequently used UM programs. We focused on the following 10 therapeutic drug classes that have specialty drugs:

- Anemia
- Antineoplastics[5]
- Botulinum toxins
- Growth hormones
- Hepatitis C
- Inflammatory bowel disease
- Multiple sclerosis
- Psoriasis
- Pulmonary arterial hypertension
- Rheumatoid arthritis/inflammatory condition

Therapeutic drug classes are groups of medications that are used to treat a same disease. A medication can be categorized in more than one therapeutic drug class.

[5] This class of drugs is used to treat cancer.

Typically, the specialty drugs that fall into these classes have high costs, as shown in the table below. Moreover, for many group health plans some of these therapeutic classes are among the highest categories of spending.

Average Per-Member, Per-Month (PMPM) Cost for Selected Specialty Drugs by Therapeutic Drug Class

Psoriasis	$118.21*
Rheumatoid arthritis/inflammatory condition	$118.21*
Antineoplastics	$60.70
Multiple sclerosis	$58.63
Hepatitis C	$25.26

* Inflammatory condition drugs are used to treat a variety of diseases, including rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis, psoriasis and Crohn's disease.

Source: Express Scripts, *Drug Trend Report 2016*

PBMs often offer plan sponsors prior authorization programs for these classes as an optional UM program, especially to those plan sponsors that want to manage their specialty costs due to increasing trends. PBMs are aware of the high cost of the drugs and the potential for inappropriate prescribing.

We asked six PBMs to provide information about their prior authorization denial rates for non-Medicare eligible prescriptions within the 10 key therapeutic drug classes for the full 2015 calendar year. Denial means that during a coverage review, based on physician responses, the drug was denied. It could mean, for example, the drug was not being prescribed for an FDA-approved use. The PBMs in the study, which include large, national PBMs as well as smaller PBMs, provided the information requested as a percentage denial rate. This report presents the results for the five PBMs that gave us permission to share their data without identifying the specific source.

The Results: Denial Rates Vary Widely by Therapeutic Drug Classes and Among PBMs

In the chart below, we rate the PBMs in the study (without identifying them by name) according to whether their prior authorization denial rates are low, medium or high for each therapeutic class according to our criteria defined in the key.

Ratings of PBMs' Prior Authorization Denial Rates by Therapeutic Class

Therapeutic Class	PBM A	PBM B	PBM C	PBM D	PBM E
Pulmonary arterial hypertension	High	High	High	Low	High
Psoriasis		Medium	High	Low	High
Hepatitis C	Medium	Low	High	Medium	High
Antineoplastics	Low	High	High	Low	Medium
Anemia	Low	Low	High		Medium
Growth hormones	Low	Low	High	Low	Medium
Inflammatory bowel disease		Low		Low	High
Rheumatoid arthritis/ Inflammatory condition	Low	Low	High	Low	High
Multiple sclerosis	Low	Low	High	Low	Medium
Botulinum toxins	Low	Low		Low	Medium

Less than 16% | 16% to 33% | Greater than 33% | No data or no prior authorization offering by the PBM

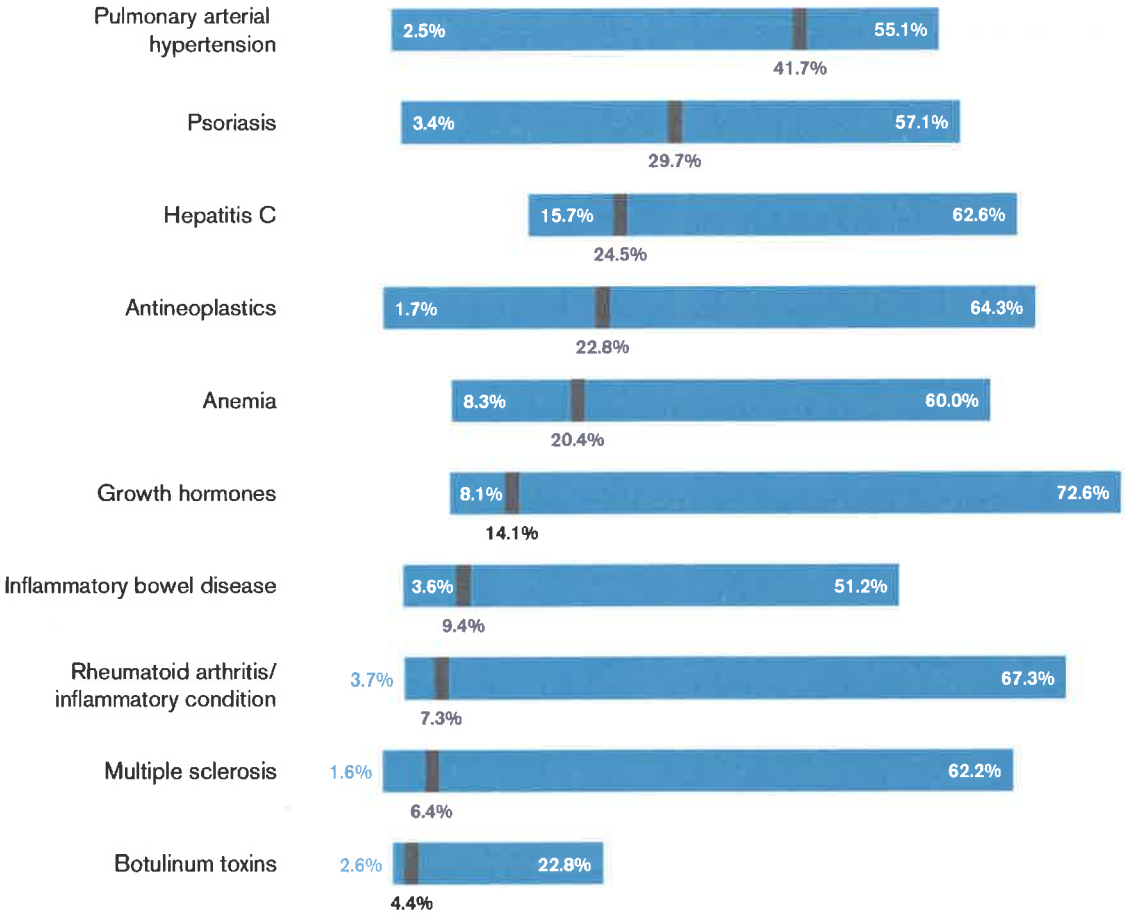
* This summary is based on un-audited data from PBMs for patients who are not eligible for Medicare.

Source: Segal Consulting, 2017

Observations The study suggests there are no industry standards for prior authorization denials. Consequently, potential savings may depend on which PBM a plan sponsor uses. The study found at least three PBMs — PBM A, PBM B and PBM D — that have a low denial rate across the board for a majority of the therapeutic classes examined. PBM D had the greatest number of low denial rates, with a low denial rate in each of the 10 classes except the Hepatitis C therapeutic class. One PBM — PBM C — stands out from the rest as having a high denial rate across the board. PBM E has an almost even mix of high and medium denial rates.

The following graph illustrates the range of PBMs' denial rates by therapeutic class, as well as the median denial rate.

Range of Prior Authorization Denial Rates and Median Denial Rate by Therapeutic Class



* This summary is based on un-audited data from PBMs for patients who are not eligible for Medicare.

Source: Segal Consulting, 2017

Observations The huge variance in denial rates we found among PBMs and the potential impact on a plan's cost and participant satisfaction strongly suggests plan sponsors should consider evaluating prior authorization approval or denial rates in their future requests for proposals from PBMs. It is safe to assume the higher the denial rate, the greater the financial savings. Some PBMs have stricter criteria than others based on therapeutic class. The highest denial rate for any one of the PBMs studied was 72.6 percent for the Growth Hormones class, which could be related to inappropriate use, such as body building. The lowest denial rate by any of the PBMs, 1.6 percent for Multiple Sclerosis, means that prior authorization program had the lowest prescription drug cost savings compared to other drug classes.

The quality of prior authorization depends on such factors as the coverage criteria determined by the PBM and its Pharmacy and Therapeutics Committee. That includes updating the criteria in accordance with current published guidance. The objectivity versus subjectivity of the written screening protocol about when the drug is recommended for use is also a factor.

Implications for Plan Sponsors: Weigh Potential Savings Against the Costs

Some plan sponsors have been hesitant to implement UM programs because they are sensitive to the potential effect on both participants and physicians. Those concerns should not be an obstacle as they can be addressed through communications.

The whole purpose of the prior authorization process is to have qualified clinical professionals oversee that participants are being prescribed and are receiving drug therapy that is right for them at the right dose and at the right cost. A denial suggests that one or more of these three pillars of ideal drug prescribing was not in place and the participants are not protected by the expertise of the PBMs prior authorization process from taking a drug that is not right for them.

A low denial rate means participants are being put through a prior authorization process for no reason. Some plan sponsors may perceive that as a negative because participants are not getting their prescription at first time they try to fill it or are getting stopped at point of sale. Other plan sponsors may see a low denial rate as being beneficial because a majority of participants' claims are being approved and appropriate use is ensured. If a low denial rate is simply the result of a poor prior authorization process, participants may receive drugs that are not ideal for their clinical situation.

Although our research focused on high-cost specialty drugs, it is important to note that prior authorization programs also extend to lower-cost drugs. Some prior authorization programs even target lower-cost generics.

Generally, there are costs associated with prior authorization and other UM programs (step therapy and quantity limits) offered by PBMs. Some PBMs offer prior authorizations that range from $25 to $60 per review. Other PBMs offer a per-claim fee or a PMPM pricing fee for bundled packages, which include prior authorization, step therapy and quantity limits, or PMPM fees for a-la-carte programs. Consequently, when considering any drug UM program, plan sponsors should take into account total net savings. These savings should include both projected savings and costs of program (and rebates, if any), as well as the impact on participants. Data mining can help plan sponsors determine which therapeutic classes and/or drugs to target.

Many plan sponsors that are already using UM for specialty and traditional prescription drugs have been able to contain rising drug costs while continuing to provide high-quality prescription drug coverage. In rare instances, the cost of implementing a UM program may outweigh the savings achieved through more aggressive management. While UM may protect plans from increasing trend and spending, there is not one single solution to manage continued growth in the cost of pharmacy benefits. However, given the growing cost impact of specialty medication on overall pharmacy plan costs, plan sponsors should take a close look at drug UM programs to see which ones meet their fiscal and participant needs.

> “Data mining can help plan sponsors determine which therapeutic classes and/or drugs to target.”

Prior Authorization for Specialty Drugs: A Case Study

One of Segal's clients, a large group health plan, saved 6 percent of gross prescription cost in 2016 through drug UM efforts including prior authorization. The savings was approximately $6.1 million, however, the savings attributable specifically to UM of specialty drugs is unknown.

Segal analyzed PA denial rates for the top therapeutic categories. The highest denial rate was for pulmonary arterial hypertension (high blood pressure in the lungs), which had a denial rate of 65.6 percent. That high rate was likely a result of the plan's step therapy program related to Revatio.® The plan's second highest PA denial rate was for the antineoplastic class (cancer treatment drugs) at 25.0 percent, and the third highest was for hepatitis C (viral infection causing liver problems) at 20.5 percent. The prior authorization process appears to have been effective in overseeing safe and appropriate drug use for patients.

The lowest denial rates were for anemia (not enough healthy red blood cells), at 2.9 percent; psoriasis (a chronic skin condition), at 6.5 percent; and botulinum toxins (for muscle spasms), at 7.65 percent. While the psoriasis denial rate was low at 6.5 percent, the combined denial rates for all the inflammatory conditions — inflammatory bowel disease, rheumatoid arthritis and psoriasis — was 10 percent. This means that the same drug may treat any of these conditions and it is possible that a drug can be categorized under an incorrect diagnosis.

It is important to understand and investigate programs that have low denial rates. Low denial rates could imply that a PA is ineffective, or that health care providers are properly prescribing the drug.

Source: Segal Consulting, 2017

Questions? Contact Us.

For assistance with pharmacy benefit cost-management UM strategies, contact your Segal consultant or the following Segal prescription drug expert:

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