Spring "Hot Topics:" Event

Presentations by:

Brenda Motheral, RPh, MBA, PhD, President, Artemetrx
Heather Sell, PharmD, BCPS, Medical Outcomes Specialist, Pfizer
Isaac Morris, Senior Counsel, Foley & Lardner LLP

Sponsored by the Business Health Care Group (BHCG)
&
Pfizer

April 22, 2015, 8:00 – 11:00
Briggs & Stratton Auditorium

Executive Summary

Representatives of employers, providers, brokers and BHCG strategic partners gathered on April 22 at Briggs & Stratton to gain valuable insights and strategies from industry experts about two critical benefit issues confronting employers today – specialty drug management and smoking cessation programs. The following are key takeaways from each of the three speaker's presentations at the event.

Brenda Motheral, RPh, MBA, PhD, President, Artemetrx – Specialty Drug Management

Background/Market Overview

- Fundamental to everything an employer does to manage specialty drugs is an accurate measurement of the problem: You can't manage what you can't measure. Employers need to get their hands on the right information and data to drive an effective specialty drug management strategy.

- There is no one definition of a specialty drug, but generally they:
    - Are medications produced via biotechnology,
    - Originally were injectibles, but now can be administered orally and inhaled,
    - Are high cost: $12,000 - $400,000 per patient per year and
    - Require complex and detailed patient care and patient compliance to be effective.
- Specialty drug pipeline:
    - Fifty percent of the drugs approved by the FDA in 2014 were specialty drugs. Going forward, the majority of the drugs hitting the market will be specialty drugs, with oral cancer drugs representing the greatest percentage of specialty drugs.
    - Sixty percent of specialty drugs are for orphan diseases (less than 200,000 people afflicted) which tend to cost even more, given the limited population for which they are designed.
- Average cost of a specialty drug is approximately $3,000 per claim compared to a generic drug costing roughly $20-$40 per claim and a brand name drug costing a couple hundred dollars per claim.
- In 2014 specialty drugs represented approximately 40 percent of an average employer's drug spend. Artemetrx forecasts that by 2018 specialty drug spend will exceed traditional drug spend.
- Coverage for specialty drugs can fall under both an employer's pharmacy and medical benefit. Presently about 50 percent of specialty drugs are covered under the pharmacy benefit and 50 percent under the medical benefit. Where they are covered can significantly impact the cost to the employer. Employers need to coordinate and manage their medical and pharmacy benefits – with respect to cost sharing, formulary and care management – to effectively manage their specialty drug spend.

Employer Strategies

- There are several tactics/strategies employers should not focus on. Spending time on these will divert attention from strategies that can truly make a difference. Do not:
    - Expect to save money on biosimilars (the equivalent of generics),
    - Wait for your plan administrator to manage your specialty drug spend,
    - Make decisions without reviewing and completely understanding your data, and
    - Rely on deep pharmacy discounts to significantly impact your specialty drug spend.
- What employers should do to manage their specialty drug spend:
    - Adopt best practices for specialty pharmacy benefit management
    - Monitor the performance of your pharmacy benefit manager (PBM) regarding prior authorization and quantity management
    - Understand your total specialty drug spend, including the medical benefit side
    - Understand the significant difference in pricing and profits of specialty drugs when delivered in different settings (MD office, home infusion, hospital outpatient, hospital inpatient)

- Implement care management programs for specialty drugs covered under the medical

Summary

- Specialty drugs, given their cost and the number in the pipeline, will consume a greater percentage of an employer's drug and health care spend.
- Employers must understand their specialty drug benefit spend on both the pharmacy and medical side.
- On the medical side, site of care management and clinical management hold the biggest opportunity for savings.

Slides from Dr. Brenda Motheral's presentation are available on the BHCG website.

Heather Sell, PharmD, BCPS, Medical Outcomes Specialist, Pfizer – Providing a Smoking Cessation Benefit, Leading Practices

Background

- While there has been considerable discussion recently about rising obesity levels in the United States, smoking remains the single largest preventable cause of premature death.
- Based on 2011 data, a self-insured employer pays an additional $5,800 per year per smoker in excess health care costs and lost productivity. Employers can see a reduction of at least $210 in health and life insurance premiums for each employee or dependent who quits smoking.
- Smokers are absent 1.5 times more often than nonsmokers. As a measure of presenteeism, smokers average 77 hours per year of lost time, compared to 43 hours for nonsmokers.
- Quitting smoking reduces three-year risk of coronary heart disease by 21 percent and reduces risk of a stroke by 12 percent when comparing smokers to former smokers. The cost of a cardiac event is approximately $66,000.

Smoking Cessation and the Affordable Care Act (ACA)

- Tobacco use screening and cessation interventions are considered adult preventive services under the ACA, requiring that they be offered without beneficiary cost sharing.
- ACA requires covering at least two tobacco cessation attempts per year which could include coverage of at least four counseling sessions and all FDA-approved tobacco cessation medications (both prescription and over-the-counter).

BHCG Member Survey

Prior to the event, a survey was sent out to BHCG self-insured employers assessing:

- Awareness of the ACA mandate related to smoking cessation coverage
- Plans for benefit design modifications if needed to comply with the ACA mandate
- Coverage of preventive services
- Communication and benefit design strategies to enhance participation in preventive services

Results of the survey are available on the BHCG website.

Isaac Morris, Senior Counsel, Foley & Lardner LLP – Tobacco Cessation: Preventive Services, Mental Health Parity, Wellness Programs

Tobacco Cessation Programs vis-à-vis Preventive Services

- Tobacco use screening and cessation intervention is a preventive service as defined under the ACA and cannot be subject to cost sharing

Tobacco Cessation Programs vis-à-vis Mental Health Parity

- The Mental Health Parity and Addiction Equity Act (MHPAEA) covers mental health (MH) and substance abuse disorder (SAD) benefits. It does not require an employer to offer these benefits, but if they do, then MH and SAD benefits are subject to financial and treatment parity with medical/surgical benefits.
- Tobacco cessation benefits are only covered under the MHPAEA if they are a SAD benefit. If an employer is only offering tobacco cessation benefits to comply with the preventive services requirements of the ACA, they are not required to comply with the MHPAEA. If an employer does not want their tobacco cessation benefit to fall under MHPAEA, they must spell this out in their plan document.

Tobacco Cessation Programs vis-à-vis Wellness Programs

- Wellness programs can be participatory, activity or outcome-based and a smoking cessation program is considered a valid outcome-based wellness program.
- As an outcome-based wellness program a smoking cessation program can require a beneficiary to participate and complete the program to gain a reward or avoid a penalty, but cannot require actual cessation.
- A beneficiary must be able to qualify for the reward/avoid the penalty at least once a year. Additionally, if a reward is provided on a periodic basis (e.g., reduced premium contribution per pay period), the plan may need to provide a "catch-up" so the beneficiary receives the full reward for the year, even though they didn't complete the smoking cessation program until sometime during the year. Alternatively, the employer can set a deadline for completion in one year with the reward effective the following year.
- With some exceptions and caveats, an employer can assess a penalty for up to 50 percent of the premium cost for tobacco use.

Slides from Isaac Morris' presentation are available on the BHCG website.

Additional Available Resources

- Summary of ACA and MHPEAE Impact on Smoking Cessation
- Tobacco Cessation Coverage: What is Required Under the ACA?
- The Synergistic Effect of PPACA and MHPAEA: Implications for Smoking Cessation Therapies