Designing An Evidence-Based Pharmaceutical Benefit Management Strategy

Rob Seidman, PharmD, MPH
Vice President
Chief Pharmacy Officer

July 13, 2006
Does Medicare Part D Give You A Headache?
Part D Will Evolve Over Time

These are my Part D principles…
If you don’t like them I have others…

– Groucho Marx
Why Are We Here?

- Protect patient safety
- Maintain long term Medicare affordability
- Ensure optimal medical outcomes
The New WellPoint

WellPoint, Inc.

- 34 M medical members as of January, 2006
- 42,000 associates
- Nation’s leading health benefits company
- Among top 40 U.S. companies
- Blue-licensed plans in 14 states
The WellPoint Way…

- Generic Maximum Allowable Cost
- Mail Service
- Specialty Pharmacy
- Public Policy
- Brand Name Pricing
- Retail Network
- Clinical Programs
- E-Connectivity
Elderly Population Will Double In Next 25 Years

Projected U.S. Population, 65+ Years of Age, 2000-2030

Source: U.S. Census Bureau, 2004
Medicare Part D Today

- 42 million Medicare eligible elderly and disabled people have access to a voluntary prescription drug plan
  - Over 38 million with credible drug coverage
  - Plans in every state
  - Most eligibles have a choice of 40 plans
    - 1,429 PDPs
    - 1,314 MA-PD
  - 50 million stand-alone Rxs per month (March data)
    - 15% of US Rx market
Medicare Pharmacy Benefit Enrollment Statistics

- **Federal Retiree, 3.5 million**
- **Alternate Credible, 5.8 million**
- **Retiree, 6.9 million**
- **Medicare/Medicaid, 6.1 million**
- **Medicare Advantage, 6 million**
- **Stand Alone, 10.4 million**
  (1 million facilitated by WLP)

Source: Medicare, June 14, 2006
The five largest stand-alone drug insurance plans control two-thirds of the market under Medicare.

- UnitedHealth, 28%
- Humana, 17%
- Member Health, 7%
- WellPoint, 7%
- WellCare, 6%
- All Others, 35%

Source: CMS
The Stand-Alone Drug Insurance Market

Monthly Script Volume For the New Medicare Part D Market (PDPs Only)

- Dual Eligibles
- Choosing Seniors

Source: CMS estimates
Balancing Pharmaceutical Cost and Utilization Was Once Easy
Pharmacy Costs in Billions and as a Percentage of All Healthcare Expenditures 1998-2014

Over the past decade, prescription drugs as a percentage of healthcare expenditures have doubled and are expected to continue to increase. The amount spent on prescription drugs in 2005 is 2.5 times the amount spent in 1998.

*Projected by Centers for Medicare and Medicaid Services.
Source: Centers for Medicare and Medicaid Services (2005d)
Variation In Evidence-Based Care

Nearly one-half of physician care not based on best practices

% of Recommended Care Received

<table>
<thead>
<tr>
<th>Condition</th>
<th>% of Care Received</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td>64.7%</td>
</tr>
<tr>
<td>Congestive Heart Failure</td>
<td>63.9%</td>
</tr>
<tr>
<td>Colorectal Cancer</td>
<td>53.9%</td>
</tr>
<tr>
<td>Asthma</td>
<td>53.5%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>45.4%</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>39.0%</td>
</tr>
<tr>
<td>Hip Fracture</td>
<td>22.8%</td>
</tr>
</tbody>
</table>

Source: Elizabeth McGlynn et al, RAND, 2003
Relative Per Capita Health Spending
By Age Cohort (Age 35-44 Equals 1), 1999

Source: Health Affairs, Nov/Dec 2003
Drug therapy has become more expensive, complicated and important to successful medical outcomes than ever before.
Only 1 in 4 Americans discuss the cost of medicines with their doctor

- Doctor prescribed a drug for me in the last year: 70%
- Discussed with doctor the pros and cons of different drugs he/she might prescribe: 43%
- As part of these discussions, discussed the different costs of different drugs: 23%
- Doctor prescribed one drug rather than another because it was less expensive: 14%

Leaders In Transformational Logic
Increasing Generic Drug Use Is Transformational

- Med D beneficiaries and CMS could save over $23 billion over the next five years as 14 major brand name drugs lose patent protection
- Growing generic density post patent expiry is not a normal event
- Availability of over-the-counter products in common therapeutic categories also provide savings opportunities

Pharmaceutical Care Management Association, 4-18-06
E-Prescribing Will Transform Rx Care

• E-prescribing savings range from 8% to 15% of drug spend
  – Increase in generic drug use
• Decrease adverse customer service encounters by 21% to 33%
  – Prior authorization, step therapy edits, quantity supply
• Implementing for primary care MDs can save from $175 to $260 per member
  – Help members navigate the coverage gap
• E-prescribing can remove 1% from the Med D cost spend
  – Provide financial buffer to growth in biotechnology cost increases

Milliman consultants and actuaries May 12, 2006
Medicare Formulary Basics

- A Part D formulary is a list of Part D covered drugs and the benefit tier on which the drug is placed
  - All Medicare drug plans use a formulary
    - Most (74%) are based on a therapeutic class scheme designed by the United States Pharmacopoeia (USP)
  - List of covered drugs varies across plans
    - Minimum number of drugs to be covered in each class
    - Required coverage in 6 protected classes
      - Anticonvulsants, antidepressants, antineoplastics, antipsychotics, antiretrovirals, and immune suppressants
  - Each formulary must be approved by CMS and meet CMS standards
  - Health plans *may* remove drugs from formulary during the year in special cases
    - New “black box” warnings
The Number of Safety Labeling Changes Involving a Boxed Warning Is Increasing

Source: FDA, The RPM Report

* Through March
Our Formulary

• Designed to ....
  – Offer the most commonly used drugs in the Senior population
  – Meet the health care needs of Seniors
  – Consider the unique health needs of Seniors, for example not including some drugs deemed unsafe for seniors, as determined by the Beers Criteria
  – Cover most generic drugs
    • We attempted to cover all generics in the USP key therapeutic classes as provided by CMS in the Model Guidelines. If a generic is not in those therapeutic classes, a Beers drug, a Part B covered drug or a CMS exclusion, then we do not cover it.
    • When a new generic comes to market for an existing formulary brand drug, we will add the generic and move the brand to the non-preferred brand tier as soon as reasonably possible and when CMS permits

• Approved by our Pharmacy & Therapeutics Committee
  – Our formulary was reviewed and approved by a panel of geriatric specialists for appropriateness
Quality First...Then Cost

National Pharmacy & Therapeutics Committee

Clinical Review Committee (CRC)

- Assigns *clinical designations* determined through review of current guidelines and treatment criteria (from sources such as major medical publications, professional journals, medical specialists, product package inserts, etc.).

- CRC may assign one of **three clinical designations**:
  1. Clinically Superior
  2. Comparable
  3. Uncertain Therapeutic Value

Value Assessment Committee (VAC)

- **Meets after the CRC** has established the clinical foundation and rationale.

- **Must take into account the CRC’s clinical designations** to recommend drugs for the Drug List/Formulary.

- Determines **tier assignments**, or coverage levels, based on designations assigned by the CRC, as well as financial data (AWP, rebates, ingredient cost, cost of care, copayments, coinsurance), market factors and customer impact.
Medicare Formulary Basics

• All PDPs use cost sharing and a tiered structure
  – Amount beneficiaries pay varies based on premium, deductible and copayment tiering
    • The most common benefit is a three tier benefit for small molecules
      – Generic, preferred brand, non-preferred brand
    • A coinsurance tier for large molecules
      – Biotech specialty drugs
• All PDPs use utilization management tools
  – Prior authorization, quantity supply, step therapy edits
WellPoint Plans/Formularies

- **We offer………..**
  - Three Plan designs (Value, Plus, Premier) that use
  - Two formularies
    - The difference between formularies is coverage of non-preferred brand drugs in the Premier plan
    - The coverage for generics, preferred brands and injectables/specialty drugs are the same for both formularies
- **Value and Plus use the same formulary**
  - But do not cover non-preferred brand drugs
- **Premier uses a different formulary**
  - Adds coverage for over 1400 non-preferred brand and generic drugs
  - No coverage gap for generics since there is benefit coverage for generics

<table>
<thead>
<tr>
<th></th>
<th>Value/Plus</th>
<th>Premier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1 Generics</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Tier 2 Brand (Preferred)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Tier 3 Non-preferred brand</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Tier 4 Injectables</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Tier 5 Specialty</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Part D Formulary Design

Excluded Drugs

1. Any drug for which as prescribed and dispensed or administered to an individual, payments would be available under Parts A or B of Medicare
2. Agents when used for anorexia, weight loss, or weight gain
3. Agents when used to promote fertility
4. Agents when used for cosmetic purposes or hair growth
5. Agents when used for the symptomatic relief of cough and colds
6. Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
7. Nonprescription drugs
8. Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee as a condition of sale
9. Barbiturates
10. Benzodiazepines
Beneficiary and physician outreach and education needed to:

- Explain “coverage gap” design
- Understand how generic drugs can help beneficiaries and MDs navigate the coverage gap
- Help beneficiaries stay compliant with Rx regimens

Source: Kaiser Family Foundation, 2003
Who Gets Trapped In The Coverage Gap?

- Low income (no gap): 44%
- Face coverage gap: 15%
- Costs are less than $2,250 (no gap): 31%
- Paid for extra coverage: 11%

Source: PricewaterhouseCoopers analysis for Healthcare Leadership Council

Numbers do not add up to 100% due to rounding.
Unintended Consequences Of Caps On Medicare Drug Benefits

• Lower drug consumption and unfavorable clinical outcomes
• Decrease in adherence to chronic drug therapy, leading to:
  – Poor control of blood pressure
  – Higher lipid levels
  – Higher glucose levels
• Drug cost savings were offset by increases in hospital and ER care

WellPoint Medicare Drug Spend

Source: UniCare Medicare Part D data, Feb, 2006
Apply best Rx practices to protect affordability and ensure optimal outcomes

Generic use based on California, 1Q06 data
Potential Savings To Medicare From New Generic Drugs Becoming Available

Potential Savings from drugs going generic in 2009
Potential Savings from drugs going generic in 2008
Potential Savings from drugs going generic in 2007
Potential Savings from drugs going generic in 2006

Source: Pharmaceutical Care Management Association, April 18, 2006
Nonadherence To Prescribed Drug Regimens Adds Costs To The System

- **Behavioral Health**
  - Depression: premature discontinuation of medication results in 77% increase in the rate of relapse or recurrence\(^1\)

- **Cardiovascular**
  - Hypertension: rates of nonadherence range from 30% to 60% and more than 50% of patients for whom medications are prescribed do not receive full benefit\(^2\)

- **Endocrine**
  - Diabetes: estimated that 93% of adult do not adhere fully to all aspects of their diabetes treatment plan\(^3\)

- **Respiratory**
  - Asthma: rates of nonadherence range from 30% to 70% with highest rates of nonadherence for preventative therapies\(^4\)

---

\(^1\) Melfi CA, Chawla AJ, Crogan TW, et al. The effects of adherence to antidepressant treatment guidelines on relapse and recurrence of depression. *Arch Gen Psychiatry.* 1998;55:1128-32


The Consequences Of Nonadherence

- Nonadherence contributes to $^{1,2}$
  - ↑ use of scarce and expensive medical resources
  - ↑ in the number and length of acute care visits
  - ↑ disease progression and dangerous complications
  - ↑ unnecessary changes in treatment
  - ↑ emergency room visits
  - ↑ inappropriate medicine use, which may lead to safety issues
  - ↓ quality of life and productivity

The Cost Of Nonadherence

• Each year, nonadherence causes
  – An estimated 125,000 deaths in patients with cardiovascular disease\textsuperscript{1,2}
  – Up to 11\% of all hospital admissions\textsuperscript{3}
  – 23\% of all nursing-home admissions\textsuperscript{4}
  – $100 billion on direct and indirect medical costs\textsuperscript{4,5}

\textsuperscript{3} CoI, Fanale JE, Kronholm P. The role of medication noncompliance and adverse drug reactions in hospitalizations of the elderly. Arch Intern Med. 1990;150:841-845.
Improved Outcomes Are Possible

• Various studies indicate that for chronic diseases, comprehensive healthcare management interventions can achieve\textsuperscript{1,2,3}
  – Reduced medical costs
  – Reduced hospitalizations
  – Improved treatments adherence
  – Improved clinical outcomes

\textsuperscript{1} Rubin RJ, Kietrich KA, Hawk AD. Clinical and economic impact of implementing a comprehensive diabetes management program in managed care. \textit{J Clin Endocrinol Metab}. 1998;83:2635-2642.
Medication Therapy Management Programs

- Disease Education
- Population Identification
- Engagement
- Intervention
- Measurement
Medication Therapy Management Program

- Provides disease based education
- Monitors and improves medication compliance rates
- Reduces polypharmacy
- Addresses potential underutilization of ACEI/ARB in Diabetes
- Monitors and intervenes questionable narcotic utilization patterns
- Web-Based Health Management Program
- Reduces potential underutilization of beta blockers post myocardial infarction
- Reduces inappropriate medications in the elderly
Do You Feel Better Now?