Observations from US Payors Today and Predictions for the Future

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TPG National Payor Roundtable — Where Decision Makers Meet

Jestarx — Evidence Based Healthcare Research & Support

TPG The Pharmacy Group — Improving Healthcare Performance

Background

- The TPG-National Payor Roundtable (TPG-NPRT) focuses on market access programs within the United States.
- The JeSTARx Group provides evidence-based research and support to the Healthcare Industry.
- The TPG-NPRT maintains a proprietary database of Chief Medical Officers, Chief Pharmacy Officers and other key decision makers from health plans in the United States.
- To control the growth of healthcare costs and ensure appropriate utilization of pharmaceutical products, payors use a variety of management tools, including prior authorization, generic substitution, step therapy, adherence management, and innovative pharmacy benefit designs.
- Pharmacy & Therapeutic (P&T) Committees and technology assessment entities are tasked with making coverage decisions with limited information available.
- Based on recent programs with US Payors, Medical Directors, and Sponsors (pharmaceutical companies, medical device, and health technology companies), TPG-NPRT and the JeSTARx Group decided to conduct a survey of medical and pharmacy directors from payors involved with P&T Committees on their formulary management policies.
  - The NPRT and JeSTARx Groups have previously published results from surveys of this pool of advisors.[1]

Objective and Purpose

- This study sought to survey medical directors and pharmacy directors of US payors representing: health plans, insurers, employer groups and pharmacy benefit managers (PBMs).
- The survey focused on the:
  - Management of mental health conditions
  - Pharmacy & Therapeutics (P&T) committee process
  - Medical benefit management policies
  - Top causes of concern today and in the future

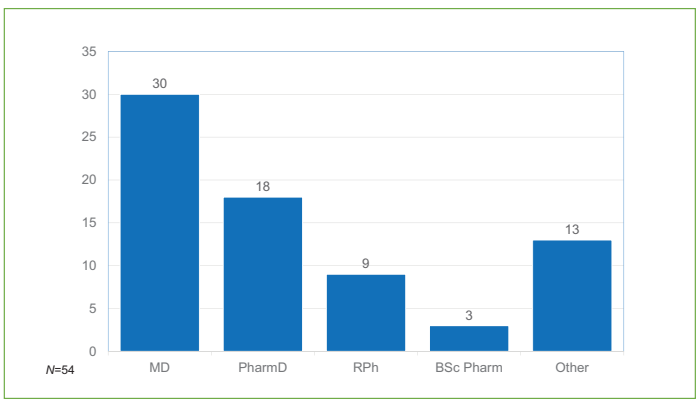
Methods

- An online, interactive survey was developed with 63 questions and included:
  - Yes / No questions
  - Lists for users to select single or multiple answers
  - Open-ended responses (ie, desired changes in their relationships with health plan sponsors)
- Invitations to participate were sent to 224 medical and pharmacy directors currently employed by US health plans and insurers from the TPG-NPRT database in December 2014.
- Material or financial incentives were not offered for completion of the survey.
- Topics included:
  - Plan coverage:
    - Geographical coverage
    - Types of lives
  - Relationships between their plans and their sponsors
  - Mental Health Product coverage
    - Use of Carve outs
    - Formulary management policies
  - Top causes of concern today and in the future

Results

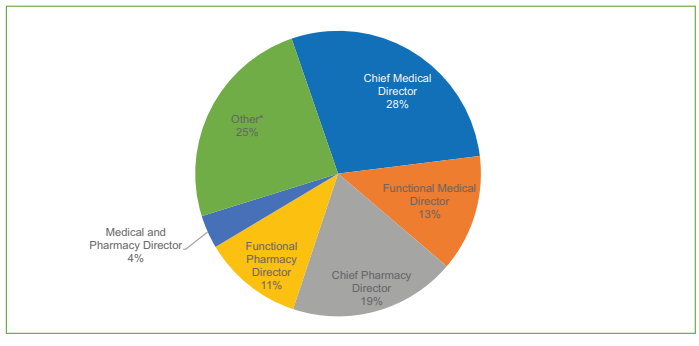
- A total of 54 persons responded to the survey invitation (**24.1% response rate**).
- Many advisors reported multiple degrees (Figure 1), and the most common degree was MD (55.6%).

Figure 1. Survey Respondent Degrees (multiple answers allowed)



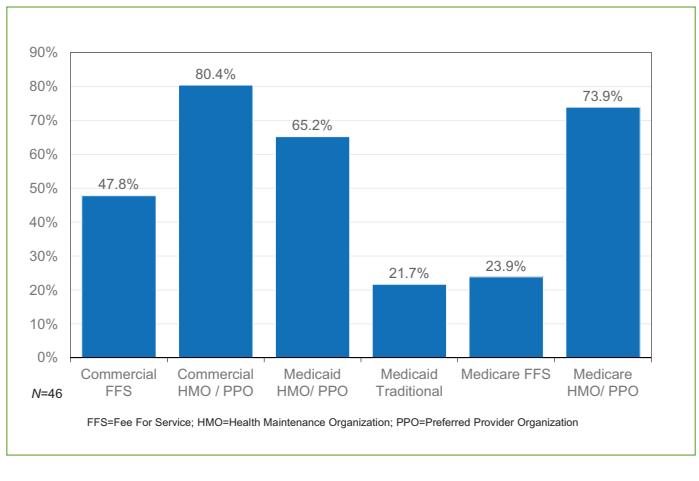
- 86% of the advisors were involved in formulary decisions.
- The respondents were mostly chief medical directors and chief pharmacy directors (Figure 2), the "Other" category included: VP (of Pharmacy, Medicine, or Medical Affairs); Chief Medical Officer, Senior Medical Director [3], and Consultant [3].

Figure 2. Respondent's Title within their Organization



- Most respondents worked for a health plan (83.6%) and 39.6% were local, 35.4% were national, and 25.0% were regional.
- The type of plans represented are shown in Figure 3.

Figure 3. Type of Plans Represented by Respondents (Respondents can cover multiple types)



FFS=Fee For Service; HMO=Health Maintenance Organization; PPO=Preferred Provider Organization

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Complete this year's survey
www.surveymonkey.com/r/NPRTSurvey2016

- At the time of the survey, clinician administered products (ex. office administered injections) were covered exclusively under the medical benefit 67.3% of the time, with the remaining 32.7% based on a cost threshold.
  - 72.9% of advisors do not anticipate a change in the management of clinician administered products; 18.8% expect a change before the end of 2016, and 2.1% before the end of 2018 (Figure 4).
- One–third of plans reported their mental health (MH) products were carved out.
  - For conditions with multiple mental health therapies are available, a variety of formulary management policies were used (Figure 5); with mandatory use of generics first the most common.

Figure 4. Expected change in the management of clinician administered products

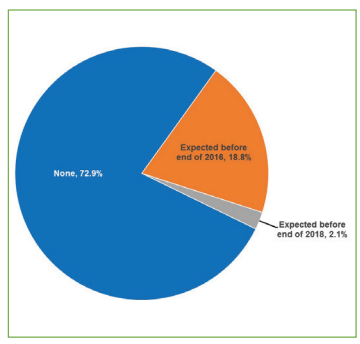
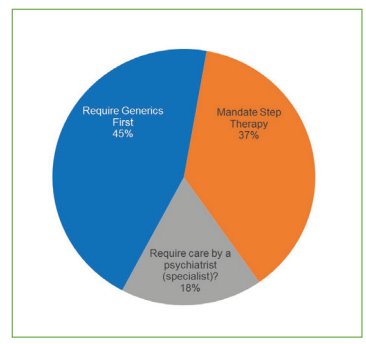
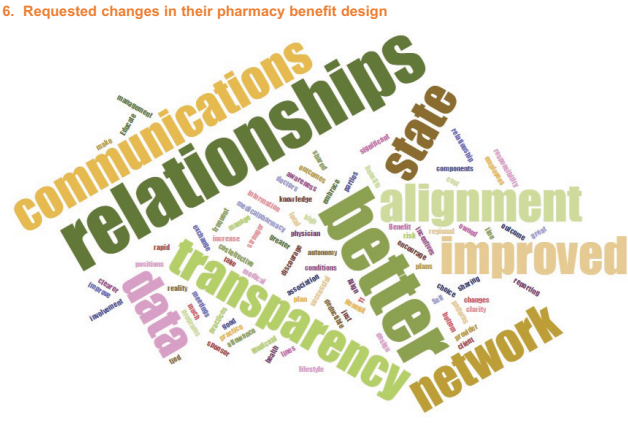


Figure 5. Policies for Mental Health Therapies



- Most were happy with their plan's medical benefit management, desired changes included:
  - *Coordination/Integration:* Increase involvement with pharmacy department in case management and clinical program development; More pharmacy and medical integration with sales; Better coordination between medical and pharmacy benefits; Combine with pharmacy; Integrate pharmacy and medical claims with clinical and laboratory data; Pharmacy has all medications under umbrella; Cost tied to outcomes;
  - *Coding and analytics:* Get more resources to work on proper coding; Better use of our in-house analytics; More data upon which to make decisions; Better data; More EMR alerts;
  - *Management programs:* Better use of automated medical management programs; Efficient utilization management program; Add local onsite nurse case managers; Tighter management with collaboration with providers;
  - *Plan design:* Increase patient cost of care; Increased out of pocket maximum; Formulary tiers; Move to a defined benefit;
  - *Network:* Closed network; Higher quality network; Mandatory use of in-plan providers before referral out of state; Convince network doctors to embrace cost-effective medical practices; Risk share contracts;
  - *Time:* More time to make decisions; More time;
  - *Education:* Enhanced staff education; Convince specialty pharmacies to provide drug delivery, purchasing, tracking for medical benefit drugs; Increase staff knowledge of interesting guidelines;
  - *Prior authorizations:* Prior authorizations of medical benefit drugs; rational prior authorizations;
  - None: (6).
- Most advisors were happy with their pharmacy benefit design, the most requested changes were more restrictive management programs; followed by changes in tiers/copays (Figure 6).

Figure 6. Requested changes in their pharmacy benefit design



Responses to open-ended questions about the top causes for concern currently, and for the coming years.

The disease states most concerning to these plan directors from a medical care point of view:

- Today:
  - Most concerning: Cancer/oncology (15); Diabetes (10); and Hepatitis C (7);
  - Second most concerning: Diabetes (9); Cancer/oncology (5); and Hepatitis C (3);
  - Third most concerning: Cancer/oncology (7); Cardiovascular/heart disease (7); and Diabetes (6);
  - Other items included: Orphan diseases; Multiple sclerosis; Biologics; Behavioral health; and HIV.
- In 5-years:
  - Most concerning: Cancer/oncology (18); Hepatitis C (9); and Diabetes (4);
  - Second most concerning: Cancer/oncology (9); Diabetes (5); and Hepatitis C (4);
  - Third most concerning: Diabetes (9); Cardiovascular/heart disease (4); Cancer/oncology (3); and Obesity (3);
  - Other items included: Orphan diseases; Rheumatoid Arthritis; Biologics; and HIV.

The disease states most concerning to these plan directors from budgetary point of view:

- Today:
  - Most concerning: Hepatitis C (16); Cancer/oncology (12); and Diabetes (7);
  - Second most concerning: Cancer/oncology (10); Hepatitis C (8); and Diabetes (2);
  - Third most concerning: Cancer/oncology (9); Rheumatoid Arthritis (5); and Diabetes (4);
  - Other items included: Orphan diseases; Cardiovascular/heart disease; Multiple sclerosis; Biologics; and HIV.
- In 5-years:
  - Most concerning: Cancer/oncology (15); Diabetes (10); and Hepatitis C (3);
  - Second most concerning: Cancer/oncology (9); Cardiovascular/heart disease (6); and Diabetes (5);
  - Third most concerning: Cardiovascular/heart disease (6); Diabetes (6); Multiple sclerosis (5); and Cancer/oncology (4);
  - Other items included: Orphan diseases, Cholesterol, Biologics, Behavioral health, Alzheimer's disease; and HIV.

Over the next 5 years, the classes of therapies expected to experience the:

- Most growth: Cancer/oncology (15); Hepatitis C (4); and Diabetes (3);
- Second most growth: Cancer/oncology (8); Diabetes (6); and Hepatitis C (3);
- Third most growth: Cardiovascular/heart disease (6); Cancer/oncology (4); and Diabetes (3);
- Other areas included: Biosimilars, Immunomodulators; and Orphan diseases.

Conclusions

- As the population ages and healthcare costs continue to grow, payors will change the ways they manage their formularies.
- The environment for P&T Committee decision making in managed care is undergoing a series of changes.
- Payor medical directors and pharmacy directors, who commonly serve as P&T Committee members, have a distinct understanding and opinions as to how to alter the process to adapt to these influences.

References

1. Brook RA, Carlisle JA, Mehr SR, Smeeding JE. The US Payor Landscape: Results from a Survey of Medical Directors and Pharmacy Directors on Comparative-Effectiveness Research. *J of Pharmacy and Pharmacology* 2 (2014) 432-438. (available at TPG-NPRT.com)

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Disclosures: TPG-NPRT (National Payor Roundtable)

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