CHELKO CONSULTING group
CENTER FOR BENEFITS MANAGEMENT

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Re-evaluating Value

They Said It

"Achieving high value for patients must become the overarching goal of health care delivery" Harvard Professor Michael Porter in the New England Journal of Medicine.

The concept of "value" ("a fair return or equivalent in goods, services, or money for something exchanged") seemingly is so well understood that making it the topic for an In Focus might strike our readers as curious. Achieving value, after all, is not a notion that is unique to health plan management. Everyone attempts to maximize value in all of their purchases and in non-financial transactions as well. So what's up? What's up is that achieving value in health plan management means dealing with an evolving conception of value and its increasing importance for effective management of specialty drugs.

Many benefits managers began their quest for value in their healthcare plan management more than a decade ago when Pitney-Bowes trumpeted "value-based insurance design (VBID)". The goal of VBID as it has been framed in the Affordable Care Act is " . . . to increase health care quality and decrease costs by using financial incentives to promote cost efficient health care services and consumer choices. By covering preventive care, wellness visits and treatments such as medications to control blood pressure or diabetes at low to no cost, health plans may save money by reducing future expensive medical procedures."

No one can question the first part of that definition. As we have noted in previous In Focus articles, the second sentence warrants more careful consideration. However, have you ever wondered how VBID might apply to the growing list of expensive specialty drugs?

With specialty drugs, we struggle with the sheer price of the drugs, for sure. But we also have cost problems associated with the site of their administration: be it at home, the doctor's office, or very expensive hospital outpatient departments. And more than half of the time, these drug claims are administered through our medical plans, not by our PBMs. This gives us less ability to ensure value than when they run through our drug plans.

One PBM recently estimated plan sponsors are wasting $4.9 billion annually as a result of inadequate management of specialty medications in the medical benefit. Most of this waste could be avoided by applying the utilization and trend-management programs that are traditionally found in the pharmacy benefit to the medical benefit. Some benefits managers know this, and are beginning to manage medical plan specialty drug utilization more assertively.

But the results of their efforts will be more limited unless they are coupled with a new resolve regarding something most benefit managers have not considered: namely, providing different levels of plan coverage for the same specialty drug when it is used for different conditions. This is important, because frequently the drugs have dramatically more, or less efficacy, that is, value, depending on the condition to which they are applied. And, now that drug manufacturers can promote off-label uses of their drugs, the stakes of the value management game will climb even more rapidly.

An example is a cancer drug, Tarceva® (erlotinib). It provides, on average, an additional five months of life for lung cancer patients. However, the same drug provides, on average, only an additional 12 days of life for pancreatic cancer patients. Yet, our plans cover the drug the same, without taking into account its different effectiveness (delivered value) from one type of cancer to another.

More and more frequently, we ration access to certain specialty drugs through preferred drug lists. That addresses the issues of price and rebates, but not efficacy. It's probably time to align how our plans will cover these drugs with the value the drugs deliver to the condition of each patient. And that means marginal value gets less plan coverage.

As such, Express Scripts (ESI) recently announced that it is creating an *indication-based formulary* that incorporates differential, value-linked plan reimbursement for an initially modest number of cancer drugs. ESI is working with pharmaceutical manufacturers and others in the industry to determine how well specialty drugs work for different medical conditions by using tumor testing, predictive analytics and pharmacogenomics to guide formulary tier placement. ESI's indication-based formulary approach will be coordinated with its Medical Benefit Management (MBM) solution that focuses on optimizing management of specialty drugs covered by medical plans. ESI's program will also include the services of its Oncology Therapeutic Resource Center®, which concentrates on the management of the large percentage of specialty drug patients with co-morbidities.

What will your employees see if you adopt an indication-based formulary? Lung cancer patients desiring Tarceva® will see it on a higher coverage tier than it will be for the pancreatic cancer patients desiring the same drug. Plan managers will probably want the difference in plan coverage per tier to be noticeable, but not so great as to effectively deny access. What that means exactly is yet to be seen.

At this point, ESI does not see any need for special messaging to plan members when introducing this new formulary. Overall, around 1% of plan members use specialty drugs. Even fewer will be impacted by this type of a plan change. However, the dollars can be significant – for the plan and, even more so, for the plan member. Will the cost share change be enough to cause someone to wonder, "is this really worth doing?" We are all used to considering value when we decide what to buy and how much to pay for it. Yes, emotions also come into play, but that is part of the value equation too.

The affordability challenges long ago prompted many plan managers to say "no" to certain items of questionable efficacy (i.e. lifestyle drugs, chiropractic care, cosmetic surgeries, etc.). As we strive to provide the greatest good for the greatest number of plan members, we now need to consider the value of certain specialty drugs with respect to certain conditions. If we don't, someone else will. It may be the hospital or physician that is being paid to do research for the manufacturer. It may be the patient who saw an advertisement while watching the news or doing online research. We'd rather it be the plan fiduciary. Just like we do in our 401k investment committee meetings, we need to decide which options are good-enough to make the cut.

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