Interagency Benefits Advisory Committee / Albuquerque Public Schools

Pharmacy Benefits Purchasing Background and Update

Interagency Pharmaceutical Purchasing Council

October 3, 2019

Interagency Benefits Advisory Committee (IBAC)

- What is the IBAC?

- An administrative construct to fulfill the obligations of the Health Care Purchasing Act [13-7-1 NMSA 1978]

- **13-7-2. Purpose of act.**

- The purpose of the Health Care Purchasing Act [13-7-1 NMSA 1978] is to ensure public employees, public school employees and retirees of public employment and the public schools access to more affordable and enhanced quality of health insurance through cost containment and savings effected by procedures for consolidating the purchasing of publicly financed health insurance.

- Purchases health (medical, pharmacy, dental and vision) services for approximately 175,000 public sector employees, retirees and family members (over 25% of the NM's commercially insured population)

    - State of NM / GSD / RMD: 57,000
    - NM Retiree Health Care Authority: 55,000
    - NM Public Schools Insurance Authority 47,000
    - Albuquerque Public Schools 16,000

- IBAC entities have written contracts under the auspices of the act since FY2000.

IBAC Pharmacy Purchasing Background

- Pharmacy Benefit Managers (PBMs) were already dominant in the industry for large payers (including health plans) when the IBAC was created
- All IBAC entities were originally part of a multi-state agreement with Express Scripts Inc. (ESI) facilitated through West Virginia
  - The agreement was “traditional” spread pricing ($0 administrative fees) with rebates playing a small role
- In 2002, IBAC began procuring PBM services on its own and evolved to “pass through” pricing at retail with rebates starting to play a larger role; not all entities used the same PBM
- In 2010/2011, all IBAC entities united under one PBM (Medco); a majority terminating their relationship with ESI
- In 2012, ESI purchased Medco
- All IBAC entities are still currently contracted with ESI

Why Does the IBAC Use a PBM?

- The infrastructure and platforms used to adjudicate financial transactions between the clinical community (i.e. doctors and hospitals) and pharmacies began to diverge in the 1980s and 1990s.

- This was originally a very good thing for members and purchasers
  - Old Medical Platforms – member paid full price of prescription at the pharmacy (prices were already starting to climb) and then submit receipts for reimbursement from their health plan
    - No negotiated discounts of retail costs or rebates
    - No meaningful tracking of the constituent elements of drug cost trends
  - New PBM Platforms – provided near real-time adjudication of claims allowing members to pay only their owed portion at the point of sale
    - Discounts off of retail and rebates became more prominent
    - Drug-specific reporting became available allowing for enhanced utilization management

- We all use the PBM model now – even health plans

What Do PBMs Do For the IBAC to Help Control Costs?

- Provide access to a network of participating pharmacies
  - Negotiate discounts with pharmacies using 83 million member market leverage
    - Brands: Average Wholesale Price (AWP) MINUS 18%
    - Generic: AWP MINUS 83%, though Maximum Allowable Cost (MAC) lists usually apply
  - Ensure adequate access to members – 65,000 retail pharmacies nation wide

- Adjudicate claims in accordance with IBAC plan designs and facilitates claim financing for self-funded payers

- Provide customer service (telephonic and web-based) including direction about where to find the lowest cost prescriptions

- Supports and/or warns plan sponsors of developing or upcoming trends and risks (i.e. compounds and PCSK9)

What Do PBMs Do For the IBAC to Help Control Costs?

- Utilization Management
  - Prior Authorizations
    - Ensure an appropriate drug is being used for the appropriate clinical purpose
    - Examples: HEP C Drugs – right drug for right genotype
    - Lumagin – Treating glaucoma and not for longer, thicker eyelashes
  - Step Therapy
    - Ensure appropriate, less expensive therapies are tried before moving to a much more expensive next “step”
    - Examples: $20 generic statin for high cholesterol before a $500 PCSK9
    - $10 hydrocortisone cream before $3,300 Humira for mild plaque psoriasis
  - Quantity Limits
    - Coverage should be based on current FDA and manufacturer dosing guidelines and current medical best practices
    - Examples: Opiod limits on initial prescription
    - Sleep aids such as Ambien
  - Safety Protocols
    - Identify and alert pharmacist/clinician regarding any contraindications with already prescribed medications
    - Advise if there are existing diagnoses which could render a drug harmful (PBMs receive medical claim data with diagnoses)
- Policy and regulatory discussions continue regarding these practices

What Do PBMs Do For the IBAC to Help Control Costs?

- Provide Access to Mail Order Facilities for Maintenance Medications
  - Bulk purchasing allows for greater savings
    - Brand Guarnatee: AWP MINUS 25%
    - Generic Guarantee: AWP MINUS 86% (NOT PASS THROUGH PRICING)
  - Copays for 90 day supply through mail generally lower than 3 separate 30 day retail fills
  - Some members prefer the convenience of mail order (some definitely do not)

- Provide access to Specialty Pharmacies for high cost drugs
  - Bulk purchasing allows for greater savings
    - AWP MINUS 20%
  - Expertise with rare drugs to ensure correct dosage and handling
  - Specialty drug costs represent the biggest challenge moving forward (more on this later)

What Do PBMs Do For the IBAC to Help Control Costs?

- Formulary Management
  - List of preferred drugs within each therapeutic class selected for safety, efficacy and value

- Formularies have been around for decades but have taken on more financial significance as rebates have increased
  - IBAC originally had open formularies where preferred brands could be obtained at lower copayments but non-preferred brands were still covered
  - Currently, within certain classes of drugs, ONLY the preferred brand is covered

- Formularies are still developed to ensure safety and efficacy, but increasingly….

- **Formularies drive rebates** from manufacturers on brand name drugs
  - Rebate Guarantees
    - Retail - $277 per claim
    - Mail - $601 per claim
    - Specialty Pharmacy - $2,662 per claim

- PBMs also provide access to copay assistance programs to increase plan revenue from manufacturers

APS Pharmacy Benefit Plan Design

	Retail (34 day Supply)			Mail/Walgreens (90 days)
	Coinsurance	Min.	Max.	Copay
• Generic	20%	$10	$25	$25
• Preferred Brand	30%	$35	$65	$70
• Non Pref Brand	40%	$70	$140	$150

Insulin & Diabetic Supplies: $0 Copayment

Generic Specialty: $70

Preferred Brand Specialty: $100

Non-Pref Brand Specialty: $150

Out of Pocket Maximum: $3,150 individual / $4,300 family

APS Has Greatly Benefited from IBAC Purchasing

- APS Topline Performance Metrics – 2013 to 2018

	2013	2018	Total Increase/Change	Annualized Increase/Change
Avg Members	17,255	15885	-8.6%	-1.7%
% Members Using Benefit	81.5%	82.5%	1.2%	0.2%
Member Cost %	14.5%			
Total Plan Cost	$12,059,356	$15,061,828	19.9%	4.0%
Total Plan Cost PMPM	$58.24	$79.16	26.4%	5.3%
Rebates	$1,403,428	$4,697,951	234.7%	46.9%
Net Plan Cost	$10,655,928	$10,363,876	-2.7%	-0.5%
Net Plan Cost PMPM	$51.46	$54.47	5.8%	1.2%
Rebates as % of Total Plan Cost	11.6%	31.2%	168.0%	33.6%
Generic Fill Rate	82.1%	85.0%	3.4%	0.7%
Specialty Drugs as % of Plan Cost	22.3%	41.8%	46.7%	9.3%

APS Successes and Challenges

- Successes
  - Improved Generic Usage – up to 87% so far in 2019
  - Have moderated pharmacy trend and kept it below national averages
  - ….not bragging because profound challenges remain

- Challenges
  - Specialty….Specialty…..Specialty
  - In 2013, 7 of APS's top costing drugs were specialty
  - In 2018, that number is now 17
  - Humira cost an average of $2,200 per script in 2013; $3,300 in 2018
  - Zolgensma – Wonderful life-saving gene therapy for spinal muscular atrophy: $2 million
  - Luxturna – Wonderful gene therapy that cures some types of blindness: $425,000 per eye
  - More are on the way

- Uncertainty with policy and market environment
  - Past market of independent PBMs no longer exists
  - State and federal attempts to regulate drug costs