An Ounce of Prevention

The Potential for Value-Based Pharmacy Benefits in Cost Containment

by John J. Malley

A growing number of companies are considering whether they can reduce overall medical costs by improving drug compliance through value-based pharmacy benefit designs. Value-based designs either provide more generous coverage for certain clinically proven drugs, or change cost-sharing or copayment levels for drugs used to treat the employee population’s most widespread and costly chronic medical problems. This article presents employer experiences, identifies important issues for those considering value-based pharmacy benefits and suggests ways to overcome barriers to implementation.

The story is an increasingly common one. A heart patient is prescribed a statin to reduce his cholesterol levels and prevent future cardiac episodes. The patient had already had a heart attack and his doctors had increased his dosage to prevent future problems. But what happens if the required copayment for that drug makes it too expensive for the patient to afford? In this case, because of the high cost of the drug, the patient took his dosage every other day instead of every day to make the pills last longer. As a result, the patient suffered additional cardiac episodes that required extended hospitalizations before his medical team discovered the problem. If the issue had been caught earlier or if the medication had been more affordable, those hospitalizations and the significant medical costs associated with each one might have been avoided along with lost work time and lower productivity while on the job.

If an ounce of prevention is worth a pound of cure, what is the value of more affordable prescription drugs and the support necessary to ensure compliance with the prescribed regimen? That is a question a growing number of companies are attempting to answer as they consider whether to reduce or eliminate certain prescription drug copayments in an effort to improve drug compliance for chronic conditions, including hypertension, diabetes, high cholesterol and asthma. The rationale is that, as drug compliance increases, employers would be able to reduce overall medical costs as individuals manage these conditions more effectively, avoid prolonged medical illnesses and hospitalizations, and remain on the job and productive.

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Such an approach does not represent a way to reduce prescription drug costs but rather a way to help employees better manage their health and, at the same time, reduce the overall costs of increasingly common and costly chronic conditions.

Value-based designs can help employers achieve these objectives by either providing more generous benefit coverage for drugs that have been clinically proven to improve outcomes, or simply changing
cost-sharing or copayment levels for drugs used to treat the most widespread and costly chronic diseases or conditions that exist among employees. These value-based designs can be particularly effective when coupled with efforts to identify the reasons why individuals do not comply with a medication regime, and to introduce programs and solutions that remove those barriers to compliance, including working with physicians and pharmacists to provide patient information, outreach and education.

Depending on the time and money an employer wants to invest in a value-based design effort, it is possible to use claims and utilization data to identify high-cost areas, calculate the impact of copay changes and pinpoint populations or locations where non-compliance is a major problem. This can include “what if” scenarios that quantify how various changes to financial arrangements and copays might affect overall costs and savings potential.

Such tools have already been used to great effect by both public and private sector employers. Within two years of implementing a value-based design, Pitney Bowes saw the medical costs associated with diabetes and asthma drop by 6% for diabetes and 15% for asthma after moving the drugs for these conditions into the lowest copay tier or 10% of the cost.1 The Asheville Project, a program run by the city of Asheville in North Carolina, used a value-based benefits approach for its employees along with an intense patient education process that engaged pharmacists and patients to work together to improve outcomes. The project, which began in 1996, increased mean costs for prescription drugs used to treat diabetes from $488 per patient per year to $1,702 over five years but reduced mean hospitalization costs from $6,906 per patient per year to $1,584 during the same time period.2 The Asheville Project also proved that combined value-based designs with patient outreach and education. To determine whether their organizations can achieve similar results, employers can conduct an upfront analysis to determine what, if any, cost reduction could be realized through value-based design, and how other steps could reduce medical costs further and increase workforce productivity.

Making the case for change

In many companies, it is not easy for the benefits department to make a case for increasing prescription drug benefit spending without quantifiable evidence that these efforts will result in overall savings. The days of double-digit prescription drug increases are still too fresh in the minds of many company executives, especially those in finance. Quantifying the available cost savings opportunity is something that these executives can understand and feel comfortable doing.

The results generated by The Asheville Project, Pitney Bowes and other employers came from efforts that combined value-based designs with patient outreach and education. To determine whether their organizations can achieve similar results, employers can conduct an upfront analysis to determine what, if any, cost reduction could be realized through value-based design, and how other steps could reduce medical costs further and increase workforce productivity. This means identifying the chronic conditions and the problems associated with those conditions that are driving medical costs and lost workdays, as well as any links that exist between hospitalization rates among individuals with these conditions and the level of pharmaceutical utilization among those individuals. Taking this a step further, it is possible to extrapolate the data to gauge the impact on hospitalization costs if copayments are higher than people can afford. Finally, employers can analyze absenteeism and productivity data to determine how chronic conditions might be affecting these metrics.

Taking steps to uncover the true reasons for non-compliance among employees can help jump-start patient outreach efforts. For example, if patients generally purchase medication for 30 days, a closer look at refill patterns might show that a significant number of patients are refilling these prescriptions every 45 days, indicating that patients are not taking the medication every day or are taking breaks from compliance. This information, which is readily available from pharmacy benefit managers (PBMs), indicates that the patient is likely to have at least 15 days of noncompliance during that time period. This not only indicates a problem but also can help pinpoint the areas for followup to determine the reason for the noncompliance. If the patient is seeing a physician during the time of non-compliance, the physician can be alerted to the problem in order to discuss the consequences of non-compliance with the patient. In addition, the company can survey these individuals in an effort to determine the reason for non-compliance.

By getting physicians and pharmacists more involved in helping patients understand the importance of drug compliance, it is more likely that patients will improve compliance efforts. For example, patients may not be aware of the importance of compliance and the potential consequences of noncompliance, particularly if they are feeling no adverse symptoms from the disease.

It’s not always about money

Although changing copay levels to make drugs more affordable can be an important way to improve
drug compliance, employers must also think carefully about how well the patient population is likely to respond to financial incentives and whether high copays are keeping patients from full drug compliance. Depending on the employee population involved, money may not be the primary reason, or the reason at all, for noncompliance. Individuals with asthma may require more education and support in order to learn how to use a nebulizer and inhaler correctly. Issues like denial of the condition, resistance to required lifestyle changes, drug side effects or any number of other reasons can lead to noncompliance; and will require a different strategy than simply implementing a value-based design.

It is important to note that value-based designs that rely heavily on financial incentives do not work for every employer simply because of employee demographics. For example, highly paid employees who are noncompliant with their medication probably have reasons other than financial considerations driving their behavior. In that case, the employer may need to take a more behavior-based approach to improving drug compliance. If an employer is uncertain how the employee population will respond to program changes, it can conduct a small pilot program involving one or two disease categories or disease states on a smaller population to measure impact before rolling out the program more broadly.

Whatever the reasons for noncompliance, an employer that wants to reduce overall medical costs, reduce absenteeism and improve productivity must uncover those reasons and then develop a plan to counteract them. For example, if this research determines that noncompliance is most likely to occur at a specific phase of the disease—say, during the first year after the initial diagnosis or five years after the initial diagnosis—the employer can develop a program for outreach and education at those crucial points. Once that is in place, it is important to track individuals’ progress and compliance to make sure additional problems do not emerge.

Once again, looking at the data can yield some important insights. Inevitably, some patients will have multiple conditions with medications that are not included in the value-based benefits program, so companies will have to determine how to handle those situations, and where to draw the lines when it comes to copays and other support mechanisms. For example, if a company is considering a value-based design that eliminates copays for diabetes medications and the data show that most diabetics covered under the company’s health insurance plan have another condition that requires medication, the company may want to rethink what drugs are included in the value-based design. After all, any effort to increase drug compliance for one condition will be undercut if patients remain noncompliant with other medications.

This is also an opportunity to manage comorbidity in patients with multiple problems. In some cases, patients are noncompliant because they cannot afford medication for all of their conditions and must choose to focus on certain ones. Or patients may not like the side effects of taking more than one drug at a time. However, noncompliance with one condition could worsen or cause complications with another condition, so it would be helpful for companies to determine how to help employees balance these competing priorities.

Because physicians and pharmacists are on the front lines and are likely to have the most access to and the most credibility with patients, these individuals must be integrated into the effort. These individuals are the best positioned to help patients understand what will happen if they are not compliant, how the drugs work and why different drugs are prescribed to people with the same disease. Pharmacists may require additional training to take on this role. In many cases, a pharmacy benefit manager can play an important role in engaging these individuals.

As value-based designs become more popular, on-site pharmacies and clinics could make a comeback among large employers. While on-site pharmacies can obtain greater discounts on drugs, employers should also weigh the convenience factor and the ability of on-site providers to develop deeper connections with patients to encourage lifestyle changes and ensure drug compliance.

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OVERCOMING BARRIERS TO ACTION

Despite its potential, relatively few companies have implemented value-based designs. There are several reasons for this reluctance. Some companies are concerned that they could end up increasing their overall prescription drug costs by reducing or eliminating copays for certain medications only to see that action yield little or no impact on other medical costs. Companies looking for assurances that reducing copays will generate an adequate financial return can create a financial model using past claims data to calculate the potential increase in prescription drug costs and the potential reduction in overall medical costs to make that case.

Companies looking for assurances that reducing copays will generate an adequate financial return can create a financial model using past claims data to calculate the potential increase in prescription drug costs and the potential reduction in overall medical costs to make that case. In general, a company with a stable workforce and low turnover is more likely to benefit from this approach because employees will be with the company long enough for it to see some return on its investment.

Discrimination is also a concern for companies because reducing copays for certain medications means that some employees will receive a richer benefit than others. Once again, the data and analysis gathered during a value-based design can help counter discrimination claims. Moreover, this data can be used to communicate the value-based design, its purpose and its goals in order to prevent concerns about discrimination from taking root among employees.

Companies concerned about these issues can also consider a small pilot program to test this approach before rolling it out more broadly. This can also help companies test the results of value-based design without going through the effort of the upfront analysis to make the case for this approach. Such pilot programs generally involve measuring and analyzing results at specific points in time, such as every six months, before moving on to the next phase. Eventually, the company will have year-to-year data to gauge the full impact of the program.

In some cases, pharmaceutical manufacturers may be willing to provide funding for these pilot programs. To avoid conflicts of interest in these arrangements, an employer can work out a mutually acceptable formal agreement with a manufacturer—for example, by stipulating that the program cannot just include that particular manufacturer’s products. Pharmaceutical manufacturers are eager to show that their medications can help reduce medical costs, so they may be more amenable to negotiations than one might think.

When all is said and done, value-based designs are about more than saving money. They also can help improve employees’ health and well-being. Therefore, the impact of these programs should be measured not only in reductions in hospitalization and other medical costs, but also in how these programs improve employees’ health, providing better morale and productivity, fewer lost workdays and disability claims, and less presenteeism.

Endnotes