RADAR on

Drug Benefits

Business Strategies and Analysis for Health Plans, Employers, PBMs and Pharma Companies

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Payers and Dialysis Providers Are Both Friends and Foes

Last week, a long-simmering payer-provider feud burst into the spotlight, with health insurers urging the federal government to stop dialysis providers from steering patients with kidney failure toward higher-reimbursing private plans.

However, a new study also offers evidence that a dialysis provider and an insurer can work together to improve care and lower costs for the challenging, expensive population of patients with end-stage renal disease (ESRD).

Highmark Inc. and DaVita Inc. co-authored the study, published in the April edition of the *American Journal of Managed Care,* which details the results of a pay-for-value contract the two organizations entered to improve care for ESRD patients.

"We believed there was an opportunity for better outcomes among these patients, knowing that they have lots of comorbidities; they're tough to treat," Bob Wanovich, vice president of ancillary provider strategy for Highmark, tells AIS Health.

Most notably, the companies found that the hospital admission rate, number of hospitalized days, the emergency department visit rate and the 30-day readmission rate all fell following the inception of their partnership.

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Priority Health Makes Case for Rx, Medical Benefit Integration

With standalone PBMs quickly becoming a relic of the past, health insurers may want to reevaluate how they approach drug benefits going forward.

While it can be challenging for some payers to handle all PBM operations in-house, one Michigan-based insurer has a model that could offer a promising compromise.

Priority Health manages its formulary internally and contracts with Express Scripts Holding Co. for help with its pharmacy network, the insurer's chief medical officer, James Forshee, M.D., tells AIS Health. And while Express Scripts is slated to be acquired by Cigna Corp. *(RDB 3/9/18, p. 1)*, Forshee doesn't expect that will make much of a difference.

"I think it's too soon to tell whether that acquisition will actually get finalized," he says. In addition, the concept of health plans owning PBMS or PBMs owning health plans "probably won't impact us in our state here in Michigan," he adds.

The real value of Priority Health's hybrid model, he says, is that it allows the insurer to integrate medical and pharmacy benefits — an approach that Forshee says makes a big difference for members.

"We really think there's a significant opportunity for us to use more of a comprehensive approach to health care," he says. "I think whenever we fragment or parse out pieces of it, there's an opportunity for things to be missed."

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Specifically, Priority Health uses pharmacy data in its care management program for patients with complex diseases and has found that using such data allows it to identify 38% more chronic diseases than it otherwise would have.

"If we leave the pharmacy data off," Forshee says, members might still be getting their prescriptions but will be not receiving the medical care they need. But if Priority Health can see pharmacy data right away, it can prompt staff members to ensure that individuals with chronic conditions are going to the doctor to get the care they need.

Integrating pharmacy and medical benefits also presents opportunities for better patient education, he adds. For example, if a parent gets a prescription filled for an inhaler for an asthmatic child but doesn't visit the doctor to learn how to use it, that child could still end up in the emergency department with an asthma attack.

"One of the things that we do with our data in general is that we look at our pharmacy data, and we feed that to our care managers on a regular basis so they not only know what medications are being taken, but they also know what medications are being filled appropriately," Forshee says.

That approach can prove very useful if, for example, a diabetes patient's blood sugar goes up not because his insulin stopped working or his diet wasn't optimal, but because he started a new antipsychotic medication, according to Forshee.

"And so I think those kind of coordination opportunities are huge and are very, very common," he says.

Priority Health also has a sophisticated predictive analytics model that allows the insurer to not only help patients know what's going to happen but also "get in front of it" and be able to prevent likely complications or disease reoccurrences, Forshee adds.

The advantages associated with integrating pharmacy and medical benefits help give Priority Health an edge when vying for employers' business, according to Forshee.

Of the insurer's 775,375 members, 226,945 are in the large group market, and 94,953 are in the small group market, according to AIS's Directory of Health Plans.

Model Can Appeal to Employers

"Being, as a health plan, a single point of contact for an employer or an employee, they don't have to call one place to learn about their pharmacy, another place about medical, another about their behavioral health," he says.

"We as a health plan, we take advantage of being able to have all of that and then have it all integrated into a care plan when a patient does need chronic medication or needs pharmaceutical benefits," Forshee adds.

Yet Ellen Kelsay, chief strategic officer of the National Business Group on Health, says the majority of large, self-insured employers that are members of her organization contract with a PBM separately to manage their prescription drug plans.

"I think over time, the pharmacy benefit managers have a focused effort on prescription drug costs, clinical effectiveness and rigor around utilization, formulary management [and] prior-authorization programs to help employers and their covered members really ensure that they're getting the most optimal arrangement for prescription drugs — whether it be from a purchasing perspective or most importantly, from the clinical effectiveness perspective," she says.

That said, employers look at specialty pharmacy "a bit differently" since some specialty drugs are administered

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in the hospital or at infusion centers — and thus are adjudicated both through the health plan's medical benefit as well as through the pharmacy benefit, Kelsay says.

On top of that, specialty drugs are some of the most expensive treatments, so employers strive to ensure their prescription drug spend from the specialty perspective "is really holistically being looked at rather than through the traditional lens of just within their health plan or just within their PBM contract," she adds.

To Forshee, though, Priority Health's whole-person view of members — which includes not only their medical care but also social determinants of health — is an argument for carving in, rather than carving out, all pharmacy benefits.

"I think that we as health plans really understand the entire patient much better than when you try to look at a person or an individual from just their pharmacy [usage]," he says. "I don't think any of us would want our doctor looking at 'well, here's the pills you use, or here's the inhaler you need, and go on your way.'"

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by Leslie Small

Study Shows Statin Gender Bias, Confirmed by Plan's Analysis

In keeping with recent research finding persistent gender bias when it comes to statin therapy, a Medicare Advantage (MA) plan in California found, after analyzing gender-specific data at AIS Health's request, that it, too, has similar discrepancies — and is working to address them.

According to research published in the April 24 *Journal of the American College of Cardiology,* women remain less likely than men to receive guideline-recommended, high-intensity statin therapy within 30 days after hospitalization for myocardial infarction (MI), despite efforts to reduce such disparities. Researchers looked at nearly 17,000 adults in the U.S. younger than 65 with commercial insurance and about 71,000 seniors ages 66-plus with Medicare coverage who were hospitalized for MI between 2014 and 2015. They found that 47% of women vs. 56% of men filled a high-intensity statin prescription within the 30-day post-hospitalization period.

> **What is of note, however, is the discrepancy we see in statin treatment and adherence rates between genders.**

SCAN Health Plan, a Long Beach, Calif.-based MA plan covering 195,000 members, is benchmarked on HEDIS and Star Rating measures, explains Sharon Jhawar, Pharm.D., the plan's chief pharmacy officer. "Statin Therapy for Patients With Cardiovascular Disease (SPC) is a measure recently introduced to the Star Ratings program," she says.

Jhawar notes that this measure focuses on the percentage of males 21 to 75 years old and females 40 to 75 years old during a given year who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria: Members were dispensed at least one high-intensity or moderate-intensity statin during the measurement year, and members remained on a high-intensity or moderate-intensity statin for at least 80% of the treatment period.

ASCVD is identified in two ways — by event or by diagnosis — and one component of this measure is statin use post-MI, she further explains.

"At SCAN, we see [an] approximately 50% higher number of men eligible for treatment vs. women for ASCVD — and this isn't unexpected," Jhawar tells AIS Health.

"The cohort of men is larger, given the greater age range, risks and disease prevalence. What is of note, however, is the discrepancy we see in statin treatment and adherence rates between genders. In 2017, for example, we saw:

- ***"Approximately 10% higher prescribing of statins in men vs. women (75.3% vs. 65.1%);*** and
- ***"Approximately 4% higher adherence rate in men vs. women (78.66% vs 74.68%)."***

"These results show us that there is a gap in care from treatment guidelines for both sexes with a greater disparity in women," Jhawar says.

"We at SCAN identify and share these gaps in care, irrespective of gender, and provide actionable data to our provider partners so it is easy for them to review and act on as appropriate," she says. "In addition, we share with them and educate them on the current treatment guidelines."

"We established a health equity work group within our organization just over a year ago and are in the early stages of understanding the disparities that exist in our specific population as they relate to race, ethnicity, sex, age, disability, etc. so that we may better address the needs of our seniors."

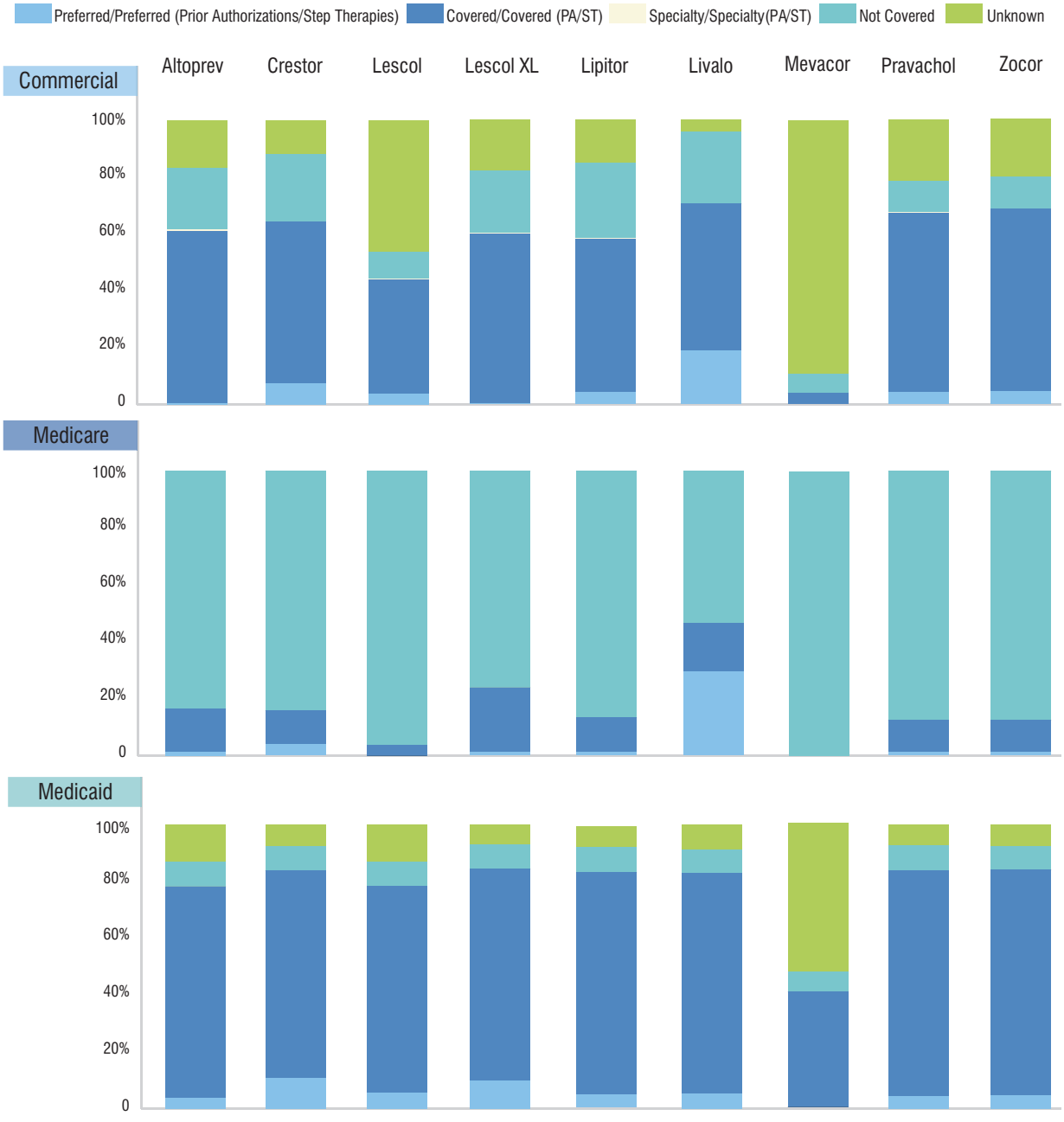
Find the study's abstract at https://tinyurl.com/ychrre5t. Contact Jhawar via Toni Galloro at tgalloro@scanhealthplan.com. ✧

by Judy Packer-Tursman

Current Market Access to Statins

by Jinghong Chen

Most private companies and Medicaid programs prefer or cover the use of statins with prior authorization or step therapy as of April 2018, whereas the majority of covered lives under Medicare programs don't have access to these medications. The chart below shows how the main statins are covered among commercial health plans, Medicare programs and Medicaid programs under the pharmacy benefit.



NOTE: The number of total covered lives is 184.7 million under commercial health plans, 40.5 million under Medicare programs and 63.9 million under state Medicaid and managed Medicaid programs. For Lipitor and Crestor, about 0.06% and 0.09% of covered lives are under the generic (preferred) tier in commercial health plans, respectively.

SOURCE: Managed Markets Insight & Technology, LLC database as of April 2018.

Dialysis Providers Are Under Fire

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However, Wanovich sees the promising results of the value-based contract with DaVita as a separate issue from the current spat over patient steering — which he acknowledges is a problem.

"As a payer we're not pleased with anyone that is promoting adverse selection for their own gain," he says.

According to an April 16 letter from America's Health Insurance Plans (AHIP), the Blue Cross Blue Shield Association, the Service Employees International Union (SEIU) and other groups, dialysis providers are doing exactly that.

The groups urge HHS Secretary Alex Azar to "take immediate action" to address the issue of dialysis providers inappropriately steering individuals with ESRD away from Medicare or Medicaid and into commercial coverage. Aiding this scheme, they say, are charitable assistance programs created by a "financially interested third party" — the American Kidney Fund (AKF) — that pay patients' premiums to entice them to choose private plans that have higher reimbursement rates.

AHIP also specifically singles out DaVita as a patient-steering offender. In an email about its letter to HHS, the trade group linked to a report from Benzinga that said about 60% of DaVita's pre-tax profit comes from patients with premiums funded by AKF, "which is heavily subsidized by charity donations from DaVita."

DaVita did not respond to a request for comment on AHIP's letter.

American Kidney Fund Responds

AKF, though, quickly shot back with its own letter to Azar, saying AHIP, SEIU and their allies are simply on a mission to force people with kidney failure off private insurance and onto government health programs. Charitable assistance provided to ESRD patients, the group says, helps them choose the plan that's best for them — whether it's public or private.

In fact, AKF writes, private insurance plans constitute a minority of its grant assistance — and more than 60% of what it issues helps patients pay their Medicare Part B and Medigap premiums.

Practice Can Harm Risk Pool

Chris Condeluci, principal of CC Law & Policy in Washington, D.C., tells AIS Health insurers are right that dialysis providers are making third-party premium payments to ensure patients are covered by higher-reimbursing private plans — "and therefore, the dialysis company benefits," he says.

Higher medical utilizers — like ESRD patients — are not good for a risk pool, Condeluci explains. "And if you have more and more high utilizers entering your risk pool because these third parties are paying premiums on their behalf, then you're going to have an adverse impact on the risk pool overall."

While he's been focused on the issue as it related to the Affordable Care Act (ACA) marketplaces, now employers are identifying a similar problematic practice, he adds — as evidenced by the employer groups that co-signed AHIP's letter.

Ashraf Shehata, a principal in KPMG's health care life sciences advisory practice, points out that such behavior can also impact efforts — made possible by the ACA and the shift to value-based care — to get better data on patient experience and outcomes.

"If those third-party payments are affecting or influencing the way the patients are being referred or moving through the system, I think that could be something that should probably be looked at," he says.

It's not certain, though, what the federal government actually can do about it. As the AKF letter points out, in January 2017 a U.S. district court judge blocked an interim final rule from HHS that would have made it more challenging for dialysis patients to use charitable assistance to buy private health insurance — reasoning that the rule might harm those patients since they may not be eligible for public plans.

Given that its previous attempt to regulate third-party premium payments didn't stand up to legal scrutiny, Condeluci says he isn't sure "what legal hoops HHS would have to jump through to be able to be able to make this stick," but adds "if there is a way, I think they'd do it."

California Bill Advances

At least one state isn't waiting for the federal government to act.

On April 18, the California Senate's health committee advanced a bill that seeks to "put an end to insurance schemes by profit driven businesses targeted at vulnerable individuals suffering from kidney disease and addiction," according to a statement from the bill's chief sponsor, Democratic state Sen. Connie M. Leyva.

Leyva's statement echoes the AHIP letter by outlining concerns about patient-steering practices. She also claims that some dialysis clinics have discouraged patients from seeking kidney transplants and adds that some drug treatments center providers "seemingly aim" to have patients relapse back into addiction in order to keep insurance

payouts flowing. The bill's supporters include Blue Shield of California and Service Employees International Union-United Healthcare Workers West, California Healthline reported.

UnitedHealth Group's insurance arm, UnitedHealthcare, meanwhile, has taken its concerns to court. On March 30, the insurer filed a complaint in the U. S. District Court for the District of Massachusetts against American Renal Associates LLC, alleging it violated state laws surrounding kickbacks and false insurance claims, according to a U.S. Securities and Exchange Commission filing made by ARA.

Those allegations were in connection with, among other things, "the submission of claims to United, the referral of patients to ARA clinics by ARA's nephrologist partners and premium payment assistance by the American Kidney Fund," according to the filing, which also noted that the

Rural Electric Co-ops Try to Spark Specialty Pharma Innovation

The National Rural Electric Cooperative Association (NRECA) administers health benefits to hundreds of consumer-owned, not-for-profit electric cooperatives, public power districts and public utility districts across the U.S. The association decided to implement a carveout for specialty drugs after it determined that its pharmacy spend accounted for about $100 million of $500 million in total annual claims paid — and specialty drugs comprised fully 35% of that pharmacy spend.

Starting in January 2016, NRECA began requiring that specialty medications be paid through the pharmacy benefit rather than the medical benefit, according to a case study in a white paper recently released by the American Benefits Council. Thus, the association was able to take advantage of deeper discounts available through its PBM. Also, patients were connected with the PBM's specialty pharmacy team to help improve their therapy adherence, and sites of care were aligned to ensure that medications were being dispensed in cost-effective settings.

"As part of its initial pharmacy claims analysis, NRECA's vendor identified the members with the highest drugs claims," the report says. "Before the new program was implemented, the vendor communicated with each of these patients and their providers to ensure that patients with serious health conditions were transitioned into the new program appropriately and without any gaps in care."

As a result, NRECA estimates that the plan saved about $1.3 million in 2016 by carving specialty medications out of the medical benefit and providing site-of-care alignment services. A figure for 2017 was unavailable since the association did not respond to requests for further information on its specialty pharmacy initiatives and estimated savings from the carveout.

However, Tracy Warren, an NRECA spokesperson, offers a sense of the scope of the association's health benefits administration. "We offer health care coverage to a little under 900 rural electric cooperatives as one of the benefits of being a member," she says, "and 60% do take advantage of that."

NRECA is not alone in its efforts. "I think the top two things that employers are focusing on is managing specialty pharmacy and managing high-cost claimants, and the two are related," says Tracy Watts, a senior partner and national leader for health reform at Mercer. Watts was a contributor to the council's report.

"From the employer perspective, a $1 million claim is big, but we're seeing claims much, much over $1 million,…and they typically do include some kind of specialty pharma driving that cost."

Mercer is testing strategies and using analytics to understand the care associated with specialty drugs in an effort to better manage costs, she says. For example, Watts says, if genetic testing is required before a specialty drug is tried, employers want to know whether such testing occurred.

"I would say all large groups are taking a closer look at their spend in pharmacy," Watts says. "I think that everybody is doing the analysis right now and…in the early stages of applying this. [Specialty pharmacy] will be at the top of the list for employers" for years to come.

See the report, including NRECA's case study, at https://tinyurl.com/ychv7ntx. Contact Watts via Bruce Lee at bruce.lee@mercer.com.

by Judy Packer-Tursman

provider "believes this lawsuit is without merit."

Collaboration Can Work

To Shehata, payer-provider discord is becoming increasingly uncommon as collaboration, integration, and mergers and acquisitions become the norm.

"I think if there's any animosity, it's kind of still in that space of maybe some of the historical models that we've seen — the separation in primary care and specialist care, the separation of the insurance model and the hospital model," he says.

Indeed, on the M&A front, UnitedHealth's Optum division inked a deal last December to buy DaVita's medical group subsidiary, DaVita Medical Group, for $4.9 billion.

Then there's DaVita's partnership with Highmark, which Wanovich says grew out of a discussion between the two organizations "about how we might work together to provide better quality of care for the dialysis community."

The result was a pay-for-value contract "layered on top" of DaVita's more traditional fee-for-service contract, Wanovich explains, so the provider gets paid to perform dialysis services and can share in the savings associated with improving outcomes and lowering costs — which the study shows DaVita was able to do.

Wanovich says the partnership was just one prong of Highmark's larger push toward paying for value, which spans multiple provider types including primary care and skilled nursing facilities. But the opportunity to improve dialysis care was a particularly compelling one for Highmark, since ESRD patients are a well-defined population who are typically high utilizers of health care and have frequent "touch points" with their dialysis provider, he adds.

"In this case you can really look at that dialysis provider as almost that primary point of contact that can really help facilitate working with that patient and getting different outcomes," he says.

Given that, Wanovich says he hopes other, similar partnerships crop up between payers and dialysis providers — though he notes not all providers have DaVita's capabilities.

"But the hope is that knowing that there are additional payments and incentives if you can move the needle, it will encourage other providers to act similarly and create the infrastructure that they need to really deliver better outcomes," he says.

Contact Shehata via William Borden at wborden@kpmg.com, Wanovich via Leilyn Perri at leilyn.perri@highmarkhealth.org and Condeluci at chris@cclawandpolicy.com. View the AHIP/SEIU letter at https://bit.ly/2HpxZ3A, the AKF letter at https://bit.ly/2Fe2Xpf, the California Healthline article at https://bit.ly/2J5c9Q0, Leyva's statement at https://bit.ly/2HtosUT and the Highmark-DaVita study at https://bit.ly/2HupsZe. ✧

by Leslie Small

News Briefs

✦ ***OptumRx's first quarter 2018 revenues grew 7.8% year over year to $16.1 billion, according to UnitedHealth Group's latest quarterly earnings report released on April 17.*** The company said its pharmacy services subsidiary's earnings from operations for the three months ended March 31 were $770 million, up from $653 million a year earlier. OptumRx fulfilled 332 million adjusted scripts in first-quarter 2018, growing 3.1% over the prior year, with a favorable mix in specialty pharmacy and home delivery services, the company said. During the earnings call, company executives reiterated UnitedHealth's intent, working in partnership with OptumRx, to support consumers in finding the lowest possible medication costs — and, toward that end, changing its practice as of Jan. 1, 2019, to apply manufacturer rebates at the point of sale of medication for seven million-plus fully insured members *(RDB 3/9/18, p. 1)*. Read the earnings report at https://tinyurl.com/ybwaonn8.

✦ ***A federal appeals court ruled April 13 that Maryland's anti-price-gouging statute for prescription drugs is unconstitutional, violating the Commerce Clause "because it directly regulates the price of transactions that occur outside Maryland."*** The Maryland law, which went into effect on Oct. 1, 2017, prohibits a manufacturer or wholesale distributor from engaging "in price gouging in the sale of an essential off-patent or generic drug." The U.S. Court of Appeals for the Fourth Circuit sided with the plaintiff, the Association for Accessible Medicines (AAM), a trade group representing generic drug makers. "As AAM has always maintained, this law, and any others modeled

News Briefs *(continued)*

from it, would harm patients because the law would reduce generic drug competition and choice, thus resulting in an overall increase in drug costs due to increased reliance upon more-costly branded medications," said Chester "Chip" Davis, Jr., the group's president and CEO. View the court's ruling at https://tinyurl.com/y74v2q8l.

✦ ***The Senate Health, Education, Labor and Pensions Committee advanced the Opioid Crisis Response Act of 2018, a bipartisan bill that was the product of a series of hearings about how to address the nation's opioid crisis.*** The bill, according to Sen. Lamar Alexander (R-Tenn.), will "help create an environment for states to succeed in fighting the opioid crisis" and includes 40 different proposals from 38 senators of both political parties, such as helping states improve their prescription drug monitoring programs, and spurring development and research of non-addictive painkillers. Read the press release at https://bit.ly/2qZN7JJ.

✦ ***America's Health Insurance Plans (AHIP) issued a statement applauding the Supreme Court's decision in the case*** **Oil States v. Greene's Energy Group,** ***which upheld a process called*** **inter partes review** ***(IPR) for patents.*** That process, AHIP says, can "prevent drug manufacturers from inappropriately prolonging patent monopolies past the time intended by Congress." Drug manufacturers wanted to scrap the IPR process, arguing it is a threat to innovation, Reuters reported. Read the Reuters article at https://reut.rs/2FgCNSI.

✦ ***Cigna Corp. and Express Scripts Holding Co. received a second request for information from the U.S. Dept. of Justice in the DOJ's review of their proposed transaction.*** The move extends the waiting period associated with the deal by an additional 30 days, but the request was not unexpected, as the companies factored it into their estimate for when the deal will close — which they still expect to occur no later than Dec. 31, according to a Securities and Exchange Commission filing by Cigna. View the SEC filing at https://bit.ly/2qX9UH7.

✦ ***Amazon has scrapped its plans to sell and distribute pharmaceutical products through Amazon Business, its marketplace for business customers, CNBC reported April 16.*** The biggest challenges include complexities around how to sell bulk to large hospitals and build a logistics network to handle pharma delivery, CNBC's sources said, adding that Amazon still could enter the pharma space in another way. Another barrier is the cost of building out Amazon's warehouse and logistics infrastructure, which currently isn't set up to store and deliver temperature-sensitive pharmaceuticals. Amazon Business has sold some supplies to medical clinics for several years and, the company told CNBC, already "serves healthcare customers of all sizes, from large IDNs [integrated delivery networks] to small- and medium-sized community hospitals. We also serve customers from physician and dental offices to senior living and long-term care facilities." Read CNBC's story at https://tinyurl.com/y8enh53t.

✦ ***In 2017, prescription opioid dosage volume declined 12%, marking the largest annual drop in more than 25 years of measurement, according to a report from the IQVIA Institute for Human Data Science called*** **Medicine Use and Spending in the U.S.: A Review of 2017 and Outlook to 2022.** In addition, after increasing annually from 1992 through 2011, prescription opioid volume averaged a 4% decline from 2012 through 2016 — a trend the report attributed to various regulatory and legislative restrictions, greater reimbursement controls and tighter clinical prescribing guidelines. Read the press release at https://bit.ly/2HXSOjz.

✦ ***The Pharmaceutical Research and Manufacturers of America (PhRMA) broke its record for spending in a single quarter by shelling out nearly $10 million on lobbying efforts between Jan. 1 and March 31,*** **The Hill** ***reported.*** During the quarter, PhRMA successfully lobbied against the CREATES Act, a bill meant to increase competition among generic and branded drug manufacturers that the trade group argued would have created "frivolous litigation." While that didn't make it into Congress's spending bill passed in February, the legislation did include a provision forcing manufacturers to pick up more of the tab to close the so-called "donut hole," a gap in drug coverage for Medicare Part D beneficiaries. Read the article at https://bit.ly/2Hr6p5K.