Executive Summary

US prescription drug costs are rising at a significant rate with spending on medications increasing 13.1% in 2014 alone, according to IMS Health, the highest level since 2001. Real per capita spending on drugs has tripled from $339 in 1995 to $995 in 2014.\(^1\) Much of the recent growth can be attributed to new innovative treatments for diseases such as hepatitis C, cancer, and rheumatoid arthritis.

In the midst of the publicity with regard to these sharply rising costs, it cannot be forgotten that cures and advanced treatments are now available that in many cases extend or save lives. Hospitals and health systems must grapple with a complex balancing act of maintaining profitability while allowing access to life-changing treatments for their employees. While the challenges can be formidable, hospitals and health systems are uniquely positioned to proactively address these rising costs.

This white paper will explore critical strategies hospitals and health systems should consider to manage pharmacy benefit costs while promoting employee health outcomes. The discussion will center on the vast array of clinical and pharmacy assets that exist within the walls of a hospital that, when properly leveraged, can result in significant value for both the organization and its employees.
Self-funded employers (including hospitals and health systems) often contract directly with a pharmacy benefit manager (PBM) to manage pharmacy drug costs for the entity. These services generally include the provision of a retail pharmacy network, processing and paying prescription drug claims and clinical services such as formulary development and utilization management. Formularies are developed by Pharmacy and Therapeutics (P&T) committees. This group of mainly physicians and pharmacists evaluates the efficacy versus cost of drugs that treat similar conditions and develops the formulary, a multi-tiered list of preferred drugs in order to encourage use of certain products.

While PBMs are necessary and provide value to the organization, it is important for a hospital or health system to recognize its own financial interests and that of the PBM are not always in full alignment. Two primary areas to consider are formulary development and clinical management.

Formulary Development

Pharmaceutical manufacturers offer discounts (rebates) off of the cost of a drug in exchange for favorable formulary tier placement. Traditionally, these rebates went directly to the PBM. More recently, some plan sponsors are negotiating to receive a portion of the rebate. Formularies in the simplest sense drive market share within a population of covered members for one drug over another as member out-of-pocket costs are directly correlated to formulary tiers.

Hospitals are uniquely positioned with P&T committees of their own who develop formularies for hospital patients. They are especially astute to the financial implications of the formulary as hospital reimbursement is often a bundled payment for a procedure or a daily rate. Consequently, the hospital does not receive additional reimbursement to cover a more expensive drug. Therefore, the financial interest of the hospital P&T committee is already in alignment with what is best for the organization unlike a PBM whose financial interest is most in alignment with its own
Leveraging your hospital’s pharmacy and clinical assets to offset rising pharmacy benefit costs

shareholders and therefore can conflict with that of the hospital.

Take for instance the usage of statins to treat high cholesterol. It is not uncommon for a branded drug to be on the preferred formulary tier due to negotiations between the PBM and manufacturer. However, this approach may not be in the best interest of the hospital. Even in a scenario where a hospital is receiving a full pass-through on rebates, which is rarely the case, a brand name statin may cost over $500 per 90-day supply. Despite a very substantial rebate, a preferred lower cost generic will be far more cost effective. Furthermore, a study published in JAMA Internal Medicine found no evidence to suggest brand-name statins are more effective or safer than their generic counterparts.²

In summary, hospitals and health systems should seriously consider in-sourcing the development of formularies for employee benefits as it could represent significant cost savings and improved patient outcomes.

Clinical Management

The cost of specialty drugs often ranges from a few thousand dollars annually all the way to $750,000 per year.³ Such tremendous costs require effective yet reasonable clinical programs to help ensure the right patients have access to the right drugs while avoiding inappropriate usage and waste. PBMs do offer their customers clinical management programs, but often further customization can yield improved results. For instance, specialty drugs are prime targets for clinical management strategies to prevent unnecessary use. However, the PBM is often financially incentivized to dispense specialty drugs as they also serve as the specialty pharmacy filling these scripts and receiving reimbursement.

The same internal P&T committee can assist in the development and assessment of clinical management programs to control utilization. Strategies that may be employed are as follows:

Quantity Limits and Split-Fills
This strategy is particularly effective with drugs that historically have a high change rate. For example, certain oncology drugs are often changed as they are not tolerated by the patient or possibly because the dosage needs to be adjusted. In a scenario where a drug costs thousands of dollars for a month’s supply, discontinuing after 2 weeks and starting a new therapy can represent significant lost dollars to the hospital. Limiting the quantity dispensed or splitting a fill can be extremely effective strategies to reduce unnecessary waste.

Prior Authorization (PA) Requirements
Nearly all specialty drugs require prior authorization from the health plan yet PAs can cause disruption and inconvenience to both providers and employees. The P&T committee can advise on what drugs make the most sense to require a PA for various clinical or financial reasons as well as in developing “smarter” clinical review criteria and processes that take into account patient medical histories and conditions to expedite reviews and eliminate unnecessary wait times/denials.

It may at times feel daunting to engage clinical employees to assist in the development of the employee pharmacy benefit. However, the potential savings available both to the organization as well as the employees’ out-of-pocket expense make this a more than worthwhile relationship to grow and develop.
Leveraging hospital-owned pharmacies to dispense medications can easily reduce pharmacy benefit costs by 10-20%. For some HR departments, there are concerns as to employee privacy, comfort and convenience. However, in light of the cost savings it is worthwhile for the HR and Pharmacy departments to work collaboratively to address the barriers in order to take advantage of the benefits.

Eliminating PBM Spread

One strategy that should be considered is for the HR department to directly contract with owned pharmacies and limit PBM involvement to only claims adjudication. In some scenarios, the PBM contracts with the hospital pharmacy allowing employees the convenience of filling scripts on location. However in this approach the PBM can generate a “spread” on prescriptions dispensed through hospital-owned pharmacies. This unknown profit goes directly to the PBM rather than to the organization or employee. When the HR department contracts directly with its own pharmacies, it eliminates the opportunity for the PBM to earn a spread on employee prescription claims.

Consider the significance of the spread when dispensing specialty drugs. Specialty spend may account for up to 40% of total drug spend by 2020, representing a significant portion of your pharmacy benefit spending. Spread is often a percentage of the cost – 2% of a $20/month maintenance drug is quite different than 2% of a $7,000/month specialty drug.

Sharing some or all of these savings with employees through reduced out-of-pocket expense can be an extremely effective strategy to offset the loss of convenience or privacy. Additionally, revenue is generated through the Pharmacy department back into the hospital.
Utilizing Supply Chain Advantages

Drug wholesalers redistribute drugs to purchasers like hospitals, pharmacies and physician offices on behalf of the manufacturers. While pricing is individually negotiated, there are certain pricing tiers established by manufacturers based on class of trade. Generally, hospitals buy drugs at an acute care class of trade rate that is lower than the rate retail pharmacies are able to acquire drugs. Hospitals may be permitted to dispense drugs purchased at this discounted rate to employees and their dependents.

A secondary program that applies to certain non-profit hospitals is the 340B program. Within this Federal program, qualified hospitals are able to purchase drugs at deeply discounted rates to distribute outpatient drugs to qualified patients. A hospital must comply with the regulatory requirements in this scenario to ensure the employee meets the qualifications of a patient under the 340B program. Due to the fact that a hospital saves on average 25-50% on outpatient drug purchases through the 340B program this can translate into substantial savings.

Drive employee engagement and wellness through dedicated clinical staffing practices

Hospitals should consider ways to make the owned pharmacies a preferred destination for care rather than simply less expensive or required. The hospital relies heavily on providers such as nurses and physicians to provide high quality care to patients and competes with a myriad of other healthcare organizations for this top tier talent. Dedicated employee pharmaceutical care providers can be tremendously effective tools.

Some hospitals staff dedicated pharmacists to go beyond filling a script to help manage chronic diseases, provide wellness services, close gaps in care and provide consultative services to help ensure medications are taken correctly. It is widely known that drug adherence and persistence, taking drugs as prescribed, are critical to the best health outcomes.
Leveraging your hospital's pharmacy and clinical assets to offset rising pharmacy benefit costs

Engaged, onsite pharmacists can help identify and mitigate issues that would impact adherence. These clinical employees are generally very aware of hospital formularies and can work directly with physicians and employees to encourage the usage of lower cost alternatives. Moreover, privacy firewalls can be established to help employees feel more comfortable using these resources.

Another effective strategy is to implement a program where staff pharmacists establish a care relationship with employees who are being discharged from the hospital. The pharmacist can help the employee understand new treatments as well as establish ongoing communication channels for future questions and concerns.

Lower costs and convenience can be effective tools for adding value to employees through onsite clinical services. Onsite delivery of medications, biometric screenings and disease management counseling are just a few of the ways to help establish the hospital as a preferred destination for care by employees.

Conclusion

Hospitals and health systems specialize in providing clinical services to people and are staffed with expertise that when utilized properly can bring tremendous value to the HR department. Additionally, internal clinical team members will be more concerned around developing programs that help to manage costs while remaining member-friendly for themselves, dependents and fellow co-workers than an outside organization. The clinical and administrative departments should work collaboratively to develop strategies that are in the best interest of the organization and its employees.

3 https://www.ahip.org/IssueBrief/Specialty-Drugs-Challenges-Issues/
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