Prescription Drug Benefits Redesign: Using Common Sense to Promote Value for All Stakeholders

This employer story is represented by a large, self-insured employer with approximately 40,000 employees

There has never been a time quite like today when the use of old fashioned common sense to design prescription drug benefits is more critical. There is a tsunami in the distance called the specialty drug pipeline and those who do not prepare now will suffer great losses. But.... we will save those details for later.

For now, you will be guided through a journey of possibilities. Over the last twenty years employers have relied on pharmacy benefits managers (PBMs) to tell them what their prescription drug benefits designs should include. There was no need to place the same level of attention on prescription drug benefits as was placed on medical benefits because the prescription costs comprised only 5-10% of total health care benefit costs and everyone knew their medical/surgical spends were the targets for intervention. A great deal of care was taken to make sure that proven methods of cost containment such as prior authorizations, utilization review, deductibles, co-insurance and disease management were solidly present in the medical coverage. But these were virtually absent in prescription drug designs and instead, we charged flat co-pays and allowed consumers to walk away with prescriptions for almost every imaginable condition without ever knowing the true costs paid by their employers, the correct way to use the medications, or importance of compliance to their treatment plans so carefully developed by their physicians. We assumed they would be wise consumers and thus read and understand the four or more-page insert of microscopic print given to them by their pharmacists.

We ignored the fact that most attempts at consumer education in the pharmacy consisted of a technician asking "Do you have any questions" and when the expected response of "No" was received, an acknowledging signature of naivety was required. The PBMs were also not assuming an educator role as their major focus was to make sure they developed formularies to guide employers in obtaining the best rebates from the drug manufacturers because a portion of those rebates were typically shared with the PBMs, in addition to the administrative charges already being paid by employers. After all, the more rebates obtained, the lower the administrative charges would need to be….right? The only flaw in this theory was a reduction in administrative fees was a rare occurrence and even the savvy employers had only a minute chance of figuring out the rebate process and assuring they were getting their correct share. We walked away from our meetings with the PBMs to assure our leadership that we were receiving substantial savings from our PBM contracts. The problem with this story was we were paying for illness rather than paying for health.

It was not until the early 2000's that employers started to notice their prescription benefits cost trends were steadily climbing as the drug manufacturers began to advertise their products directly to consumers. Television commercials, magazine and newspaper ads were full of reasons why their drug was the best drug and using it would allow one to dance through a field of flowers or lounge on the beach hand in hand. The marketing strategies worked and consumers began to walk into the physician's office with a clear decision about what "me too" brand medications they needed to walk out with. With only a flat co-pay and very little cost difference for choosing a non-formulary medication, why would they even consider one of the proven older medications that had worked well for their parents or grandparents?

A Day of Reckoning

It was a cold and windy day in 2002 as I stood in line at the local retail pharmacy waiting for the antibiotic that would cure my bronchitis. A co-worker approached to chat. She was there to fill her prescription for hormone replacement therapy to ease her hot flashes. We were both called and ended up paying almost exactly the same amount for our prescriptions. As I was driving home, it hit me…I paid about the same amount for a prescription to restore normal

functioning of a body system that is essential to life as she paid for a prescription to ease the symptoms of a normal body process that in no way threatened her life or the functioning of a body system essential to life. Where was the common sense in that? If employers are to continue offering affordable prescription drug benefits, we must carefully examine our current designs and return to the basics upon which our designs evolved.

As with medical benefits, prescription drug benefits are not designed to cover every condition. They were developed to financially assist our employees in obtaining medications primarily used to preserve life or functioning of major body systems essential to life. We want our employees and their family members (the consumers) to avoid the hazards of acute and chronic illnesses that negatively impact their quality of lives and inhibit the achievement of maximum productivity. We want to assist them in curing their infections, reducing their pain, lowering their cholesterols and blood pressures and maintaining normal blood glucoses; as doing so provides great value to our employees as well as our companies. While medications that cure acne, toe nail fungus, impotence and hot flashes may provide some value to consumers, they provide little if any value to employers. Why then, should employers cover such medications in the same ways as those of shared value? Why should full coverage be provided for prescription medications with multiple over-the-counter equivalents? For example, should our benefits dollars be used to fund prescription proton pump inhibitors when the majority of consumers are incorrectly using them on a daily basis for treatment of intermittent indigestion that could effectively be tackled with dietary improvements and the many over-the-counter products available today? Can we return the focus to the principles upon which prescription benefits were established? Can we develop a benefits design based on shared value that achieves intent and is accepted by employees with little or no noise? These are the tough questions we must ask ourselves, our leadership and our employees.

Our business leaders trust us to look for opportunities in benefits design that will achieve our business goals without placing significant burdens on our employees. Our decisions must be data driven and easily understood. We must consider the positions of all stakeholders and be ready to answer their challenging questions. This is often more difficult than expected when dealing with benefits based on the achievement of clinical outcomes. We must call on those best trained to understand the pharmaceutical maze…the PBM's account manager and lead

clinical pharmacist. We must ask them to take off their PBM hats and walk with us down a visionary path where the words "we can't" get replaced with "we could, if". This can be accomplished for both self-insured and fully insured healthcare plans. We can convince our PBMs to work with us to develop a benefits design that actually achieves the goals of our consumers and our companies and can be successfully marketed to other customers of the PBMs who will recognize and appreciate their efforts to meet our companies' business goals. You start by understanding what your consumers are buying today. What are the leading medications in terms of both volume and cost? Are the top 25 lists for both variables more heavily weighted by medications that achieve outcomes of value to both the consumers and the employer or are they heavily weighted with the "me too" medications of the year? In other words, are they both primarily lifesaving drug lists, or does one or both contain more convenience medications? If convenience is present, our question needs to be "How could we change the game so we are paying for health rather than convenience?"

The answer lies in returning to the basic principles of prescription benefits design. First, we must work with our PBM's clinical pharmacist to identify the classes of medications not primarily used to preserve life or major body system functioning and thus are of little or no value to the employer, as well as those that may achieve outcomes of some value to the employer, but the same outcomes can also be achieved through alternative means. Examples include: contraceptives, nail fungus treatments, hormone replacements, non-sedating antihistamines, acne treatments, proton pump inhibitors, weight loss enhancers, smoking cessation enhancers, sexual function enhancers, fertility enhancers, hair growth aids and skin enhancement agents. Next, we establish principles of shared value upon which employer funding should be based for these classes. For example, it makes little sense for the employer to provide financial assistance for obtaining medications that provide value only to the consumer, such as those primarily used to enhance sexual function, hair growth, and skin appearance.

In addition, while one may argue that acne, nail fungus, and menopause are inconvenient medical conditions, they typically do not threaten life or major body system functioning and should not be funded in the same manner as conditions that do. While there is general agreement of value to both the consumer and the employer to avoid pregnancy or treat

obesity, nicotine addiction, allergies and indigestion, there are highly effective and much less costly alternatives to achieve these outcomes. Why then, should the employer pay the majority of the cost of a medication such as a brand name drug for allergies when the same outcome can be achieved by taking a regular OTC antihistamine at bedtime or one of the many OTC non-sedating antihistamines that once were leading branded prescription medications? It would seem fairer for the employer and the employee to split the cost evenly or even for the employee to assume the greater cost share when they choose specific prescription medications over the less costly alternatives. It is not uncommon for employers to charge employees the cost difference between a generic medication and a multi-source brand medication, so why not do the same when very similar clinical outcomes can be achieved through less costly means?

While this shared value approach to prescription benefits design seems simple, there are a few watch-outs to consider. For example, we must determine if there are legal implications that can complicate the design simplicity and move medications out of the realm of consideration. We are all very much aware that health care reform legislation now requires prescription contraceptive methods to be covered at 100%, and thus the law overrules the principle of shared value. In addition, the inability to think clearly or reproduce were recently deemed disabilities and thus care must now be taken to assure that coverage of adult ADD treatments and fertility enhancers is equal to that of the majority of other medications.

It goes without saying that legal review of prescription benefits design is a must and should occur as one of the first, rather than last steps in the design approval process. The early teamwork of employers' and PBMs' legal resources can help avoid many future headaches and rework.

Medications with multiple indications comprise another area of complexity. The clinical pharmacist can assist in identifying the medications that are most likely to require special attention to determine the appropriate member cost share. For example, the allergy brand name drug is approved for the treatment of asthma as well as allergies. Asthma can most definitely threaten life while seasonal allergies are more of a nuisance than a threat. The PBM can program their system to check for other prescription asthma treatments and when detected, automatically apply the lower member cost share for the brand name drug.

There are, however, some situations that will require prior authorization to determine the appropriate cost share. For example, antifungals are used to treat systemic fungal infections as well as nail fungus. While systemic infections may threaten life, nail fungus is typically nothing more than an unsightly nuisance. There is no diagnosis indicated on the prescription so prior authorization is required to determine the purpose of treatment with antifungal medications. It pays to work with the clinical pharmacist to identify medications with multiple indications and proactively develop systems to reduce consumer frustrations and appeals. While prior authorizations and appeals can result in added costs, they also create a sense of fairness and security for employers and consumers. Prior authorizations are imposed by employers to assure that the right medication is prescribed for the right patient, at the right dosage and time. The authorization process may also include step therapy to assure that less expensive but equally effective alternative medications are used prior to the newest "me too" brands. Appeals are imposed by law to assure that a patient's special circumstances are given consideration by those making coverage decisions.

It is important to regularly review the list of PBM recommended medications requiring prior authorization and require reporting of the return on investment provided by the process. A moderately priced medication that is consistently approved for use produces little return and does not belong on the list. It is also wise to negotiate the lowest possible price for prior authorizations and appeals before implementing a value-based design and require that the pricing be held for several years after implementation.

It takes time for consumers to adjust to value-based design but the number of appeals will decrease over time. The consumer usually initiates an appeal, but the treating physician should provide the required medical history to support an appeal approval. It is important to assure that the PBM has a robust appeal review process as there are only a few valid reasons why a particular medication would be required over other available alternatives. The most obvious reason would be that the alternatives have already been tried without success. This can be validated through a step therapy look back process coupled with physician documentation. The occurrence of intolerable side effects or allergies with one alternative medication is not reason to exclude all other alternatives. Although a physician may attempt to gain approval for step jumping by arguing that an alternative medication is not as effective

as the newest flavor of the month, there are only a few circumstances where research has proven this to be the case. A request by the PBM for published research confirming this assumption is usually all that is required to calm a raging bull.

Establishing Leadership Buy-In

So we have identified the medications to target, worked through the potential barriers, and confirmed that the PBM has all the right systems in place…are we ready to seek leadership approval? Not quite! The first question we will be asked is why should a change be implemented that is different from anything ever done before and has potential to create significant noise in the system? The answer is because there are substantial savings in benefits spending to be gained and those savings can be redirected into a design strategy that fosters compliance to pharmaceutical treatments of the chronic diseases that are driving the medical costs. When consumers are faced with 50% or more cost share for convenience medications, they will seriously reconsider whether the convenience is worth the cost. Suddenly the tiny $180 bottle of Penlac to paint on toe nail fungus is not as appealing when the consumer's cost changes from $20 to $60 and the investment in a portable fan for the purse starts to make more sense when the monthly cost of hormone replacement therapy doubles.

Utilization of convenience medications plummets when a value-based design is implemented and those who do continue to use the medications have greater appreciation for the true cost of drugs and the benefits provided by their employer. We pay our PBMs to maintain the actuarial systems to predict the impact of design changes, so now is the time to use the available resources. Our leadership needs to understand the potential savings involved and decide if these savings need to be kept to support current business deficits or can be reinvested to improve clinical outcomes and avoid longer term medical costs.

Companies such as Pitney Bowes and Procter & Gamble have already established the value of lowering employee cost share to improve medication adherence and medical and nursing journals are full of research about the benefits of using carved out disease management programs to improve clinical outcomes. So why not propose the use of savings from value-based design to fund a powerful wedding of the two? Imagine the consumer of the future who

not only completely understands the long-term value of treatment compliance, but also realizes their employer cares enough to make sure they can afford to be compliant. One only needs to explain the cost of one hospitalization for a heart attack caused by poor control of cholesterol or the ongoing costs of kidney dialysis required for uncontrolled diabetes to get leadership buy-in to a design aimed at improving clinical outcomes. Our data is there waiting to be mined. We should review medical cost data as well as disability data to identify the key chronic diseases driving the losses in quality of life and productivity. There will be many we will expect to see, but there may also be some we did not anticipate. For example, we may discover that depression is one of our top drivers. We will need to narrow the list to be able to focus our efforts. It is best to choose the diseases that often result in co-morbidity. For example, uncontrolled hypertension will ultimately result in heart failure, kidney failure, stroke and damage to the blood vessels supplying other vital organs and extremities. The annual hospitalization costs for these complications are certainly enough to convince a doubting chief financial officer.

But wait, aren't we already paying per employee per month or per member per month administrative fees to our medical carrier to improve clinical outcomes through case management and disease management? When was the last time we received a detailed report of the type and number of cases managed, and were the program results validated using the methodology explained in publications by Al Lewis, the one person brave enough to tell some disease management kings they have no clothes? No worries, we already know the answer!

Let me make this easier. We simply ask our medical carrier to provide a list of all of the cases in the previous plan year that cost $50,000 or more. We do not need any details other than the primary diagnosis and the scrambled case number assigned by the carrier. Once we receive the list, we give it back to the carrier and ask for identification of all cases that received case management or disease management as they are defined in our administrative contracts. When we receive the pitiful results, we do a quick calculation of the dollars spent in the last plan year to fund case management and disease management (these really should be itemized in the overall administrative fee). Now we ask …what in heaven's name did we pay for and could the disease management dollars be better spent by paying for the services of a vendor that actually specializes in disease management and health promotion? Add these

dollars to the expected savings from the value-based prescription drug design and we can now present the sources of funding needed to support a robust wellness program aimed at meeting the needs of all of our consumers, regardless of their position on the healthy to unhealthy continuum.

The Toughest Sell

We are almost there, but we have yet to close the deal with our toughest judge…the consumer. It should be no surprise that consumers have little understanding of the total costs of the prescription drug benefits they enjoy. We have, after all, designed it to be so!

- Consumers have no idea about the distribution of drug classes used by those covered by the plan. Why then would we expect them to believe anything other than every prescription written should be covered in the same manner, regardless of intended outcome?
- Why would we expect them to understand that employer funding of convenience medications ultimately ends up hurting them because their cost share for health care benefits increases as the costs to the employer increase? We cannot expect them to understand these important points unless we tell them about them!
- They need to know how many employees are out of work because of the long-term complications of poorly controlled chronic diseases and how much it costs to fill in for these employees while they remain employed and receive disability and health care benefits.
- They need to know the annual dollars being spent by employees and the employer for the most common classes of convenience medications.
- They need to understand that their health care premiums, co-pays and co-insurance are being increased each year because cost share goals require their share to increase along with the employer's share.
- They need to understand that just as the medical benefits for hospitalization do not cover items of convenience such as plasma televisions and gourmet meals, the prescription benefits should not provide the same level of coverage for convenience medications as is provided for the medications that keep us alive and productive.

Once these concepts are clearly articulated, then and only then can the details concerning the new value-based design be provided.

Communicate, Communicate, and Communicate Again

As the details of design are shared, there will be numerous reasons offered for why the coverage terms should not be applied "to me". The key to working through the issues is a return to the questions of whether a particular medication is primarily used to preserve life or functioning of body systems essential to life; and whether there are other treatment alternatives that are less expensive but effective in producing similar clinical outcomes. The consumer needs to be reminded that a no answer to the first question or a yes to the second creates a need for a choice and if the choice is to use the targeted medication, it is also a choice to pay a greater share of the cost. There should be no guessing required concerning the medications that have been deemed for convenience.

A list of the classes of medications as well as the current medications in each class should be developed by the PBM's clinical pharmacist, made available to all employees and family members and updated on a regular basis as new medications are released or older medications become available OTC. The list should have a qualifying statement that explains the possibility of updates as changes occur in the market. As changes occur, the PBM should provide documentation of programming changes to assure that all members receive the same level of coverage at the same time. If the decision has been made to decrease member cost share for specific chronic care medications at the same time as the increase in cost share for convenience medications, less confusion will occur if we divide medications into the following four groupings:

1. Lifestyle-Enhancing medications used primarily to enhance one's ability to perform/achieve a lifestyle related activity/goal. These are medications such as Viagra, Chantix and Retin-A. *All or the greatest amount of cost for these medications would be assumed by the consumer.*
2. Convenience medications that produce outcomes not directly associated with the preservation of life or the normal functioning of body systems essential to life; or medications with one or more less costly treatment alternative that results in similar

clinical outcomes. Examples include Nexium, Clarinex, Provera, Testosterone, Penlac and Ambien. *The consumer and the employer at least share equally in the total costs of these medications.*

3. Life-Preserving medications directly associated with the preservation of life or functioning of body systems essential to life. This is the largest of the groupings and includes medications for treatment of conditions such as infections, pain, seizures, depression and cancer. *Typically, the employer would assume the greatest amount of cost for these medications.*
4. Business-Preserving medications used to treat controllable chronic health conditions resulting in the highest levels of lost work time and long-term disability. This is typically the second largest grouping and includes medications for treatment of conditions such as hypertension, high cholesterol, diabetes, and asthma. Consumers are likely to question why the medications they use to treat chronic conditions may not be included in the Business Preserving grouping. It is important to clearly explain that the Business Preserving medications are selected based on current data concerning employee lost work time and disability, and as other conditions become leading causes, the list may change. It is also important to reinforce the message that a value-based prescription drug design is based on the level of shared outcome value between the consumer and the employer. It may take several communication attempts before consumers begin to understand and accept the common sense behind the fact that the employer should pay more for medications to control the major chronic conditions that keep employees out of the workplace, as these medications have the greatest value to the employer. *These medications would have the lowest level of consumer cost share or no cost.*

Another common question that may be asked by leadership is if it would make more sense for the employer to cover more of the cost for Business Preserving medications used only by employees. The answer is two-fold. First, if an employee is worried about the well-being of a family member, they cannot fully focus on their work. Second, HIPAA antidiscrimination legislation allows differences in coverage only when the difference is applied to all like individuals. While it could be argued that employee status is a qualifier for like individuals,

the value of controlling the chronic conditions driving lost productivity far outweighs the added costs of including all covered members with specific diagnoses. The fairness factor goes a long way toward overall acceptance of the design change.

Implementation

A seasoned human resources manager knows that regardless of how many times a change is communicated, there will always be individuals who believe the change does not apply to them and therefore pay little attention. One way to deal with this phenomenon is to have the PBM complete a 6-12 month look back and send personalized letters to each consumer with a history of use of the targeted medications. The letters should include the names of the medications, the date of the planned change, as well as the approximate cost differences to be expected. While the PBM may be reluctant to execute such a time consuming communication effort, this step will significantly decrease the amount of post implementation follow-up required. The approximate cost difference may be best handled through use of an online pricing tool that adjusts for market cost changes as well as informs the consumer of alternative medications.

It is also useful to seek the assistance of a consumer sensing team (e.g. team of employees, spouses, friends) to develop a series of questions and answers to include with the letters. In the case of convenience medications, a last minute benefits rush should be expected with budgeting to cover it. The PBM's call center representatives should be well trained prior to announcement of the change and again just prior to actual implementation. A special flag should be entered into the PBM's system to alert the representative of the unique design. The entire list of impacted medications and the predetermined questions and answers should be readily available to the call center representatives, consumers and key employer resources. While the majority of questions will occur within the first two months of implementation, it would not be uncommon for the questions to continue for three or more months as those using mail order pharmacies begin to seek prescription refills.

Measurement of Results

The planning of results measurement needs to occur during initial design discussions with the PBM. The standard reporting tools will not fully capture the data needed to convince leadership that the design is the driver behind the improvements in clinical outcomes and costs. Since there may be multiple business factors that can contribute to improvements, it is essential that member utilization of the targeted medications is measured pre- and post-implementation. The pre-measurement period should span several years prior to implementation and focus on utilization by continuous users of the targeted medications. This will establish an average medication possession ratio that is not significantly influenced by incidental business events such as increased hiring or downsizing. The post-implementation measurement should not begin until completion of at least 6 months of experience. Again, the medication possession ratio of the continuous users will solidly establish design outcomes. The decreases in use of Convenience Medications could be expected to be 20-60%, depending on the type of medication.

The PBM can calculate the dollar value of outcomes compared to previous use. It is possible that the savings associated with reductions in use of Convenience Medications can fund the increased employer costs for greater coverage of Business Preserving Medications thereby producing an employer cost share similar to the pre-implementation level. Further measurement should include comparisons of the PBM's book of business for similar sized employers in terms of medication possession ratios for the targeted medications. As the ratios for the Business Preserving medications increase there should over time be corresponding reductions in emergency room visits and hospitalizations associated with targeted diseases. The medical benefits administrator should be prepared to provide analyses of these rates for consumers remaining covered throughout the measurement periods.

Back to the Tsunami

For many years, benefits managers have remained astonished that 5% of covered consumers will often incur 80% of medical benefits costs. It will not be long before the same will be true of prescription benefits, as biologically engineered specialty medications will make-up the entire lists of the 50 top medications based on cost and possibly utilization. In 2011, specialty

medications comprised a mere 1% of utilization but often close to 46% of medical and pharmacy drug costs. The changes we should expect for the future are increases in utilization and costs. It only takes a few incidences of diseases such as Cystic Fibrosis treated with medications such as ~$830 per day Kalydeco for a cost trend explosion.

Over 50% of the medications currently in the pipeline are specialty medications and over half of these are indicated for the treatment of cancers. With cancer being one of the most feared diagnoses, consumers are not going to easily tolerate traditional pharmaceutical protocols such as step therapy. They will demand to be immediately treated with the perceived "best-in-class" medications and employee relations issues and litigations will be abundant if they face barriers. Is the consumer at fault? Absolutely not! These medications work very well and help avoid costly hospitalizations when the right medications are prescribed for the right patients, at the right dosages and times. The key is the word "right".

There are common sense steps that need to be taken today to limit the possible damage of tomorrow. The first step is to determine what is happening today. What are the current utilizations of Specialty Medications in the prescription and the medical benefits arenas? The prescription benefits analysis is rather simple because we are researching utilization and costs of well-defined and typically self-administered medications obtained from retail, home delivery and specialty pharmacies. The medical analysis is much more involved because we must include not only the medications, but also all of the associated expenses for administrative supplies and the actual administration charges. The specialty medications being covered under the medical benefits are typically not self-administered and often require intravenous administration with medical monitoring.

We have heard stories about excessive mark-ups on the costs of the specialty medications obtained through the medical benefits. This may be more of an issue when there is carve out of prescription benefits administration from medical benefits administration. Our medical benefits administrator must do the job we are paying them to do in order to avoid this. There are established reasonable and customary charges for purchase and administration of specialty medications. It is a matter of attention to detail. There are facilities that specialize in the acquisition and in-home or facility administration of specialty medications. If our

consumers primarily reside in only a few locations, it may be beneficial to investigate a contract for use of one of these. The facility staff provides individualized case management resulting in high quality outcomes. Our best pricing will be obtained when we agree to the facility having exclusivity for purchase and administration of the medications. This is difficult to implement when employees reside in multiple locations across the U.S.

Our design for self-administered specialty medications should absolutely require the acquisition of the medications from Specialty Pharmacies. The PBMs and medical benefits administrators typically have Specialty Pharmacies, and there are independent ones. The key is to avoid on-going use of regular retail pharmacies for the purchase of specialty medications. Specialty Pharmacies employ highly trained pharmacists and nurses who provide individualized case management that is specific to the type of medication being used. They stay in frequent contact with the patient and the treating physician to assure that barriers to optimal clinical outcomes are immediately addressed. They become the trusted confidants for the patient and their family. They also prevent waste by monitoring the patient's medication inventory to assure that refills are only sent when needed.

This typically does not happen when medications are obtained through retail pharmacies, especially those that use automatic refill systems. Consumers who change from a retail pharmacy to a Specialty Pharmacy will often say the difference in quality of care is like night and day. This is not because retail pharmacies provide poor quality services. They are designed to provide excellent services for the acquisition of acute and chronic non-specialty medications. The demand for their services simply does not allow for the time consuming case management required to achieve high quality outcomes from specialty medications. The required use of a Specialty Pharmacy does not have to create employee relations issues. When consumers are diagnosed with conditions that require Specialty Pharmacy use, they are frightened by their diagnoses and want to begin treatment immediately. They may also be unaware of our required Specialty Pharmacy use design because until now, they had no need to pay attention to this design feature. The requirement can cause extreme frustration when they visit the local retail pharmacy to obtain their medication. It is therefore best to allow at least one fill and possibly one refill of the medication at the retail pharmacy as this avoids frustrating delays in treatment.

This does not, however, mean that brief delays should not occur in order to complete required prior authorization and step therapy assessments. The retail pharmacists are electronically alerted by the PBM when these processes are required and they typically handle the notification of the treating physician of the need to contact the PBM. The PBM messaging should request that the pharmacist inform the patient of exactly what is happening and explain that the length of the delay will depend on how quickly their physician responds to the PBM with appropriate information. This will usually prompt the patient to call the physician's office to request timely action. With the first retail fill, and the refill if allowed, the pharmacist should be electronically alerted by the PBM to advise the patient of the requirement to use the Specialty Pharmacy for refills and provide the patient with the telephone number of the Specialty Pharmacy. In addition, the PBM should immediately generate a letter to the patient that explains the requirement.

Once contacted by the consumer, the Specialty Pharmacy does the work to get the prescription transferred. There are some specialty medications where longer delays in treatment must occur in order to assure the right patient is receiving the right medication at the right dosage and time. These are typically the medications that are only effective in specific dosages for patients with specific genetic markers and thus pharmacogenomic testing should be completed prior to initiation of treatment. One would think physicians would complete this testing before initiating therapy, but this is not always the case. There are some that prefer to gradually initiate therapy and assess for response because pharmacogenomic testing is often costly and many outdated medical benefits plans exclude all forms of genetic testing, leaving a very upset patient with the bill. The bottom line is if pharmacogenomic testing is indicated, it should be completed prior to initiating treatment. Our PBM should make sure it is and our medical benefits plan should be updated to provide coverage. The costs of the testing are far less than the cost of ongoing treatment with a specialty medication that will never be effective for the patient.

It is important to understand exactly what programs the Specialty Pharmacy offers in terms of management of specialty medication use and include them in our design. For example, assessment for physician use of evidence-based medical standards may or may not be a part of the standard prior authorization process. There may be a separate specialty guideline

management program that assures evidence-based standards are being followed and requires periodic reporting by the physician of clinical outcomes to assure ineffective treatments are not unnecessarily maintained because of reasons such as the patient missing assessment appointments. The case management provided through the Specialty Pharmacy coupled with a specialty management guideline program should totally eliminate this type of waste.

A Few Last Words Concerning Common Sense

I would be remiss to not include the most obvious common sense approach to prescription benefit design… informing the consumer of the real cost of their medications, how much of the costs are being paid by their employer and how their employer's costs directly impact their personal costs. It is amazing that some of the largest retail pharmacy chains provide consumers with receipts that only identify the consumers' costs even though their systems contain information about how much the consumer paid as well as how much their self-insured employer or fully insured plans paid. There are various business reasons for this, but we must make absolutely sure that consumers know the entire costs of their medications. While consumers can typically access their PBM websites for this information, they usually do not. It makes sense to have the PBM send at least bi-annual statements to each consumer that inform them of their itemized costs as well as the employer's or plan's itemized costs.

Consumers should also be taught the relationship between increases in the employer's/plan's costs to increases in their overall health care costs that will be seen in their future premiums, co-pays, deductibles and co-insurance; as well as the impact that prescription benefit cost increases have on sustainability of the employer's business and therefore their future success.

It should be clear to the consumer that they have a very important role in the partnership to preserve the quality of their healthcare benefits. At a minimum, they should understand the following eight great questions to ask their physician before a prescription is written:

1. What is this medication supposed to do for me?
2. Do you know which medications I am already taking and what I am allergic to?
3. Are there food, drinks, other medications or activities that I should avoid while taking this medication?

4. What should I do if I miss a dose?
5. What should I do if I accidentally take too much of this medication?
6. Are there any side effects that may create the need for me to stop taking the medication?
7. How often should I take the medication and how many refills will I have?
8. Is there an alternative treatment or a less expensive medication that could achieve the same desired effect?

The last question is critical as even today there are physicians who ask their patients if they have an insurance drug card and the answer is a major contributor to the medication prescribed. Since most physicians are insured under fully-insured health care plans, they typically do not receive much information about prescription drug costs or cost trends and do not understand the impacts of these on their patients' overall healthcare benefits costs.

If their patients ask question #8, they often will be reminded to use the tools provided to them by the PBMs to identify medication costs and treatment alternatives. Even if they do not access the tools, they are more likely to consider starting treatment using an older generation generic medication and ramping up to the newer brands only if needed. Consideration might be given to providing consumers with an inexpensive wallet card that contains the eight great prescription questions on one side and the following eight great diagnostic testing questions on the other:

1. What kind of information will this test provide that you do not already have?
2. Do I need to have this test before you can determine if I need treatment or what type of treatment I need?
3. Is this test the only way to obtain the needed information?
4. How accurate is the test?
5. Are there any special steps that I must take to prepare for the test?
6. How is the test performed?
7. How long will it take to get the results and how will I get them?
8. What can we do to be sure that all of the providers who will be involved in my test are network providers?

At the End of Our Journey I promised to guide you down a journey of possibilities and I hope I kept my promise. While we stopped at many of my favorite locations along the way, we by no means visited them all. I hope you are leaving this journey with an understanding that common sense can and should be used to design prescription benefits. This can best be achieved by partnering with your leadership, your PBM, your medical carrier and last but certainly not least, your consumers. And don't forget, there are always more tour guides to contact and paths to follow!