BUILDING A SMARTER EMPLOYER

In a system of healthcare financing that largely doesn't work for specialty drugs, the Midwest Business Group on Health is leading an ambitious initiative to educate and empower employers. The project's scope and potential outcomes are unprecedented.

BY MICHAEL D. DALZELL

It could be argued that when it comes to health benefits, employers — not health plans — are the real innovators. "Employers essentially built the wellness industry," says Cheryl Larson, vice president at the Midwest Business Group on Health (MBGH). "Employers had hoped health plans would do it, but they didn't."

Larson ticks off the accomplishments of the business community. "Some 'cannonball' employers have worked with their PBMs and said, 'This is the benefit design I want,' and the PBMs [pharmacy benefit managers] said, 'Gosh, that makes sense' and used that knowledge with other clients." Ditto for cost comparisons. When health plans didn't answer their customers' requests for comparative charges of, say, a colonoscopy, employers fostered the growth of an industry of cost-transparency vendors, Larson says.

And for a while, it all worked. But the migration of midsize and smaller employers from the fully insured to the self-insured market coupled with the high cost of biologics means the employer-as-insurer is on its own in navigating a healthcare environment driven by fast-paced technological advances. Suddenly, even progressive employers are realizing they don't know what they need. And one misstep could be very, very costly.

Into these uncharted waters enters a coast guard escort: MBGH. In what may be the largest employer-education blitz of its kind, MBGH is moving into the second year of its Biologics and Specialty Pharmacy National Employer Initiative. Through educational initiatives and demonstration projects, MBGH is determined to build a smarter employer — one who is equipped to manage biologics and specialty drugs effectively.

Getting their attention

The starting point for MBGH's initiative was last year's survey of 120 midsize and large employers: 78 percent said they had, at best, a moderate understanding of specialty pharmaceuticals, and a sizeable chunk admitted to little to no understanding (see "Don't Know Much").

"Employers don't know much about these drugs because employers aren't clinicians," says Randy Vogenberg, RPh, PhD, principal at the Institute for Integrated Healthcare and co-founder of Bentelligence, who is partnering with MBGH on this project. "A lot of things you would assume they know, they don't."

Case in point: The vast majority of employers surveyed last year had no idea what they spent on specialty medications. "When you talk with a lot of employers," Vogenberg says, "they say, 'I'm guessing.'"

When trying to help employers understand what biologics will mean to them, Vogenberg knows how to work a room. The first thing he shows them is how the mix of conventional and specialty drugs will change in the coming years. "They see reports of what their top 10 drugs are and where they spend money. So, when you go from two or three biologics in the top 10 today to six or seven by 2015, that's a 50 percent or greater shift. You get their attention at that point." Then Vogenberg talks about how biologics come with their own financial booby traps: molecular diagnostics, drug-delivery devices, office visits to monitor therapy, adherence programs. "Now it's more like a hospitalization, with a lot of pieces to it," he says. "And you get their attention even more."

Building smarter employers starts with teaching them to fish, so to speak. "Employers tend to focus far more on medical benefits than pharmacy benefits," says Cheryl Larson of MBGH, "and that needs to change."

The topper comes when Vogenberg introduces the pace-of-change concept. Gone are the days of gradual, predictable change in healthcare. Today, new therapies are introduced every month — even as employers try to stay on top of healthcare reform. "It's like shaking up a soda and it starts to spill all over the place. That's what's going on," he says. "And they're just flabbergasted."

Employer toolkit

With the exception of a handful of progressive purchasers, the

audience Vogenberg describes is MBGH's starting point for building the smarter employer.

Daunting? Maybe. Doable? Larson is determined to make it so.

The MBGH initiative consists of four workstreams to be implemented through 2014 (Figure, page 8). The employer survey is a baseline for determining what goes into Workstream 1: a freely accessible online employer toolkit. The toolkit will be rolled out in three sections, which will be presented in interactive, user-friendly modules.

The first section, expected to go live by the end of this year, is about education and awareness. "This section talks about where are and where we need to go," says Larson, "a Specialty Pharmacy 101." It includes downloadable PowerPoint presentations for human resources staff to use and educates them about the current state of affairs and issues that could affect them down the road — like biosimilars. Also included are what Larson calls "low-hanging-fruit strategies," like how to incentivize employees to adhere to treatment.

The second section, to go online in early 2013, will give employers the tools they need to work with PBMs and health plans: how to ask the right questions to determine whether a benefit plan meets the employer's needs; how to know whether a vendor offers effective case management resources; and how PBMs design formularies and manage utilization, to name a few. "Without being empowered with this kind of knowledge, employers will continue to do what they are doing because that's all they know," says Larson. This section will also include cost calculators, checklists for bidding, and downloadable contract language to include in plan design.

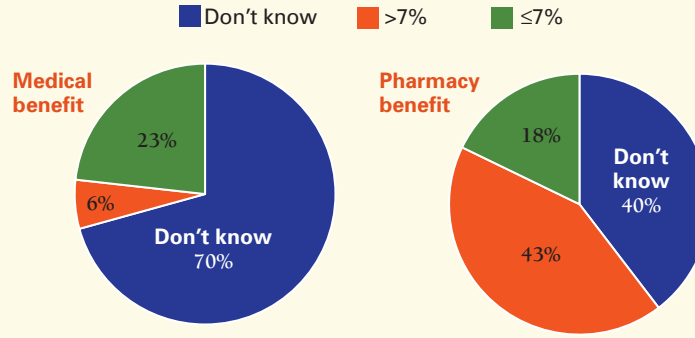
Later in 2013, MBGH will introduce the third section, which focuses on management and communications. In the baseline survey, employers admitted to uncertainty about how well they communicate benefit information to their workers. With specialty drugs raising the stakes for employers, reinforcing how to use the benefit is important.

To promote employee engagement, this section will include a disease information library. "There also will be studies and other resources

Don't know much…

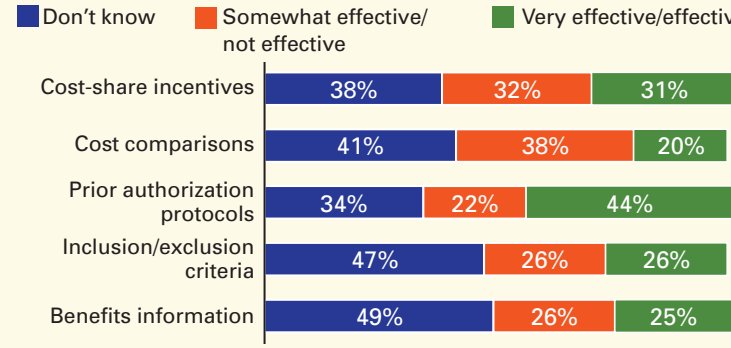
Biologics and specialty pharmaceuticals drive drug-cost trends, and with each passing year, they consume a greater portion of drug spend. But if a Midwest Business Group on Health survey is any indication, most employers have little — or no — idea of how much they're spending on biologics and specialty drugs through either the medical benefit or the pharmacy benefit.

What share of your budgets do specialty drugs consume?[a,b]



Nor do employers have a strong idea of how effectively they have communicated simple benefit information to their workers. Successful communication is important with specialty drugs, given that cost-containment strategies involve concepts that could be unfamiliar to most employees: site of service, partial fills, and use of specialty pharmacies, to name a few.

How effectively have you communicated with employees about the following benefit aspects over the last 3–5 years?[a,b]



[a] Figures may not add up to 100 percent because of rounding.
[b] Based on a survey of 120 employers with 500 to 25,000 employees.

Source: Midwest Business Group on Health, 2011

for employers," says Larson, "for presenting to senior management."

A road test

If you're an employer, Workstream 1 sounds like a road map for success. But the rubber really hits the road in Workstreams 2 and 3.

"We'd like to recommend some high-quality but easy-to-implement benefit plan designs — the basics of what you should do," says Larson. "But we need to pilot these benefit designs before we put them in a format that can go on the website. So, Workstream 2 focuses on our demonstration project."

This project will involve employers who are willing to work with their PBMs to see how a change in approach affects utilization, cost management, and patient outcomes. Low-, medium-, and high-impact designs will be tested with the goal of developing case studies to share with other employers. "We have employers that would like to do something different to see how it affects costs," says Larson. "They are very familiar with value-based benefit design, so this won't be a huge leap for them."

This past summer, MBGH collaborated with the National Pharmaceutical Council to host a summit for manufacturers, employers, specialty pharmacies, pharmacy benefit managers, health plans, and case managers. What emerged may yield some components of the MBGH demonstration project.

At that meeting — Vogenberg calls the attendees "people who really know the nitty gritty" — the group evaluated the effectiveness of several common managed care techniques. Ultimately, the group concluded that only seven would make a difference in the world of specialty drugs (see "7 Strategies for Managing Specialty Drugs").

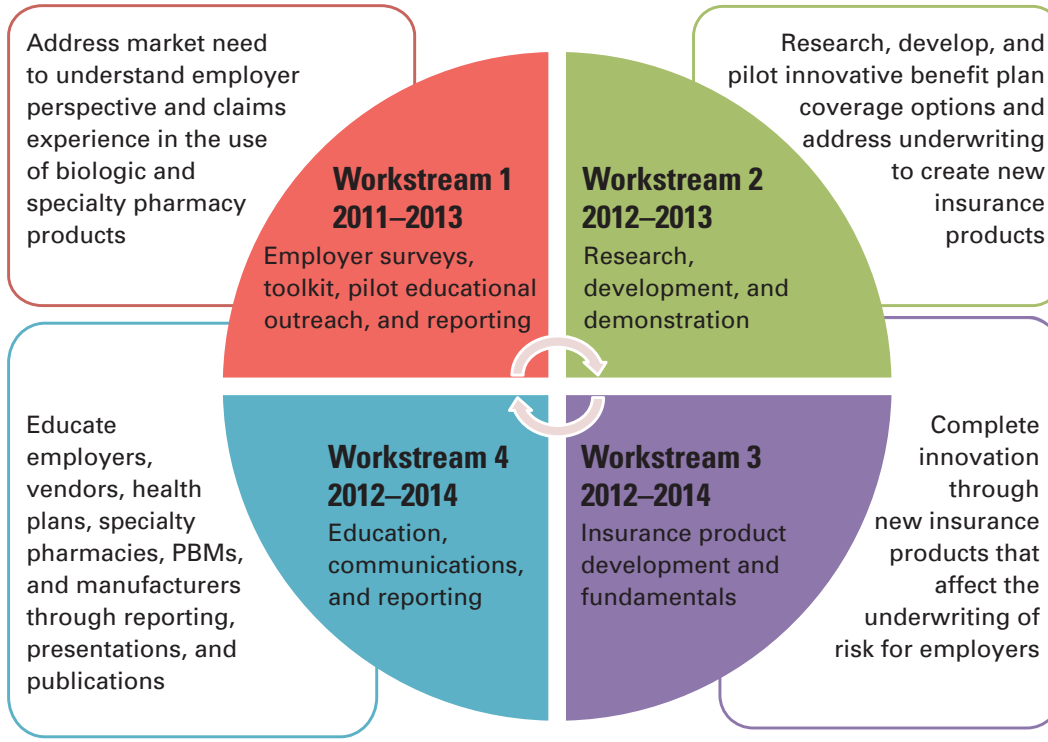
"That's remarkable," says Vogenberg. "Managed care is all about barriers. But now we're in a world of how do you get better outcomes, how do you deal effectively with different providers, and how do you keep patients happy. Biologics are a whole different environment than what this system was built around."

In other words, a system intended to finance and manage access to drugs that cost $50 or less won't work for biologics and other specialty drugs. And yet, most payer organizations promote the same old tactics.

"We talked a lot about prior authorization," says Vogenberg. "A lot of products don't need prior auth because providers are following guidelines. CareFirst, for example, has over 90 percent compliance with guidelines, and when there's an exception, there's usually a reason. So, why do prior authorization? It's a waste of time and money and it doesn't help anyone in terms of

FIGURE

Workstreams in the MBGH Biologics and Specialty Pharmacy National Employer Initiative



Source: Midwest Business Group on Health, 2012

7 strategies for managing specialty drugs…

The Midwest Business Group on Health brought together representatives from six stakeholder groups* to talk about strategies for cost-effective specialty drug use. In reviewing more than 20 avenues commonly used to manage pharmacy benefits, the group settled on only seven that could make a difference with specialty drug spending:

- Case management
- Drug utilization
- Cost sharing
- Prior authorization
- Practice guidelines
- Combining medical and pharmacy data
- Quantity approaches

*Stakeholders included pharmaceutical companies, employers, specialty pharmacies, pharmacy benefit managers, health plans, and case managers.

Source: Midwest Business Group on Health, 2012

… but which strategies move the needle?

According to Diplomat Specialty Pharmacy, drug rebates yield little in the way of overall drug cost savings. Employers will reap greater cost savings by moving specialty drugs from the medical benefit to the pharmacy benefit and ensuring that beneficiaries get support services, such as adherence and side-effect help and monitoring.

Tactic	Financial impact (% of spend)
Moving products from medical to pharmacy benefit	5–10
Drug treatment management	5–10
Prior authorization/step therapy	2–5
Formulary management	2–3
Managing drug acquisition cost	1–2

Source: Diplomat Specialty Pharmacy, Flint, Mich., 2011

patient outcomes."

For Larson, the exercise emphasized how stakeholders' understanding of one another's perspectives is the first step toward aligning priorities. "It was interesting to see the key areas that the group wanted to focus on, but then hear employers say, 'Well, those aren't necessarily the things we would have focused on, or maybe not in that order.' We have to find out what everyone's priorities are and marry the two."

Practical, relevant models

What if you could design your own insurance plan? That's the gist of Workstream 3: Take what was learned from the demonstration project and hammer out innovative benefit design models.

That doesn't mean MBGH will develop an insurance product; its 501(c)(3) tax status limits it to educational activities. Moreover, the scope of the workstream may change as employer needs change and as providers, payers, and other stakeholders express interest in partnering with MBGH on the project.

If all that comes of Workstream 3 is a series of blueprints to help employers manage costs, ensure adherence, and demonstrate a return on investment, that's more than what most would probably say they have now.

The empowered employer

Workstream 4 is what Vogenberg calls the "living, breathing component" — ongoing outreach beyond the employer community through publications, white papers, and other communications.

"We want people to understand the employer perspective and that the employer is the purchaser," he says. "As health plans go to a service model, they have to make the purchaser happy. "

Before employers can flex that kind of muscle, though, they have to understand specialty drugs. Larson is passionate about filling that void.

"If we present to an employer audience, about 10 percent will know what I'm talking about. About 50 percent will know that it's part of the pharmacy design and kind of know what the general issues are. The rest will sit with their mouths open and say afterward, 'Please! Here's my card!'"

Before long, they'll all be smarter.

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On the web:
Midwest Business Group on Health: **www.mbgh.org**
National Employer Initiative on Biologics/Specialty Pharmacy: **www.specialtyRxtoolkit.com**