The 2015 US Payor Landscape: Results from a Survey of Medical and Pharmacy Directors on Formulary Management

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Background

- The TPG-National Payor Roundtable (TPG-NPRT) focuses on market access programs within the United States.
- The JeSTARx Group provides evidence-based research and support to the Healthcare Industry.
- The TPG-NPRT maintains a proprietary database of Chief Medical Officers, Chief Pharmacy Officers and other key decision makers from health plans in the United States.
- To control the growth of healthcare costs and ensure appropriate utilization of pharmaceutical products, payors use a variety of management tools, including prior authorization, generic substitution, step therapy, adherence management, and innovative pharmacy benefit designs.
- Pharmacy & Therapeutic (P&T) Committees and technology assessment entities are tasked with making coverage decisions with limited information available.
- Based on recent programs with US Payors, Medical Directors, and Sponsors (pharmaceutical companies, medical device, and health technology companies), TPG-NPRT and the JeSTARx Group decided to conduct a survey of medical and pharmacy directors from payors involved with P&T Committees on their formulary management policies.
  - The NPRT and JeSTARx Groups have previously published results from surveys of this pool of advisors.[1]

Objective and Purpose

- This study sought to survey medical directors and pharmacy directors of US payors representing: health plans, insurers, employer groups and pharmacy benefit managers (PBMs).
- The survey focused on the:
  - Management of mental health conditions.
  - Pharmacy & Therapeutics (P&T) committee process.
  - Medical benefit management policies.
  - Plan design and operations.

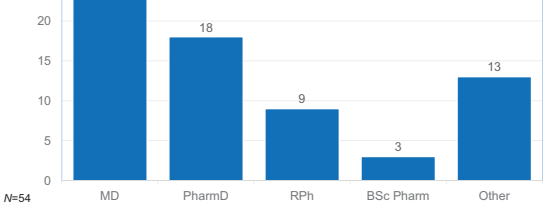
Methods

- An online, interactive survey was developed with 63 questions and included:
  - Yes / No questions
  - Lists for users to select single or multiple answers
  - Open-ended responses (ie, desired changes in their relationships with health plan sponsors)
- Invitations to participate were sent to 224 medical and pharmacy directors currently employed by US health plans and insurers from the TPG-NPRT database in December 2014.
- Material or financial incentives were not offered for completion of the survey.
- Topics included:
  - Plan coverage:
    - Geographical coverage
    - Types of lives
  - Relationships between their plans and their sponsors
  - Mental Health Product coverage
    - Use of Carve outs
    - Formulary management policies
  - Changes in their plan design and operations.

Results

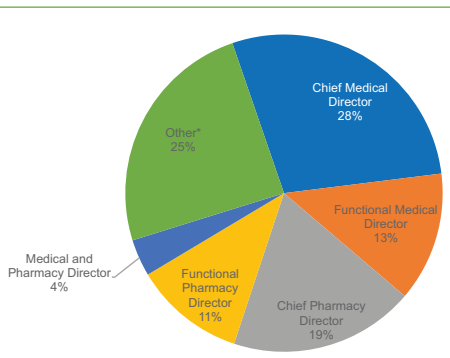
- A total of 54 persons responded to the survey invitation (**24.1% response rate**).
- Many advisors reported multiple degrees (Figure 1), and the most common degree was MD (55.6%).

Figure 1. Survey Respondent Degrees (multiple answers allowed)



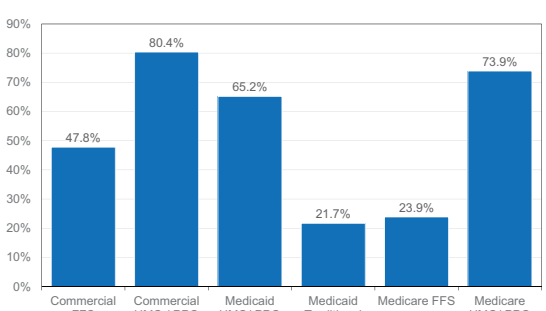
- 86% of the advisors were involved in formulary decisions.
- The respondents were mostly chief medical directors and chief pharmacy directors (Figure 2), the "Other" category included: VP (of Pharmacy, Medicine, or Medical Affairs); Chief Medical Officer, Senior Medical Director [3], and Consultant [3].

Figure 2. Respondent's Title within their Organization



- Most respondents worked for a health plan (83.6%) and 39.6% were local, 35.4% were national, and 25.0% were regional.
- The type of plans represented are shown in Figure 3.

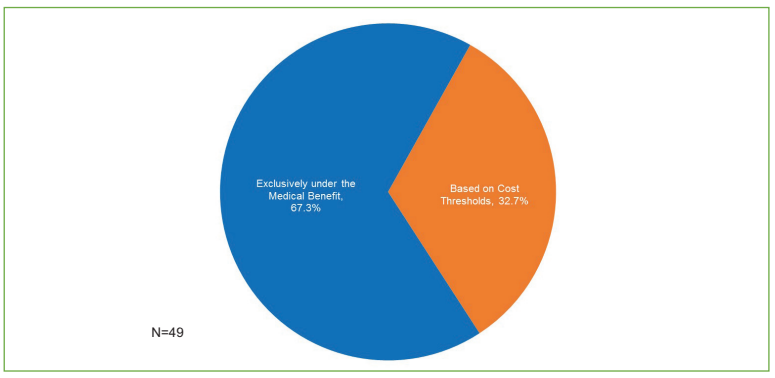
Figure 3. Type of Plans Represented by Respondents (Respondents can cover multiple types)



FFS=Fee For Service; HMO=Health Maintenance Organization; PPO=Preferred Provider Organization

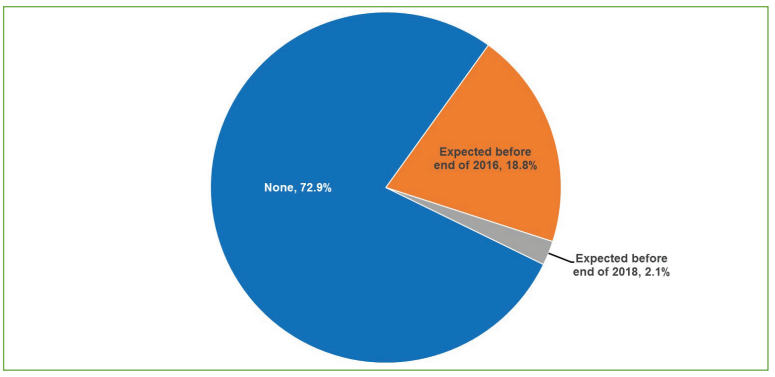
- At the time of the survey, clinician administered products (ex. office administered injections) were mostly covered exclusively under the medical benefit, many plans determined the benefit based on a cost threshold (Figure 4).

Figure 4 Management of clinician administered products



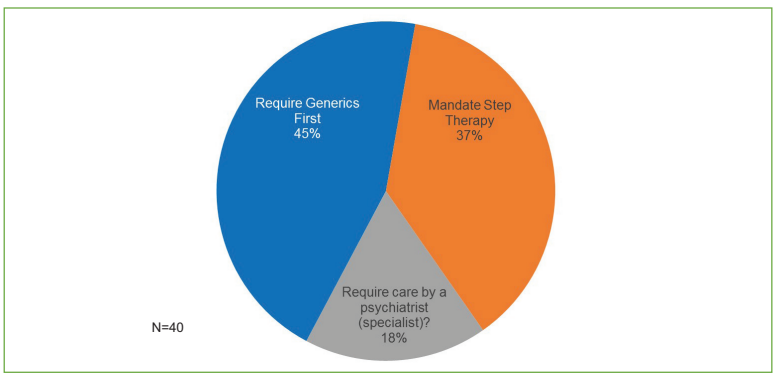
- The majority of advisors do not anticipate a change in the management of clinician administered products (Figure 5).

Figure 5 Expected change in the management of clinician administered products:



- One–third of plans reported their mental health (MH) products were carved out.
- For conditions with multiple mental health therapies are available, a variety of formulary management policies were used (Figure 6); with mandatory use of generics first the most common.

Figure 6. Policies for Mental Health Therapies



- Most advisors were happy with their pharmacy benefit design, the most requested changes were more restrictive management programs; followed by changes in tiers/copays.
- The most common desired P&T process change was no change; followed by more frequent meetings/time; and the use of Comparative Effectiveness Research.
- Most were happy with their plan's medical benefit management, desired changes included:
  - *Coordination/Integration:* Increase involvement with pharmacy department in case management and clinical program development; more pharmacy and medical integration with sales; Better coordination between medical and pharmacy benefits; Combine with pharmacy; integrate pharmacy and medical claims with clinical and laboratory data; pharmacy has all medications under umbrella; cost tied to outcomes;
  - *Coding and analytics:* get more resources to work on proper coding; better use of our in-house analytics; more data upon which to make decisions; better data; more EMR alerts;
  - *Management programs:* Better use of automated medical management programs; Efficient utilization management program; add local onsite nurse case managers; tighter management with collaboration with providers;
  - *Plan design:* Increase patient cost of care; Increased out of pocket maximum; formulary tiers; Move to a defined benefit;
  - *Network:* closed network; higher quality network; Mandatory use of in-plan providers before referral out of state; convince network doctors to embrace cost-effective medical practices; risk share contracts;
  - *Time:* More time to make decisions; more time;
  - *Education:* enhanced staff education; Convince specialty pharmacies to provide drug delivery, purchasing, tracking for medical benefit drugs; increase staff knowledge of interesting guidelines;
  - *Prior authorizations:* Prior authorizations of medical benefit drugs; rational prior authorizations;
  - None: (6).

Advisors desired changes in their plan's relationship with their health plan sponsor(s):

Conclusions

- As the population ages and healthcare costs continue to grow, payors will change the ways they manage their formularies.
- The environment for P&T Committee decision making in managed care is undergoing a series of changes.
- Payor medical directors and pharmacy directors, who commonly serve as P&T Committee members, have a distinct understanding and opinions as to how to alter the process to adapt to these influences.

References

1. Brook RA, Carlisle JA, Mehr SR, Smeeding JE. The US Payor Landscape: Results from a Survey of Medical Directors and Pharmacy Directors on Comparative-Effectiveness Research. *J of Pharmacy and Pharmacology* 2 (2014) 432-438. (available at TPG-NPRT.com)

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Disclosures: None

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