

MAGELLAN RX MANAGEMENT
**MEDICAL PHARMACY
TREND REPORT™**

2016 EMPLOYER GROUP SUPPLEMENT





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Introduction

Magellan Rx Management is pleased to present the fifth annual Magellan Rx Management Medical Pharmacy Trend Report™ Employer Group Supplement.

Increasing costs of medical specialty drugs continues to be a growing concern and key issue for employer groups. Over the next three to five years, medical pharmacy costs will continue to increase exponentially. The upcoming release of novel, breakthrough therapies in oncology and costly new agents in rare diseases will increase rather than slow the medical pharmacy trend.

Traditionally, employers rely on their medical carriers and/or third-party administrator (TPA) partners for specialized programs to manage and implement solutions regarding changes in healthcare costs and treatments.

As a supplement to the 2016 Magellan Rx Management Medical Pharmacy Trend Report™, the Employer Group Supplement is meant to assist employer groups in determining what to explore and implement to control the overall increasing costs of specialty drugs paid on the medical benefit.

We worked to improve the format and organization of the 2016 survey to expand the information we share with employer groups and create a more dynamic picture of employer group management.

It is our hope that the survey data presented in this report helps employer groups begin to think about and investigate escalating medical pharmacy costs.



2016 EMPLOYER GROUP SUPPLEMENT

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Executive

KEY FINDINGS IN THE REPORT INCLUDE:

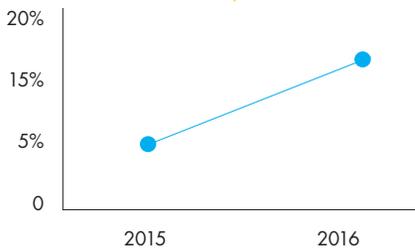
MEDICAL BENEFIT

SPEND



88% of employers reported spend of **less than \$10 million**

TREND



and a year-over-year drug trend between **1 and 20 percent**.

PRIOR AUTHORIZATION PROCESS



83%

of employer groups had a prior authorization process in place to review medical necessity for medical benefit drugs.

SITE OF SERVICE

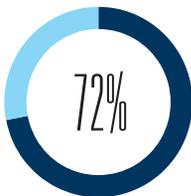


41% of employer groups recognized the patient home via home infusion as the lowest cost site of service.



23% recognized either the physician office or specialty pharmacy as the lowest cost site of service.

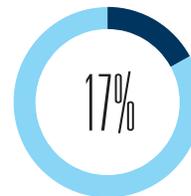
CARVING OUT MEDICAL BENEFIT DRUGS



of employer groups expressed they would be interested in carving out drugs with their pharmacy benefit manager (PBM).



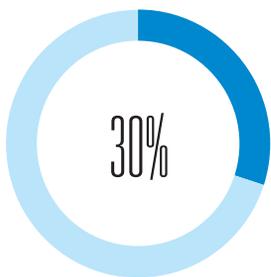
of employers had been approached by their PBM with this solution.



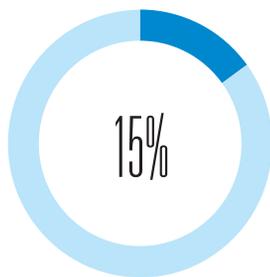
had begun carving out medical benefit drugs for management in the pharmacy benefit.

Summary

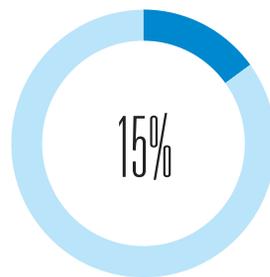
Of the **35 percent** of employer groups that provided an oncology-specific drug program



were patient assistance programs,



were oncology drug rebate programs,

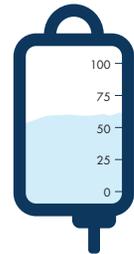


were clinical pathways programs.

MEDICAL BENEFIT DATA



DISEASE MANAGEMENT PROGRAMS



52 percent of employers had an oncology and oncology support disease management program.



50 percent of employer groups had autoimmune programs.



43 percent of employer groups had care management programs for hemophilia and other blood disorders.



MEDICAL BENEFIT DRUG SPEND AND MANAGEMENT

Specialty drug spend is not slowing and is expected

to continue to increase with the introduction of new specialty agents for oncology, autoimmune disorders, and rare diseases. The 2016 Medical Pharmacy Trend Report™ stated a 13 percent year over year increase in commercial per member per month (PMPM) medical drug benefit spend from \$20.95 to \$23.68. This translated to a spend of over \$2.8 million per year for an employer group with 10,000 medical benefit lives. For 2016, on par with this spend, 88 percent of employer groups in the Employer Group Supplement survey reported a medical

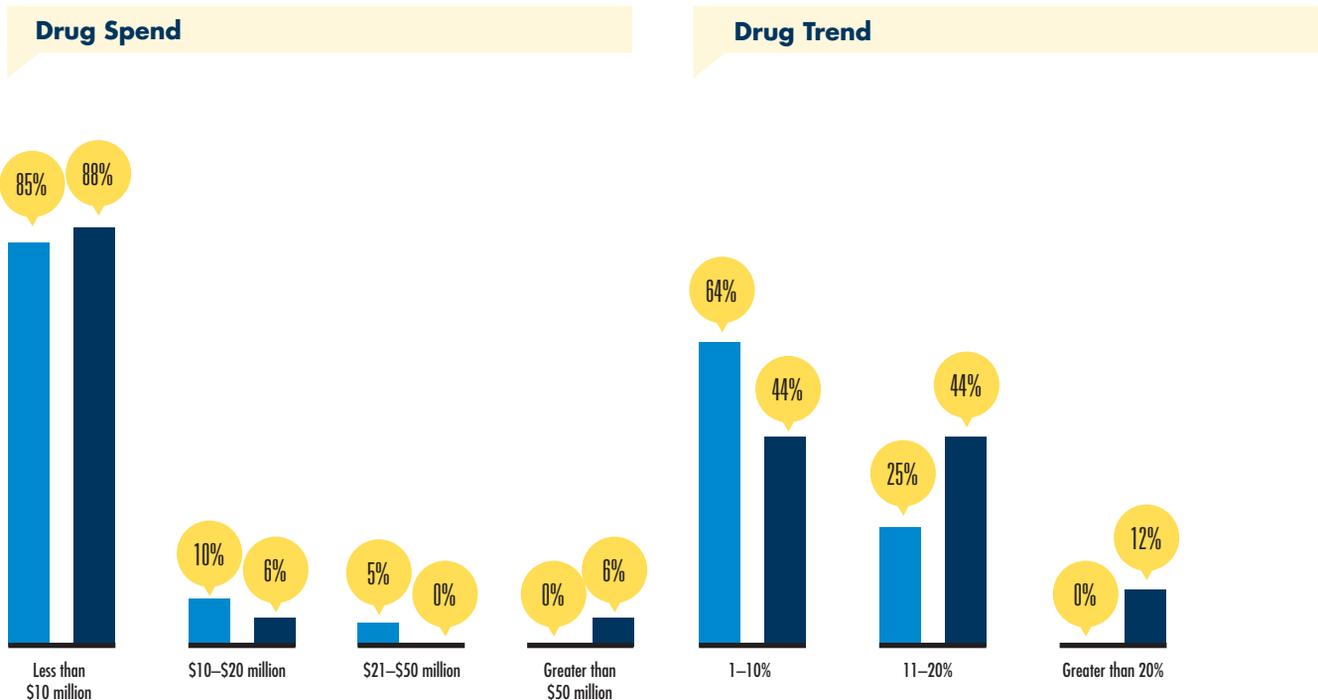
benefit drug spend of less than \$10 million. The few employer groups with spend above \$10 million had a higher number of lives. It may also be assumed that the employee mix for these groups may have included employees with more costly health expenditures (see figure 1).

Comparable to the 13 percent increase in commercial PMPM, 88 percent of employer groups reported a drug trend between one and 20 percent (see figure 1).

FIGURE 1

Employer Groups Medical Benefit Drug Spend and Trend (n=16); (n=32)

■ 2015 ■ 2016





Based on data from the 2016 Magellan Rx Management Medical Pharmacy Trend Report™, oncology and oncology support represented 47 percent of commercial and 57 percent of Medicare medical pharmacy costs, no doubt a significant spend for employers. It was the most critical driver of increased spend and trend on the medical benefit. To corroborate the effect and level of oncology and oncology support spend for employer groups, we asked their oncology-specific benefit spend.

Only 7 percent of employer groups knew their spend specific to oncology and oncology-support medications (i.e., colony-stimulating factors (CSFs), erythropoiesis-stimulating agents (ESAs), antiemetics, and gastrointestinal agents). Of those who were aware, 67 percent of employer groups reported that less than 10 percent of the medical benefit spend was attributed to these categories, although 33 percent attributed more than 75 percent of medical benefit spend to oncology and oncology support. It is evident from the 2016 results that these employers likely did not have a clear indication of the impact of the oncology-related spend (see figure 2).

To manage the medical benefit drug spend and trend, 52 percent of employer groups worked with a pharmacy benefit manager (PBM) who offered a formal management program. The majority of employer groups (84 percent) were satisfied with the current programs offered by their PBMs (see figures 3 and 4).

FIGURE 2

Employer Groups Oncology and Oncology Support Medical Benefit Drug Spend

■ Less than 10% ■ 10–25% ■ 26–50% ■ 51–75% ■ Greater than 75%

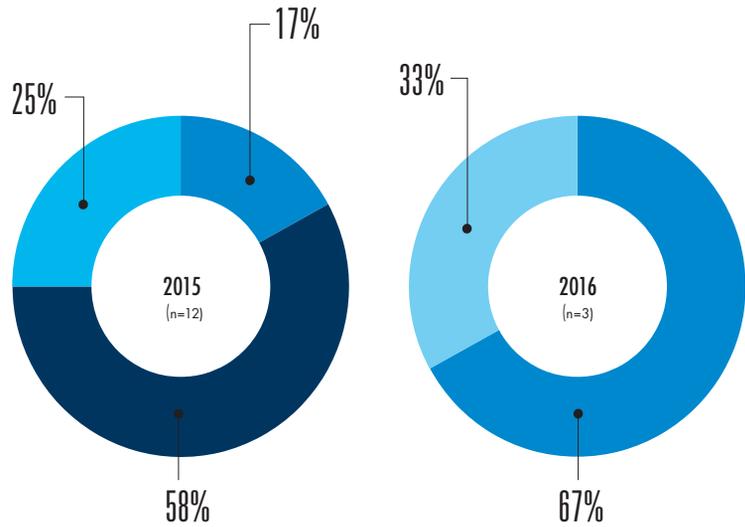


FIGURE 3

Formal Medical Benefit Management Program Offered (n=46)

■ % of respondents

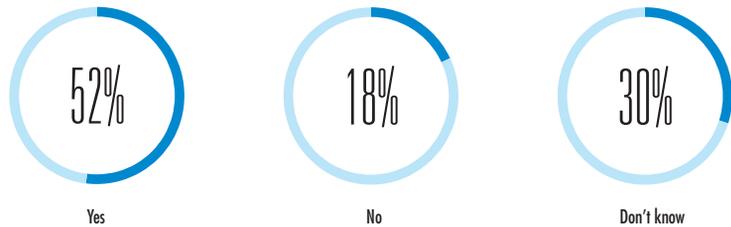
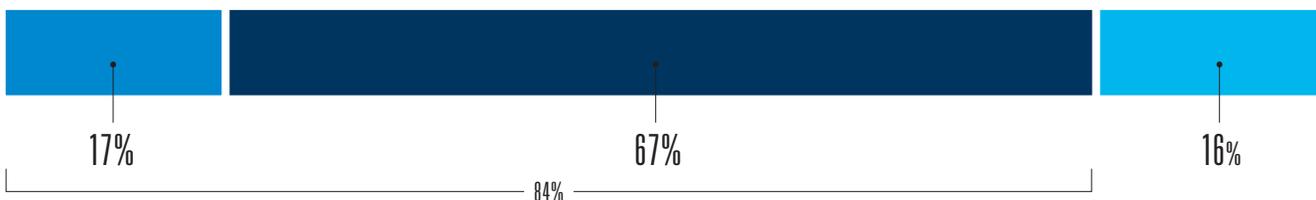


FIGURE 4

Satisfaction with PBM's Formal Management Program (n=24)

■ Very satisfied ■ Somewhat satisfied ■ Neither satisfied nor dissatisfied





MEDICAL BENEFIT DRUG UTILIZATION MANAGEMENT

For the medical benefit, utilization management of specialty drugs is a complex and ever-evolving landscape with a continued influx of new drugs and indications. To control these costs, the most prominent management tools used under the medical benefit are prior authorization (PA) programs. According to the 2016 Magellan Rx Management Medical Pharmacy Trend Report™, 70 percent of commercial payers used some form of prior authorization to manage the medical benefit. In 2016, 83 percent

of employer groups followed suit and had a prior authorization process in place to review medical necessity for medical benefit drugs. These programs were most often administered (42 percent) by a third-party administrator (TPA), although 34 percent used a PBM and 19 percent used a medical carrier. A small percentage of payers (5 percent), used in-house pharmacy personnel to administer their programs (see figures 5 and 6).

FIGURE 5

Medical Benefit Prior Authorization Process in Place (n=46)

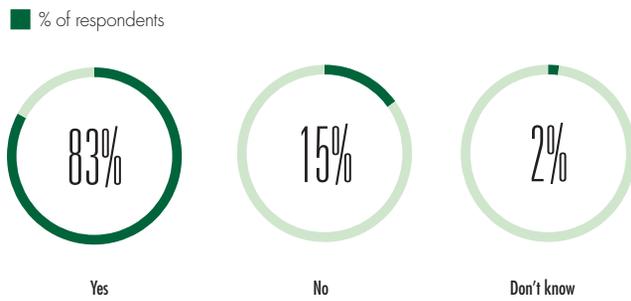
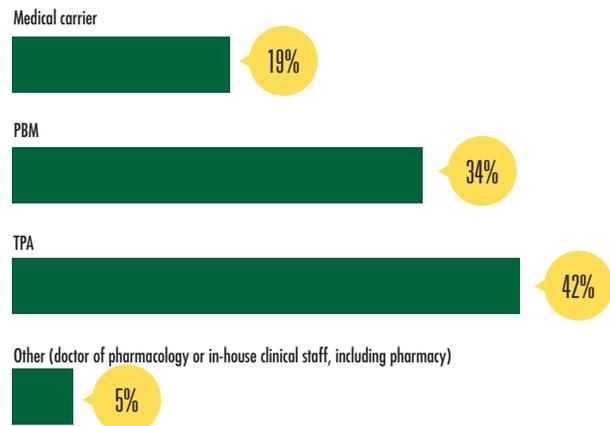


FIGURE 6

Administrator of Medical Benefit Prior Authorization Program (n=38)

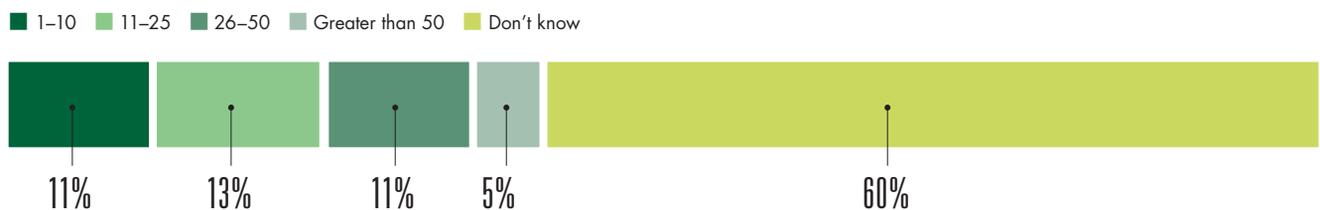


Because employer groups seldom administer their own PA programs, 60 percent of employers did not know the number of medical benefit drugs currently on the prior authorization program. For those who did know, 24 percent included 25 medical benefit

drugs or fewer and 11 percent had 26 to 50 medical benefit drugs. A small group (5 percent) had greater than 50 drugs on their PA program (see figure 7).

FIGURE 7

Number of Drugs in Prior Authorization Program (n=38)

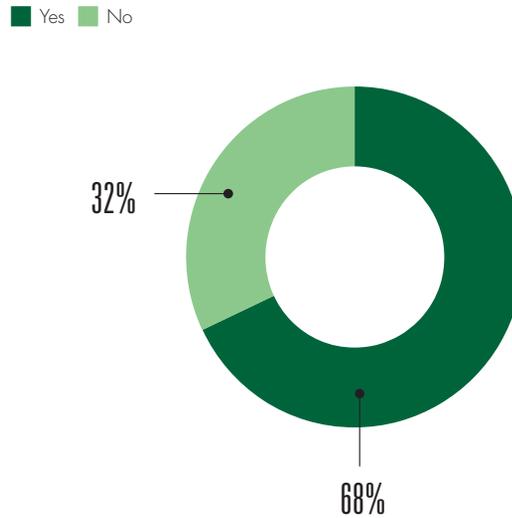




Although many employer groups were not aware of the number of drugs in the PA programs, 68 percent indicated their PBMs and TPAs allowed them to have input into what drugs were included in the PA program. The drug categories mainly included autoimmune (47 percent), oncology (37 percent), and oncology support (47 percent) drugs (see figures 8 and 9).

FIGURE 8

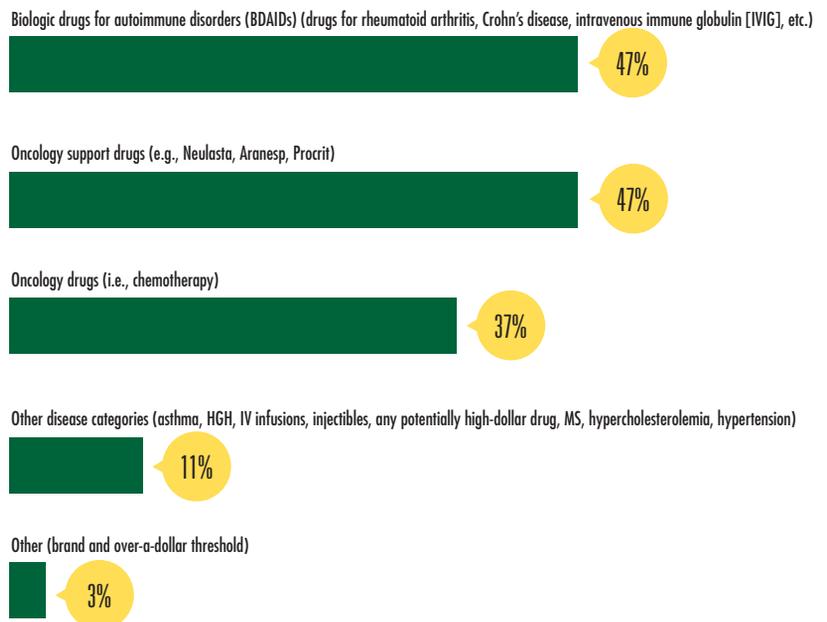
Input on Drugs in PA Program (n=38)



83% of employer groups used some form of prior authorization to manage the medical benefit

FIGURE 9

Therapeutic Classes of Drugs on PA Program (n=38)





Another cost control strategy directed members (employees) toward a lower cost site of service. Typically the hospital outpatient setting is the most expensive site of service. Overall, costs may be double or triple to administer medical benefit drugs in a hospital outpatient setting versus a physician office, infusion center, or patient home. To understand how well employer groups and their medical benefit managers controlled this, we asked if employer groups knew the overall difference in costs of drugs associated with the site of service where those drugs were administered.

Over half of employer groups (n=24; 52 percent) were unaware of the lowest cost site of service, indicating they were dependent on their medical benefit managers to carry out this program. Even so, for those who were aware, 41 percent of employer groups recognized the patient home via home infusion as the lowest cost site of service. Twenty-three percent recognized the physician office or specialty pharmacy as the lowest site of service (see figure 10).

Although employer groups may not steer employees toward the lowest cost site of service, 35 percent indicated there were programs or education to encourage the use of lower cost sites of service provided to their employees (see figure 11).

FIGURE 10

Presumed Lowest Cost Site of Service (n=22)

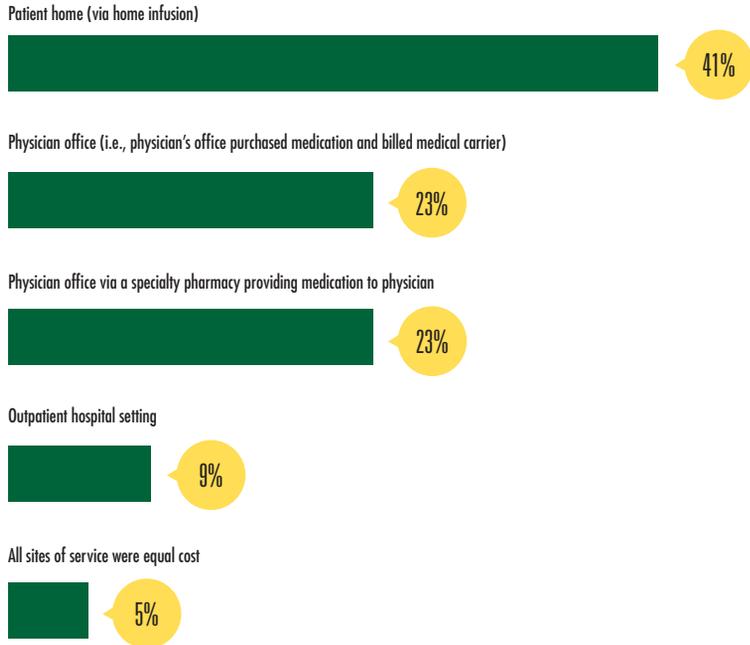
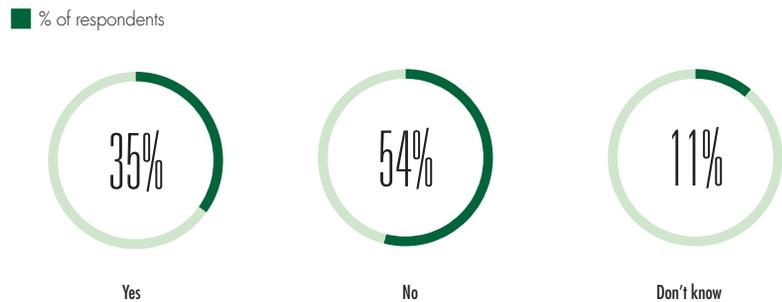


FIGURE 11

Education on Lowest Cost Site of Service (n=46)





MEDICAL BENEFIT MANAGEMENT PROGRAMS

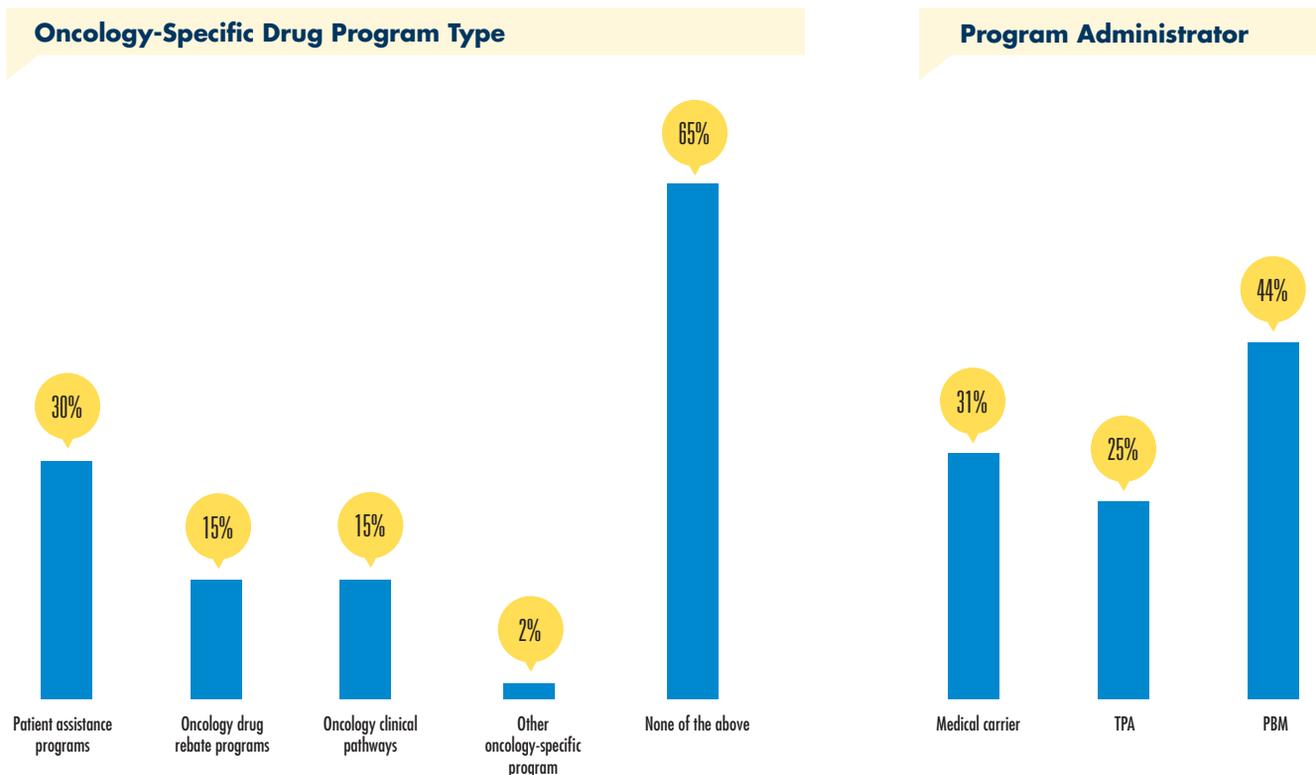
In 2016, employer groups relied on their medical benefit managers to provide programs. Thirty-five percent of employer groups provided an oncology-specific drug program, most often in the form of a patient assistance program (30 percent). Only 15 percent of employers provided an oncology drug rebate program or clinical pathways program (see figure 12). This is in sharp contrast to payers where, according to the 2016

Magellan Rx Management Medical Pharmacy Trend Report™, 41 percent of commercial payers and 67 percent of Medicare payers provided an oncology-specific clinical pathways program.

For those providing programs, 44 percent were administered through a PBM, 31 percent were administered through a medical carrier, and 25 percent were administered through a TPA (see figure 12).

FIGURE 12

Oncology-Specific Drug Program and Administrator (n=46; n=16)

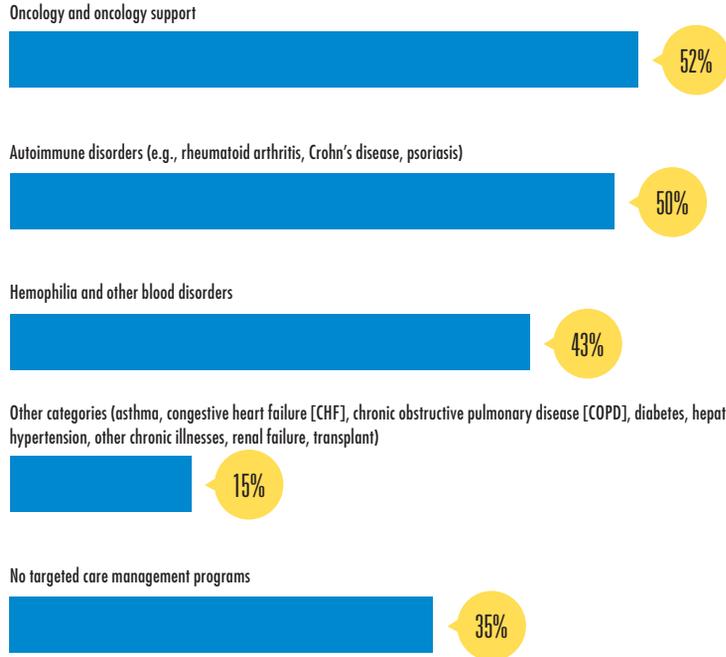




In contrast, employer groups were more likely to have disease-specific care management programs. While 35 percent did not have any targeted care management programs; 52 percent had oncology and oncology support programs; 50 percent had autoimmune disorder programs; 50 percent had autoimmune disorder programs; 43 percent had care management programs for hemophilia and other blood disorders (see figure 13).

FIGURE 13

Disease-Specific Care Management Programs (n=46)



For diseases other than oncology, 67 percent of employer groups indicated there was some form of drug management included in these programs (see figure 14).

FIGURE 14

Drug Management Component to Care Management Program (n=30)

% of respondents



BENEFIT DESIGN

Employee cost share on the medical benefit mirrored the pharmacy benefit with copay, coinsurance, or a model with some combination of the two. In 2016, 37 percent of employer groups indicated their employees were under a model requiring both copay and coinsurance. Another third (33

percent) indicated that employees were required to pay only a copay and 20 percent indicated that employees were required to pay only coinsurance. Copay rates have been on a steady incline, while coinsurance rates have decreased (see figures 15 and 16).

FIGURE 15

Medical Benefit Drug Cost Share

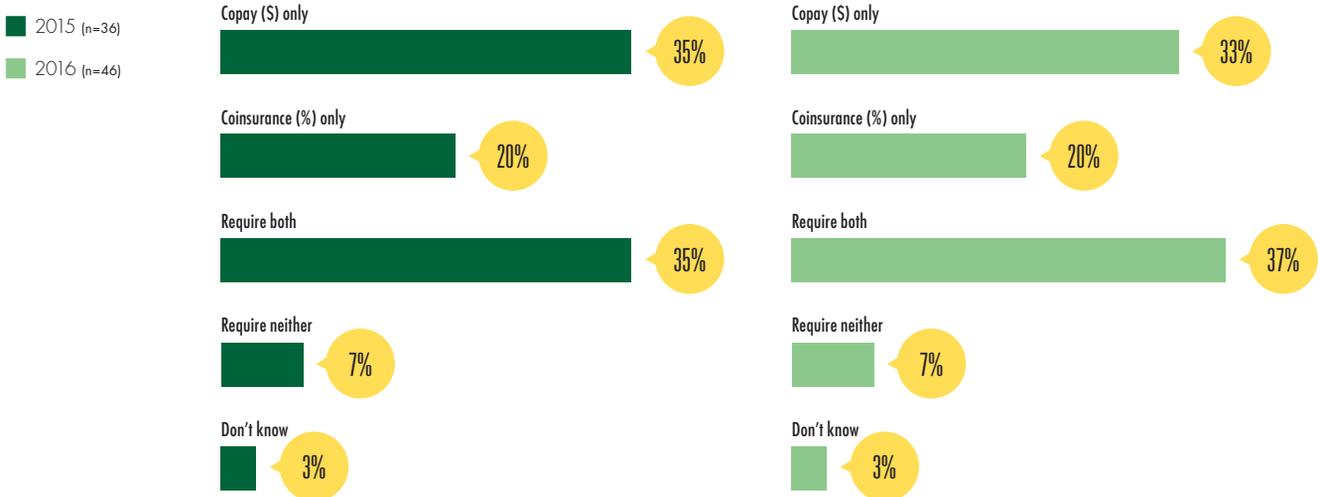
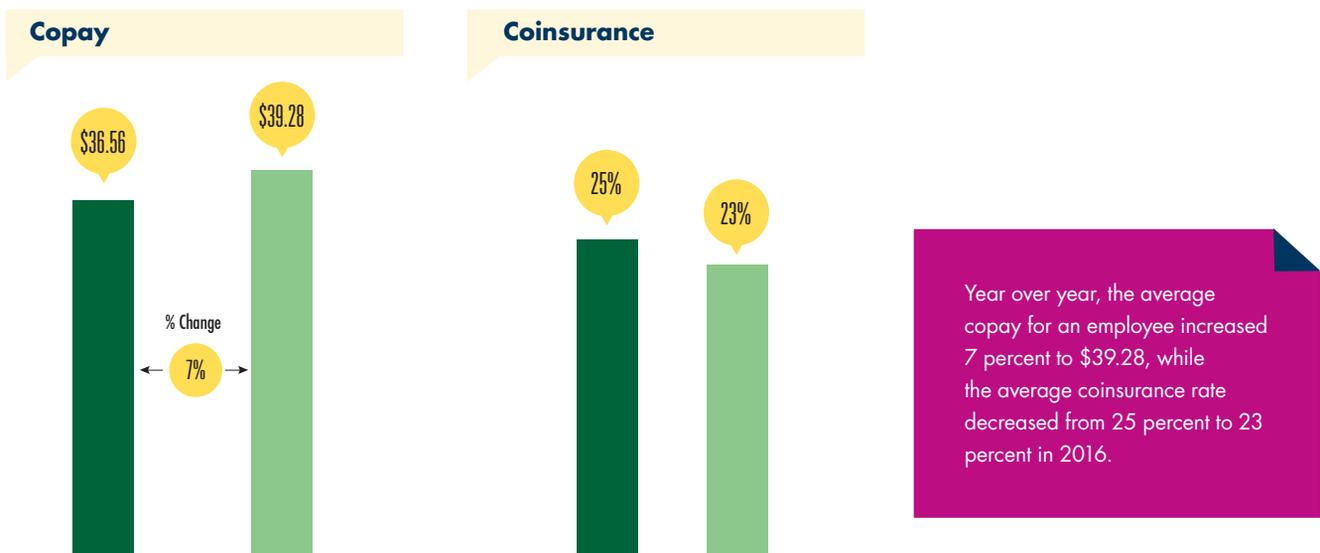


FIGURE 16

Medical Benefit Drug Cost Share Rates

2015 (n=36) 2016 (n=46)



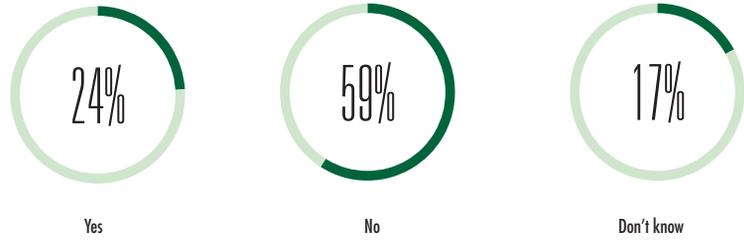


In addition to the copay or coinsurance paid by employees, there may have been an additional administrative cost for a healthcare provider administering specialty medications. In 2016, 59 percent of employer groups did not have this additional cost; although 24 percent of employer groups did have some form of these costs (see figure 17).

FIGURE 17

Cost Share in Addition to Standard Copay/Coinsurance (n=46)

■ % of respondents

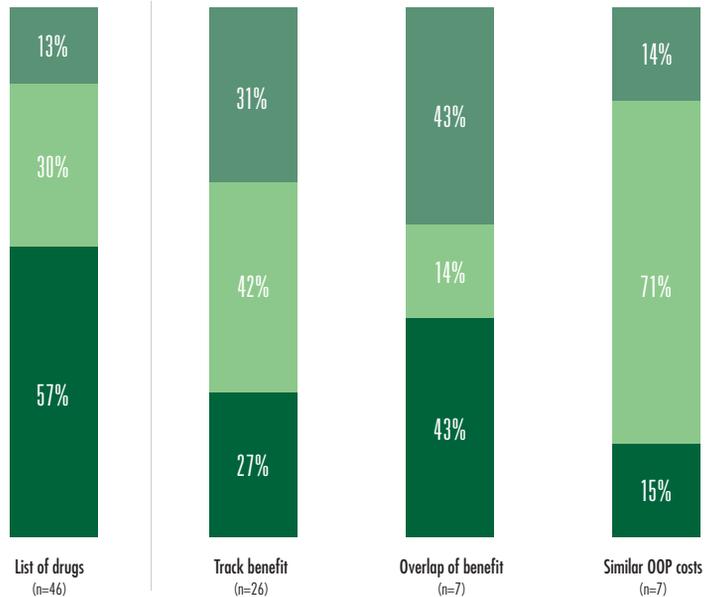


To understand how employers determined the benefit design for employees and how cost share was handled, we asked respondents several questions. We asked employer groups if they maintained a current list of specialty drugs, under which benefit that drug was listed, what the overlap between medical and pharmacy benefits was, and if the out-of-pocket (OOP) costs were similar. More than half (57 percent) of employer groups tracked the list of drugs, but only 27 percent of those employer groups knew under which benefit the drug was housed. For the 27 percent of employers who tracked the benefit, 43 percent indicated there was an overlap between the medical and pharmacy benefit (n=7); although 71 percent said the out-of-pocket costs were not the same across benefits. In other words, the drug could be billed to either benefit, but one benefit would have a lower OOP cost for the employee than the other (see figure 18).

FIGURE 18

Medical Benefit Drug Tracking

■ Yes ■ No ■ Don't know

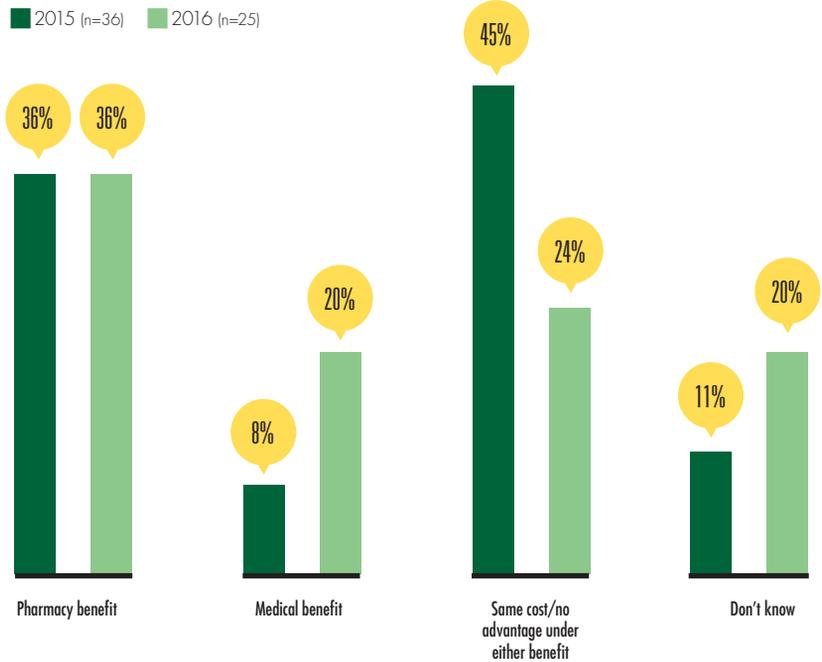




In line with employers who tracked the OOP costs for the medical and pharmacy benefit, 36 percent of employer groups indicated specialty drugs billed under the pharmacy benefit had a lower OOP cost for employees than if billed under the medical benefit. Close to one-quarter (24 percent) believed there was no advantage under either benefit, a contrast from 2015 when 45 percent of employer groups felt there was no advantage (see figure 19).

FIGURE 19

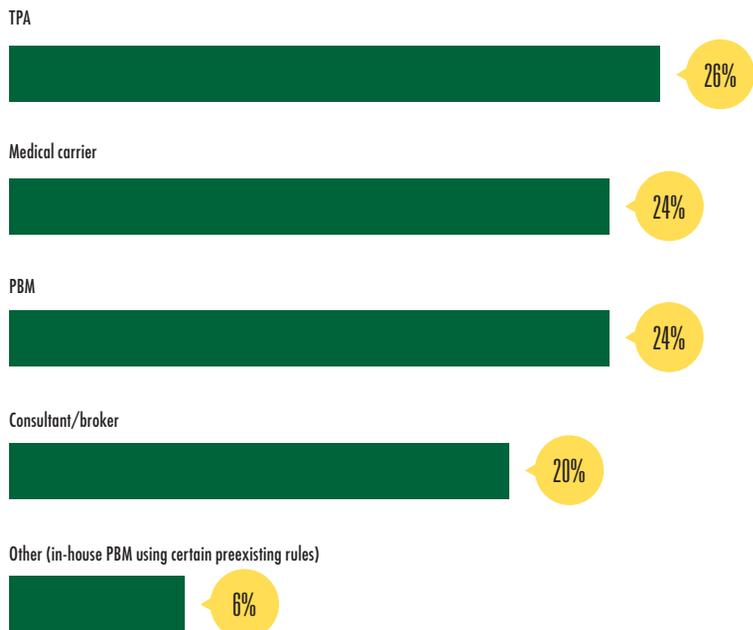
Lower OOP Cost for Medical Benefit Drugs



Those responsible for tracking which drugs were reimbursed under which benefit was a split decision among employers. Overall, 26 percent of employer groups gave the responsibility to their TPA, but 24 percent relied on either their medical carrier or PBM for those decisions. Another 20 percent utilized a consultant or broker for such decisions (see figure 20).

FIGURE 20

Responsible for Tracking Benefit (n=46)





COMPREHENSIVE DRUG MANAGEMENT

PBMs may offer employer groups the option to carve out medical benefit drugs. In 2016, 72 percent of employer groups expressed they would be interested in carving out drugs with their PBM vendor (see figure 21).

Only 26 percent of employers had been approached by their PBM with this solution. Of those employers, only 17 percent had begun carving out medical benefit drugs for management in the pharmacy benefit (see figures 22 and 23).

FIGURE 21

Interested in Carve-Out Solution with PBM (n=46)

■ Yes ■ No

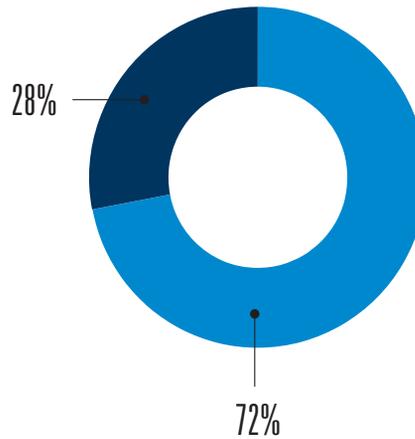


FIGURE 22

Approached by PBM About Carve-Out Solution (n=46)

■ % of respondents

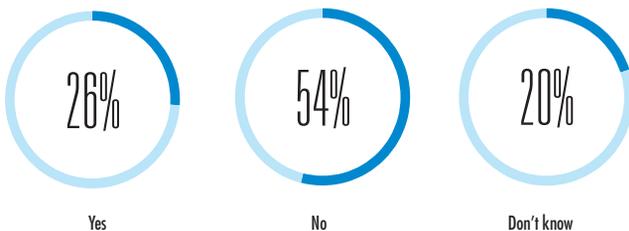
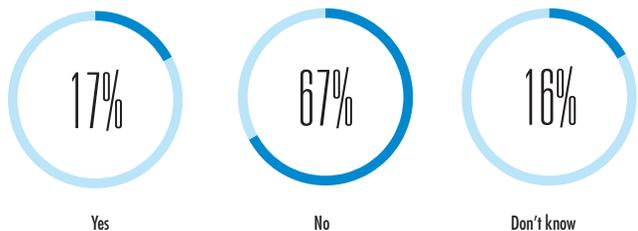


FIGURE 23

Have Begun Carve-Out Solution (n=12)

■ % of respondents





Some employer groups created a comprehensive health system including on-site clinics that assisted in managing total care as well as medical drugs administration. One-quarter (26 percent) of employer group respondents opted for this option. For those with an on-site clinic, 25 percent offered drug infusions at the clinic (see figures 24 and 25).

FIGURE 24

On-Site Clinic for Employees (n=46)

■ Yes ■ No

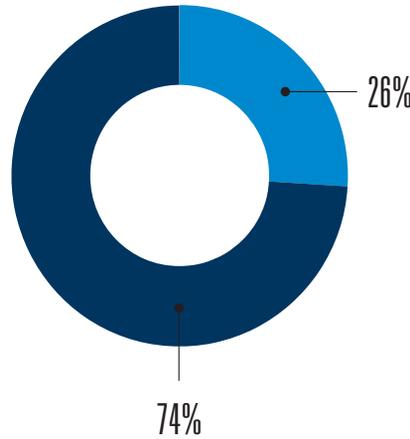
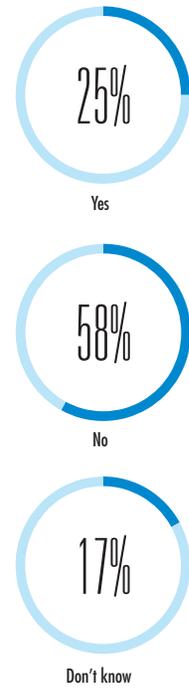


FIGURE 25

On-Site Clinic for Employees for Drug Infusions (n=12)

■ % of respondents

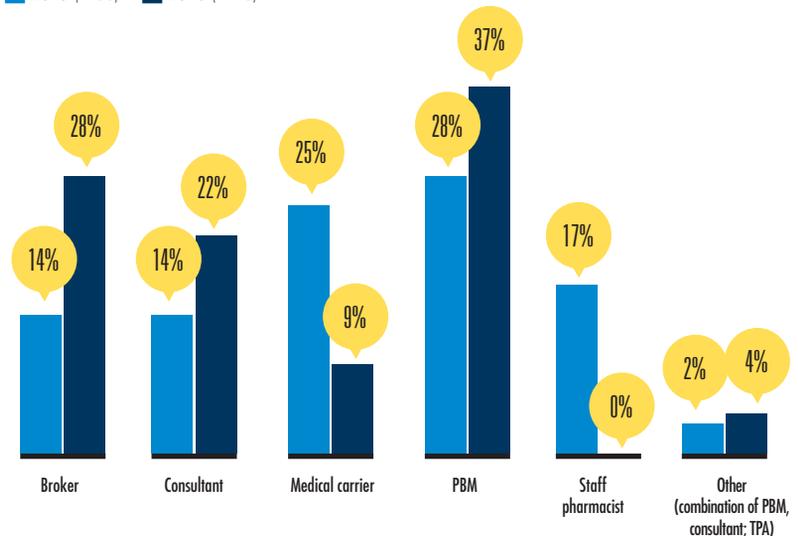


Even with many employer groups being more hands-off with the management of medical drugs, they must still be aware of changes in pharmacy. Thirty-seven percent of PBMs, 28 percent of brokers, and 22 percent of consultants provided this intelligence to employer groups. In contrast from 2015, no employer groups relied on an internal staff pharmacist (see figure 26).

FIGURE 26

Primary Provider of Pharmacy Intelligence

■ 2015 (n=36) ■ 2016 (n=46)





In line with employer groups either not employing or having access to intelligence from staff pharmacists, 70 percent preferred to have a pharmacy consultant available to answer questions related to overall management. But only 30 percent of employer groups were willing to pay for this service. For the few employers willing to pay, 46 percent said they would only be willing to pay \$1,000 or less, and 36 percent would pay from \$5,001 to \$10,000 for an average of around \$7,500 for such a service (see figures 27, 28, and 29).

FIGURE 27

Preferred Pharmacy Consultant to Help Manage Overall Drug Spend (n=46)

■ Yes ■ No

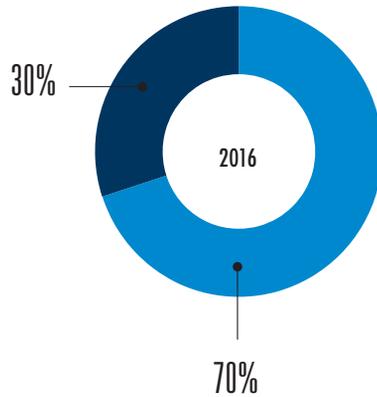


FIGURE 28

Paid for Pharmacy Consultant to Help Manage Overall Drug Spend (n=46)

■ Yes ■ No

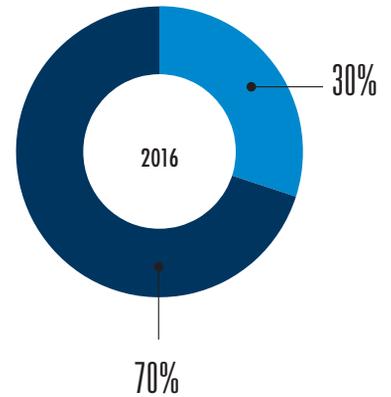
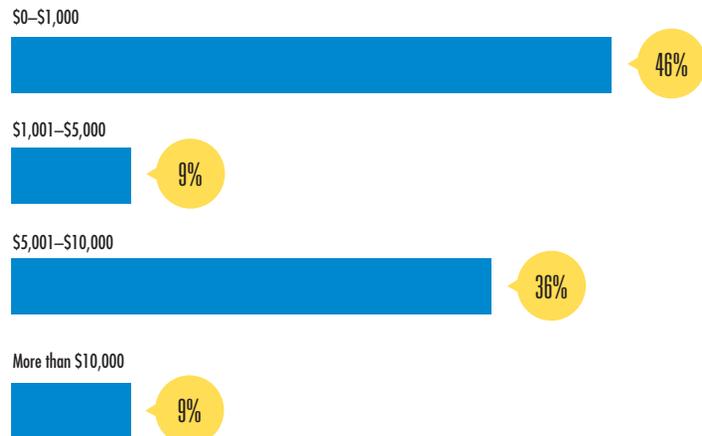


FIGURE 29

Cost Willing to Pay for Pharmacy Consultant (n=14)





MEDICAL BENEFIT DRUG DATA

As health information technology evolves, employer groups may receive more sophisticated information on the cost, spend, management, and trends of their medical benefit. In 2016, 65 percent of employer group PBMs were able to capture medical benefit drug data and 76 percent were able to report utilization data for medical benefit drugs. More than half of that

data (56 percent) was summarized at the HCPCS level, while 44 percent received data at the site of care level. Another 28 percent received the data in aggregate. The majority (85 percent) of employee groups were able to take action based on the data they received (see figures 30, 31, and 32).

FIGURE 30

Data Received from PBM (n=46)

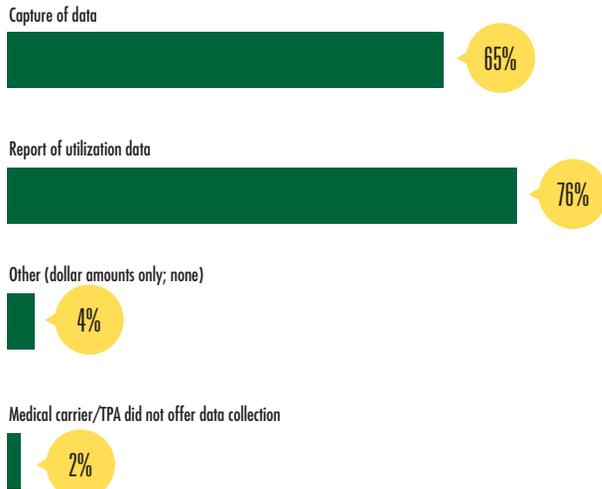


FIGURE 31

Data Summarization Level (n=39)

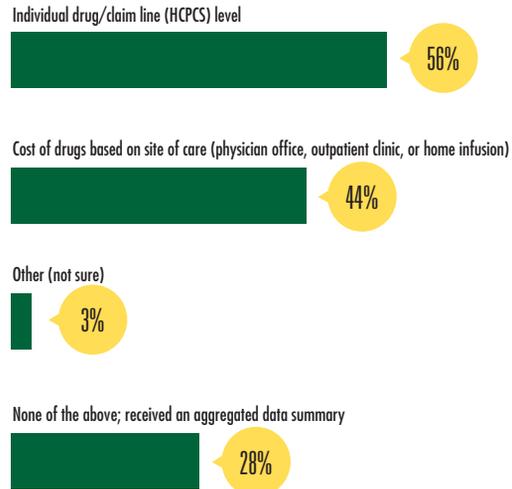


FIGURE 32

Ability to Take Action (n=39)

Yes No





One-third (34 percent) of employers got this data monthly or quarterly; and if their PBM shared the cost of this service with them, there was generally no additional charge for the data (see figures 33 and 34).

FIGURE 33

Frequency Received Data on Medical Benefit Drugs (n=39)

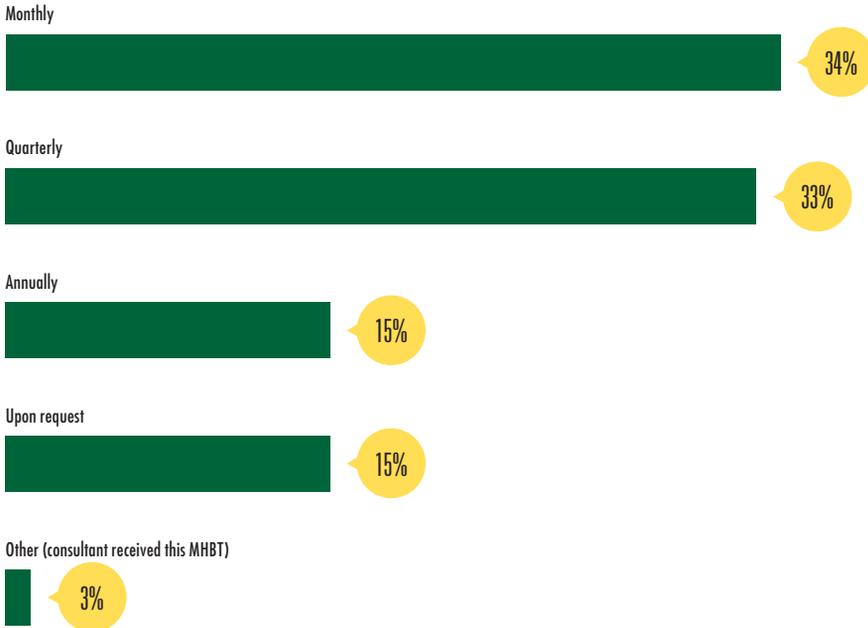
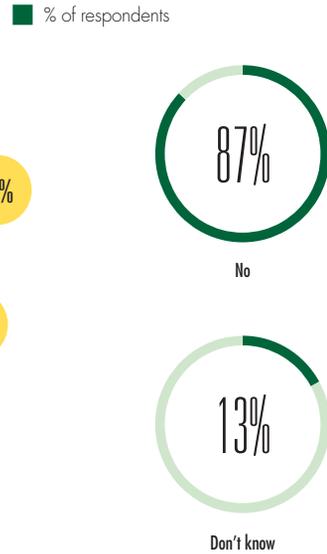


FIGURE 34

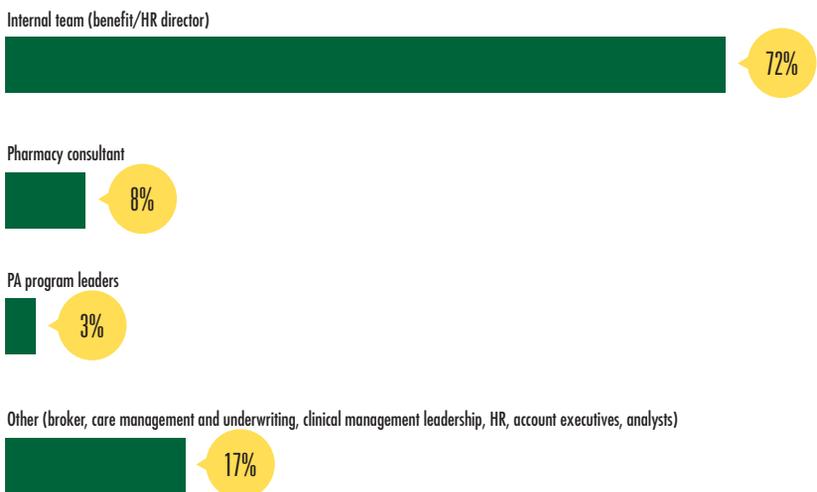
Additional Charge for Data on Medical Benefit Drugs (n=39)



Overall, 72 percent of employer groups assigned an internal team in the benefit or human resources (HR) department to review the medical benefit drug data (see figure 35). We asked employer groups how they used the data to inform their medical benefit strategy. Respondents indicated that a review of the data aided employers in the development of targeted programs, review opportunities for plan design, and analysis of cost-containment strategies.

FIGURE 35

Primary Reviewer of Data (n=39)





2016 REPORT METHODOLOGY AND DEMOGRAPHICS

This report includes an analysis of data from a survey conducted with employers from companies ranging in size from 1,000 to more than 1 million employees. The survey results offer insight into employer-sponsored plans and the management of their medical benefits through medical carriers, TPAs, PBMs, and/or consultants/brokers. The survey questions were related to medical pharmacy drugs (provider-administered infused or injected drugs paid under the medical benefit, also referred to as medical benefit drugs). These medical pharmacy drugs are commonly used to treat cancer, autoimmune disorders, and immunodeficiencies.

For the 2016 survey, the majority of respondents (77 percent) indicated their employees were under Administrative Services Only (ASO)/self-insured plans. Close to one-quarter (23 percent) were under fully insured plans (see figure 36).

Employers offered a variety of products for their employees. The majority (70 percent) offered a commercial product such as an HMO or PPO; 63 percent offered a consumer-directed health plan (CDHP); and 13 percent offered another option, such as a pre-Medicare retiree or Employee Retirement Income Security Act of 1974 (ERISA) plan option (see figure 37).

FIGURE 36

Type of Plan Offered

ASO/(self-funded) lives Fully insured lives

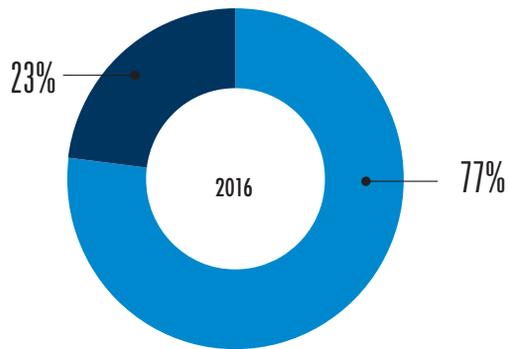
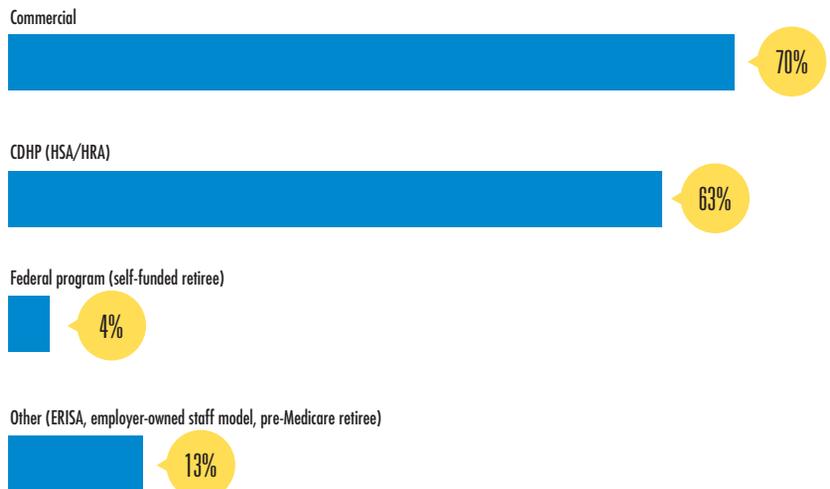


FIGURE 37

Medical Benefit Products Offered to Employees

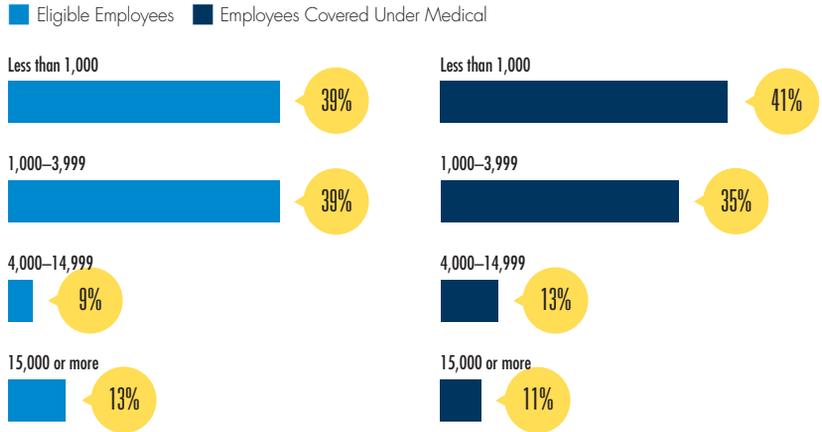




The majority of respondents (78 percent) had less than 4,000 employees who were eligible to be covered for medical benefits. Nine percent of respondents had 4,000 to 14,999 eligible employees, of which 13 percent were enrolled in a plan with medical benefits. (see figure 38).

FIGURE 38

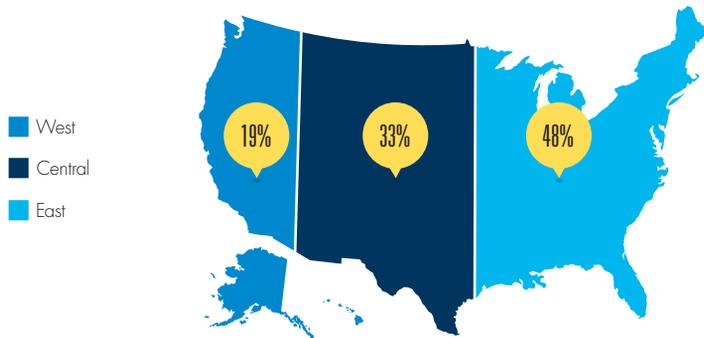
Covered Eligible Employees and Covered Lives Who Received Medical Benefits



Employer group respondents represented all 50 states across the country. Close to half (48 percent) of respondents were representative of the eastern portion of the country, one-third (33 percent) were located in the central region. The remaining 19 percent were employer groups located on the West Coast (see figure 39).

FIGURE 39

Geographic Dispersion of Covered Lives



Throughout this report, we asked employers the type of assistance they received and the influence of their medical benefit administrators. The number of employers under a health plan versus a TPA was split with 43 percent of employers under the health plan and 57 percent under the TPA model. Half (50 percent) of employer group medical carriers were national organizations. Twenty-five percent were local, and 25 percent were regional (see figure 40).

FIGURE 40

2016 Health Plan Versus TPA and Medical Carriers Region

