HealthCore

THOUGHT LEADERSHIP

The Value of Pharmacy and Medical Benefit Integration

Introduction

As health care costs continue to rise, employers and payers are under increasing cost pressure to optimally manage their members' care. Formerly, it was believed that employers could save money for their employees by carving-out pharmacy benefits and purchasing options a la carte. In recent years, more and more large health care providers have been vertically integrating with pharmacy benefits managers (PBMs) to offer more carve-in solutions. With today's technology, having complete data on members from carve-in clients enables health plans to generate a more holistic view of the member. This in turn provides information to ensure members are receiving the right care, which leads to appropriate utilization of health care resources and lower total medical costs. This White Paper explores the impact of integrated Anthem medical and pharmacy benefits on medical costs.

Table of Contents

Executive Summary

The United States spent over $3.5 trillion dollars on health care in 2017, and this is expected to increase to nearly $4.2 trillion by 2022.[1] This translates to $10,739 in annual health care costs per person. While the majority of this cost burden is borne by employers, health insurers, and the tax payer, members have seen a 12% increase in their share of health care costs in 2018 alone.[2] As these costs continue to rise, employers and payers are under increasing cost pressure to optimally manage their members' care.[3]

PBMs

Formerly, it was believed that employers could save money for their employees by carving out pharmacy benefits and purchasing options a la carte. In recent years, more and more large health care providers are vertically integrating with pharmacy benefits managers (PBMs) to offer more carve-in solutions. With today's technology, having complete data on members from carve-in clients enables health plans to generate a more holistic view of the member. This in turn provides information to ensure members are receiving the right care, which leads to appropriate utilization of health care resources and lower total medical costs. This White Paper explores the impact of integrated Anthem medical and pharmacy benefits on medical costs.

Analyses

The analyses for this White Paper include almost 700,000 health plan members who were continuously enrolled over a four-year period (2015 -2018) from over 600 employer groups. An average difference was identified in medical costs of $30.70 (9.0%) less per member per month (PMPM) for employers and their members when integrated medical and pharmacy benefits were purchased through Anthem compared to when employers purchase Anthem medical benefits but carve-out their pharmacy benefits to a third-party PBM. These savings were comprised of a plan paid savings of $26.25 PMPM and $4.45 PMPM lower out-of-pocket costs for members. Member savings are becoming more important to emphasize given the increasing member share of health care costs.

Validation

The design, methodology, and interpretation of the analyses presented in this White Paper were reviewed and validated by HealthCore, Inc. HealthCore is a full-service health care research organization with a 23-year history of leadership and expertise including clinical research, health economics and outcomes research, safety and epidemiology research, health services research and program evaluation, comparative effectiveness, econometrics, and other modeling programs. Established in 1996, HealthCore's associates include experts in biostatistics, epidemiology, health services research, clinical trials, social sciences, and behavioral sciences. For these analyses, HealthCore validated: the member sampling, the methods used for matching cohorts, the statistical analyses that were conducted, and the statistical and clinical interpretation of the outcomes obtained.

Study Members

- **18-64 years of age**
- **48 months of continuous exposure over the four-year time frame (2015-2018)**
- **Included non-retiree, private sector workers, and family members**
- **The final groups were similar in size, actuarial value of the benefit, and access to clinical programs.**

Methods

These analyses looked at medical claims data from 2015-2018 to demonstrate the impact that plans with integrated medical and pharmacy benefits have on medical spend compared to those who purchase these benefits separately.

Time period, duration, and population

This was an analysis of integrated medical claims and eligibility data comparing a study (Carve-in = CI) and comparison (Carve-out = CO) group. Members with continuous medical benefit coverage from January 2015 to December 2018 represented 600 employer groups, including National Large Groups (defined as having 10k+ members in more than one geographic area), National Medium Groups (defined as membership between 1k-10k in more than one geographic area), and Local Groups (all sizes).

All members were required to be between 18-64 years of age, have 48 months of continuous exposure over the four-year time frame (2015-2018), and included non-retiree, private sector workers, and family members. The final groups were selected such that they were relatively similar in size, actuarial value of the benefit, and access to clinical programs.

Brief description of methods used

Within balanced, comparable groups, PMPM medical costs over the four-year time period were compared after adjusting for geography (Milliman Area Factors) and health status risk (DxCG risk scores) and consistent exposure over the time period. The retrospective risk score is a risk adjustment methodology used to predict member costs based on the prior year's claims and to identify member-level complexity/comorbidities. Members with more comorbidities and higher costs have higher scores.

Aggregated costs exclude members with high-cost conditions (i.e., pregnancy, transplants, cancer, kidney failure, or liver failure) and outliers at the 99th percentile (annual top percentage of cost). These analyses evaluated plan paid amounts and member paid amounts combined.

Cost analyses

Medical costs were analyzed using both health plan paid amounts and member out-of-pocket costs from medical claims to achieve a medical cost calculation. Both plan paid and member paid costs (deductible, co-pay, co-insurance) were included as these costs reflect the cost to the health care system, and not just costs incurred by the payer alone. Costs were compared over the entire four-year analysis period.

Results

The final population consisted of 278,285 and 408,137 members in the CI and CO groups, respectively, enrolled for the entire 48 months from 2015 to 2018 and meeting all other criteria. The average age was approximately 44 years old in both CI and CO groups with an equal distribution of sex within the population. The average risk score was 1.5 for both groups. The CI popula-

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tion had a slightly higher proportion of members in the Midwest (47.7% vs 44.5%) and South (33.3% vs. 31.5%), and fewer members in the Northeast (10.6% vs. 14.0%) and West (8.4% vs. 10.0%).

Adult members in groups with integrated pharmacy and medical benefits realized an average savings of $30.70 (range $23.83 - $38.44) PMPM in medical costs, consisting of $26.25 (range $19.62 - $33.06) PMPM plan paid savings and $4.45 (range $3.54 - $5.38) PMPM member paid savings. Inpatient and outpatient costs were 5.5% and 11.6% lower, respectively, for the carve-in members. **(Table 1)**

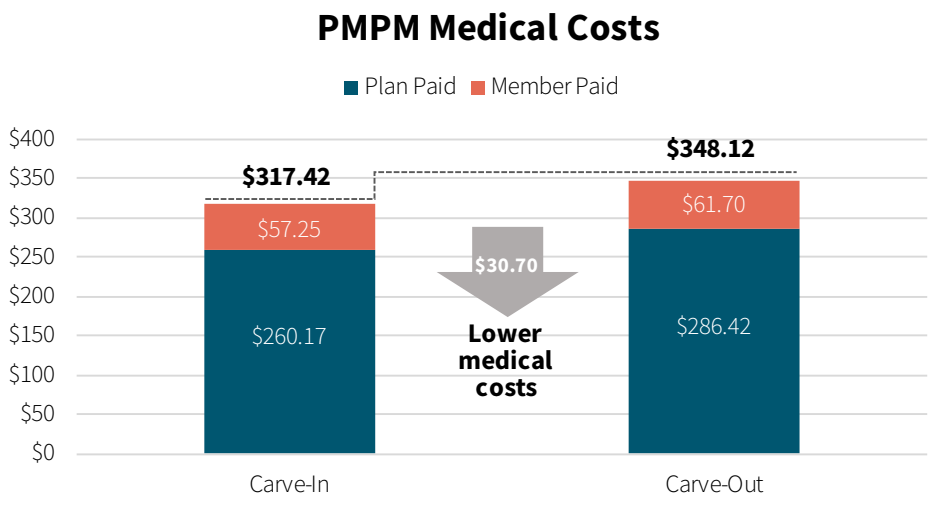
The medical savings for this research population can be attributed to the combined programs and interventions designed and employed by Anthem to optimize members' quality of care. **(Figure 1)**

Table 1. Demographics

Demographics	Carve-In	Carve-Out
Adult Population (≥ 18 and ≤ 64), N	278,285	408,137
Age, Mean (Median, SD)	44.1 (46.0, 12.6)	43.7 (45.0, 12.4)
Gender, %		
Female	48.7%	50.0%
Male	51.3%	50.0%
Risk Score, Mean (Median, SD)	1.5 (0.8, 2.7)	1.5 (0.8, 2.7)
Geography, %		
Midwest	47.7%	44.5%
South	33.3%	31.5%
Northeast	10.6%	14.0%
West	8.4%	10.0%

SD = Standard Deviation

Figure 1. PMPM Integration Savings, 2015 - 2018 ($30.70 lower medical costs)



Discussion

While the results of these analyses clearly demonstrate the impact that integrating pharmacy benefits with medical benefits has on lowering overall health care costs, more work is required to quantify the impact of individual dimensions of an integrated benefit. There are several benefits of integration that are clear:

When pharmacy and medical plans are separated, a member's drug use and management cannot be connected across pharmacy and medical benefits

Cost-management strategies focused only on the pharmacy benefit miss the impact on the total health of the member. Solely promoting lower-cost drugs may actually result in higher total health care costs if analyses and strategies aren't coordinated across all health benefits.

Review of Anthem data has shown that approximately 25% of medication spend occurs on the medical benefit while 75% occurs on the pharmacy benefit. By separating these benefits, health plans and their PBMs lose the ability to manage the overall pharmacy costs properly. This is important for specialty drugs, which represent the largest area of growth, where 42% of specialty drugs are paid by the medical benefit, with a proportion of costs that may be even higher. Using multiple sclerosis as an example, approximately 60% of medication costs are covered under the medical benefit.

Medical policies and clinical criteria should not be created in silos

If benefits aren't connected, policies and clinical criteria may not be consistent. This puts undue burden on the member and provider, impacting cost and timely access to care treatments. It also creates confusion for providers and members if there is a misalignment of criteria for approval of drugs that can be covered under the pharmacy benefit or the medical benefit.

More connected data leads to more actionable insights

When members have integrated benefits, more health care gaps can be identified and closed more quickly, as compared to members with carved-out benefits. By looking at members holistically, potential issues can be identified more easily — such as not taking medications as prescribed, missing important lab tests, or not being prescribed medications that have evidence-based success in treating their conditions.

Case managers who work with members with chronic, 'high-touch' health conditions are an important part of the member experience. Case managers have access to integrated data and care gap information to help members to stay on track with medications and improve their health.

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Optimizing pharmacy benefits in isolation can have unintended consequences

A central component of pharmacy benefits is formulary design which is intended to direct members toward therapeutic options that optimize clinical outcomes at the best possible cost. In a carved-out setting, there is potential for drugs to be evaluated purely from the pharmacy perspective without considering the downstream health impact of a particular therapeutic option.

Medication list management

Anthem's outcomes-based formulary management begins with a careful evaluation of the clinical evidence to determine the true clinical benefits and harms for each drug. Medications with strong, high-quality evidence to improve health are prioritized along with those that have fewer side effects. Economic assessments take into account the impact medications may have on the total cost of care, and not just medication costs alone. In some cases, a more expensive drug can lead to lower overall health care costs.

A variety of strategies are used to manage use of medications with low clinical value and/or high cost that contribute to wasteful spending. Specifically, clinical edits and prior authorizations are used only when clinically necessary to guide therapy towards those that have the best evidence of clinical benefit and minimize use of clinically-inferior therapies. Criteria is consistently applied across both pharmacy benefits and medical benefits.

Many high-cost prescriptions are billed through the medical benefit due to how they are administered

Specialty drugs covered under the medical benefit typically require a health care professional to administer them in a doctor's office, ambulatory infusion center, at home, or in an outpatient hospital setting. Outpatient hospital clinics tend to be two to three times more expensive than the other locations and can also create member inconvenience. Redirecting members from the outpatient hospital setting can result in savings as well as increased member satisfaction. Anthem's redirection efforts are done before the drug is dispensed as part of the pre-certification/prior authorization process on the medical benefit, which helps to minimize any delays in initiating treatment.

Multiple benefit providers generate more work and confusion for members and employers

Members have to keep track of different websites, ID cards, customer service numbers, and sources of coverage information. Employers have to manage multiple contracts, invoices, data feeds, and account teams.

Conclusion

These analyses have demonstrated that integrating medical and pharmacy benefits for Anthem members has shown a medical savings of $30.70 PMPM, specifically in those members who maintain continuous benefits over longer periods of time. The longer a member is enrolled with the same health plan, the more information is available, and thus, quality of care can be optimized.

References

1. Deloitte, 2019: 2019 Global health care outlook l Shaping the future.

2. Blumberg D. (2019). Out-of-Pocket Costs Rising Even as Patients Transition to Lower Cost Settings of Care. Retrieved from https://newsroom.transunion.com/out-of-pocket-costs-rising-even-as-patients-transition-to-lower-cost-settings-of-care/

3. Amadeo K. (June 25, 2019). The Rising Cost of Health Care by Year and Its Causes: See for yourself if Obamacare Increased Health Care Costs. Retrieved from https://www.thebalance.com/causes-of-rising-healthcare-costs-4064878

Appendix - Drug list management

Description	IngenioRx
Formulary Strategy	Promote drugs with evidence to: • Improve health • Keep total cost of health care affordable • Improve member and provider experience
Promote Drugs with Evidence to Improve Health and Lower Medical Costs	Promote drugs that improve member health • Diabetes -- Jardiance • Diabetes -- Victoza • COPD -- Spiriva • Hep C -- Mavyret
Discourage Use of High Cost Low Clinical Value Drugs	Discourage drugs like: • HP Acthar • Ampyra • Farxiga • Invokana • Livalo • Lyrica • Mydayis • OxyContin
Opioids	All programs are standard offerings • Opioid use reduced by 43% • Short-acting opioids reduced by 42% (Sep 2016 vs. May 2018) • Long-acting opioids reduced by 48% (Aug 2016 vs. May 2018) • Overdoses reduced by 11%
Provider and Member Experience	1. Electronic prior authorization (ePA) 2. Proactive prior authorization (PA) leverages integrated medical and pharmacy data to seamlessly approve PA override, if applicable, at point of service
Pipeline Monitoring	Implement PA criteria at the time of launch to help ensure clinically appropriate use
Cost Impact Estimate of Pipeline Drugs (Forecasting Pharmacy & Medical)	Yes
Pharmacy and Therapeutics (P&T) Committee	• Separate clinical and financial committees • Negative changes twice a year • P&T Committee independent and external
Same Clinical Criteria Applied to Pharmacy and Medical Benefits	Yes
Cost Effectiveness Analysis/Value Analysis	Yes
Integrated Pharmacy and Medical Analysis	Yes
Evidence that Formulary Drugs Are Associated with Lower Medical Cost	Yes