GMCB Prescription Drug Cost Advisory Group

Out of Pocket Costs Sub-Group

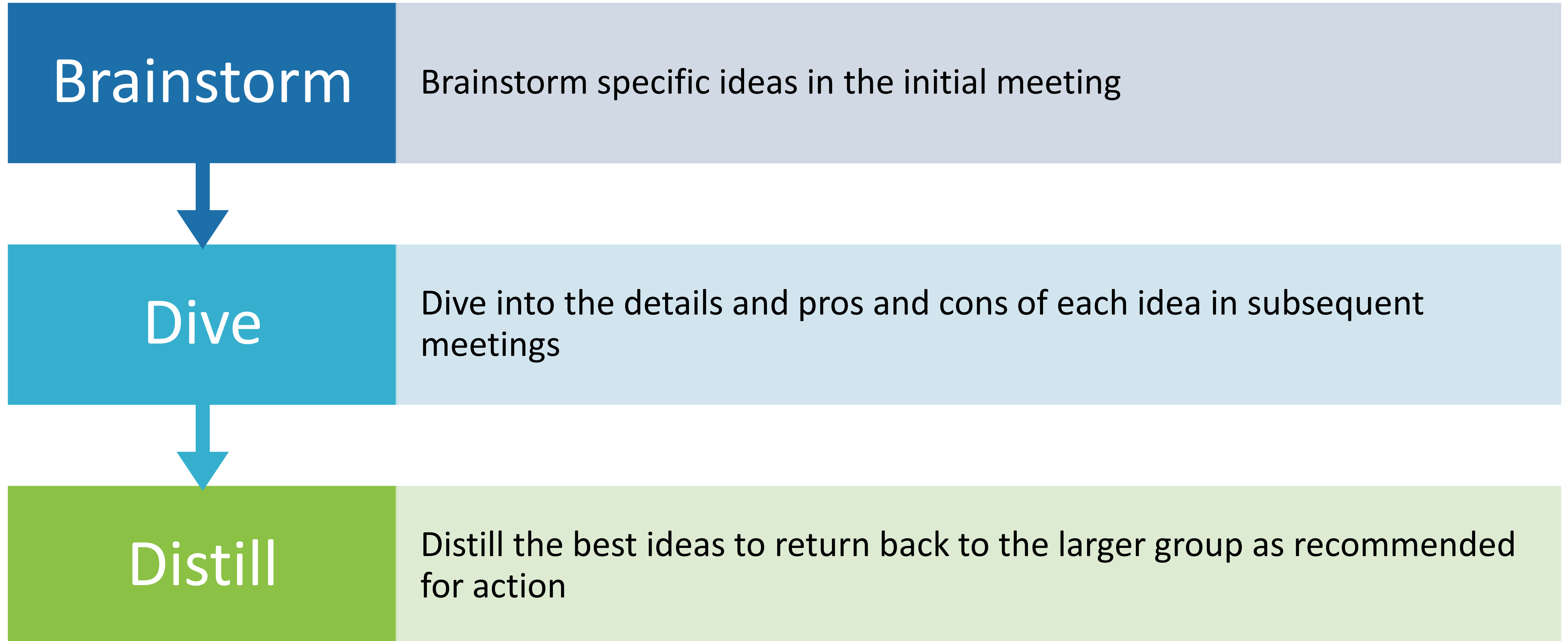
Understanding the problem

Rising out of pocket costs, especially for high-cost drugs, prevent patients from accessing needed treatment.

For patients who don't qualify for Medicaid, or "extra assistance" with Part D copays, there are few options to get help.

Some programs - like discount cards and manufacturer coupons - charge pharmacies high fees and commercialize patient data while providing limited savings to patients and increasing overall costs.

Process outline



Brainstorming Solutions

- Healthy Vermonters
- OOP Maximum Rules
- Manufacturer Assistance Programs (Coupons)
- Resource Hub for Patient Assistance Programs
- Get Medicaid-eligible people signed up (e.g. marketing campaign)
- Enhanced wellness formulary (agreed by VT payers) - adjust cost share for specific drugs
- Pharmacist substitution on therapeutic class
- Modify Eligibility Requirements for Medicare Savings Program (MSP)

Healthy Vermonter Program (HVP) Overview

- The HVP is not maximizing discounts to eligible members.
  - A recent analysis of over 8,000 claims confirmed that, for brand drugs, HVP pricing was the "lower of" pricing on only 26% of claims.
  - Even among members with only Healthy Vermonters and no other insurance, the pricing was not adjusted on over 30% of claims.
  - Of claims that priced off HVP program pricing, an analysis comparing the HVP discount to the GoodRx® Discount for the top 20 drugs utilized by HV members revealed that only two drugs priced lower through HVP versus GoodRx® and by only a 2% margin.
  - In CY2020, a total of 764 members processed 9,432 claims and paid $212,868 out of pocket through HVP. The program eligibility is limited to 350% of FPL, or 400% of FPL for those with Medicare.

OPTION 1: Expansion of the Healthy Vermonters and modification of reimbursement structure

- Eligibility to include all Vermont residents
- Adjust prices to a level more comparable to GoodRx® - the savings obtained here are TBD
- Provide a more meaningful discount and offer consumers less out of pocket exposure.

Pros & Cons

- Any Vermonter could access the drug discount
- Low-cost to create and implement, HVP is already operational. Some costs to gear up for volume, different process than one based on eligibility.
- Pharmacies would likely favor HVP with a competitive discount versus GoodRx® due to the high participation fees of that program
- Non-funded benefit
- OOP exposure less for any given prescription however total OOP exposure under insurance plan would not change

Option 2: Changing HVP to be a limited-funded benefit (State Pharmaceutical Assistance Program)

- Requires legislative changes to enacting statute. Substantive rulemaking would be necessary.
- Provides a capped benefit (amount to be determined) for eligible consumers including high deductible plans and copayments.
- Benefit caps and number of enrollees limited by allocation of funding
- Could also be beneficial for lower income Vermonters who have Medicare but are not eligible for Medicaid, VPharm, or the Low-Income Subsidy (LIS), as HVP could assist them when they are in the coverage gap of their drug plan.
- Eligibility criteria could remain the same: Vermonters with household income equal to or less than 350% FPL; or less than 400% FPL if 65+ or disabled and eligible for Medicare.

Option 2: Changing HVP to be a limited-funded benefit (State Pharmaceutical Assistance Program)

There are two potential funding sources for Option 2:

- 2A) The Legislature could require the 14 Vermont hospitals participating in the 340B drug discount program to allocate a small percentage of their 340B savings to fund the HVP limited benefit program.
- 2B) DVHA could fund the limited benefit with State dollars. The program should not rely on rebates however, as a stand-alone program, it is unlikely to be well supported by drug manufacturers. (Funding sources for state dollars could include fees paid by drug manufacturers).

Option 2: Changing HVP to be a limited-funded benefit (State Pharmaceutical Assistance Program)

Pros and Cons:

- Funded benefit/capped dollar amount per person of assistance with out-of-pocket drug costs. Because state law sets an OOP maximum exposure for individuals/families with non-ERISA plans, this program could potentially cover their entire OOP exposure annually.
- Most administratively burdensome option to operationalize and possibly the most expensive to implement.
- It would only cover Vermonters at or below 400% FPL.
- It is unknown if the 340B entities would support this but given a choice, 340B entities would most likely prefer Option 3 over Option 2.
- Could desensitize members to drug costs and remove incentives for making cost-effective drug choices.

Option 3: Modify HVP to a 340B Contract Pharmacy Program

- Members would receive drugs at no cost from a pharmacy contracted with a 340B entity
- Drug cost and pharmacy dispensing fee would be funded by 340B entities in Vermont
- Most of the time, a partial payment from the primary insurer is enough to cover the 340B acquisition cost and dispensing fee for the entity and pharmacy.
- The drug, prescriber, pharmacy, and patient all must be eligible for 340B discount. How many people might fall into these categories together is currently unknown.

Option 3: Modify HVP to a 340B Contract Pharmacy Program

Pros and Cons

- No/minimal expense to the State and Taxpayers
- No/minimal expense to 340B entities
- Members would have no OOP cost for 340B eligible drugs.
- Should be generally supported by hospitals, FQHCs, and RHCs as it is self-supporting as reported by UVMMC.
- Majority of Vermonters believed to have access to the benefits of this Option.
- Could cover all Vermonters regardless of income?
- The average Vermonter is not familiar with how the 340B program works, may be difficult to understand why some prescriptions are covered and some are not.
- Doesn’t serve all members, at all times, for all drugs
- This option may be opposed by non-qualifying entities
- Further research needed re: geographical access for members

Modify Eligibility Requirements for Medicare Savings Program (MSP)

Description: Raise income limits for the Medicare Savings Program (MSP). Currently eligibility limits are 100% Federal Poverty Level (FPL) for Qualified Medicare Beneficiaries (QMB), 120% FPL for Specified Low-Income Beneficiaries (SLMB), and 135% FPL for Qualified Individuals (Q-I1). Several states have higher income limits than Vermont. Connecticut and D.C. are the best models for consumer affordability.

- **Pros**
  - This would significantly lower the cost of services and prescription drugs for Vermont Medicare beneficiaries.
  - Focusing on the prescription drug benefit:
    - If someone is on a Medicare Saving Program, they are automatically deemed eligible for federal program called, Low Income Subsidy (LIS), also known as “Extra Help” that helps pay for Part D premiums and keeps co-payments low.
    - More Vermonters would receive help with Medicare premiums and cost-sharing.
- **Cons**
  - Cost to state (partially offset with federal match).

OOP Maximum Rules

- Current annual limit of $1400, legislature just added monthly OOP max for insulin ($100 for all types of insulin)
  - Only applies to VT exchange and large group plans (not self-funded plans)
    - Around 70-80k lives in Vermont (BCBSVT, MVP, Cigna etc.)
  - Consider monthly cap for all drugs
    - Does any other state do this? Haven't been able to identify any that do
    - Are there other plans that do this now?
    - Standardizing monthly cap could reduce consumer confusion
  - Some consumers may prefer to cover OOP max up front and then not pay the rest of the year
  - May increase premiums (decrease overall cost-share from plan members)
  - If you limit drugs, may need to increase medical OOP costs to hit AV (actuarial values) targets for metal levels
  - Indexing it – account for drug price inflation and how it interacts with AV values
    - Index to the medical (health care) CPI or prescription drug CPI (https://data.bls.gov/timeseries/CUSR0000SEMF01?output_view=pct_3mths)

- **Recommendations**
- Simplify and streamline conflicting rules
  - Medical caps, pharmaceutical caps, new insulin caps
- Develop a unified cap
- Consider monthly out of pocket cap
  - Would help with patient budgeting

Manufacturer Assistance Programs (Coupons)

- Consider possibility that they increase total costs
  - Direct patients to brand drugs instead of generics
  - Leave patients on brand drugs after coupon program ends
- Pharmacy fees and costs
- Increases administrative complexity
- No visibility to payers
- Uneven access to programs
  - Some are eVoucher, some are not
  - Some programs require application process (esp foundation funding)
- These programs are prohibited for patients using federally funded plans (CMS, Tricare) as "inducement"
- Can't eliminate these without further research because some patients do rely on them for access
- Mass. study (Adherence, other issues, from Sara: https://www.mass.gov/doc/prescription-drug-coupon-study/download)

- **Recommendations**
  - State should consider regulating coupons (perhaps starting by mandating reporting on pharmacy fees, cost of coupons, other elements examining the practice)
  - Prevent negative financial impact on consumers through increased premiums by preferring brand drugs
  - Address consumer protection issues – use of PHI
  - Prevent suspension of coupon programs without sufficient notice to patients

Patient Assistance Programs

Recommendations

Central source for Vermonters as to what programs are available

- Website, database
- Perhaps via 211 or health care advocate's hotline
- Programs can include foundation supported programs, manufacturer programs, FQHC sliding scale structures, hospital-supported programs, etc.
- Resource provides access to wide audience on nature of program, requirements, support offered

Get Medicaid-eligible Vermonters enrolled

- **Recommendations**

- Explore ways to expand outreach to eligible individuals via DVHA (may receive FMAP match?)
- Raise awareness of HCA hotline that can help patients address affordability
- Investigate easier ways for individuals to enroll in Medicaid (e.g. via tax forms)

Get Medicaid-eligible Vermonters enrolled

- What outreach happens now to enroll people in Medicaid?
    - Grassroots
    - Assistance from agencies and providers?
    - Hospital FAP programs and registration folks help, FQHCs may as well
    - Capability of hospitals may be uneven, room for improvement
    - What about people who don't interact with hospitals or do rarely
    - Nursing facilities help with enrollment too
- What % of uninsured patients in Vermont are eligible? What about people who are on catastrophic or otherwise poorly covering plans?
    - Health sharing ministries (some Medicaid eligible? If so, would they care?)
    - Other religious objectors may just be uninterested in traditional coverage or health care
    - Short term limited duration insurance (barred in Vermont now)
    - This data question was analyzed during consideration of a statewide mandate several years ago
    - Does GMCB have this data?
    - Household survey may be a good source – Emily will look for info
- Another state may let people enroll in Medicaid through tax forms, give more information on subsidies for exchange
    - Not all Medicaid eligible folks will be filing taxes
- Did the health care navigator folks help with Medicaid enrollment? (No longer active, funding discontinued)
    - May be re-implemented for smaller part of the population (CMS $80m funding opportunity for navigators; only in states with federal marketplace – not Vermont)
    - The CMS-funded navigators do the exchange, Medicaid and CHIP
- Health care advocate office helps people enroll in Medicaid
    - Hotline helps people who need coverage or have been denied coverage (Medicaid or commercial)
    - Some pharmacies refer people to HCA when they can't afford their medication
        - Can help identify Medicaid eligibility, cost-sharing assistance (selecting the right plan to get full subsidies)
    - Get more people to the hotline, raise awareness
- DVHA may not have a budget for outreach; doesn't really have a good way of reaching members either
    - Population may be moving a lot, transient, homeless (also means hard to target with outreach)
    - If it went into the DVHA budget, may get federal match (FMAP)
- Who is covering costs associated with uninsured patients now? Health care providers, hospitals

Unused Drug Repository

It is estimated that the U.S. annually wastes $5 billion worth of unexpired prescription drugs in unopened, tamper-proof packaging

- S 164 (Act 114) passed and signed by Gov in May 2018 asking AHS, Board of Pharmacy, Board of Medical Society to evaluate
- AHS issued a report in Dec 2018; approx. cost of $300-$350k based on estimate provided by SafeNetRx. Iowa reported a cost savings of $8 for each $1 invested in the program
- Comparator program called SafeNetRx (Iowa) was evaluated
- SafeNetRx is an Iowa-based 501(c)3 established in 2001, 20 yrs experience
- They operate Charitable Pharmacy a non-profit, mail-order pharmacy serving Iowans
- In 2019, the Drug Donation Repository distributed over $7.6 million of medication, of which $2.4 million were cancer medications
- Meds can be donated if they are in a sealed package (unit dose, syringe pack). Pharmacists inspect donated drugs, determine if they are safe / sealed
- Donations are received from long-term care dispensing pharmacies, medical facilities and individuals
- Drugs become available for other people to use via a pharmacy

- Contract / service managed by a state agency or by a non-profit in VT?
- SafeNetRx program reports receiving drug donations from nearly all 50 states
  - Currently only serves Iowans (FPL<200%) but Vermonters could be granted access to the program
  - DSCSA / issues with recalls etc. recalled as concerns
- **Recommendations: Reconnect with SafeNetRx and revise the cost estimate. Revisit this option from 2018 to see if economically viable for Vermont or if other states have developed new models**

Pharmacist Therapeutic Substitution

- Act 178 allows pharmacists to make therapeutic substitutions for the purpose of reducing costs (as an expansion of the existing authority to make generic substitutions) or complying with payer requirements for therapeutic selection
    - "Therapeutic substitution" is defined in the statute
- GMCB can be supportive of these efforts, push the establishment of protocols and raise awareness among providers, pharmacists, patients
- Evaluate the e-prescription standard, and the interface in prescribing systems e.g., a checkbox for therapeutic substitution? Are providers using free text to indicate approval for therapeutic sub?
- Evaluate whether there are barriers to using this authority. How can we facilitate implementation?
- Is the Board of Pharmacy writing rules/guidance for this?

Appendix

Food Farmacy – Table for now

- Benchmark Analysis Working Group (the Benchmark plan is sold on the exchange) is taking this up, instead of the OOP Costs sub-group
  - Might be an element of the benefits of the plan (part of the wellness section)
  - OOP subgroup might return to this topic if the Benchmark process doesn't end up incorporating the food farmacy concept
- Providers prescribe food instead of prescribing a drug to address food insecurity (related to health conditions like diabetes), social determinants of health that lead to chronic conditions
  - Cost of the program compared to cost of treating chronic conditions, benefits from food access demonstrates an overall savings in health care costs
- Patients take the food farmacy order to a CSA or food delivery service (there is a program for new moms for ready-made meals for delivery)
  - Funding source for participation unclear (hospital funded? Medicaid?)

Funded HSAs/HRA (funded by whole group / company)

EMPLOYER FUNDED

SELF-FUNDED (PEOPLE CAN TAKE ADVANTAGE OF PRETAX SPENDING)

ALLOW PRE-TAX SPENDING (ENCOURAGE USE OF HSAS TO COVER COSTS)

Enhanced wellness formulary (agreed by VT payers) - adjust cost share for specific drugs

- Limited list of drugs with no cost share already (perhaps for commercial plans)
- Idea to expand the current drug list
- Need info on current state (no wellness formulary requirement in statute or reg per Emily)