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November 25, 2014

The Honorable Mayor Dan Devine
and Members of the Common Council
7525 West Greenfield Avenue
West Allis, WI 53214

Dear Mayor Devine and Common Council Members:

Recommended changes to the health insurance program, for plan year effective date of March 1, 2015, were introduced as part of the City's 2015 Budget. A portion of those changes were acted upon and subsequently approved through said process. However, as you may recall, prior to making any decision with respect to the prescription drug program the Administration and Finance Committee requested additional information on the recommended changes pertaining thereto. The attached document prepared by the City's health insurance consultant, Willis, in conjunction with the City's health insurance third party administrator, Humana, provides further details on these items for your consideration:

- Prior Authorization;
- Step Therapy;
- Quantity Limits;
- Generic "*Pay the Difference*" Provision; and,
- Specialty Pharmacy Co-pays.

I will be present and available to address your questions or concerns at the upcoming meeting.

Sincerely,

Audrey Key
Human Resources Director

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Prescription Drug Clinical Program and Benefit Plan Administration Recommendation for 2015

Prior Authorization (PA)

Physicians have wide discretion in their prescribing practices. A prior authorization program attempts to make sure that medication is being used properly – as approved by FDA (that means the approved diagnosis, dose, route and interval). 1% - 2% of all drugs covered by Humana carry a PA requirement. When PA is required, the prescriber is asked to submit the clinical documentation supporting his / her use of the drug in the fashion they desire. Once the paperwork is received by Humana we usually make a determination within 24 business hours. If the request cannot be approved the prescriber is offered an opportunity to discuss the case with a Humana physician, a process we refer to as Peer to Peer review. The purpose of that conversation is to give the prescriber an opportunity better explain his / her intention as the paperwork may not have clearly shown the intent. It also gives the Humana physician an opportunity to talk about current standards of care in the field. The Peer to Peer review may result in approval or the mutual agreement to select a different therapy. If the Peer to Peer does not result in an approval or treatment alternative the member may exercise their rights under the Appeals process.

Step Therapy (ST)

Step Therapy seeks to ensure that tried and true low cost alternatives are the first line of therapeutic choice when treating certain health disruptions. Usually we are referring to using generics before brands, and preferred brands before non-preferred brands. For example, there is no clinical reason to prescribe Nexium (which costs over $200 per month) as the first treatment option for a member with a new diagnosis of acid reflux when a generic like omeprazole (costs about $10 per month) will work just as well in 99.9% of the population. If a member or physician disagree with the protocol they may use the same process as outlined in the PA section above to find resolution.

Quantity Limits (QL)

Contrary to popular belief, the main reason for quantity limit edits is safety, not cost containment. Obviously cost containment is a factor, but it's not the primary reason for this clinical program. Consider this: The popular migraine-relief drug Imitrex usually carries a quantity limit of 9 tablets per month. The drug works to relieve headaches by constricting the migraine-sufferer's blood vessels. The drug is not so specific that it can target just those blood vessels in the brain and doesn't "know" when the blood vessels have been constricted enough to relieve the headache. So if a person takes too much medication they could end up with serious side-effects like stroke or heart attack. So when the FDA approved the product they stated something like the following,

"Take one tablet for migraine headache. If the headache is not relieved in XX minutes, take one more tablet only. If the patient is experiencing more than 4 migraine headaches per month, this is likely not the proper therapy." So, four headaches times 2 tabs each equal eight tabs per month. But the maker of Imitrex packages it in packs of 9. No one expects pharmacists to break these packs apart at the counter so most carriers / PBM's placed a quantity limit of 9 tabs on Imitrex.

Generic Pay The Difference Provision

Here is the language from the City of West Allis / Humana New Case Document (NCD):

CO-PAYMENT DIFFERENTIAL LOGIC

1. This Plan requires the use of generic drugs only. If an employee/eligible dependent chooses to purchase a brand name drug, and an equivalent generic is available, he/she must pay the difference in cost between the brand name and generic equivalent, plus any applicable generic co-payment, regardless of who is requesting the brand name medication. If the physician writes on the prescription "dispense as written," the drug will be dispensed as such; however, the employee/eligible dependent will still be required to pay the difference in cost between the brand name drug and the generic equivalent, plus any applicable generic co-payment.

If an employee/eligible dependent purchases a brand-name drug, and an equivalent generic is available, the employee/eligible dependent must pay the difference between the brand-name cost and the generic cost plus any applicable generic co-payment. If the physician writes on the prescription "dispensed as written" the drug will be dispensed as such, the employee/eligible dependent will only be responsible for the brand drug co-payment.

The employee/eligible dependent is never responsible for the cost difference between the brand name drug and the generic equivalent; regardless of who is requesting the brand name medication.

The rationale behind this approach is not to make generics mandatory, but to give members the choice. But if they choose a brand that has a generic equivalent available they pay the difference in cost. That way the Plan is kept whole financially.

Specialty Pharmacy Co-Pays

Thus far in 2014 the average allowed amount (*cost of drug discount and before member cost share*) is around $3500 per script. People on these meds are typically the most ill and most fragile in your population. What is most common is a copayment that is a percentage co-pay with a per script maximum. This way the member is reminded of the cost of the drug but also is protected from undue financial hardship. A reasonable recommendation would be a 5% cost share to a maximum of $100 per script for a Specialty Prescription.