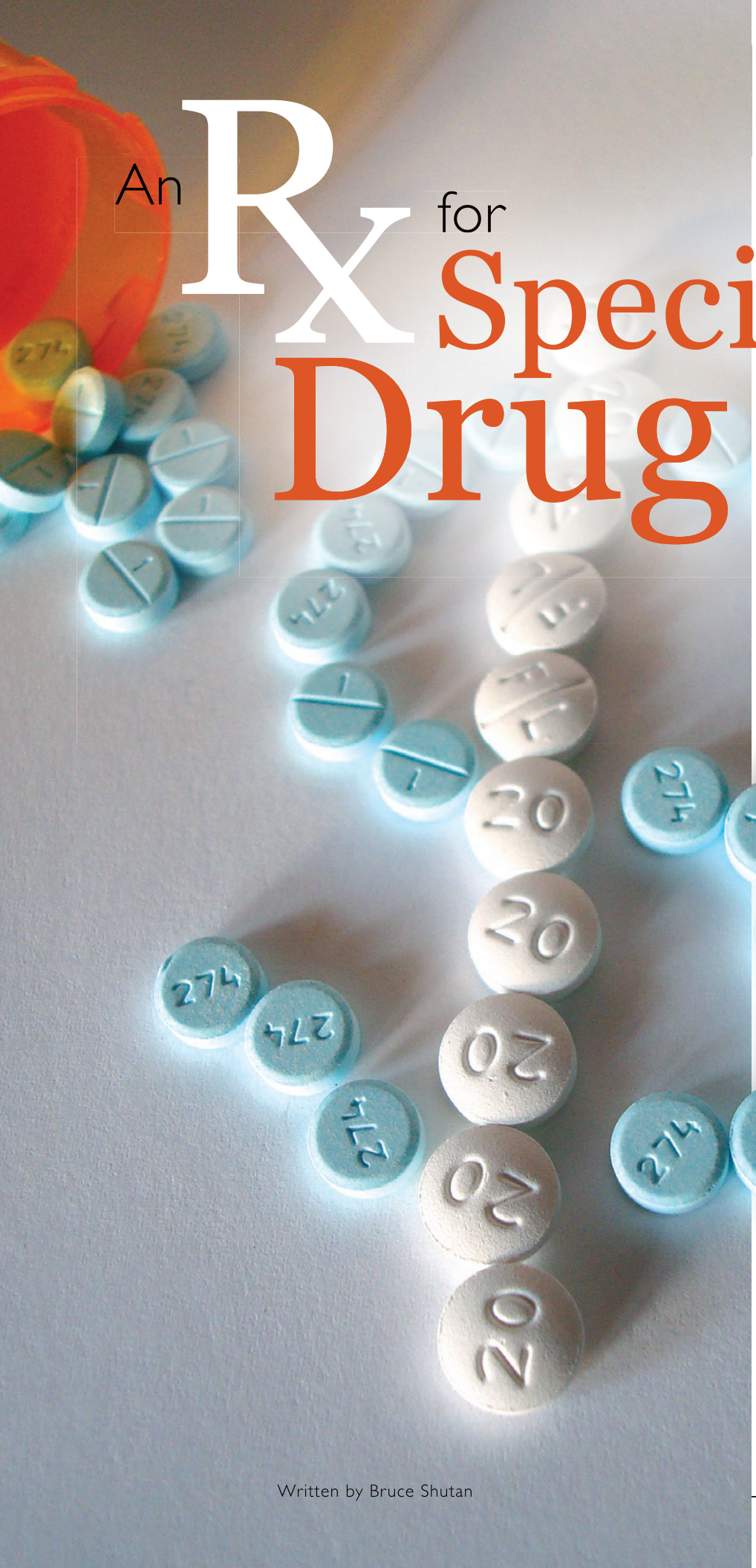


An Rx for Specialty Drug Management

Key to success lies in better PBM contracts, plan design tweaks

Written by Bruce Shutan

Specialty drugs have long shown promise as a prudent alternative to surgery for treating chronic and costly conditions, but they also come with a high price-tag that self-insured employers have struggled to manage.

One culprit, or course, is that they're fueling skyrocketing health care expenses at a harrowing time of no benefit caps under the Affordable Care Act. While the nation's specialty drug spend was $87 billion in 2012, or 3.1% of the overall U.S. health care tab, it's expected to top $400 billion, or 9.1% of that spend, by

2020, according to an American Pharmacists Association report. Some analysts predict that as many as 7 of the 10 best-selling drugs could be specialty products within 4 years.

A recent survey by Aon plc found that specialty scripts are expected to climb 22.7% this year from 18.2% in 2014 – more than twice the hike in overall pharmacy costs, which could reach 10% from 6.3% within the past year.

With specialty drugs averaging more than $3,000 a month and some scripts exceeding $20,000 a month, the Pharmacy Benefit Management Institute (PBMI) notes that it's critical to understand how those costs can be managed in conjunction with maximizing clinical quality and outcomes.

PBMI publishes an annual specialty drug benefit trend report that offers health care purchasers significant insight into this topic. But there's a serious lack of knowledge about the way these medications are priced, as well as enough sophisticated expertise across the marketplace to help the self-insured community actually bend the specialty Rx cost curve.

Negotiating Meaningful Discounts

Self-insured employers need to carefully review their contracts with a pharmacy benefits manager (PBM) to ensure that the right protections are in place so that they can better control their specialty drug benefits spend, explains Linda Cahn, president of Pharmacy Benefit Consultants and head of the National Prescription Coverage Coalition.

She says every PBM client needs to ensure that it is receiving a "minimum guaranteed discount" for *every* existing specialty drug (currently more than 950+ drugs), as well as an automatic "default discount guarantee" for every new-to-market specialty drug. These guarantees are based on average wholesale price (AWP). PBM clients also must have a contractual "right to renegotiate" every specialty drug discount, she notes, to prevent being locked into pricing that will undoubtedly become obsolete relatively soon after the three-year contract begins.

The thinking is that unless every specialty drug – including every new drug – has a guarantee, the PBM can charge what it wants for non-guaranteed drugs.

So-called spread pricing is one mechanism used in a traditional PBM model, according to Brian Ball, a broker and national VP of employee benefits strategy and solutions for USI Insurance. That's when a PBM pockets a piece of each claim instead of charging fixed administrative fee. Noting that specialty drugs are expensive in their own right, he says there's no governing body to rule whether the "up-charge" is excessive.

Another issue Ball considers noteworthy is when PBMs negotiate a preferred price or rebate with drug manufacturers for scripts in competitive categories that may not necessarily be in the best interest of an employer client or patients. The PBM's can then direct utilization through tiering co-pay benefits to drugs in which have the most financial benefit to the PBM. In many situations PBMs are making patient approvals of drugs where they make large sums of money, a true "conflict of interest." The PBM makes more money if they approve the drug. "Philosophically, I have a major problem with that," he says.

Jane Lutz, executive director of PBMI, declined to address the contracting component of specialty drug benefits. "We don't manage, monitor, write or even review PBM contracts," she says, adding that "specialty drug costs continue to be a growing concern for employers of all sizes and with all funding types."

Lutz did, however, point to a lack of consensus on what needs to be done, as well as a largely reactive approach among employers with inadequate education that are unsure about the right questions to ask their PBMs.

Industry consolidation could be troublesome for uneducated purchasers of specialty pharmacy benefits. "When you look at the mergers and acquisitions over the past decade with regard to the PBM space, look at the multiples they're generating," observes Rob Melillo, second VP and head of stop loss at the Guardian Life Insurance Company of America.

His larger point is that self-insured employers and their partners together must determine the way specialty scripts are priced and pinpoint where exactly their high-end Rx spend is leaking as part of a more transparent approach. Otherwise, they'll never be able to negotiate any substantive impact on cost.

The brokerage community could play a significant role by devoting more time to specialization of the health care spend and varying facets, Melillo believes. He says self-funded clients can use their assistance identifying volatile components within the specialty drug spend that they would like to better manage and getting PBMs to reveal "where the spread is on their charge-backs, or how their rebates are handled and managed."

Stepping in the Right Direction

There are several other substantive solutions at hand for self-funded health plans that want to track their specialty pharmacy benefits drug spend with greater

precision. Ball says it's critical to ensure health plans are getting the best possible price on each drug, as well as controlling utilization of those drugs by using prior authorization, step therapy, or alternative scripts to control the access and utilization of these costly specialty meds.

He cites as an example the new once-monthly injectable to treat hyperlipidemia, or high cholesterol. "If Atorvastatin, the generic version of Lipitor, is working effectively and is costing $150 a year for the drug, a person shouldn't be able to go directly to the $12,000-a-year injectable without having first tried the tablets," Ball notes.

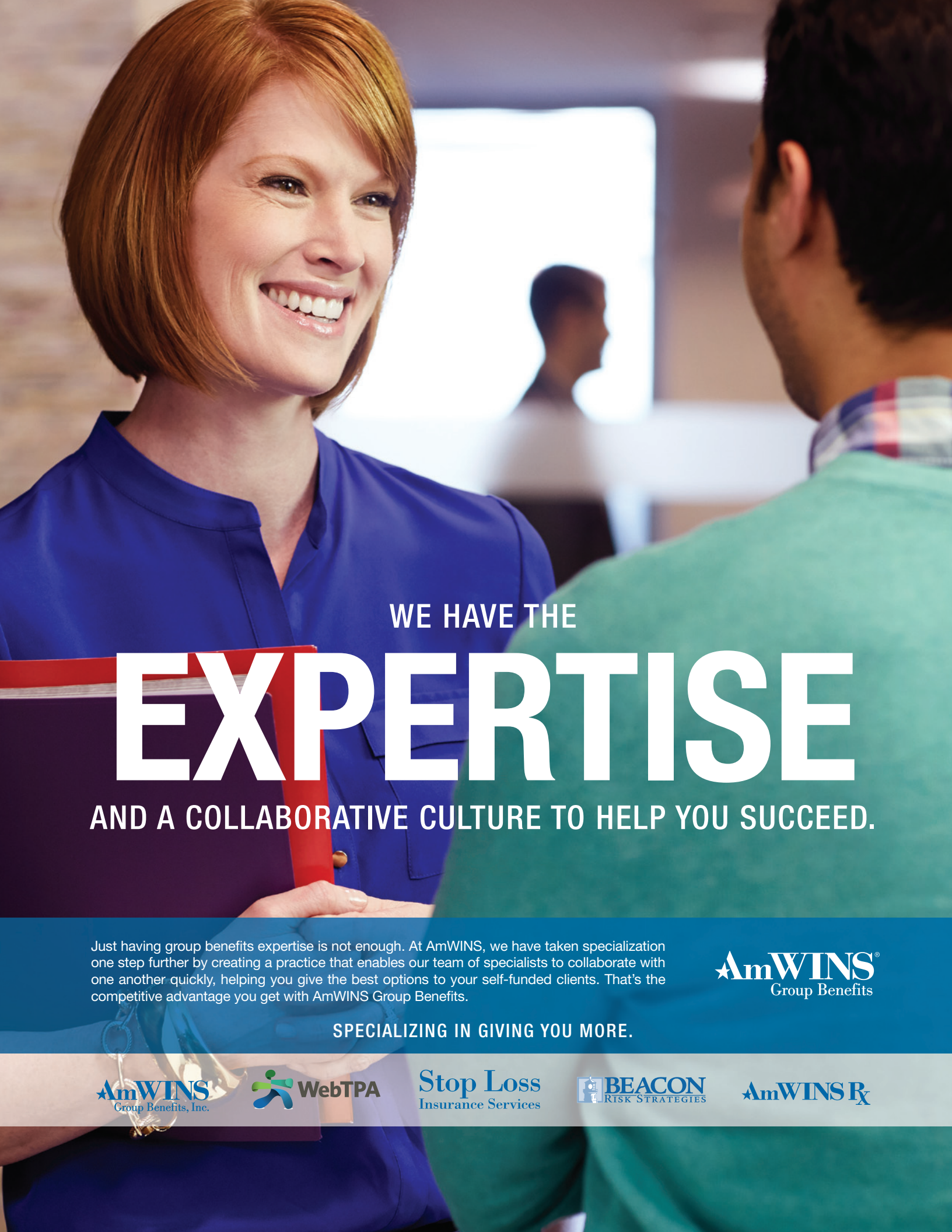
Another strategy involves the work of sophisticated specialty carve-out vendors that negotiate deals with specialty drug manufacturers. He describes the arrangement as a budding business and a possible solution to reduce cost of specialty drugs. In many situations, specialty drug management is not always getting the attention it deserves.

Cahn says the first step along the road to taming specialty drug costs is to replace the typical contract definition for "specialty drugs" with an "airtight" definition that typically states these scripts may be high-cost drugs or may require special handling, etc. An airtight definition will pin down exactly which meds are specialty drugs by cross-referencing to a list of all 950-plus drugs and including all new-to-market specialty drugs.

The next step is to make sure that the contract includes a mandated discount for each drug on the list, each time the drug is dispensed from the specialty pharmacy, she says. If employers are conducting a request for proposal, then they can compare the discounts each PBM is offering and tell those that are not providing competitive discounts to improve them if they want to win the contract.

Another step Cahn suggests is that contracts enable employers to address any changes in pricing that might occur. Employers need a right to renegotiate, or improve upon, a particular drug's discount guarantee. "Available pricing for specialty drugs is continuously changing," she says, "and given that fact, everyone must be positioned to update and improve contract guarantees. You can't lock yourself into the same discounts for the length of a contract."

In addition, she says it's imperative for PBM clients or health plans to retain control of prior authorization, step therapy and quantity limit programs; otherwise, PBMs can secretly make deals with manufacturers to use these programs to favor certain high-cost products in exchange for being paid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financial benefits that might not even be passed through as rebates. Assuming a client obtains a "right to review and customize" all programs, she says the employer needs to exercise those rights to protect itself against inappropriate PBM decisions.

Two major problems, Cahn cautions, are the industry-wide absence of expertise for drafting specialty drug contract terms and a similar lack of expertise for following up to address continuous marketplace changes. However, if enough employers wrest control of the process by implementing appropriate contract terms, then it stands to reason that consulting firms will develop expertise to take advantage of those terms and thus better control specialty drug costs for their clients. Without such changes, she notes the potential for perilous consequences for employers.

There's an App for That

Thankfully, technology has advanced to a point where price-estimator tools are now available to help manage pharmacy prescriptions and save money. Ball mentions the availability of apps that can be downloaded to assist the member in finding the cheapest alternatives.

"If you put in Harvoni, which is a hep C drug and you put in what is the cost of Harvoni with insurance, it's going to say something like $32,000 per script," he says. "If I'm a member who needs Harvoni and I don't have insurance and there's a coupon associated with it, the cost is somewhere around $4,000. There's a $27,000 or so difference on whether or not I have insurance. Something is fundamentally wrong with that if the employer is left paying that huge bill. Because the employer has money, they're going to charge them that much. That, to me, is the fundamental flawed.

Lutz reports that the specialty drug spend on cancer treatments has reached "an all-time high and the drug pipeline would indicate that category is going to continue to grow." But she also points to improvements in cancer care and overall survival rates that are worth noting, albeit at "very large price tags."

In addition, she says employers are dealing with promising new therapies in the area of hep C and super-statins called PCSK9 inhibitors.

"What we're hearing is that many of these are coming to market mid-year after benefit budgets have already been set and really leaving employers facing tough decisions around the benefits and very big concerns around being able to offer sustainable and affordable benefits to their employees," Lutz observes. ■

Bruce Shutan is a Los Angeles freelance writer who has closely covered the employee benefits industry for more than 25 years.