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News and Strategies for Managing High-Cost Specialty Products

Plans Should Look at Individual Data When Considering Medical vs. Pharmacy Benefit

Moving specialty drugs from the medical benefit to the pharmacy benefit has long been viewed as an effective management tactic by some industry experts. Others, though, contend there are good reasons to keep some drugs in the medical benefit. And while two recently released reports have reignited that debate, the best advice for plans may be to determine what's best for them based on an analysis of their own data.

In early March, specialty drug services firm Artemetrx LLC released An Evaluation of Specialty Drug Pricing Under the Pharmacy and Medical Benefit, which was prepared by two Artemetrx employees. About a month later, the CVS Caremark Corp.-commissioned Evaluation of Medical Specialty Medications: Utilization and Management Opportunities, which was prepared by Milliman, Inc., was released.

The Artemetrx study looked at pricing in pharmacy and medical claims for Epogen and Procrit (both branded versions of epoetin alfa), Neulasta (pegfilgrastim), Remicade (infliximab), Tysabri (natalizumab) and Xolair (omalizumab) among 10 different commercial plan sponsors. "These drugs were selected because they represent high aggregate expenditures and are frequently paid under both the medical and pharmacy benefits, allowing for direct comparison within the claims data," says the report.

Researchers compared prices for the drugs when billed by physician offices or home infusion providers with those prices billed by pharmacies. Drugs in the outpatient hospital setting were not included because "it is widely recognized that drug pricing in the outpatient hospital setting is typically 2-3 times that of the physician office for commercial plan sponsors," the report contends.

It found the "prices per unit dispensed" were higher for the drugs under the pharmacy benefit than for those on the medical side. "Across all plan sponsors, the mean price was 4% to 38% higher under the pharmacy benefit, depending on the drug," says the report. The Milliman study looked at multiple self-administered oral, inhaled and injectable drugs, as well as provider-administered injectables and infusibles that "represent 43% of medical specialty allowed cost."

Provider-infused agents did not include oncology drugs. There were 30 targeted categories, including allergic asthma, autoimmune conditions, erythropoiesis-stimulating agents, multiple sclerosis and respiratory syncytial virus, and more than 100 drugs included in the study.

That analysis was based on Milliman's Health Cost Guidelines 2012 claims data and included commercial group members. The report found that shifting products in 14 classes of self- and provider-administered drugs from the medical benefit to the pharmacy benefit can save payers an average of 19%. Of that percentage, the report claims that the following savings were shown when drugs were moved to the pharmacy benefit:

- Injectable drugs administered in the hospital outpatient department showed an average savings of 34%.
- Drugs administered in the home setting generated 19% savings.
- Medications administered in physician offices had 12% savings.

“Transitioning specialty medications from the medical benefit to the pharmacy benefit results in savings because payers can implement more effective management tools such as formulary design, utilization management, and preferred or exclusive networks under the pharmacy benefit,” Alan Lotvin, M.D., Executive Vice President of specialty pharmacy at CVS Caremark, tells SPN. “In addition, offering patients more convenient and cost-effective options by addressing where infusion care is administered can produce significant savings. We believe both strategies work together to help payers achieve optimal savings.”

More Than Half of Spend Is on Medical Side

He points to the report’s observation that 53% of specialty drug spending is in the medical benefit. “According to the Milliman analysis, implementing an effective transition — moving prescriptions from the medical benefit to the pharmacy benefit — can produce significant savings for health care payers by improving management of these complex and costly drugs,” says Lotvin.

Because claims in the pharmacy benefit are adjudicated at the point of sale, it is easier to apply various utilization management tactics in this benefit. Brenda Motheral, Ph.D., president of Artemetrx and co-author of that report, maintains that “plans do have medication policies under the medical benefit for drugs that are high spend” that also can offer real-time adjudication. In addition, she says, the Milliman study “included a lot of self-injectables already under the pharmacy benefit.”

Some experts have questioned why Artemetrx excluded the hospital outpatient setting from its report and wonder if its contention that pricing in this setting is two to three times higher than that in the physician’s office is accurate. Motheral points to one of the Milliman analyses as being “very similar to what we did, at least on the surface.” Exhibit 12, she tells SPN, shows that “hospital outpatient cost is running about two times — sometimes a little more or a little less — versus the physician office.” That’s consistent with not only Artemetrx’s findings but also ones by Walgreen Co., the Pharmacy Benefit Management Institute and others, she says.

“More than a decade ago, PBMs tried to convince payers to move select drugs from the medical benefit to the pharmacy benefit,” observes Bill Sullivan, principal consultant with **Specialty Pharmacy Solutions** LLC. “The argument back then was “We can finally manage the utilization of these drugs now under ‘buy and bill.”’ Many payers tried the tactic, but it presented a lot of problems.”

Physician Considerations Are Important

The first issue, he says, is “changes intensified the friction between the medical and pharmacy benefit” because plan members had to make copayments for drugs that previously had been included in their physician visit copay. Second, “it required many plans to restructure their plan designs, often requiring state board of insurance approval. For many payers, that was a lot of states.” And the third problem, which Sullivan contends “was a doozie,” is that “physicians were really torqued off by payers ripping the margin out from under them for the drugs administered in the office. That battle set off a firestorm of recontracting — and the flames are still not out.… Trying to ‘kill’ off buy-and-bill,” he maintains, risks “further alienating network physicians who still depend on drug margin to a large degree.”

The bottom line, Sullivan says, is that nothing has changed since PBMs first tried to shift drugs into the pharmacy benefit. “All three problems still persist.” “It’s a fine line with physicians,” agrees Motheral. Plans want them to have competitive rates, but the insurers have to be careful “not to squeeze them too hard.” When that happens, such as when physicians are forced to use a specialty pharmacy to get their drugs, providers may push administration to the hospital outpatient department, which is exactly where plans don’t want them to go.

Taking drugs out of “the hospital outpatient setting is where all the savings occur,” maintains Motheral. As far as what Artemetrx recommends, “there’s no question that we want to get drugs, when we can, out of the hospital outpatient setting” and into the physician office. This is “low-hanging fruit,” she contends. Making a wholesale move to shift all drugs from the medical benefit to the pharmacy benefit presents challenges that plans don’t really need to take on, she says. Shifting the site of service represents “more savings with less destruction.”

In addition, says Motheral, “We know class-of-trade pricing for physicians is better — about 15% to 20% better” — than pricing for specialty pharmacies, so plans likely are getting “a better rate from physicians. And once Medicare moved to ASP [i.e., Average Sales Price], the rates came down in doctors’ offices.”

One crucial point, contends Elan Rubinstein, Pharm.D., founder and principal at EB Rubinstein Associates, is that neither analysis “included manufacturer rebates, as both made clear in their reports. This is important when comparing the medical benefit drug to the pharmacy benefit drug allowed, because for competitive therapeutic classes — like several of the drugs analyzed in the Artemetrx report — PBMs often receive formulary rebates for pharmacy benefit drugs. A pharmacy rebate would reduce the average price per unit of these drugs — and recall that the Artemetrx conclusion is ‘the study found that prices per unit dispensed for specialty drugs were higher under the pharmacy benefit than the physician office or home infusion for the five drugs studied.’ But would inclusion of rebates have extinguished this difference?”

No One-Size-Fits-All Approach Exists

So what approach should plans opt for? There may not be a one-size-fits-all approach. Rather than being in opposition to each other, the two reports “go hand in hand and illustrate the need to focus on strategy in plan design,” maintains F. Randy Vogenberg, Ph.D., principal at the Institute for Integrated Healthcare.

Indeed, says Motheral, if plans are “considering pulling drugs out of the medical benefit, they first need to analyze their own data” in order to determine the “true cost of care,” not just their spending on drugs.

“Do not make hasty decisions,” cautions Sullivan. Plans “need to do their own detailed analysis.” It “should not be seen as an either/or” situation in terms of the pharmacy benefit vs. the medical benefit, and “other innovations need to be considered that could create more value to the plan.”

Sullivan points to “the emergence of ISSPs [i.e., integrated single specialty providers] like Cardinal P4 for oncology, [as] an example of pulling whole therapeutic categories out of the standard model and overlaying a comprehensive medical/ pharmacy management model that can ensure consistency and appropriateness, including right drug, right amount of drug, right length of therapy, right price, right utilization management, [and] right medication therapy management under both medical and pharmacy benefits.”

View the Artemetrx report at www.artemetrx.com and the Milliman report at http://tinyurl.com/mfltge7. Sullivan at wsullivan@specialtyrxsolutions.com , Vogenberg at randy@vogenberg.com , Motheral at bmotheral@artemetrx.com and Lotvin through Jordan McNerney at Jordan.McNerney@edelman.com