The Impact of SPECIALTY DRUGS on the Self-Insured Employer: The Current and Future Challenge & What You Can Do

by Kjel Johnson, PharmD, BCPS, FCCP, FAMCP; Senior Vice President of Strategy and Business Development, Magellan Pharmacy Solutions
Specialty drugs represent the fastest growing component of health care-related costs facing self-insured employers today. In the wake of a decade of double-digit growth, specialty pharmaceuticals have continued on this path and are currently trending at 20 percent. This perpetual growth in the segment has led to sizable spending on specialty drugs, which will likely reach 40 percent of all drug sales by the end of this year. Furthermore, forecasts clearly demonstrate that specialty pharmaceuticals will continue to trend towards an even greater share of drug expenditures: within the next five years, spending on these agents is expected to surpass that of conventional drugs.

As a result of this fact, a disconnect is evident among employers – the price tag remains a constant. Unlike traditional pharmaceuticals for high-volume conditions such as cardiovascular disease and diabetes, specialty drugs often target a smaller population of patients with relatively less common diseases. And yet because of these agents’ cost, the specialty drug spend can be onerous. Cancer, which is the foremost disease driver of the specialty trend and the leading condition in terms of medical and pharmacy costs among employees, accounts for only 1 percent of a typical employer’s health care claims but equates to >10 percent of health care costs. As such, a single employee receiving certain chemotherapies can decimate a self-insured employer’s health care budget. The same is true for increasingly rare conditions often treated with specialty medications, such as hemophilia or Gaucher’s disease, with annual treatment costs of $100,000 and $600,000 respectively.

As mentioned previously, these already high costs – in combination with seemingly endless price increases in oncology, a wave of traditional pharmaceuticals losing patent protection, and a burgeoning specialty pipeline – are all contributing to the emerging dominance of the specialty drug market. In particular, the median monthly cost of cancer therapies has risen from $100 in 1965-1969 to >$5,000 in 2005-2009 (2007 US$). These exceedingly high costs are now the norm, as all 13 of the oncology agents receiving FDA approval in 2012 were priced in excess of about $6,000 per month. Self-insured employers will bear a significant portion of the estimated $104 billion in annual direct medical costs attributed to the cancer; while lower cost alternatives begin to abound in previously high-cost disease states dominated by traditional pharmaceuticals. And with approximately 600 agents for 10 leading cancer types in research trials, it is readily apparent that cost concerns of cancer and other specialty drug care cannot be ignored.

**Actively Managing the Specialty Drug Spend**

Traditional pharmacy benefits managers (PBM) often use specialty pharmacy distribution as a cost-containment tool; a specialty pharmacy is a closed-door pharmacy that is generally focused on the distribution of specialty products directly to an employee. Slightly more than half of employers require the use of a specialty pharmacy and a quarter have implemented benefit incentives to direct employees to use their preferred specialty pharmacies. Still, the reality is that this approach is not effective in managing specialty drug spend.
curbing the specialty trend or spend. For example, when considering self-injected specialty agents covered under the pharmacy benefit, retail distribution frequently offers a more aggressive rate to the employer (i.e., more favorable AWP pricing) than specialty pharmacy distribution.

Rather, savvy employers are creating provider incentives, promoting appropriate utilization, and eliminating fraud, waste, and abuse to manage specialty across all benefits and all sites of service. That said, Table 1 reviews what really works in terms of managing an employer’s specialty drug spend by addressing the closely interrelated cost-drivers at play: reimbursement, benefit design, channel management, formulary management, medical management, and health plan operations.

The effect of managing drug reimbursement rates is based upon what benefit a particular specialty agent is paid under. For drugs under the pharmacy benefit, little to no savings can be found by switching from one specialty distributor to the next since today’s specialty pharmacy reimbursement rates are virtually at rock bottom. An employer’s choice of specialty pharmacy should instead be based upon the quality of utilization/formulary management programs available through a particular vendor; therein lays the real specialty pharmacy savings opportunity. For drugs paid under the medical benefit, reimbursement for provider-administered drugs can be configured to promote the selection of lower cost alternatives via a variable fee schedule. In general, fair and favorable reimbursement should be in such a manner that keeps provider-administered injectables in the most economical and employee favorable site of care: the physician’s office. Today, two-thirds of provider-administered injectables paid by managed care plans are delivered in the physician’s office.1 This concept is commonly referred to as distribution “channel management”, which essentially seeks to deliver specialty pharmaceuticals in the most financially sound. Hospitals and other facilities typically carry much higher costs, more than twice that of a doctor’s office.1 The administration of specialty drugs in the physician’s office also ensures that a patient’s care is not fragmented, thereby maintaining continuity and quality of care as their physician oversees the process in its entirety. Another scenario in which channel management comes into play is the allowance of self-administered injectables to be paid under the medical benefit. This practice, which is still common among some employers,

Table 1: Drivers of the specialty drug trend/spend: Related management interventions with accompanying considerations on timing and potential cost savings.

<table>
<thead>
<tr>
<th>Drivers</th>
<th>Sample Initiatives</th>
<th>Timing</th>
<th>% Redn</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reimbursement</td>
<td>Pharmacy: Improve specialty pharmacy rates</td>
<td>18 mo</td>
<td>1%</td>
</tr>
<tr>
<td></td>
<td>Medical: Implement a variable fee schedule</td>
<td>3 mo</td>
<td>5%</td>
</tr>
<tr>
<td>Benefit Design</td>
<td>Pharmacy: Appropriately design Pharmacy benefit</td>
<td>&gt;18 mo</td>
<td>Variable</td>
</tr>
<tr>
<td></td>
<td>Medical: Appropriately design Medical benefit</td>
<td>&gt;18 mo</td>
<td>Variable</td>
</tr>
<tr>
<td>Channel Management</td>
<td>Pharmacy: Use distribution to optimize formulary</td>
<td>1 mo</td>
<td>Variable</td>
</tr>
<tr>
<td></td>
<td>Medical: Prevent costly site of service changes</td>
<td>3 mo</td>
<td>Variable</td>
</tr>
<tr>
<td>Formulary Management</td>
<td>Pharmacy: Formulary optimization</td>
<td>1 mo</td>
<td>7%</td>
</tr>
<tr>
<td></td>
<td>Medical: Incent lowest net cost products</td>
<td>3-6 mo</td>
<td>Reimb</td>
</tr>
<tr>
<td>Medical Management</td>
<td>Pharmacy: Establish prior auth when appropriate</td>
<td>Variable</td>
<td>5%</td>
</tr>
<tr>
<td></td>
<td>Medical: Implement stepped-care programs</td>
<td>Variable</td>
<td>8%</td>
</tr>
<tr>
<td>Health Plan Operations</td>
<td>Pharmacy: No opportunity</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td></td>
<td>Medical: Recover errors, fraud, irrational Rex</td>
<td>1 mo</td>
<td>4%</td>
</tr>
</tbody>
</table>

Note: Table 1: Drivers of the specialty drug trend/spend: Related management interventions with accompanying considerations on timing and potential cost savings.
is not financially sound and these self-administered agents should be moved under the pharmacy benefit.

Benefit design is actually a useful vehicle for channel management in that it is a key driver of the particular settings in which certain agents will be paid for. For example, some employers have offered benefits that keep provider-administered injectables in the physician’s office by offering these agents with no employee cost-sharing in this setting. Alternatively, their benefit design requires a 50 percent coinsurance if an employee receives his or her provider-administered injectable in the hospital- or facility-based sites of care. This form of benefit design initiative is also provides an effective solution to the Patient Protection and Affordable Care Act (PPACA)-driven trend of facilities buying up large physician’s practices, and then assessing the more costly facility charge.

Also in terms of cost-sharing, recent data indicate that managed care organizations are increasingly using coinsurances instead of copays for provider-administered specialty drugs (those paid under the medical benefit). This trend represents the payers’ desire to increase cost contribution from the member (and thus more impactfully direct behavior), with average coinsurance recently rising from 20 percent to 26 percent. However, self-insured employers appear to be lagging in implementing such benefit changes. Approximately half of employers used the same copays for specialty drugs as they did for traditional pharmaceuticals and only 1 in 4 employers cite having a specific specialty drug benefit.

A separate specialty drug benefit allows for the provision of employee contribution rates and management interventions that are specifically tailored to the unique characteristics of these agents. Regardless of the particular benefit used for the coverage of specialty drugs, the general attitude among both payers and employers indicates a willingness to shift more financial responsibility to the member/employee. Employers should be mindful, however, of the impact of cost-sharing on therapeutic adherence. Studies demonstrate that annual out-of-pocket outlays exceeding $2,500 can have a distinctly adverse effect on this adherence.

Formulary management can be used to drive the utilization of lower-cost alternatives to specific therapies in cases where another viable therapeutic option exists. This can be accomplished through benefit design and reimbursement strategies that encourage the selection of low-cost, high-quality alternatives. Likewise, formulary management links to medical management in that certain medical management interventions can be built into the formulary so that predetermined disease- or prior treatment-specific criteria must be met before a higher-cost agent will be covered.
be covered. In these cases, medical management comes into play, including prior authorization and step-therapy (based on prior treatments). To do this, employers must carefully select drugs for utilization management initiatives based on scenarios in which they are frequently used inappropriately or where an opportunity for a lower-cost alternative exists. By and large, the vast majority of drugs paid under a particular benefit will not have utilization management requirements. For example, approximately 900 drugs exist under the medical benefit, but only approximately 12 of them should have a prior authorization opportunity. Instead, employers should focus on areas of frequent misuse, such as human growth hormone (HgH), where denial rates currently reside in the 10 percent to 20 percent range.

Additionally, employers should work with claim managers to reducing billing errors, waste, and fraud. Billing errors alone account for 3 percent to 5 percent of the cost of provider-administered specialty products. Regardless of how this is accomplished, as either pre-service reviews or post service edits, such initiatives are advisable for self-insured employers to curtail billing errors, fraud, waste, and off-standard-of-care use.

Installing a Comprehensive Specialty Drug Management Strategy

A comprehensive strategy is necessary to effectively manage an employer’s specialty drug spending. Past experience indicates that the conventional management strategies used for traditional oral pharmaceuticals are inadequate for controlling costs while maintaining quality of care in the specialty sector. And while developing such a management strategy can be a complicated endeavor, the good news is that the necessary tools and proven interventions are readily available for self-insured employers who actively seek solutions. Fortunately, self-insured employers can implement such initiatives extremely quickly.

The specialty trend and spend is already significant and the pipeline robust; this will lead to an employer’s specialty spend eclipsing that of traditional agents in the next five years. Although daunting, the most prudent approach is to immediately size the specialty spend and trend, and then actively evaluate the cost-containment solutions described herein.

References
2 Artemetrix. Specialty Drug Trend Across the Pharmacy and Medical Benefit. 2013.
5 Peyenson B. Cost of Cancer to Employers. Milliman, American Cancer Society, C-Change. 2007.