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Experimental Cost Controls: Plans Moving Doctor-Administered Drugs From Medical To Pharmacy Benefit

By Scott Steinke

Health plans have a range of options to manage drug spending. Now, some plans are trying to switch drugs from a medical benefit to the pharmacy as a way to control costs. Drug manufacturers should be paying attention.

Prior authorization, quantity limits and step therapy are some of the primary tools health plans use to control costs. Now, they're testing another: switching physician-administered drugs from the medical benefit to the pharmacy benefit.

It's not a trend just yet, but the strategy is being used enough to start a buzz among consultants and other industry watchers trying to gauge success of the change.

What is piquing interest is that once the physician-administered drugs in question—drugs that usually get lumped into the definition of "specialty"—start making the migration to the pharmacy benefit, plans can explore other ways to control their use. For manufacturers that may be affected by that switch, it's a cost-control strategy to watch.

Payors: Making a Switch and Managing Use

Most plans still cover physician-administered drugs under the medical benefit; in that model, physicians buy the drug and administer it to the patient. The physician then bills the plan for the procedure and the drug, usually including a mark-up on the drug. The patient pays a single copayment for the procedure.

However, some plans have discovered that by moving those drugs into the pharmacy benefit, they can apply drug utilization management techniques to ensure those drugs are being used appropriately, the plans say, and eliminate the premium they pay physicians.

"For the payors, one real driver is they want to take reimbursement profits on drugs out of physician's office. So they want to get it out of that buy-and-bill model into the specialty model," Mary Bordeaux, who has her own consulting business, said at the Pharma Forecasting Excellence Summit Oct. 3 in Boston, sponsored by Eyeforpharma.

In other words, if physicians are no longer purchasing the drug, they can't charge the payor a markup on the drug.

“The other driver is, they want to cost shift more burden to the patients, and that’s easier to do under the specialty arena rather than the medical arena,” Bordeaux said.

Boston Healthcare Associates’ Stephen Chan notes that drugs covered under the medical benefit traditionally have not been subject to review by a plan’s pharmacy and therapeutics committee. “Drugs under the pharmacy benefit go through a much more systematic and rigorous drug review through the P&T process,” he said (*See “Welcome to the P&T Committee,” The RPM Report, July/August 2006*).

Chan continued: “The prior authorization process is much simpler from their perspective under the pharmacy benefit because it’s all electronically automated.”

Another bonus to the plan is that coding becomes much more precise in the pharmacy benefit, Chan said. Under the medical benefit, drugs are reimbursed by J-code, which can lack specificity. But in the pharmacy benefit, national drug codes are used, which are specific as to type of drug, manufacturer, and dose sizes, allowing the plan to track drug use much more closely.

How common is it to see plans making the switch? “It’s becoming more prevalent. Is it catching on rapidly? I don't know that I could say that yet,” Chan said. “I think you're seeing it more today than you saw last year.”

WellPoint Takes On Specialty Rx

WellPoint is one health plan that has been focusing on the need to control utilization of specialty products.

“We have a fixed, phased specialty pharmacy strategy that we’ve been deploying over the past year and a half,” WellPoint’s chief pharmacy officer Brian Sweet says. “We’re about halfway through that right now. And part of that is utilizing the distribution and the utilization management and care techniques of our own specialty pharmacy.” WellPoint has been requiring members in some states to receive products from its specialty pharmacy, which is part of its in-house PBM NextRx.

“The next piece of it is really utilizing the same formulary management and utilization management techniques that we’ve done in pharmacy, and putting them in the medical benefit, so that when we have a prior authorization, if a member was to get it in a pharmacy, we also have that same criteria as part of a utilization management guideline when it comes through as a medical claim,” Sweet says.

“That is clearly going to help us manage some of those claims that come through now, oftentimes as a J-code or something that is not as clearly defined.”

WellPoint’s requirement for certain drugs to be filled through a specialty pharmacy rather than a typical retail pharmacy is in line with Chan’s observation that some payors are mandating that specialty drugs be obtained through a specialty pharmacy.

WellPoint’s experience in requiring specialty versus retail has been positive. For example, WellPoint’s research outcomes company, **HealthCore**, found that patients receiving medication for multiple sclerosis who were managed by WellPoint’s specialty pharmacy showed a 93% “medical possession ratio”—the

percentage of time a patient is in possession of medication—compared to 79% for those managed by a traditional pharmacy. They also showed better clinical results as measured by inpatient, emergency room and physician office visits, as a result of improved compliance with therapy.

Bordeaux observed that one problem plans need to avoid in switching drugs is setting a copay level that discourages patients from filling prescriptions or from seeking an alternative that can be administered by a physician.

Under the medical benefit, the patient's copay covers the drug and the administration, and in some plans, the patient pays no copay for the medical benefit. Therefore, the copay could serve as a barrier to filling the prescription under the pharmacy benefit.

"There's this misalignment of out-of-pocket between medical and pharmacy, and what we are beginning to talk to payors about is that is causing patients and physicians in some cases to opt for a less-than-optimal therapy," Bordeaux said.

WellPoint appears to have addressed that problem in its plans. Sweet says his company "offers the ability to have fair and consistent coverage, so that if we have a 20% out-of-pocket on the pharmacy if they get it from a retail pharmacy or a home infusion vendor, it's the same out-of-pocket when they come to the medical benefit. So, it doesn't matter where the member chooses to get that site of service; the reimbursement and the out-of-pocket would be the same."

Specialty Tiers Being Driven By Part D

The addition of a specialty drug tier on the formulary is one thing that tends to go hand-in-hand with the benefit switch.

Most commercial plans now have a first tier for generic drugs, a second tier for preferred brand-name drugs and a third tier for non-preferred brands but have yet to embrace a fourth tier for specialty drugs. While payment models vary, many plans charge a flat copayment for drugs in the first three tiers but a percentage coinsurance for the fourth.

"The payors that are progressive enough to take a look at how they're paying for drugs and move some of the physician-administered drugs from the medical benefit to the pharmacy benefit probably also have a specialty fourth tier," Chan says.

Commercial plans have not typically had a specialty tier of drugs in their formularies. However, most Medicare Part D plans have specialty tiers, and the experience health insurers have gained through Part D is causing some to think about adding specialty tiers to commercial plans.

Bordeaux cited data showing that 87% of Part D plans place specialty drugs in a fourth tier, while only 7% of commercial plans do so, "because employers have not yet embraced this model….That's changing."

The Medicare Part D drug benefit has opened up the way for Medicare plans to have the specialty fourth tier, Chan says, even though those tiers existed prior to the 2006 kickoff of the program. "Now they're basically saying, 'Okay, this is something that maybe we've always wanted to try. Now Medicare says

it's okay. It's relatively popular in Medicare.' So, that's why you're seeing it show up more and more on the private side."

Experimenting With Five Tiers

Bordeaux and Chan both said differential coinsurance rates for preferred and non-preferred specialty drugs—essentially creating five tiers—is a logical next step that is being tested by plans.

Some plans are mulling creating a differential coinsurance within the fourth tier, according to Bordeaux. For example, plans are implementing a 10% rate for preferred brands and a 20% rate for non-preferred brands. "We're going to start seeing all kinds of variations of management of that tier four category."

"I haven't seen it a lot, but it's kind of the next step in the progression," Chan says. "Back in the day, when pharmacy benefits first came out, early, there were one or two tiers, and then they expanded to three. Now they expanded to four. And once you start talking about this differential co-insurance in the specialty tier, you're really talking about five tiers."

What It Means For Manufacturers

So what is a drug manufacturer to make of this possible evolution in the payor landscape for specialty drugs?

Bordeaux recommended manufacturers ask themselves a set of question as part of their market research:

1) Will there be an access requirement?

2) Does the manufacturer want to drive the access requirement?

3) Is the requirement predictable?

4) Are there other drug categories that you can model that have lived through this transition into specialty?

There is a silver lining to having a drug switched: data. Once a drug is moved from the medical benefit to the pharmacy benefit, manufacturers will get access to new levels of data, according to Bordeaux.

Drug companies "can build a hub or a central intake program to really build on the advantages" of that the benefit change," Bordeaux explained. Manufacturers can collect more data and know when patients are refilling their scripts.

Monitoring compliance is also easier under the pharmacy benefit, Bordeaux said. "I'll know why they're going off their drug, because we'll actually call them and find out why did you not refill, why are you not compliant with your drug? There's really a lot of benefit from building these kinds of programs and building that into our marketing strategy."

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