

Five Hot Pharmacy Benefit Trends for 2006



By Robert T. Taketomo, Pharm.D, MBA
Pharmacy benefit management in California is unique in that the major health plans covering the state have their own in-house pharmacy benefit management (PBM). To a large extent, these firms and their clients and brokers are

shielded from the challenges facing some of the national PBMs used by many other health plans. However, pharmaceutical costs are still an issue whether the PBM is in-house or not and you can expect some shifts in the upcoming years. Here are some projections:

Trend #1: More Injectable Drug Costs May Be Incorporated into the Pharmacy Benefit Design

Historically, there were not many injectable drugs. Since many of these products were vaccines or blood products, they were managed largely under the medical benefit.

Exhibit I: Possible Injectable Benefit Design

A benefit design must address affordability and access in order to be a true benefit. Given that an average injectable prescription costs over \$1,000, traditional pharmacy benefits used for oral drugs do not apply. Application of coinsurance is a natural trend since the range on cost for injectables can be as little as \$100 to over \$50,000. Complicating matters is a possible legal requirement that the actual cost should be used in calculating coinsurance since coinsurance is based on a percentage of "cost." (For example, including all rebates and discounts).

An injectable benefit design that provides a true benefit: A three-tier program with \$50 deductible/prescription and an annual out-of-pocket maximum (OOPM) of \$2,000/year (separate from medical OOPM):

- Tier 1 (Life Saving): Lower of flat \$100 co-payment or actual cost
- Tier 2 (Life Enhancing): Lower of 20% – 25% coinsurance, actual cost or \$250 OOPM/prescription
- Tier 3 (Life Style): Lower of 35% – 40% coinsurance, actual cost or \$400 OOPM/prescription.



Starting in early 2000, there has been an explosion in the number of injectable products being brought to market to treat more diseases. Look for this trend to continue. While an average generic and brand oral prescription may cost \$15 and \$70, respectively, an average injectable prescription easily tops \$1,000. This could mean an average of \$10,000 to \$25,000 per patient, per year for injectable drugs used on a chronic basis. The medical claims systems used by managed care plans are largely unable to support sophisticated injectable benefit designs and utilization management practices (See Exhibit 1 below). This has spurred the move towards putting these agents into the pharmacy benefit instead of medical so that pharmacy systems can be used to administer benefits and manage utilization. This makes some sense, as injectables are just another dosage form of a drug. Wouldn't life be simpler if all drugs were managed consistently?

Trend #2: More Patients or Employers Share the Costs of Injectable Agents

Historically, injectable drugs were available for little, if any, co-payment. This has created somewhat perverse incentives for patients. For example, in the treatment of arthritis, a patient facing a third tier co-payment for a Cox-II drug (cost around \$100) could get an injectable drug for the treatment of rheumatoid arthritis (cost over \$1,000) for little, if any, co-payment. Look for higher co-payments or premiums attributable to injectable drugs as managed care plans get a better grasp on the cost for these agents. In one health plan in California, it was estimated that this expense for injectable medications could rise an additional \$150 million annually within two to three years. Part of this is being fueled by expanded Medicare coverage for injectable drugs as part of the Medicare Modernization Act (Covered injectables were severely limited in the past). But, the health plans face a challenge in developing systems and infrastructure to manage all of these agents, so cost-shifting strategies are easier solutions, such as higher co-payments and premiums.

Trend #3: More Restrictions and Prior Authorization Requirements for Drugs

Employers and members are starting to feel the pinch of higher drug costs. Many are wondering if managed care is truly "managing" healthcare. More prescription drug controls will be implemented due to the pressure to keep premiums and co-payments at an acceptable level while justifying the need for certain PBM services. Unfortunately, continuing the reactive prior-authorization pharmacy systems will do little to appease patient demands or make life easier for physicians.

Trend #4: More Rebates and Drug Deals

This activity is not usually public knowledge, but pharmaceutical manufacturers will be under more pressure to cough up higher rebates and discounts. In this situation, aggressive contracting entities benefit at others' expense as pharmaceutical companies cost shift through higher prices charged to others. The managed care plans and PBMs face a challenge in that they do not have any reliable measure of how effective their contracting efforts are compared to others. Finally, the pharmaceutical industry has been facing a frustrating situation – with current PBM business models, only a portion of the discounts and rebates reaches the intended target, such as payors and patients. This amount varies, but it appears to be a significant number. Thus, the pharmaceutical industry may be called on to provide more discounts and rebates, but will not have any control over how much they would actually contribute towards lower premiums and co-payments.

Trend #5: More Pharmacy Carve-Outs

Employers may consider external PBMs to reduce costs by carving pharmacy management out of the health plans. Employers may even take the step of carving pharmacy coverage out of medical plans since pharmaceutical treatment, from a societal perspective, has

only been definitely shown to be economically effective in two types of programs – smoking cessation and immunizations. However, depending on the situation, the absolute reduction in the premium may not be significant since it could be argued that patients who can't afford medications will get sicker and require more medical care. In addition, external PBMs can recoup their costs and gain revenue by other means that are not defined or prohibited in the contract language with the payor. Most employers may not have the specialized knowledge to discover these clauses and PBM sales people have sophisticated talking points to address most issues. Finally, if health plans are to facilitate good healthcare, they need access to integrated information for medical and pharmacy transactions.

The pharmacy benefit management industry will face a continuing challenge in the years ahead. Employers and brokers are asking for more information and transparency regarding drug costs, rebates, and other incentives. State and federal regulators are becoming more active in investigating PBM business practices. Providers and patients are not happy with the current delivery model for prescription services. There is an opportunity for change and a new channel for delivering pharmacy benefit services. Imagine if an employer could act as its own PBM, receive all rebates, and see the entire dollar flows for prescription drugs for its employees. That time could be closer than you think. □

Robert T. Taketomo, Pharm.D, MBA is president and CEO, Ventegra. Ventegra is a contracting services organization that provides innovative solutions for cost efficient and transparent pharmaceutical services to maximize the benefits for payors, providers, and patients. Ventegra's commitment offers a new prescription and a new channel through which pharmaceutical services are delivered in a more transparent and efficient manner. For more information, call 858-551-8111 or visit www.ventegra.net.

