The shift in the drug development pipeline to specialty drug domination is transforming the pharmacy benefits industry. Today, 2% of Humana’s members account for 20% of the drug costs—largely driven by the high cost of specialty pharmaceuticals. This disparity is expected to grow even larger, with 2% of members projected to account for 40% of drug costs by 2016 and for 50% of the drug cost by 2020.

Industry forecasts show continuing increases in specialty drug spending; one report estimates annual increases of more than 20% through 2017. According to another estimate, US specialty drug spending will increase 361% from 2012 to 2020, from $87 billion to $402 billion. This uptick in specialty drug utilization and costs has led Humana and other payers to explore value-based contracting strategies tied to evidence-based outcomes measurements.

Value-based payment, by definition, entails payers creating incentives and disincentives that reward their suppliers for delivering superior value. The current model of payment for drugs is essentially a transactional, fee-for-service payment model and is the antithesis of the direction in which payers will need to innovate to deliver sustained affordability of healthcare and prescription drug coverage. Drug manufacturers need to change their thinking from a fee-for-service model to a value-based payment model—the same type of payment reform that is creating a paradigm shift in the delivery and payment of physician services.

This type of drug-payment model could fundamentally change how manufacturers set the market prices for new drugs and allow health plans to develop more sophisticated reimbursement models for high-cost specialty drugs. For example, novel payment models could be developed with specialty drug manufacturers whereby fair market value payment would be made up front, and the remaining value-based balance of the payment would be placed in reserve or in escrow until the mutually agreed on clinical end point is achieved. Once the clinical end point is achieved, thereby demonstrating the desired value, the manufacturer would receive the value-based portion of the payment.

Capping the Copays

In another attempt to control specialty drug spending, some states have enacted or proposed legislation that aims to reduce patient out-of-pocket expenditures for specialty drugs by limiting copays to $100 to $200 monthly, regardless of the drug’s real cost or complexity. According to a 2014 issue brief by the Robert Wood Johnson Foundation, Delaware, Louisiana, and Maryland have enacted such laws, and a handful of other states have proposed similar bills.

Behind the introduction of copay-limit bills for specialty drugs are advocacy associations, such as Cap-the-Copay coalitions currently active in Illinois and Kentucky. A closer look reveals that these campaigns are supported by a grant from a pharmaceutical company. This illustrates the creative ways in which drug manufacturers are attempting to reduce copays under the guise of disease advocacy associations. Although this seems well-intentioned at first glance, it merely shifts the focus from the real problem of escalating drug prices without providing evidence of value to the consumer.

Copay limits for specialty pharmaceuticals will have a substantial impact on premiums and benefit design, with the hidden repercussion of increased copays for consumers and out-of-pocket spending for medical services, while doing nothing to control the underlying drivers of specialty drug costs.

Humana has modeled the impact of this type of legislation on the commercial healthcare coverage for a typical state. A $100 cap per drug per month would increase health insurance premiums by up to 3.3%. As a result, the cap alone would be responsible for more than 50% of the projected increase in a state’s health insurance costs for 2016—after taking into account overall healthcare cost inflation, healthcare utilization trends, increased cost of new medical technologies, and other contributing factors.
The impact of Cap-the-Copay legislation on health plan benefit design is equally profound. These bills essentially require insurers to shift out-of-pocket spending from the pharmacy benefit to the medical benefit. Using the example of a bronze-level plan in a typical state marketplace exchange, a member’s annual out-of-pocket maximum in 2016 would need to be increased by $500 (from the current level of $6350 to $6850). In addition, annual deductibles for medical services, including doctor visits and hospital admissions, would need to be increased by $1250 (from the current level of $4850 to $6100). Similar benefit design changes would be required for silver-level plans as well.

Even with these significant increases in out-of-pocket spending, the plan would barely fit within the Centers for Medicare & Medicaid Services mandated actuarial value ranges for bronze-level plans. As a result, it would be nearly impossible for carriers to continue offering high-deductible health plans or catastrophic plans if these bills were passed into law, because these plans must meet an even lower actuarial value range.

Rather than using ineffective strategies to lower copay costs, pharmaceutical manufacturers will have to undergo a paradigm shift in which financial incentives are based on demonstrated clinical value.

Demonstrating Clinical Value
Health plans, states, pharmaceutical manufacturers, and patient advocacy organizations must come together to develop meaningful solutions to overcome the escalating access and affordability challenges in this specialty drug era. However, manufacturer-funded efforts such as Cap-the-Copay legislation artificially insulate consumers from the true cost of drugs and will have unintended consequences of 25% higher out-of-pocket costs for medical benefits to finance exorbitant drug-pricing tactics.

Rather than using ineffective strategies to lower copay costs, pharmaceutical manufacturers will have to undergo a paradigm shift in which financial incentives are based on demonstrated clinical value.

Author Disclosure Statement
Dr Fleming reported no conflicts of interest.

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