CVS Health Payor Solutions

Insights / Specialty

A Foundational Approach to Specialty Cost Management

BRIEFING
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Pharmacy benefit managers (PBMs) have long used sophisticated tools to ensure that plan members receive the best-value medications for their conditions. The cornerstone of PBM cost-control strategies are managed formularies and utilization management tools such as prior authorization, step therapy, and multi-tier plan designs. Such tools help payors ensure members have access to the treatments they need, while encouraging the use of clinically appropriate, cost-effective alternatives when available.

Tiered formularies have been particularly effective in helping control spend in traditional drug classes. Through 2018, our managed formulary strategy is expected to deliver $13.4 billion in cumulative savings to our PBM clients through drug removals, inclusion of lower-cost brands, and transitioning members to generics.*

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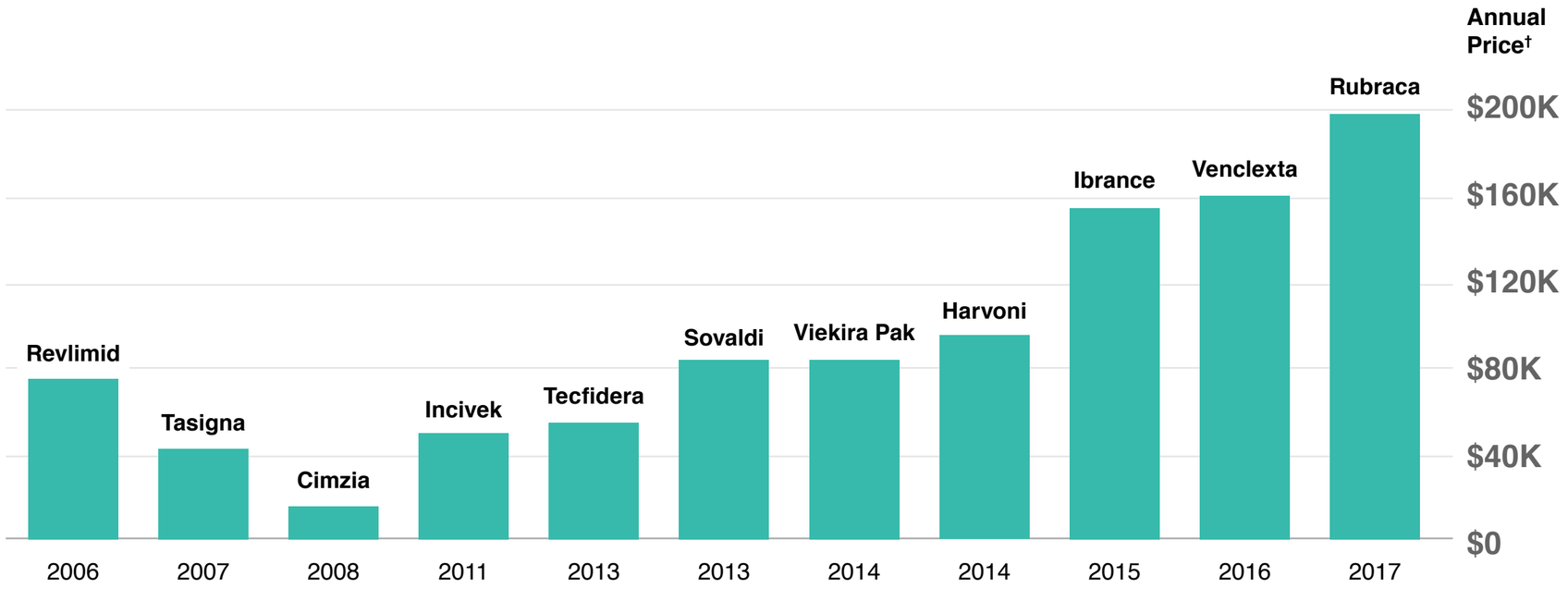
Until recently, tools such as tiered formularies were not applicable — or needed — for specialty therapy classes. Historically, specialty drugs were used to treat rare or life-threatening conditions with small patient populations. As recently as 2007, specialty drugs made up less than one percent of total health care spending and less than 7 percent of per-patient drug spending for Medicare and Medicaid.[1] Spending on specialty prescriptions per specialty drug user averaged just $2,641 per year.[1] In addition, there was very little competition, with only one drug available to treat a condition in most instances.

The Evolving Specialty Landscape

Today the situation is radically different. Specialty drugs make up roughly 40 percent of drug spending, or almost 7 percent of the total cost of health care, and that percentage is expected to continue to rise.[2] Several trends are driving the uptick:

- The American population is aging into the part of life where disease is increasingly common; each day, 10,000 Americans turn 65 — a pace that should continue through 2030, driving utilization of health care of all sorts.[3]
- Specialty drugs are no longer restricted to rare and life-threatening conditions. Increasingly there are specialty drugs being developed to treat everything from arthritis to eczema, and even common conditions like asthma.
- The pipeline for specialty drugs is robust. Of the 533 new drugs expected to seek marketing approval from the U.S. Food and Drug Administration (FDA) between now and 2020, 291 are specialty drugs.
- More specialty drugs are seeking supplemental indications to treat additional populations, indications or stages of the disease, often vastly expanding their market. There are currently 140 supplemental indication applications under review by the FDA.
- Today's specialty drugs are expensive. The three most recently approved oral oncology drugs came to market with an average price tag of $178,000 per year.[4]
- Year-over-year inflation is high. Prices of existing specialty drugs tend to rise at almost three times the rate of conventional drugs and they are expected to rise almost 18 percent in 2018.[5]

High Launch Prices Contribute to Specialty Spend



Manufacturers set drug prices based on their perception of value

Launch prices increase year after year

Manufacturers increasingly seeking supplemental indications

In short, specialty therapies have moved from being a minor issue to being one of payors' greatest concerns. To stay ahead of market trends and effectively control specialty trend, payors need to evolve their management strategy with the changing dynamics of the specialty pharmaceutical landscape. The time is ripe for a new approach to managing cost and utilization.

Changing Strategies with the Market

Specialty drugs begin with a high price tag and year-over-year inflation continues to be high. This makes targeted cost-control strategies critical for payors looking to manage spend. One opportunity may come in the form of generic drugs. With an estimated $2 billion to $5 billion of specialty brands losing exclusivity each year through 2020, true generics for specialty drugs will offer payors options to save. In addition, biosimilars are also beginning to gain market momentum.

By applying non-specialty PBM best practices to specialty drugs — such as three-tier formulary — and tying reimbursement to the value a drug delivers, payors can capitalize on these market trends and better manage their specialty spend. Payors who seek even greater savings can layer aggressive management tools to the foundational strategies to achieve the highest level of savings.

Exploring Opportunities to Increase Specialty Management Control and Savings

Apply PBM and non-specialty strategies

Leverage best practices, visibility and control

Connect price, value and coverage

Go beyond traditional formulary strategies

Adopt more aggressive tools

Help achieve highest level of savings

Tiered Specialty Formulary

Historically, most payors have applied the same patient copays or tiers to both specialty and non-specialty drugs. When specialty therapy classes are separated on a formulary, they are typically all assigned a single — usually fourth — tier, with the same copay or coinsurance amount for all drugs.

CVS Health is introducing a novel — and yet foundational — plan design approach to specialty drugs. Our approach applies proven formulary strategies to the increasingly more expensive specialty therapy classes by separating them into three distinct copay or coinsurance categories:

- Specialty generics
- Specialty preferred brands
- Specialty non-preferred brands

Specialty Tiered Copay Plan Designs Provide Flexible Options to Align with Your Goals

Recommended Standard Specialty Tiered Copay Plan Design Options with Example Client Savings**

	Option 1	Option 2	Option 3
Generics	Non-Specialty Generic cost share	$50	10% ($100 max)
Preferred Brands	$250	10% ($1000 max)	30% ($1000 max)
Non-Preferred Brands	$400	30% ($1500 max)	50% ($1500 max)
Total Estimated Net Savings†† Plan Design Change implemented and Copay Card True Program Accumulation	**16.5%**	**19.9%**	**21.2%**

Clients with a standard formulary (opt-in or opt-out), Advanced Control Specialty Formulary, or Value Formulary can layer the specialty tiered formulary approach. Such an approach can help maximize the use of clinically appropriate, cost-effective options such as generics and biosimilars, where applicable. Payors can choose the option that is right for their plan goals.

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True Accumulation

As competition in specialty therapy classes grows, manufacturers have been increasingly using tools common in the traditional brand drug market — such as copay coupons — to build consumer loyalty, increase sales, and bypass payor cost-control strategies. Copay cards — those not based on financial need — help encourage the use of more expensive therapies by negating the impact of higher cost-sharing tiers on member out-of-pocket (OOP) cost. Payors seeking more aggressive control of their specialty spend can combine the tiered specialty approach with a True Accumulation feature, which ensures only true member cost share (non-third party dollars) is applied toward deductibles or OOP caps. The accumulator automatically adjusts member OOP costs when specialty copay cards are billed by a CVS Specialty pharmacy. The amount subsidized by the copay card does not count toward the member's deductible or annual OOP maximum. True Accumulation may also be used independent of the specialty tier design and will cover all specialty drugs that offer a non-needs-based copay card.

Based on our analysis, payors who adopt a moderately aggressive three-tier specialty drug plan design could save up to 21 percent on their specialty net cost.**

Our proven solutions helped keep drug price growth in 2017 to a minimal 0.2 percent for clients aligned with our managed formularies. With a three-tier specialty formulary, we are now bringing the same effective PBM tools to bear on increasingly more expensive specialty therapy classes to help payors control costs while putting members on their path to better health.

Do you want to learn more about how a three-tier formulary can help you save money on specialty therapies? Ask Us

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1. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4250050/.
2. https://www.biopharmadive.com/news/drug-spending-increase-2018-specialty-meds/519001/.
3. The State of Aging in America 2013, www.cdc.gov/aging.
4. CVS Specialty Analytics. Drug launch cost based on Wholesale Acquisition Cost (WAC) launch pricing accessed Spring 2018.
5. http://ww2.cfo.com/health-benefits/2017/09/specialty-drug-costs-soar-2018/.

*CVS Health Finance, 2012 – 2018E. Projections based on CVS Caremark data. Individual results will vary based on plan design, formulary status, demographic characteristics and other factors. Client-specific modeling available upon request.

**Requires adoption of True Accumulation and $1000 specialty drug deductible. Projections based on CVS Caremark data. Individual results will vary based on plan design, formulary status, demographic characteristics and other factors. Client-specific modeling available upon request.

†CVS Specialty analysis of Medispan data. Annual drug costs based on average wholesale price (AWP) accessed December 2017.

††Percent of specialty spend.

Data source: unless otherwise noted, CVS Health Enterprise Analytics, 2018.

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