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. As the cost of these drugs, and spending on them, continues to increase, payors need to consider plan design strategies common in traditional medications — such as a three-tier formulary design — to better manage trend.

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. Manufacturers also continue to seek supplemental indications to treat additional populations, indications or stages of the disease, often vastly expanding their market.

The time is ripe for a new approach to managing cost and utilization.

While the growing number and price of specialty drugs are challenging for payors looking to control costs, they also present an opportunity to evolve management strategies to stay ahead of market trends.

**Key trends that payors can leverage to better control costs include:**

- Greater competition within specialty therapy classes
- Possibility of generics coming to market with an estimated $2 billion to $5 billion of specialty brands losing exclusivity
- Biosimilars beginning to gain market momentum

By applying non-specialty PBM best practices to specialty drugs — such as a three-tier formulary design — and tying reimbursement to the value a drug delivers, payors can capitalize on evolving market trends to 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

CVS Health’s novel — and yet foundational — plan design approach to specialty drugs applies proven formulary strategies to the increasingly more expensive specialty therapy classes. Our three-tier specialty formulary divides specialty therapies into distinct copay or coinsurance categories:

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

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.

True Accumulation

Payors seeking more aggressive control of their specialty spend can combine the tiered specialty approach with a True Accumulation feature, which helps combat tools such as non-need-based copay coupons used by manufacturers to build consumer loyalty, increase sales and bypass payor cost-control strategies by reducing member out-of-pocket (OOP) cost. The True Accumulation feature 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.

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

Ask Us for more information about a three-tier specialty formulary strategy for your plan design.


*Requires adoption of True Accumulation and $1000 specialty drug deductible.

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

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