



Managing the Increasing Cost of Specialty Drugs

By Debbie Echlin, PharmD, CGP, Clinical Pharmacist

The specialty pharmaceutical market has grown substantially over the last decade. With the increasing number of patients using specialty drugs and the increasing number of specialty drugs approved for more common conditions, cost containment is a top concern for patients and plan sponsors.

As the trend in specialty drug dispensing continues to move from the medical benefit to the pharmacy benefit, affordability is crucial to benefit design. It is a balancing act to craft a plan design that adequately distributes the cost share between the patient and plan sponsor, while structuring patient cost share to encourage compliance and discourage abandonment of therapy.

The addition of a specialty drug tier to the existing multi-tier formulary copay structure is one strategy employed by plan sponsors. Simply put, the goal is to assign a cost share more reflective of the actual cost of specialty drugs. This strategy generally manifests itself in the creation of a 4-Tier formulary structure where all specialty drugs are assigned to Tier 4 of the formulary. Prescriptions for Tier 4 drugs are assigned the highest patient cost share amount compared to prescriptions for drugs on Tier 1, 2 or 3.

Cost share amounts are typically structured as either flat-dollar copayments (for example, \$100 per RX) or as percentage coinsurance (for example, 20% of the price of the drug). Percentage coinsurance plan designs are increasingly popular, as they are believed to foster better patient decision making and also help recoup some of the burden associated with drug price inflation, which grossly outpaces inflation overall. The potential pitfall with implementation of a coinsurance plan design is the failure to also implement reasonable per-Rx maximum amounts.

Multiple recent well-designed studies show that as patient cost share on prescription drugs increases, adherence to prescribed therapy decreases. For example, a large managed care organization examined the association between out-of-pocket (OOP) expense and new therapy prescription abandonment for multiple sclerosis (MS) specialty drugs, and demonstrated that MS medication OOP expense greater than \$200 per claim was associated with a 6-fold higher rate of abandonment compared with OOP expense less than \$100.¹ Another study examining claims data from 45 large self-insured employer plans found members were 8% more likely to stop therapy for every \$10 increase in weekly OOP expense.² With this and other data in mind, the Serve You account team works with our clients at implementation and renewal to optimize plan cost share structure to meet each plan's goals and objectives.

Another increasingly common method used to manage specialty drug costs is the implementation of a "per family" or "per member" deductible across the entire plan. This method helps the plan sponsor recoup some of the additional costs associated with specialty drugs while not burdening individual patients, and still providing a robust prescription drug benefit.

To learn more about these specialty cost management strategies, including the 4-Tier plan design, copayment vs. coinsurance and the use of deductibles, please email sales@serve-you-rx.com.

¹ Association of Prescription Abandonment with Cost Share for High-Cost Specialty Pharmacy Medications. JMCP. 2009;15(8):648-58.

² Compliance With Biologic Therapies for Rheumatoid Arthritis: Do Patient Out-of-Pocket Payments Matter? Arthritis Care & Research. 2008; 59(10):1519-1526.