



An Evaluation of Specialty Drug Pricing Under the Pharmacy and Medical Benefit

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Executive Summary

Given the limited research on specialty drug pricing across sites of care, the purpose of this study was to compare pricing for specialty drugs billed by physician offices or home infusion providers with those billed by pharmacies (i.e., paid by the pharmacy benefit) for commercial groups. The study included ten commercial plan sponsors of varying size and location. The drugs examined Epoetin (including both Epogen and Procrit), Neulasta, Remicade, Tysabri, and Xolair.

The study found that price per unit dispensed for specialty drugs was higher under the pharmacy benefit than the physician office/home infusion for all five of the drugs studied. Across all plan sponsors, the mean price was 4% to 38% higher under the pharmacy benefit, depending on the drug. While this finding counters conventional wisdom about the lowest-cost sites of care for specialty drugs, it is consistent with other published data. Plan sponsors should complete an analysis of their specialty drug pricing across the pharmacy and medical benefits and consider other financial and nonfinancial factors before deciding whether to move coverage of any specialty drugs to the pharmacy benefit.

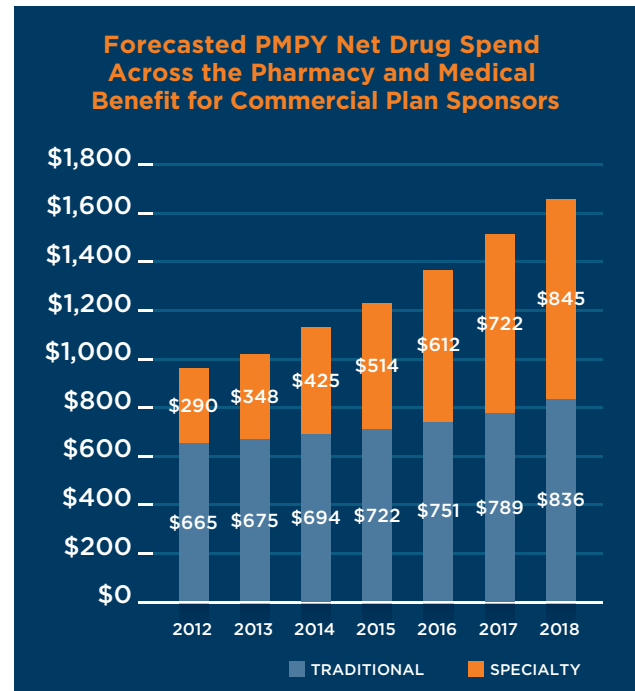
Background

Specialty drug spending is expected to grow at double-digit rates for the next several years, in large part due to the pipeline of new specialty therapies coming to market. Our analysis forecasts that when aggregated across the pharmacy and medical benefits, specialty drug spending will surpass traditional (i.e., nonspecialty) drug spending by 2018 (Figure 1).^{1,2}

As plan sponsors seek out effective strategies to manage specialty drug spending, one option is to move coverage of specialty drugs from the medical benefit to the pharmacy benefit. A 2012 survey of 50 large commercial health plans found that the use of specialty pharmacies for specialty drugs administered in physician offices grew from 44% to 51% for nonchemotherapy drugs and from 25% to 32% for chemotherapy drugs between 2011 and 2012.³

In mid-2013, The National Business Group on Health (NBGH) recommended eight strategies for managing specialty drugs, one of which was identifying medications in the medical benefit that can move to the pharmacy benefit. The NBGH report cited several advantages of moving specialty drugs under pharmacy, including greater ability to track the drug under pharmacy, less price variation, and higher cost-sharing under pharmacy where there is typically no out-of-pocket cost maximum.⁴

This trend towards increased use of the pharmacy benefit for infused biologics runs counter to a recent report that on a



weighted average basis, pricing is 17% higher for drugs obtained from a specialty pharmacy than under a “buy and bill” arrangement.³ However, research suggests that some plan sponsors may not be aware of the price differential across sites of care and/or distribution methods for infused specialty drugs. In a 2013 survey of larger employers, 30% of respondents were not sure which site of care has the lowest cost under their medical benefit. More than one-quarter of employers selected the “physician’s office via a specialty pharmacy” as the lowest-cost channel, and 22% selected “the patient’s home.” Only 10% said that “buy and bill” in the physician’s office was the lowest-cost arrangement, and 4% indicated that all options are approximately equal in cost.⁵

Study Objectives and Methods

Given the limited published research on specialty drug pricing across channels, the purpose of this study was to compare pricing for specialty drugs billed by physician offices or home infusion providers with those billed by pharmacies (i.e., paid by the pharmacy benefit) for commercial plan sponsors. This study did not examine pricing in the outpatient hospital setting as it is widely recognized that drug pricing in the outpatient hospital setting is typically 2-3 times that of the physician office for commercial plan sponsors.^{6,7}

The study included a convenience sample of ten different commercial plan sponsors, spanning health plans, employers, and labor groups. Only members with primary coverage through the plan sponsor, as evidenced by the eligibility file or the claims data, were included in the analysis.

The drugs examined were Epoetin (specifically Epogen and Procrit), Neulasta, Remicade, Tysabri, and Xolair. These drugs were selected because they represent high aggregate expenditures and are frequently paid under both the medical and pharmacy benefits, allowing for direct comparison within the claims data.

Both pharmacy and medical claims were examined for each plan sponsor for the year 2012. Within the pharmacy benefit, specialty drugs can be distributed by a retail, specialty, or mail-order pharmacy. The base analysis included all three types of pharmacies.

Specialty drugs were selected from the pharmacy claims based on the National Drug Code (NDC) and from the medical claims based on the Healthcare Common Procedure Coding System (HCPCS). Physician office and home infusion claims were identified by the place of service. Retail, mail-order, and specialty pharmacies were identified by their National Provider ID (NPI) or National Association of Boards of Pharmacy (NABP) numbers.

The study examined the price, defined as the allowed amount as reported on the pharmacy and medical claims for each of the specialty drugs of interest. To adjust comparisons for quantity administered, calculations were performed per dosage unit. Epoetin allowed amounts were calculated per 1,000 units, Remicade per milligram (mg), and Xolair per mg. Tysabri and Neulasta calculations were per administration.

For each plan sponsor, the mean allowed amount was determined for each drug for the medical (physician office and home infusion) and pharmacy channels in 2012. The percentage difference in price was calculated as the difference in mean price between the pharmacy and medical channels, divided by the mean price for the medical channels. The mean allowed amount was also calculated as a percentage of average sales price (ASP) for drugs covered under the medical benefit, to allow for comparison to national pricing benchmarks. Sensitivity analysis examined median allowed price as an alternative to the mean, and a second sensitivity analysis included specialty pharmacies only.

Results

The plans were geographically diverse, with four located in the Northeast, three in the Midwest, two in the West, and one in the Southeast (Table 1). Six of the plans contracted with the same national pharmacy benefit manager (PBM). More than 30,000 specialty drug claims were analyzed across the ten plans. Across the plans, specialty drug spending per member per month (PMPM) under the pharmacy benefit ranged from \$7.81 to \$33.43. The plan with the highest spending had generous coverage of infertility agents. Specialty drug spending under the medical benefit ranged from \$7.35 to \$19.49 PMPM. Within the pharmacy benefit, the percentage of specialty drugs that were filled by a specialty pharmacy ranged from 32% to 88%. Less than 3% of the medical claims were administered through home infusion.

Table 1. Profile of Plan Sponsors, 2012

PLAN	LIVES	PAYER TYPE	MEDICAL VENDOR	SPECIALTY RX SPEND PHARMACY (PMPM)	% RX SPEND IN A SPECIALTY PHARMACY	SPECIALTY RX SPEND MEDICAL (PMPM)
PLAN A	100K - 500K	HEALTH PLAN	SELF	≤\$10	≤35%	≤\$10
PLAN B	25K-50K	EMPLOYER/ LABOR	REGIONAL BLUES	≤\$10	≤35%	≤\$10
PLAN C	> 500K	HEALTH PLAN	SELF	n/a	>65%	n/a
PLAN D	< 25K	EMPLOYER/ LABOR	MULTIPLE	>\$15	>65%	\$11-\$15
PLAN E	100K - 500K	HEALTH PLAN	SELF	\$11-\$15	≤35%	\$11-\$15
PLAN F	< 25K	EMPLOYER/ LABOR	NATIONAL	\$11-\$15	36-65%	≤\$10
PLAN G	100K - 500K	EMPLOYER/ LABOR	REGIONAL BLUES	>\$15	>65%	>\$15
PLAN H	25K-50K	EMPLOYER/ LABOR	REGIONAL BLUES	≤\$10	>65%	≤\$10
PLAN I	25K-50K	EMPLOYER/ LABOR	REGIONAL BLUES	\$11-\$15	>65%	≤\$10
PLAN J	25K-50K	EMPLOYER/ LABOR	REGIONAL BLUES	\$11-\$15	36-65%	≤\$10

N/A=not available because member months were not available to calculate PMPM spending.

The final sample included 26 unique comparisons across five drugs and ten plan sponsors. The price (i.e., allowed amount), relative to ASP, varied from 91% to 165% (Table 2). The price per unit of medication was higher in the pharmacy benefit for 85% (22) of the drug-channel price comparisons. The pharmacy channel was a higher price for all five drugs when claims were aggregated across all plan sponsors.

The percentage price difference between pharmacy and the physician office/home infusion varied by drug (Table 3). For Epoetin, pharmacy was 38% higher when examining the mean price differential for all plan sponsors, ranging from 29% to 81% higher. For Neulasta, the mean pharmacy benefit price was 13% higher across all plan sponsors, ranging from 2% to 31% higher. Mean pharmacy pricing was 8% higher for both Remicade and Tysabri. For Xolair, the pharmacy

benefit pricing averaged 4% higher, ranging from 37% less expensive to 3% higher. For Plan J, which had significantly lower Xolair pricing under pharmacy, the physician office/home infusion pricing for Xolair averaged 165% of ASP.

Sensitivity analyses of specialty pharmacies only and comparing medians rather than means produced similar results.

Table 2. Mean Specialty Drug Allowed Amount Per Unit, by Channel, 2012

PLAN	CHANNEL	VARIABLE	EPOETIN	NEULASTA	REMICADE	TYSABRI	XOLAIR
PLAN A		ASP		123%	109%	103%	
	HOME INF	PER UNIT		\$3,501	\$7.11	\$3,581	
	PHARMACY	PER UNIT	\$18.28	\$3,840			\$4.78
PLAN B	PHYSICIAN/	ASP	110%	99%	119%	93%	97%
	HOME INF	PER UNIT	\$10.82	\$2,802	\$7.75	\$3,226	\$4.56
	PHARMACY	PER UNIT	\$16.68				\$4.69
PLAN C	PHYSICIAN/	ASP	128%	119%	113%	105%	96%
	HOME INF	PER UNIT	\$12.68	\$3,373	\$7.34	\$3,645	\$4.54
	PHARMACY	PER UNIT	\$16.38	\$3,683	\$7.52	\$3,770	\$4.64
PLAN D	PHYSICIAN/	ASP		96%	102%	100%	100%
	HOME INF	PER UNIT		\$2,720	\$6.65	\$3,473	\$4.69
	PHARMACY	PER UNIT				\$3,895	\$4.81
PLAN E	PHYSICIAN/	ASP	127%	131%	104%	97%	95%
	HOME INF	PER UNIT	\$12.54	\$3,726	\$6.75	\$3,358	\$4.45
	PHARMACY	PER UNIT	\$17.86	\$3,811			\$4.47
PLAN F	PHYSICIAN/	ASP		93%	91%	97%	
	HOME INF	PER UNIT		\$2,652	\$5.91	\$3,366	
	PHARMACY	PER UNIT				\$3,736	
PLAN G	PHYSICIAN/	ASP	106%	108%	107%	106%	
	HOME INF	PER UNIT	\$10.47	\$3,062	\$6.94	\$3,685	
	PHARMACY	PER UNIT	\$17.51	\$3,709	\$7.83	\$3,956	
PLAN H	PHYSICIAN/	ASP	107%	132%			
	HOME INF	PER UNIT	\$10.59	\$3,737			
	PHARMACY	PER UNIT	\$19.15				
PLAN I	PHYSICIAN/	ASP		103%	106%	100%	107%
	HOME INF	PER UNIT		\$2,920	\$6.91	\$3,488	\$5.04
	PHARMACY	PER UNIT	\$17.85	\$3,830	\$7.83	\$3,961	\$4.82
PLAN J	PHYSICIAN/	ASP	141%	133%	137%		165%
	HOME INF	PER UNIT	\$13.88	\$3,787	\$8.96		\$7.77
	PHARMACY	PER UNIT		\$3,890	\$7.85		\$4.87
ALL	PHYSICIAN/	ASP	122%	117%	111%	103%	96%
	HOME INF	PER UNIT	\$12.06	\$3,333	\$7.21	\$3,597	4.54
	PHARMACY	PER UNIT	\$16.68	\$3,775	\$7.77	\$3,890	4.74

ASP=average sales price. HOME INF=Home Infusion.

Table 3. Percentage Difference^a Between Mean Allowed Amount Per Unit in the Pharmacy Benefit Relative to the Physician Office/Home Infusion, 2012.

PLAN	EPOETIN	NEULASTA	REMICADE	TYSABRI	XOLAIR
PLAN A		10%			
PLAN B	54%				3%
PLAN C	29%	9%	2%	3%	2%
PLAN D				12%	2%
PLAN E	42%	2%			0%
PLAN F				11%	
PLAN G	67%	21%	13%	7%	
PLAN H	81%				
PLAN I		31%	13%	14%	-4%
PLAN J		3%	-12%		-37%
ALL	38%	13%	8%	8%	4%

^aThe percentage difference in price was calculated as the difference in mean price between the pharmacy and medical (physician office/home infusion) channels, divided by the mean price for the medical channels.

Discussion

The study found that prices per unit dispensed for specialty drugs were higher under the pharmacy benefit than the physician office or home infusion for the five drugs studied. As the vast majority of claims were administered in the physician office, this study is more representative of the physician office than home infusion. That said, other research shows that pricing across the two channels is similar, at least in aggregate.⁷

Across all plan sponsors, the mean price was 4% to 38% higher under the pharmacy benefit, depending on the drug. While this finding counters “conventional wisdom” about the lowest-cost sites of care for specialty drugs, it is consistent with other published data.³ This pricing dynamic has not been well-understood due to the complexities of comparing NDC-based/average wholesale price (AWP) under the pharmacy benefit with HCPCS-based /ASP pricing under the medical benefit. Given that the pharmacy benefit and increasingly the physician offices offer competitive pricing,^{7,8} the higher price under pharmacy likely reflects differences in acquisition costs due to class of trade.⁹

For one plan sponsor, both Remicade and Xolair had lower pricing under the pharmacy benefit because the plan was reimbursing the two drugs under medical at 137% and 165% of ASP, respectively. These rates are significantly higher than self-reported reimbursement rates for commercial plans, which average 107%-109% of ASP for the physician office and home infusion.⁷

This study is limited by the number of plan sponsors, drugs compared, and PBMs represented. While the discount rates for these plans are generally consistent with

nationally published data on specialty drug discounts across the pharmacy and medical benefits, further research is needed to validate this analysis and to understand price competitiveness across a larger sample of plan sponsors.

Beyond drug acquisition cost, there are other potentially relevant considerations when deciding whether to move specialty drugs out of the medical into the pharmacy benefit. First, real-time adjudication under the pharmacy benefit allows for active management of quantity errors, prior authorizations, early refills, and other clinical issues. Under the medical benefit, these reviews typically occur either through a manual process, in which the physician office calls the health plan for a prior authorization, or retrospectively once a claim is submitted. Electronic prior authorization and pre-adjudication technology under the medical benefit may lessen the advantages of the pharmacy benefit as these tools penetrate the market.

A second consideration is the trend towards hospital purchasing of physician practices,¹⁰ which puts plan sponsors at risk for higher pricing if the physician’s pricing schedule transitions to that of the outpatient hospital after the acquisition.¹¹ A third consideration is the net amount paid by the plan sponsor after the member cost-share. Many plan sponsors have inconsistencies in cost-sharing policies for specialty drugs under the pharmacy and medical benefits.⁵ However, deductibles under the medical benefit complicate this comparison, and the Affordable Care Act requirement for integrated pharmacy and medical out-of-pocket maximums in 2015¹² will likely mitigate the financial advantage of higher cost-sharing that often occurs under pharmacy.

While coverage under pharmacy has some potential advantages, moving specialty drugs to the pharmacy benefit has potential financial risks that have not been sufficiently studied. First, the risk for wasted product and hence, higher costs, grows if the drugs are distributed through the specialty pharmacy and then shipped to the physician office. The waste, which has been reported to occur in 20% of drugs shipped to the physician's office, may be due to changes in dose or duration, disenrollment, or other unforeseen issues.³ In addition, specialty pharmacies cannot bill for partial vials with an NDC number, which can result in payment for medication that was not used.³ Given the limited detail provided on these two findings in the referenced report, research is needed to quantify the magnitude of excess cost that each of these factors contributes to specialty spending. In addition, the AWP and ASP pricing mechanisms differ in important ways that may lead to differential rates of inflation for the same drug across the two pricing benchmarks. Research is needed that incorporates these price inflation dynamics when examining the financial considerations of specialty drug distribution.

Beyond the financial considerations is the potential for physician and patient disruption when plan sponsors require office-infused drugs to be covered under the pharmacy benefit. Unintended consequences are also a potential risk—physicians may respond by

encouraging patients to use the outpatient hospital setting, which may not be subject to the same benefit restrictions, possibly increasing costs. This risk exists as well when physician reimbursement is set at overly aggressive rates. None of these considerations has been well-studied.

In summary, the decision of whether to move specialty drugs out of the medical to the pharmacy benefit is a complex one in which both financial and nonfinancial issues should be considered. The purpose of this study was to provide critical information about relative price under the pharmacy and medical benefits that would serve to inform an overall strategy for specialty drug management.

A crucial first step is that plan sponsors complete an analysis of their specialty drug pricing in the pharmacy and medical benefits before deciding whether to move any specialty drugs to the pharmacy benefit. Each plan sponsor's analysis, in conjunction with the other considerations outlined in this paper, should inform its strategy for specialty drug distribution. Plans should recognize that a "one-size-fits-all" approach may not be appropriate given the relative differences in pricing that are seen across the benefits for different specialty products. Furthermore, given the dynamic nature of specialty drug pricing, it is prudent to monitor the pricing differentials on an ongoing basis to ensure that specialty distribution is optimized on a long-term basis.

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- ⁹ Class of trade defined—Under federal law, customers such as buyers of pharmaceuticals that share similar profiles and attributes may be categorized into a class of trade (COT) to be eligible to receive similar pricing concessions, such as discounts and special offers. Most pharmaceutical companies have developed lists of similar customers and grouped them into different COTs. For more information, see AMCP Guide to Pharmaceutical Payments 2009 Update (Version 2.0). Available at <http://www.amcp.org/data/jmcp/1002.pdf>.
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