



# Bend the Curve: A New Era for the Management of Specialty Pharmaceuticals

## **Authors**

F. Randy Vogenberg, Ph.D., R.Ph.  
John Santilli, M.B.A  
Kirby Eng, R.Ph.

## **Reviewers and Contributors**

Cheryl Larson  
Tom Morrow, M.D.  
Tom Sondergeld

**AM**Intelligence  
*Access Market Intelligence*

## Forward

# Specialty Pharmaceuticals: A Call to Action

Each year, there are an increasing number of biologics and specialty drugs produced for a number of rare and chronic conditions. With more of these drugs coming down the pipeline, and faster drug approvals, employers continue to seek effective management strategies that support the health and productivity of their workforce, drive optimal patient outcomes, address transparency issues from third-party program administrators and positively impact the bottom line.

But there are still gaps. Employers recognize that specialty drug management requires different thinking around benefit design, yet industry surveys indicate employers have made little to no change in their approaches and identification of best practices. Proven strategies that can provide a road map to all have also failed to emerge.

One of the biggest challenges is identifying what costs are running through the medical benefit versus the pharmacy benefit. With a high percentage of costs occurring through medical, as well as a variety of payment and dispensing options, it can be difficult to achieve full transparency on overall spending and utilization. The gaps in benefit administration alignment within or across vendors makes this objective even more challenging.

Employers want to continue offering health benefits that attract and retain the best employees in a competitive market, and they recognize that specialty drug coverage is an important component to maintain in their overall benefit designs. But they still have significant concerns about rising cost trends and believe if they continue at current rates, significant changes may need to be made to offset the impact on their ability to provide high-quality employee benefits. Effective collaboration with vendor partners to optimize health benefits' coverage and patient outcomes around all prescription drug use has become critical for employer decision-makers.

This is a call to action for employers that must also be extended to their vendor partners. For today's employer, doing nothing is no longer an option. But promising approaches are on the horizon.

Cheryl Larson  
Vice President  
Midwest Business Group on Health  
Chicago, IL

*Larson co-leads the National Employer Initiative on Specialty Drugs, an employer-driven, multi-year research project that serves as a roadmap to support employers by providing knowledge, access to the latest research and best practices as well as no-cost resources.*

## Contents

An Introduction to Today's Specialty Marketplace	3
What is MBM? A Useable Definition	5
Why MBM is Important & the Need for Holistic Strategies	5
Why is MBM Difficult to Accomplish: Challenges with Specialty Drugs	9
Approaches for Delivering MBM in the Post-ACA Marketplace	11
Best Practices for Delivering MBM	13
The Time is Now: A New Era for Specialty Drug Management	14
Sources and Glossary	15
Industry Abbreviations	16

# Bend the Curve: A New Era for the Management of Specialty Pharmaceuticals

## An Introduction to Today's Specialty Marketplace

Biologic, biotechnology-based, rare disease, or high-cost pharmaceuticals — collectively known as specialty drugs — can be covered under the pharmacy benefit, the medical benefit, or both depending on the benefit design plan sponsors require of the third-party administrator (including the pharmacy benefit manager – PBM; administrative service organization – ASO; or any administrator of a medical or pharmacy benefit).

On average, up to 50% of specialty drugs today are covered under the medical benefit.<sup>1</sup>

Finding ways to ensure access and manage costs is difficult for these drugs. Plan sponsors seeking optimal clinical and financial outcomes for specialty drugs under the medical benefit struggle to find workable solutions due to the lack of actionable data (i.e., data analytics and reporting) that can identify the best clinical and financial practices as well as:

- Conflicts of interest due to third-party administrator;
- Specialty Pharmacy and physician office drug dispensing revenues;
- Patient OOP (out-of-pocket) or co-pay/co-insurance discrepancies;
- Site of service fragmentation producing different costs; and
- Inconsistent application of prior authorization requirements.

With the exception of a few key therapy areas, traditional tools used to manage specialty drugs under the medical benefit, such as prior authorizations and medical benefit carve-outs (i.e., “white-bagging”), have yielded limited value to plan sponsors.

This thought leadership analysis, with insights from recognized industry experts, will provide an overview of the challenges, a summary of the key issues plan sponsors must address and insights into best practices through an innovative new approach, **Medical Benefit Drug Management (MBM)**.

### What is a specialty drug?

It's simple: Any of the costly, yet life-saving, life-extending and/or newly prescribed drugs typically (but not always) injectable, which payers struggle to effectively cover and manage. Insulin is an injectable, but is low-cost. Hepatitis C antivirals (HCV) are now available as oral drugs but because they are expensive they are categorized as specialty. Expensive can be a subjective term. For purposes of this paper, it covers any single prescription drug with an annual cost of more than \$25,000.

Table 1  
Key Differences Between Pharmacy And  
Medical Benefit Billed Drugs

Note: abbreviation definition key on page 16

Category	Pharmacy Benefit	Medical Benefit	MBM Challenges / Opportunities
Claims Format	NCPDP	CMS 1500	CMS 1500 provides diagnosis and demographic information but lacks relevant clinical (i.e., labs, diagnostics, co-morbidities) and drug details (i.e., dose and quantities administered to patient).
Drug Identifier	NDC	HCPCS codes	HCPCS codes lack drug manufacturer identification, strength, dose and quantity dispensed.
Reimbursement	AWP based	AWP and ASP based	Balancing drug trend management with preserving access to high-quality, cost-effective care.
Site of service	PBM, Specialty Pharmacy, Retail Pharmacy	Physician office, Hospital outpatient clinic, Ambulatory infusion centers, Home for self-administered drugs	Optimizing site of service in light of continuing hospital acquisitions of community-based specialist practices (i.e., oncology, rheumatology).
Drug formulation	Mostly oral capsules, tablets, liquids and self-administered injections	Intravenous, injectable and self-administered injections	Most medical benefit drugs require clinician oversight for drug administration.
Data specificity	Drug, dosage, manufacturer, package sizes, quantity dispensed, patient demographics	Drug, quantity billed, patient demographics, diagnosis	Medical benefit drug reporting has been difficult to obtain and when available, limited in scope for clinical and financial applications.

## What is MBM?

### A Usable Definition

Like many new areas of health care, definitions lag behind the changes in clinical or administrative practice. To establish a clear context for the rest of this paper, here is a definition to use:

**Medical Benefit Drug Management (MBM)** refers to the tactics and strategies to help control specialty drug spending for drugs that are specifically billed through a third-party administrator or a payer's medical benefit drug design. Drugs billed through the medical benefit are typically liquid or powder formulations requiring intravenous and injectable administration in a physician's office, hospital outpatient clinic or ambulatory infusion center.

A MBM program, at a minimum, must be able to address the payer's complex existing work flow, from utilization management to claims, while providing increased attention to specialty drug selection and spending through services. This should include any network and collaborative utilization management that helps control spending for specialty drugs billed through the medical benefit.

At the optimal level of operation, a MBM program has the potential to maximize clinical and economic investments of the plan to deliver consistently sustainable and measurable outcomes.

## Why MBM is Important & the Need for Holistic Strategies

To address the sobering trends of specialty drug spending, it is critically important to manage drug spend adeptly regardless of benefit design.

While they add up to only about 1% of all prescriptions written, specialty drugs account for more than 30% of spending on all U.S. prescription drugs, according to various sources. Statistics and projections vary, but sources agree that specialty drug spend will continue to play a major role in a third-party payers or plan sponsors budget.

- Specialty drugs accounted for 37% of drug spend in 2015 and are expected to reach 50% by 2018.<sup>2</sup>
- Net spending on medicines was \$310 billion, up 8.5% over 2014 levels. Specialty drug spending reached \$121 billion on a net price basis, up more than 15% from 2014. Spending on specialty medicines doubled in the past five years, contributing 70% of overall medicine spending growth between 2010 and 2015.<sup>3</sup>

*continued*

## Industry Insight

Until recently, much of the focus from a cost and design perspective has been on medical spend and trend, and rightfully so. With medical costs contributing to nearly 80 to 85% of total spend, it is a much easier cost category to make an impact of any significance. However, with the ever-increasing numbers of specialty drugs coming to market, the focus is changing to look more aggressively at all pharmacy costs in employer benefit plans.

The challenge now is to look at total medical and pharmacy spend together. As we do, we find it is quite difficult to peel away the onion and to align all pharmacy spend, no matter where it occurs, under one umbrella.

Thomas A. Sondergeld  
Vice President  
Global Benefits & Mobility  
Walgreens Boots Alliance



continued

## Industry Insight

There continues to be ongoing issues with employers getting data from their vendors. If they do get the data, are they able to integrate it and make sure that it's actionable?

Data isn't the only problem employers experience with their vendors; there is a continuing lack of transparency with rebates, contracting and costs. These challenges, along with minimal vendor innovation to support cost management efforts, have resulted in employers searching for real world learnings from each other.

Cheryl Larson  
Vice President  
Midwest Business Group on Health  
Chicago, IL

- The estimated number of Americans with annual drug costs greater than \$50,000 increased 63% in 2014, from 352,000 people to 576,000. Many of these patients take multiple drugs, and 92% use high-priced specialty drugs.<sup>4</sup>
- Third-party administrators' drug trend reports all project specialty trend in the same range: CVS Caremark projects specialty trend to range from 14% to 19.5% in 2016; Express Scripts forecasts 18.2% trend; Catamaran's forecast range is 16.0% to 23.6%; and Prime's 2016 forecast range is 17% to 19%.<sup>5</sup> (PBM-generated trend reports typically focus only on pharmacy benefit managed drugs.)
- A recent analysis published in *Health Affairs* modeled the impact of a hypothetical specialty drug costing \$100,000 per treated patient that would increase total health care costs by \$250 for every 0.25% of the population using the drug. Under this model, such a specialty drug used by just 5% of the population would lead to an almost 15% increase in premiums.<sup>6</sup>
- The surge of new and innovative treatments for patients with cancer continued in 2015 and contributed to rising expenditure on cancer therapeutics (excluding medicines used for supportive care). These expenditures reached \$39.1 billion, up 18.0% from 2014. Oncology medicines comprise the greatest share of launches by therapeutic area over the past 10 years, accounting for 35% of all launches in 2015.<sup>3</sup>

Therapeutic breakthroughs assure a major shift in care or condition management. While traditional tools from third-party administrators, such as prior authorization or mandatory specialty (white bagging), have been used to control utilization and costs, they are minimally effective with specialty drugs billed through the medical benefit. This is due to a number of reasons such as fragmented IT system management (i.e., third-party administrator, specialty pharmacy, health plans); physician revenue considerations; lack of reliable and timely reporting; and misaligned stakeholder incentives.

Market surveys indicate the marketplace is looking for a full spectrum solution for specialty drugs under the medical and/or pharmacy benefit.<sup>7</sup>

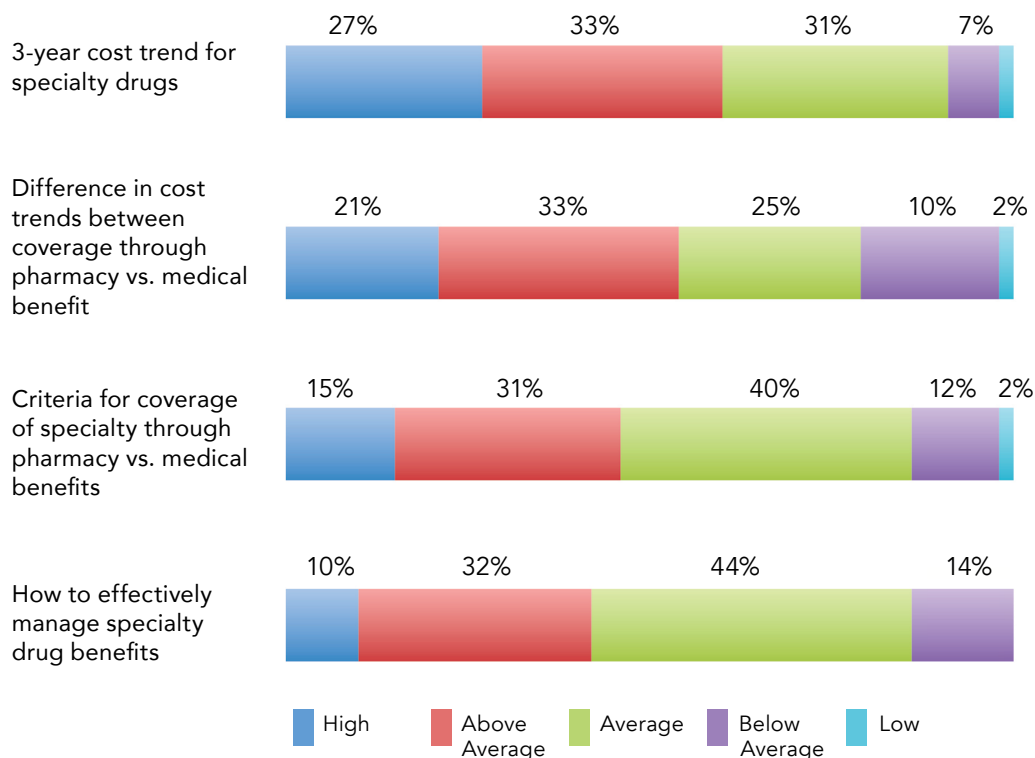
Employers play a large role in shaping health plan benefit design by payers; they rely on vendors to recommend and provide products and services to enable companies to provide health benefits to employees.

The Midwest Business Group on Health (MBGH), a non-profit employer coalition of mid to large, self-funded public and private employers, has taken the lead in evaluating employers' understanding and acceptance of specialty drugs through its annual survey. This survey is part of the MBGH's employer-driven research project, the National Employer Initiative on Specialty Drugs.

In its 2015 benchmarking survey report in collaboration with The Institute for Integrated Healthcare (IIH), and analyzing 2014 data, MBGH found the overall level of employer understanding of specialty drugs and how to effectively manage those benefits to be average to below average. The 2016 report from the 2015 survey shows a continued knowledge gap:

Graphic 1

## Level of employer understanding of specialty drugs...



Copyright © 2015 MBGH/IIH

The MBGH/IIH survey also revealed that although 88% of employers still use traditional plan designs to help control the cost of specialty drugs, the majority are willing to try new strategies.

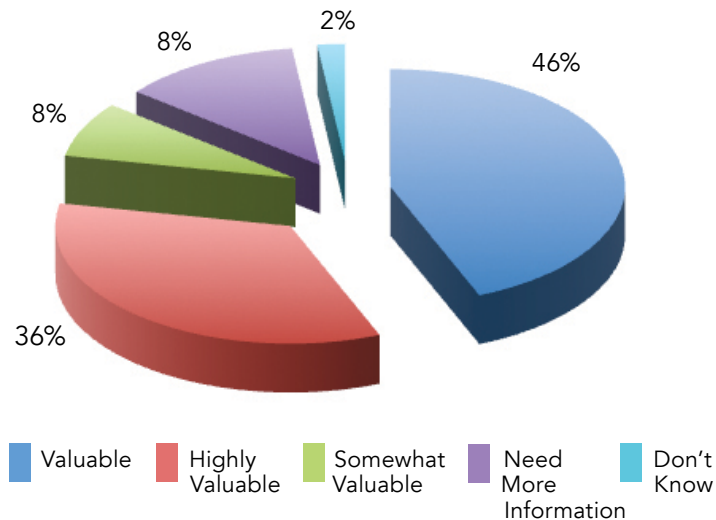
Interestingly, when asked about the value of specialty drugs in significantly improving disease outcomes, 82% ranked them as valuable or highly valuable (see Graphic 2, page 8), yet only 13% of employers surveyed ranked them as highly valuable in improving workforce productivity (see Graphic 3, page 12). These results show a disparity in understanding specialty drugs and their value proposition.

The need for a comprehensive medical benefit drug strategy applies to health plans, providers and purchasers. Effective strategic planning requires identification of immediate and long-term needs. For any business to grow and prosper, business leaders need to anticipate change in the internal and external environments.

Business leaders need to monitor the regulatory and political environment, technology advances, market forces, and competition to anticipate and develop effective strategic planning to guide the business to growth.

Graphic 2

### Value of specialty drugs in significantly improving chronic or life-threatening disease outcomes



Copyright © 2015 MBGH/IIH

---

## The Value of MBM

A successful MBM program provides deep and actionable clinical, operational, and financial guidance. Translating the best practice benefits of a MBM program to third-party administrators and plan sponsors includes:

- **Control of spending** from a clinically based partner with evidence-based experiences.
  - **Alignment of appropriate transparent** nationally recognized evidence-based guidelines, dose checks, and competent clinic dialogue.
  - **Evidence-based insights** through the combination of good, measurable outcomes, and integration with most up-to-date peer-reviewed clinical data.
  - **Efficiency in benefit design**, provider capabilities, and identification of providers who significantly deviate from transparently developed "best practice" metrics.
  - **Meaningful, collaborative clinical support** that recognizes unique patient characteristics.
  - **Administrated utilization management** that mirrors physician specialist clinical and operational workflow while minimizing management burdens.
-



## Why is MBM Difficult to Accomplish: Challenges with Specialty Drugs

Specialty and biologic-based drugs are significantly more expensive than traditional clinical-based drugs. Specialty drugs used to treat cancer, autoimmune diseases (i.e., rheumatoid arthritis, psoriasis, Crohn's disease), multiple sclerosis, hemophilia and macular degeneration are the prime drivers of medical benefit specialty drug spending.

The MBM concept is considered by plan sponsors to be a proactive tool to increase attention of specialty drug selection and spending through related services. The concept has the potential to maximize clinical and economic investments of the plan to deliver optimal outcomes more consistently over time.<sup>7</sup>

The complexity and challenges in controlling specialty drug spend, along with the growing trends of these drugs, have only made it more difficult to draft and implement cost-effective containment strategies.

Table 2  
**Challenges and Implications for Controlling Specialty Medical vs. Pharmacy Benefit Drug Costs**

Challenges	Medical Benefit	Pharmacy Benefit
Wastage	<p>Patients do not use all of drug in commercial package sizes.</p> <p>Reimbursement is based on cost plus a percentage markup, such as ASP plus 6%, which may encourage use of more expensive drugs.</p> <p>Use of mandatory specialty (white bagging) incurs waste when patient does not receive the drug yet payer pays for the unused portion.</p>	<p>Lower opportunity for waste if patients are given quantities based on daily requirements, and limited to short days' supply (e.g., 14 day) versus 90-day mail order quantities.</p> <p>Drug delivery is coordinated with patient and provider.</p>
Special handling	<p>Most drugs are injectable or intravenous liquid or lyophilized formulations, so there are greater requirements for refrigeration and/or avoiding high temperatures; and for minimizing breakage of glass vials and syringes.</p>	<p>With some exceptions, most pharmacy benefit drugs do not require refrigeration or other unique delivery methods. White bag drugs could have some temperature and fragility issues.</p>
Claim integration	<p>Site of service and data fragmentation (PBMs, Physicians, Payers) create significant barriers to integrating across benefit utilization and costs.</p>	<p>Site of service and data fragmentation (PBMs, Physicians, Payers) create significant barriers to integrating across benefit utilization and costs.</p> <p><i>continued</i></p>

Table 2 *continued*  
Challenges and Implications for Controlling Specialty Medical vs.  
Pharmacy Benefit Drug Costs

Challenges	Medical Benefit	Pharmacy Benefit
Prior authorizations	<p>Inconsistently applied and/or typically single, rather than multi-drug-focused, creating administrative burdens and possible treatment delays.</p> <p>Pathway vendors (i.e., oncology) may utilize proprietary rule sets that create lack of transparency issues across stakeholders.</p>	<p>More extensive utilization management tools such as formulary, dose, and quantity are available, but coverage confusion or proprietary rules create some transparency issues.</p>
Adherence and abandonment	<p>Adherence is presumed to be high since the patient usually needs to be treated under clinical supervision in a physician office or clinic.</p> <p>Abandonment is low since injectable or infused drugs are only prepared when the patient is physically in a physician office, clinic, or ambulatory infusion center.</p> <p>Does not address lack of patient engagement to seek or continue treatment.</p> <p>Obtaining data on both cost and quality or outcomes is limited.</p>	<p>Adherence and abandonment are a well-recognized challenge in both retail and mail-based pharmacy settings.</p> <p>Does not address lack of patient engagement to seek or continue treatment.</p> <p>Obtaining data on both cost and quality or outcomes very limited.</p>
Identification of providers not optimizing evidence-based and/or cost effective care	<p>Inconsistently applied prior authorizations make identification very difficult.</p>	<p>Well-established processes, such as prior authorizations for drugs processed through the pharmacy benefit, allow for effective prospective utilization management.</p>
Patient drug education	<p>Key challenge is ensuring consistent patient education across varied and/or multiple sites of service (physician office vs. outpatient clinic).</p>	<p>Drug education usually handled by telephone and, while operationally efficient, the debate on face-to-face versus remote continues.</p> <p>Current drug therapy management removes an element of personalized human interaction, especially during times of new start drug use.</p>

Plan sponsors have developed a number of strategies to address unsustainable increases in the prices of specialty drugs. These approaches include providing patients with tools and support to help them manage their specialty drugs; promoting collaborative arrangements with physicians and pharmacies; and focusing on the supply side through the use of specialty pharmacies.

These strategies have started to make some progress in controlling the specialty drug cost spend. However, third-party payers and plan sponsors who take risks are becoming more aware of many of the challenges they face.

Plan sponsor market surveys have identified waste mitigation as the challenge they are most aware of and believe is of key importance (strategies include: minimize unused drugs, improved adherence, etc.). Identification of providers not optimizing evidence-based, cost-effective care also has been identified as significant.<sup>7</sup>

To proactively address these challenges, plan sponsors realize that a more integrated medical drug benefit management approach and strategy are critical.

## Approaches for Delivering MBM in the Post-ACA Marketplace

Since the passage of the PPACA, known as the Affordable Care Act (ACA), many changes have impacted the marketplace. At the same time, health plan and employer plan sponsors are searching for the right solution to help control specialty drug spend.

Although many plan sponsors have programs administered by third party entities, they are discovering that these programs do not meet their needs when it comes to effectively managing specialty pharmacy – denying or limiting coverage is not a strategy. Many plan sponsors find there is often a lack of consistent, available, objective, and actionable data from third-party plan administrators to provide the insights that answer the hard questions on how to provide access to drugs in a cost-effective manner. Gaps in these programs only become apparent as plan sponsors introduce new drugs and issues arise, such as care integration and appropriate drugs at service sites.<sup>7</sup>

Here's where strong MBM programs play a critical role. Plan sponsors should look for the following from a MBM program:

- Assistance in controlling spend from a clinically based partner with evidence-based experience.
- Alignment with appropriate guidelines, dose checks, and competent clinical dialogue.

*continued*

## Industry Insight

The ability for plan administrators to more easily bring pharmacy services together, in order to take advantage of discounts and improved delivery methods, should be the direction we head.

One note of caution as we look to the medical benefit drug spend is the importance that needs to be placed on careful analysis prior to taking action. Some medical benefit drug spend may actually turn out to be accomplished more cost effectively by pulling it out of the physician office. What's more, other delivery methods may do the exact opposite of what is desired and drive up cost. A surgical approach to interventions, with good data mining, is essential.

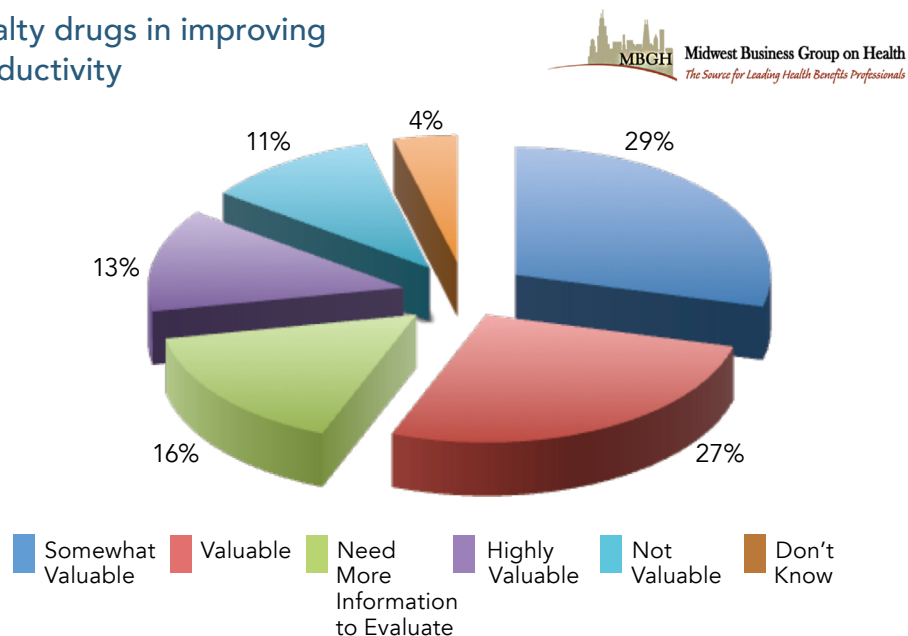
Thomas A. Sondergeld  
Vice President  
Global Benefits & Mobility  
Walgreens Boots Alliance

continued

- Outcomes integrated with the most up-to-date, nationally recognized evidence-based references.
- Economic results combined with good financial and clinical outcomes, resulting in strong returns on investment for payers.
- Ability to provide effective and targeted benefit design based on data analysis, experience and goals of the plan sponsor.
- Identification and support, as well as collaborative education, for providers who may not meet best practice metrics.
- Explanation of how the MBM will manage pharmacy spend and deliver value.
- Identification of clear, delineated ways to have certain policies in place to assist physicians without adding a significant administrative burden.
- Integration of data that measures provider alignment with evidence-based and cost-effective drug therapy for optimal care outcomes.
- Meaningful clinical support to work collaboratively with physician specialists such as medical oncologists, hematologists, rheumatologists, neurologists and ophthalmologists.

Some administrators will embrace MBM because they view it as a competitive advantage. However, ensuring vendor support of this approach is the responsibility of the plan sponsor. Therefore MBM will need to be incorporated into RFPs and ultimately final contracts. As more plan sponsors move to require adherence to the principles of MBM, more vendors will adapt.

Graphic 3  
Value of specialty drugs in improving  
workforce productivity



Copyright © 2015 MBGH/IIH

## Best Practices for Delivering MBM

In a well-designed MBM program, a number of concepts and metrics need to be considered upfront before a decision is made. For example, a measure of actual average drug therapy costs for a specific diagnosis (i.e., lung cancer) rather than an average cost spread across an entire member population that includes all disease states. Such an approach is a more accurate representation of drug costs incurred by payers and plan sponsors.

An example of such a metric using the approach above would be per utilizer per month (PUPM) rather than the widely used per member per month (PMPM). PUPM allows the plan sponsor to determine the average cost for a utilizer/member receiving disease therapy to reflect costs more accurately. PUPM measures all treatment costs only for that targeted drug for that specific disease billed that month through the medical benefit.

Conversely, per member per month (PMPM) spreads drug costs more broadly across all diseases rather than focusing on one specific disease.

Other best practices include:

- Near real-time reporting of relevant clinical and financial medical claims data, whether monthly or quarterly. In order to determine and influence what should happen next, the plan sponsor needs to know what is happening right now.
- Prospective or pre-service utilization management supported by peer-to-peer interventions by rheumatologists, oncologists, and other medical professionals, where appropriate. Optimal pre-service utilization management aims to be minimally burdensome to the provider, rapidly identifies evidence-based cost-effective care, minimizes or eliminates denials and appeals processes, and facilitates patient drug therapy as quickly as possible.
- Retrospective or post-service utilization review. Post-service review of patient records assesses their completion and accuracy after treatment. Responses to review findings can be used by the healthcare system to address findings that may not be optimal.
- Reports that show payers' details on sustainable savings and metrics such as ROI and cost avoidance. The process should include measures that set and meet expectations, such as ROI, which result in continued and sustainable savings for the organization.
- Programs to identify, limit and reduce fraud, waste and abuse. These activities are usually lumped together as improper payments. Fraud is a criminal behavior aimed at deceiving claims payers. Examples of waste include the unbundling of procedures and duplicate billings. Abuse is identified with behaviors such as bill splitting and the upcoding of procedures.





## The Time is Now: A New Era for Specialty Drug Management

Specialty drugs are not the same as traditional drugs. Establishing a management process to control costs should be comprehensive and carefully reasoned. Solutions require full knowledge of plan design, existing payer's medical benefit workflow, waste monitoring, and real-time data.

However, today's tools and approaches to manage specialty drug spend under the medical benefit have proven ineffective. It's time for change. An optimal strategic solution includes clinical and financial management – regardless of benefit design, drug formulation, and site of service – as well as tactically including positive economic and clinical outcomes.

MBM programs are part of the solution. They provide the oversight, data, reports and analysis that will help payers and other constituents better understand the value of specialty pharmacy and how even these high cost drugs can be worked into the overall benefit.

Such programs represent a change in the status quo... and they have many moving parts. These parts include multiple stakeholders, variable fee schedules, and the alignment of clinical and financial interests among the stakeholders, coverage rules, and different formulations that complicate the process. But these programs will work... and in fact, are working.

Deciding on and implementing a MBM program in a benefit plan takes time and requires a thoughtful discussion of the strategy and business needs with all internal stakeholders, including pharmacy, medical, member services, case management, sales, and marketing.

The need for a MBM strategy highlights the sizeable difference for commercial versus Medicare members in the post-ACA marketplace. Like Medicare, commercial plan sponsors now need to drive overall member and provider behaviors designed to improve plan performance more effectively. A MBM plan can help commercial organizations succeed by standardizing processes, implementing best practices, managing condition care optimally, and applying a balance of clinical and business acumen.

For these reasons, and most importantly to ensure access to breakthrough drugs for patients, MBM should become an integral component of a holistic strategy for commercial plan sponsors that want to improve plan performance to meet their business needs.

### Industry Insight

Some items to consider including in vendor contracts are:

- taking advantage of co-pay assistance,
- collecting clinical data on outcome of therapy,
- ensuring double dipping from both medical and pharmacy benefit do not occur,
- measuring adherence over the long term, and finally...

the overall cost in order to determine a true comparable value to the MBM therapy versus the pharmacy benefit alternatives.

Thomas Morrow, M.D.  
Consultant/Chief Medical  
Director, Next IT  
Atlanta, GA



## Sources

1. American Pharmacists Association, Pharmacy vs. Medical Benefit, October 1, 2015
  2. Express Scripts 2015 Drug Trend Report, March 2016
  3. Medicines Use and Spending in the U.S., IMS Institute for Healthcare Informatics, April 2016
  4. Express Scripts, "Super Spending: U.S. Trends in High-Cost Drugs Use" (2015), <http://lab.express-scripts.com/insights/drugoptions/super-spending-us-trends-in-high-cost-drugs-use>.
  5. Access Market Intelligence Analysis of Pharmacy Benefit Drug Trend Reports
  6. The Impact of Specialty Pharmaceuticals as Drivers of Health Care Costs. Health Affairs, 33, no. 10 (2014): 1714-1720. Available at: <http://content.healthaffairs.org/content/33/10/1714.full.pdf>
  7. Medical Benefit Drug Management Webinar/Survey Findings Report, April 1, 2016, Access Market Intelligence, LLC
  8. Specialty Drugs: Issues and Challenges, AHIP Issue Brief, July 2015
- 

## Glossary

**Biologic drug** - A biologic drug is manufactured in a living system such as a microorganism, or plant or animal cells. Most biologics are very large, complex molecules or mixtures of molecules. Many biologics are produced using recombinant DNA technology.

**Brown bagging** – Infused or injected drugs are shipped directly to the patient who takes them (brown bagging) to a medical office to be administered.

**Denial** - Denial of claim is the refusal of an insurance company or carrier to honor a request by an individual (or his or her provider) to pay for health care services obtained from a healthcare professional.

**Holistic Strategies** (for drugs) – These strategies are optimal clinical and financial management regardless of benefit design, drug formulation or site of service.

**Intramuscular administration** – An intramuscular injection is a technique used to deliver a drug deep into the muscles. This allows the drug to be absorbed into the bloodstream quickly.

**Intravenous administration** – Intravenous is a term that means "into the vein." Intravenous drug administration occurs when a needle is inserted into a vein and drugs are administered through that needle. The needle is usually placed in a vein near the elbow, the wrist, or on the back of the hand. Different sites can be used if necessary.

**Mail-order pharmacy** – A mail-order pharmacy fills faxed, emailed or phoned prescriptions, sending the drug products to a distant client in a matter of days.

**Medical benefit plan** - A medical benefit plan is a contractual agreement, specified evidence of coverage, determining covered services provided by insurers to members. Benefits are specific areas of a plan's coverage (i.e., outpatient visits, hospitalization and so forth) that make up the range of medical services that a payer markets to its subscribers.

**Payer/third-party administrator** – These are organizations with the expertise and capability to administer all or a portion of the claims process.

**Pharmacy benefit plan** – Plan sponsors offer a pharmacy program as part of their benefit plans for members. These programs offer a wide variety of high quality, effective generic and brand-name drugs.

**Plan sponsor** – This entity is legally responsible for the financial risk associated with the offer of health insurance coverage for covered members. A plan sponsor could be a state licensed health plan or a self-funded employer plan under federal law.

**Prior approval/authorization** – Prior authorization is a cost-containment procedure that requires medical staff to obtain permission to prescribe a drug prior to specifying it for the patient.

**Purchaser/payer** – This entity not only pays the premium but also controls the dollar spend before paying it to the provider (care, service, or product). Included in the category of purchasers/payers are patients, businesses, and managed care organizations.

**Retail pharmacy** – This state-licensed site is a healthcare entity that provides pharmaceutical services to a local or specific community. Typically, a state-licensed, registered pharmacist dispenses medicine/drugs from the community pharmacy.

**Specialty drug** – This category of drugs generally comprises high-cost prescription medications used to treat complex, chronic conditions like rheumatoid arthritis, multiple sclerosis, and cancer. The drug may come in different formulations for use and require special handling and/or tracking requirements.

*continued*

**Specialty pharmacy** – This pharmacy focuses on high-cost, high-touch drug therapy for patients with complex disease states. Drugs in a specialty pharmacy range from cutting-edge oral and injectable to biologic products. The disease states treated range from cancer, multiple sclerosis and rheumatoid arthritis to rare genetic conditions.

**Subcutaneous administration** – A subcutaneous injection is a method of administering drugs. Subcutaneous means under the skin. In this type of injection, a short needle is used to inject a drug into the tissue layer between the skin and the muscle.

**White bagging** – White bagging is the method of delivery by which physician-administered drugs are dispensed by a specialty pharmacy for a specific patient, shipped to the physician for administration, and generally paid under the pharmacy benefit rather than the medical benefit.



## Review of Industry Abbreviations

**ASO** – Administrative Service Organization provides outsourced solutions to meet the administrative needs of a client, which typically retains risks and liabilities.

**ASP** – Average Sales Price - ASP must be calculated by the manufacturer every calendar quarter and submitted to CMS within 30 days of the close of the quarter.

**AWP** – Average Wholesale Price is a benchmark that has been used for over 40 years for pricing and reimbursement of prescription drugs for both government and private payers.

**CMS 1500** – is the Professional Paper Claim Form used by providers with computer software that meets HIPAA and CMS electronic filing requirements to submit to payers.

**HCPCS** – Healthcare Common Procedure Coding System – developed by CMS.

**HIPAA** – Health Insurance Privacy and Portability Act of 1996 – legislation that sets national standards for the protection of certain health information.

**MBM** - Medical Benefit Management – with a much more targeted focus for the challenges of managing specialty pharmacy, MBM refers to the tactics and strategies to help control specialty drug spending for drugs that are specifically billed through a third-party administrator or a payer's medical benefit drug design.

**NCPDP** – National Council for Prescription Drug Programs – creates and promotes standards for the electronic exchange of health information related to pharmacy services.

**PBM** – Pharmacy Benefit Managers – *The Wall Street Journal* reports that PBMs process prescriptions for groups that pay for drugs; they are the intermediaries between pharma and payers.

**PMPM** - "Per member per month" is a widely used term to indicate the total cost of care for a population by individual member.

**PUPM** – "Per utilizer per month" is a metric that allows the plan sponsor to determine the average cost for a member receiving disease therapy by more accurately reflecting the cost of treating a specific disease.



Sponsored by PharMedQuest

For more information:  
Whitepaper@pharmedquest.com  
(714) 599 - 8250