
DRUG BENEFIT NEWS

Reform Is Double-Edged Sword for Payers As More Patients Mean More Rx Controls

Health reform's promise of higher revenue for health plans, PBMs and pharmacies resulting from more enrollees is considered the greatest benefit for payers by some industry analysts. But reform also brings challenges: Payers will have to find creative ways to control drug spending because of "donut hole" gap provisions that encourage seniors to stay on brand drugs, PBMs will have to abide by increased transparency requirements, and retail pharmacies will have fewer uninsured patients who pay full price in cash.

On March 30, President Barack Obama signed into law the Health Care and Education Affordability Reconciliation Act of 2010, H.R. 4872. While the law made a number of fixes sought by House Democrats to the Patient Protection and Affordable Care Act, H.R. 3590 — signed by Obama a week earlier — it made only a few changes to pharmacy provisions affecting payers.

"Overall, health reform should be a net positive for the PBMs [by] allowing them to continue to be part of the strategy in reducing health care costs," George Van Antwerp, general manager of pharmacy solutions at Silverlink Communications, Inc., tells *DBN*.

However, he adds, "retail profits for combined entities like CVS Caremark [Corp.] may be negatively affected as cash patients are processed under negotiated contracts."

Cash patients typically pay more per prescription drug than do insured patients, since the insured have the benefit of heavily discounted prescriptions based on group purchasing. "As pharmacies lose the last remaining cash patients, their profits will be impacted," he explains. But that could be offset by increased utilization among newly insured patients.

"Some players like CVS Caremark might also benefit by the ability to drive utilization to their stores versus cash patients that can go anywhere and might likely go to the discounted pharmacies like Costco [Wholesale Corp.]," Van Antwerp maintains.

Part D plan sponsors may see both positive and negative effects from a measure that will close the donut hole coverage gap for Part D beneficiaries — which is the period between when total drug spending reaches \$2,830 and out-of-pocket expenses reach \$4,550. Under the rec-

onciliation law, the federal government will pay all Part D enrollees who enter the donut hole a one-time \$250 rebate. In addition, the law calls for pharmaceutical manufacturers to provide a 50% discount on prescriptions filled in the coverage gap beginning in 2011, plus federal subsidies of 25% of the cost of brand-name drugs phased in beginning in 2013.

The law also provides for the phase-in of federal subsidies of 75% of the cost of generic drugs in the gap beginning in 2011. Moreover, between 2014 and 2019, the bill would reduce the out-of-pocket amount that qualifies a beneficiary to reach catastrophic coverage (the period after the beneficiary reaches \$4,550 in out-of-pocket expenses for 2010). The goal is to completely close the gap by 2020.

The reconciliation measure "makes the 50% discount program easier to administer since it changes the effective date to January 2011... thus getting rid of what probably would have been a lot of retroactive adjustments in 2010," Jean LeMasurier, senior vice president for public policy at Gorman Health Group, LLC, tells *DBN*.

On the downside, Van Antwerp warns that the reduction in the donut hole "will negatively impact PBMs, as it will encourage seniors to stay on brand drugs, which are less profitable than generic drugs." However, he acknowledges that it will increase patient adherence with their medications because more will be able to afford their drugs.

PBMs also will need to support donut hole changes by helping clients address claims processing, says Health-Trans LLC CEO Jack McClurg, "including making rapid plan design changes, accumulators and more."

To alleviate the cost burden of some specialty drugs, the reform law establishes a regulatory approval pathway for biosimilars. However, this is a long-term benefit because of the 12-year market exclusivity that was given to branded biologics — substantially longer than the standard five years given to small molecule drugs. At the same time, the data-exclusivity period does not apply to those biologics already on the market, many of which have patents that already expired or will soon expire. For now, health plans can prepare for biosimilar market entrants by having "well-established formulary review processes," Bill Sullivan, principal consultant with Specialty Pharmacy

Solutions, LLC, tells *DBN's* sister publication *Specialty Pharmacy News*. "And each drug should be reviewed on its own merit."

More bad news for payers came from the decision to drop the provision banning "pay-for-delay" deals from the reconciliation bill. That measure would have prohibited brand-name drug companies from compensating generic drug companies to delay the market entry of a generic. Former FTC attorney David Balto, now a senior fellow at the liberal think tank Center for American Progress, says pay-for-delay settlements have been a "chronic problem" caused by a "misaligned incentives system" that has cost payers and consumers \$3.5 billion a year in excessive pay-

ments for brand drugs. However, a separate bill banning such deals has been introduced by Sen. Ben Nelson (D-Neb.) and will likely pass later this year, Balto says.

Another potential negative for PBMs is the reform law's stronger transparency requirements, which allow for greater government oversight of PBMs' practices and mandate pass-through pricing for PBMs participating in the state exchanges starting in 2014. The reconciliation law did not change the underlying Senate provision on PBM transparency, which requires PBMs to share information about rebates with the HHS secretary, Part D providers and plans in the exchanges.

According to Van Antwerp, financial disclosure may have a slightly negative effect by creating new reporting and auditing burdens and "may ultimately affect client savings as deal parity becomes more normal versus allowing firms with better leverage and negotiating power to drive deeper deals." However, he adds, "most PBMs are providing transparency today at a client level, so this isn't anything dramatically different."

Employers also may see higher drug costs under reform, as H.R. 3590 reduces allowable deductions for the 28% subsidy employers receive for providing drug coverage for retirees. The Retiree Drug Subsidy program furnishes plan sponsors with a tax-free subsidy payment if they continue to provide retiree drug coverage that is at least actuarially equivalent to the basic benefit under the Part D program. For 2010, the subsidy is equal to 28% of the first \$6,300 the employer spends on a retiree's net drug costs, minus a \$310 deductible. Under the reconciliation law, the 28% subsidy will be subject to corporate tax effective Jan. 1, 2011. The change will substantially increase "liabilities for the very companies providing the most comprehensive coverage to the largest populations of current and future retirees," according to the American Benefits Council trade association.

As for Medicaid sponsors, the reform law increases drug rebates for brand name drugs to 23.1% immediately. However, rebates for clotting factors and drugs approved exclusively for pediatric use increase to only 17.1%. The law also increases the Medicaid rebate for noninnovator, multiple source drugs to 13% of average manufacturer price and extends the drug rebate to Medicaid managed care plans. To apply the additional rebate, the reconciliation law narrows the definition of a new formulation of a drug to "a line extension of a single source or an innovator multiple source drug that is an oral solid dosage form of the drug."

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2009 Pharmacy Costs for Selected Health Plans

Health Plan	Pharmacy Costs
Arkansas BCBS	\$187,594,942
BCBS of Mississippi	\$192,199,864
BCBS of Florida	\$967,384,028
BCBS of Louisiana	\$312,562,708
BCBS of Nebraska	\$179,892,234
BCBS of North Carolina	\$731,603,933
BCBS of Alabama	\$446,647,707
Health Care Service Corp.	\$2,226,159,628
BCBS of Massachusetts	\$885,848,915
BCBS of Michigan	\$972,240,062
BCBS of South Carolina	\$277,095,768
BCBS of Tennessee	\$386,543,562
Capital Blue Cross	\$2,779,025
CareFirst BCBS	\$524,306,440
CareSource	\$379,636,166
Excellus BCBS	551,083,430
Group Health Cooperative	237,972,653
Group Health Incorporated	491,894,701
Harvard Pilgrim Health Care	\$288,860,022
Hawaii Medical Service Assn.	\$290,111,886
HealthPartners, Inc.	\$4,200,633
Highmark BCBS/Keystone West	\$964,851,073
HIP Health Plan of New York	\$289,609,028
Horizon BCBS of New Jersey	\$1,118,206,055
Kaiser Permanente (California)	\$30,448,961
Medical Mutual of Ohio	\$256,211,001
Premiera Blue Cross	\$287,108,286
Regence BCBS of Oregon	\$216,876,990
Regence BlueShield	\$242,584,163
SelectHealth	\$100,165,804
Tufts Associated Health Plans	\$274,282,289
Wellmark, Inc.	\$422,935,945

SOURCE: Compiled by AIS from statements filed with state insurance departments. A spreadsheet of key financial indicators for leading health plans can be downloaded for \$141 each quarter at www.aishealth.com/Products/gkq.html.