Banking on Rx Alternative Funding

As prescription drug use explodes and prices soar, health plans are increasingly being forced to tap other avenues and patient advocacy

Written By Bruce Shutan

Specialty drugs, along with cell and gene therapy, have made a growing number of scripts unattainable for many working Americans. However, self-insured health plans have several avenues of alternative funding and patient advocacy at their fingertips to help defray enormous price tags.

One such source, patient assistance programs (PAPs) also known as medication assistance programs, come courtesy of pharmaceutical manufacturers that are able to earn goodwill with the public, along with tax breaks. However, the rising cost of prescription drugs, tightening Rx margins and a federal crackdown on high prices have pared the number of PAPs, which some insiders are predicting will disappear altogether.

Another is the 340B federal subsidy set up in 1992 for those in need of charitable care, which is ascending. It's now the second-largest federal prescription drug program behind Medicare Part D. However, 340B has sparked a congressional investigation and federal lawsuits and even triggered a Supreme Court ruling. Created to support hospitals that care for a disproportionate number of low-income patients, it requires discounts on outpatient drugs by as much as 20% to 50% off the list price. A tug of war has ensued between pharmaceutical manufacturers miffed about lost profits and safety-net hospitals wanting to preserve a lifeline for cash-strapped facilities.

In addition, there are many opportunities to land grants to reduce out-of-pocket costs for the neediest patients. But even with the best of intentions in mind, the Rx alternative funding market is rife with fraudulent activities or egregious practices involving service providers, PBMs and brokers exchanging fees below the radar that compromise savings.

PASSING ALONG SAVINGS

While alternative funding may target the neediest patients, the swath of assistance is potentially wider than meets the eye. "People often assume that in order to be effective through the advocacy process that the patient has to be nearly qualifying at an indigent income level or no income, and that's not true," explains Bill Stafford, a recently retired principle with Rx Help Centers, an independent patient advocacy group for prescription drug use.

Those who qualify for a PAP typically earn $75,000 gross adjusted income as individuals and $100,000 for families, according to Ryan Rice, president and founder of Prism Health Group, LLC, which provides consulting and analytics solutions in the pharmacy benefits space. They're able to receive drugs at a highly subsidized rate or at no cost whatsoever. He says another type of funding involves copay assistance for patients with insurance who are underinsured as more of a true subsidy.

The trick is seeing through industry smokescreens. Pharma earmarks as much as 56 cents on the dollar for rebates, patient assistance or coupons, reports Anthony Masotto, general manager and executive VP for Drexi, an AMPS Company and PBM devoted to price transparency. The real issue, however, is that it doesn't get back to the end user. He explains further: "If you look at the drug Stelara, for example, it's $25,000 a month. The rebate on that drug is around $15,000. But the plans never get to that because the group purchasing organization, PBM and brokers take their piece, and so now, all of a sudden, you're buying a drug for $25,000. You might get a $5,000 rebate. You're netting out $20,000, but you really should be netting out somewhere around $10,000."

Without question, alternative funding entities have good intentions. Masotto notes that AbbVie was the first to catch on that patient access was being limited and involved jumping through loopholes as drugs became very expensive really quickly. But they're still going to charge $7,000 a month or $100,000 a year for a drug that they're selling in other parts of the country for a fraction of that, he adds.

WEIGHING MULTIPLE OPTIONS

More than half of the several hundred resources Rx Help Centers taps throughout the year as a patient advocate do not involve pharmaceutical manufacturers. "You may only have one or two patients with a particular resource," Stafford says, "but that's the difference between active advocacy and just some type of an alternative funding mechanism. Whenever we save patients money through the advocacy process, we save the employer groups hundreds of millions a year."

He says there are many types of programs available, including independent grants and patient foundations, some of which are public while others are private. There are also discounted

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Oftentimes, Stafford notes that situations arise wherein the relationship with a particular vendor becomes invaluable. One example is the infusion therapy space, where a service provider may have access to better patient prices for onsite or home infusion or whatever the particular drug calls for. "There are ways of getting pretty good discounts with some of those organizations that provide those services that may or may not be the preferred vendors of the carriers," he adds.

To vet the integrity of Rx alternative funding, self-insured employers are advised to pay close attention to shared savings, which Rice says is the primary method and mechanism for how fees are garnered.

"There's only so much juice in the sweets and the math – and how it's ultimately performed in front of a client can be quite extravagant," he observes. "Let's call it sales math… The starting point in the calculation of savings is oftentimes very much against the employer, meaning the average wholesale price is not what is paid if they don't have patient assistance. They're paying a discount off of the average wholesale price."

If the average wholesale price of Humira is $10,000, for example, the discount that the PBM applies is about 20%, or $2,000, that's being applied to that transaction. "So why should I pay a 20% premium for that?" Rice asks.

"I am saving a lot in terms of not having to pay for the drug," he continues. "But that basis of savings should be $8,000, not $10,000, and that optic is very complex for folks to understand. They don't know what AWP is; they think it means 'ain't what's paid,' and they'd be right. But the fact is, it's that tactic that we find the most prevalent. They're calling them marketing fees or some other kind of fee that falls outside the realm of what the 5500 and Consolidated Appropriations Act demands. That's why we have tried to commoditize these programs by capping fees with flat dollar amounts instead of this open-ended shared saving."

With alternative funding, the goal is to obtain a true transparent or pass-through arrangement that passes along savings to the patient. "They're adding on a transactional or per-fill fee, or they're doing a flat PEPM administrative charge," Stafford says, "but the cost of the drug is the cost of the drug that your self-funded client is paying to that PBM."

There are players in the Rx alternative funding space that may misrepresent patient income, number of dependents and other things that have an impact on qualifying a patient, he warns. "It's a bad thing for the industry," he says. "But in recent years, there have been a number of those who have gotten caught with their hands in the cookie jar. If any buyer is taking a percentage savings as a PEPM or some type of a fixed-fee arrangement, I think they're working on a very thin tightrope."

THE FATE OF PAPS

Massive expenditures associated with expensive products such as Humira and Cosentyx are wreaking havoc to a point where half of the overall pharmacy spend is for specialty pharmacy, Rice explains. He says this is why there's such a high demand to offer patients financial relief.

The genesis of PAP, which his firm began warning four years ago would eventually vanish, was to provide a meaningful cost offset and relief for patients who needed it most, as well as employers.

Medications under PAPs are covered, generally speaking, for a year, and when it comes time to renew those prescriptions, the drug manufacturer will request updated income verification information,

explains Mary Ann Carlisle, COO of ELMCRx Solutions, LLC, a PBM solution hub. Many times, she says doctors will apply for medications on behalf of their patients.

These strategies help manage specialty medications, which account for 35% to 55% of an employer's drug spend and typically fewer than 5% of claimants, she notes. "So usually in these programs, you don't have that many people, maybe 10 or 15 per 1,000, that these alternative funding companies manage and procure the medications for," according to Carlisle.

PBMs have responded in kind to both demand and opportunity for alternative funding. There's a segment of PBMs that aren't the Big Three with different mechanisms and levers that have to be flexible in meeting the consumer where they are, Rice explains. In many cases, he says, it has resulted in building PAPs that ultimately help employers offload some of the Rx cost. "The shelf life of these programs is very much limited in some of the lawsuits that we've seen against Payer Matrix, ScoutRx and others, which are very much good examples of where and why this is bound to change, and how I think employers were getting why the getting was good," he says.

There are caveats to consider along the way to procuring PAP funding. "Patient assistance is going away," Masotto bluntly reports. "Gentech just pulled out and redid their contract. Johnson & Johnson and AbbVie are all following suit, saying, 'If you have commercial insurance, I don't care if you carve anything out or not. We are not going to approve you for free drugs.' What's happening now is all of these bolt-on vendors were making a lot of money on that, 25% or 30% of savings. Then, you have to factor in the loss of rebate and member copay.

"You have to be very careful about the entities that you do

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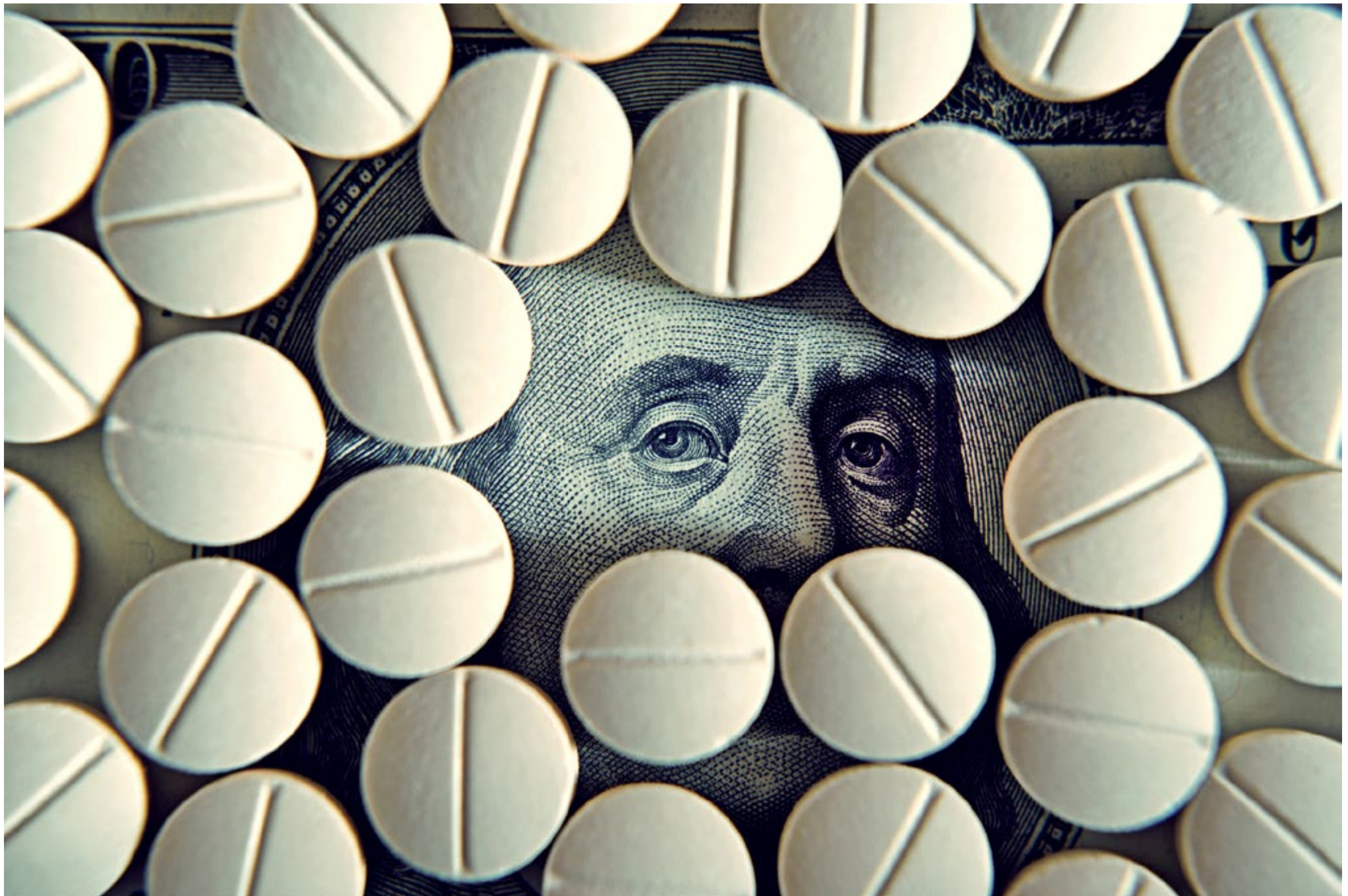

this stuff with," he continues in cautioning self-insured health plans, "because now you are creating another hurdle for members to acquire their drugs. Is all of that worth it now for a 10% savings vs. where it should be 30% to 40%? And are some of these entities moving drugs that shouldn't be moved in the first place? Discounts mean nothing because they can be manipulated."

Aside from PAPs, there are other opportunities for employers to reduce costs for their neediest health plan members. Grants, for example, are most prevalent with highly complex treatments such as gene and CAR T-cell therapies, or orphan-class drugs, according to Rice. He says cystic fibrosis is "another good example of where some manufacturers are the only gig in town and know they have the golden goose."

In instances where the complexity of care is significantly higher, Rice notes that more charitable organizations, such as faith-based entities and not-for-profits like the American Cancer Society, have created pharma-aligned programs. That's because pharma receives valuable research and information through different kinds of opportunities to collaborate with patients.

UNPACKING 340B PROGRAMS

As suggested earlier, the federal government appears to be a safer conduit for helping dispense Rx discounts than pharmaceutical manufacturers, but there's a logical explanation as to why that's the case. Under the 340B program, hospitals are able to purchase drugs at next to nothing or very low prices in contrast to conventional wholesale contracts and sell them for a significant markup. This allows facilities that

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target underserved populations to mine another revenue stream to help keep their doors open. "I think there's this misconception across much of the market about getting the shaft by hospitals because they're buying them cheaply," Rice observes.

If the 340B program were to go away, he cautions that the U.S. healthcare system would crater because so much of care is delivered in disproportionate-share hospitals, research facilities, federally qualified health centers and critical-access hospitals. "Many of these institutions make millions of dollars in terms of the revenues from 340B," he adds. "If that were to just atrophy and go away, we would be looking at one of the largest crises in American healthcare that we've ever seen. So, it's too big to fail."

Whatever the future holds for 340B, Carlisle expects the emergence of a catastrophic fund that people will contribute to in the future, which will cover the exorbitant cost of cell and gene medications. The thinking behind this concept is that it will be well managed and peeled out of the regular plan. "Ultimately, that fund will have enough of these claims to potentially do some negotiating," she says. "When you can get everything together and have the power of bargaining, that's potentially a plus." ■

Bruce Shutan is a Portland, Oregon-based freelance writer who has closely covered the employee benefits industry for more than 35 years.

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