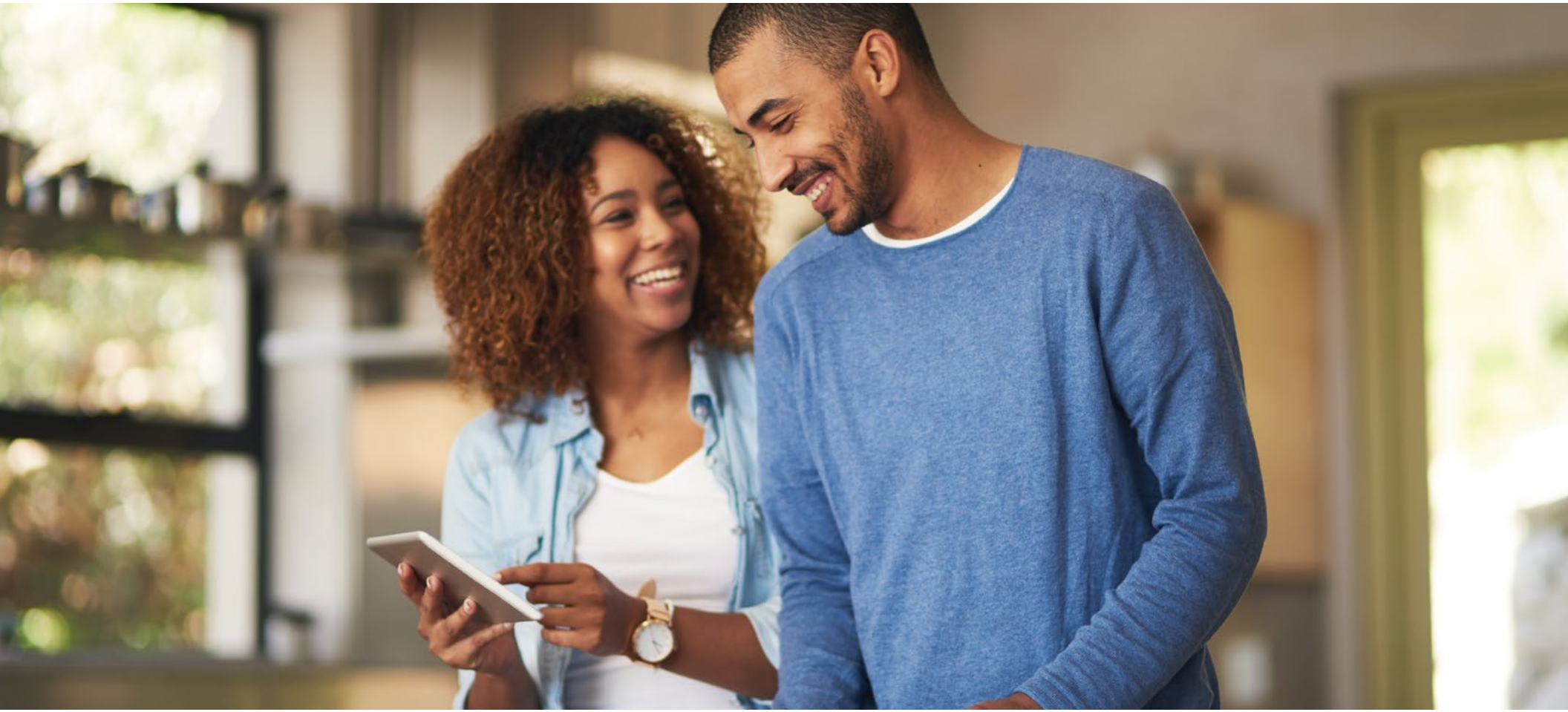
OPTUMRx®

White Paper

Better together: PBM and Integrated Specialty Management Strategies

Separate myth from reality and understand the impact to your plan and members



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Introduction

Studies show that HR managers place a high value on the entire range of Pharmacy Benefit Manager (PBM) services—pricing negotiations, reporting, medical management, utilization management and more.[1] Nowhere is this integrated approach more valuable than in the support of patients taking complex, high cost specialty medications. In particular, OptumRx has created a uniquely integrated infrastructure that delivers proven value to plan sponsors.

OptumRx extends its focus far beyond utilization management and reducing the unit cost of drugs. We optimize recovery during and after treatment. From the point of prescribing we optimize dispensing, administering medication and recovery.

Our approach provides integrated clinical support for both the providers who choose the drugs and the patients who take these specialty medications. We apply clinical expertise at every touch point, singling out the best treatments for the highest patient quality of life. Our pharmacy value levers simultaneously consider lowest net cost, including copay funding, network eligibility and other innovative clinical strategies. We support patients along their entire care journey and are able to focus on improving their health and quality of life. At the same time, plan sponsors are able to lower their specialty spend.

Carving out elements of specialty management means many aspects of integrated specialty care are lost. For example, pharmacists are unable to view a patient's full therapy regimen and provide high value pharmacy care services.

The reality is, PBM services like manufacturer assistance programs, or utilization management services are supporting blocks in a tower. The value of the model resides in the integrity of the structure. Each service connects to the others and has a role to play in supporting the overall structure.

Carve-out vendors have stepped into this space making big promises about savings and pulling out critical building blocks in the value model. This may yield some short-term impact, but only at the cost of disrupting the patient experience and undermining clinical care.

What are the types of carve-outs?

Let's review some of the specialty alternatives plan sponsors are considering. They vary in scope and detail, but what they all share is **separating elements of specialty pharmacy from the PBM.** This may take the form of excluding certain drugs from the formulary, or even removing the specialty pharmacy function altogether. Specialty carve-out vendors offer various drug management services, often promising significant savings over their PBM. These vendors can take many different forms, including these main types:

Utilization management (UM) and prior authorization (PA) carve-out

These vendors claim to provide tighter management of UM and PA by separating these services from the PBM. They argue this will better align incentives and remove potential conflicts of interest around which drugs to approve.

Coupon maximizers

These vendors aggressively maximize coupon assistance from manufacturers to reduce plan sponsor paid costs.

Alternative funding vendors

These work by removing specialty drug coverage out of the plan completely, then rerouting patients to alternative funding mechanisms such as patient assistance and foundation funding.

Carve-out specialty pharmacy

A client may choose not to use Optum® Specialty Pharmacy and instead contract for specialty dispensing exclusively with another specialty pharmacy.

Standalone specialty drug management

These solutions take over all PBM services for specialty drugs. They often claim "cross benefit" capabilities and may offer additional services in areas like oncology.

In this paper we will examine the impact of these carve-out approaches. We will show how these carve-outs work against patient experience and clinical value. And, perhaps even more important, we will show how the integrated OptumRx approach works better for all stakeholders. This results not only in better patient care, but ultimately delivers additional overall care and clinical value for plan sponsors.

Carve-out myths and the reality

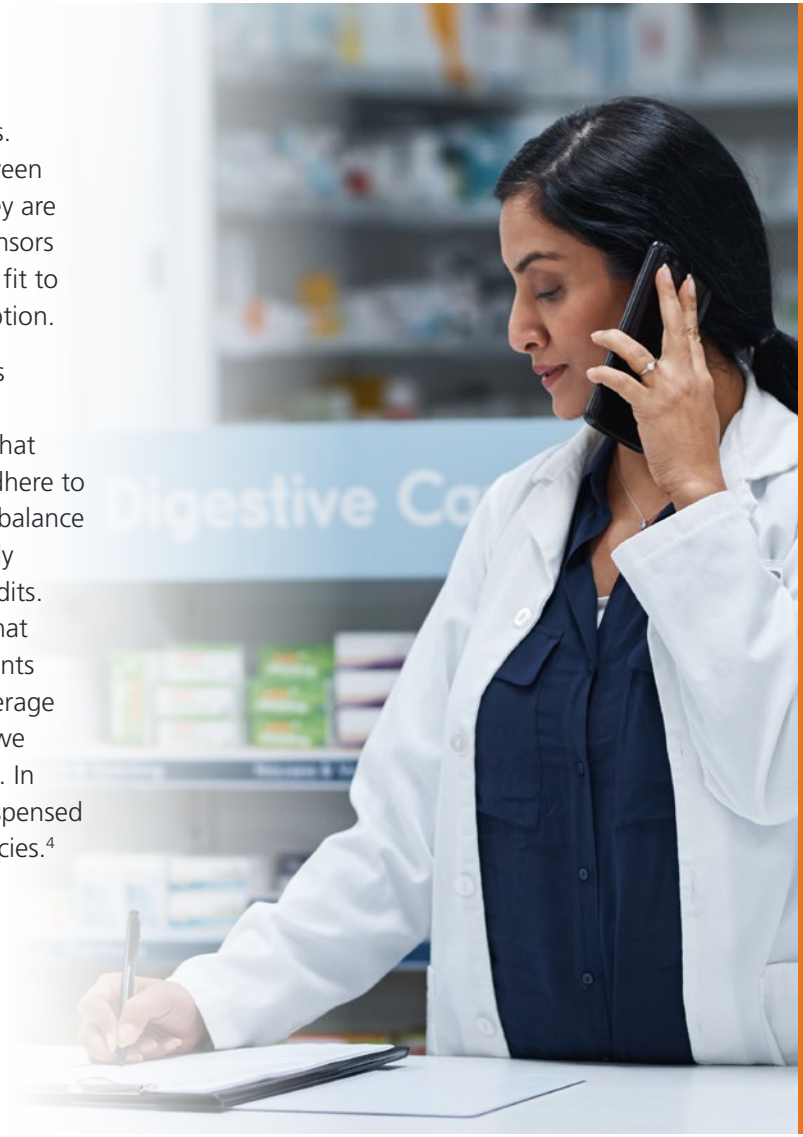
Myth #1: Plan sponsors can better manage utilization with a specialty carve-out.

Specialty carve-out vendors claim to provide tighter utilization management of specialty medications by separating services from the PBM. They say this better aligns incentives and removes potential conflicts of interest between the PBM and its owned specialty pharmacies.

Our analysis of PA approval rates does not support this myth. We compared PA approval rates for patients who filled exclusively through Optum Specialty Pharmacy vs. those who could go anywhere to fill their scripts. The analysis found no statistically significant difference in the approval rates. Moreover, there was no difference in approval rates at any of the therapy class levels.[2]

OptumRx has **rigorous, independent clinical management processes.** Our UM criteria are grounded in a robust, comprehensive library of criteria that are subject to clinical Pharmaceuticals & Therapeutics process reviews. Plan sponsors that carve out to vendors who do not align to our UM standards will see an impact to their financial guarantees. We also **maintain a very rigid firewall** between how these clinical policies are set and how they are executed. Our UM offerings allow benefit sponsors the opportunity to select UM edits as they see fit to help control costs and manage member disruption.

In addition, OptumRx offers multiple strategies delivered at the pharmacy counter to carefully dispense specialty medications. These ensure that patients get the medications they need and adhere to therapy, while reducing waste. Our strategies balance maintaining adherence with limiting oversupply by avoiding auto-refill programs and surplus edits. For oncology, we offer a **Split Fill program** that avoids costs associated with waste when patients discontinue therapy early. Program savings average $4,400 per affected patient per year.[3] Finally, we collaborate with physicians to optimize dosing. In hepatitis C, our efforts result in 25% lower dispensed volume than other specialty and retail pharmacies.[4]



Myth #2: Patients receive equally good pharmacy care when specialty is carved out.

Carve-out vendors claim that they can offer the same clinical support that a patient would receive with an integrated benefit. This clinical support plays out in aspects like sufficient access to therapy, managing drug-drug interactions and continuity of care.

The reality is the exact opposite. Among our 55M patients that are on a specialty medication, 79% of them are also on one or more traditional medications.[5] Specialty carve-out vendors will only be able to support some of these drug regimens. Drugs that are accessed through a carve-out do not benefit from drug utilization reviews. Reviews are particularly important for the growing number of polypharmacy patients. Patients can also face significant risks of disruption to continuity of care.

Alternative funding sources are not a guarantee of coverage. Funding from coupon maximizers often runs out early in the calendar year, leaving patients without any coverage and often requiring them to halt therapy. These are just a few examples where patients must navigate a confusing and tedious clinical process, winding up with a suboptimal or potentially dangerous outcome.

Better together puts patients first. Systematic end-to-end specialty drug management includes cost and clinical management from the point of prescribing, to dispensing, through first use, and recovery. At no point is the patient left alone with nowhere to turn. Nor do caregivers lack a complete picture of the patient. This strategy offers not only better value, but better care.

Our **Clinical Management Programs** are a core value provided by the PBM. We offer patients a personalized approach to drug utilization reviews and safety checks that make it easy to avoid drug-drug interactions.

Our analysis has shown that integrated prior authorization with the patient's full treatment history and PBM/pharmacy interactions means patients initiate therapy faster. **Optum Specialty Pharmacy** has an extensive national footprint to also provide clinical support. The pharmacy holds accreditations from nationally recognized bodies demonstrating our commitment to exceed specialty pharmacy requirements. Currently we hold accreditation from Accreditation Commission for Health Care (ACHC), National Association of Boards of Pharmacy (NABP), and URAC.

Myth #3: Specialty carve-out vendors offer a seamless patient experience with white glove support.

The pitch made by carve-out vendors rests on a seamless experience that hand-holds patients on their complex care journey. They market white glove support that leads patients through onboarding processes and over the course of the benefit cycle.

In fact, carve-out only further fragments the patient experience. Imagine a patient who is served by both a PBM and a carve-out vendor. His medicines are in two different places—some with his PBM, some with the carve-out vendor. This fragmented service is disruptive for both affordability and access.

For example, alternate funding vendors draw from a finite pool of foundation or assistance program dollars. Available funds are often quickly exhausted, which affects those who truly need the assistance. Moreover, patients with carve-out vendors are often forced to use a copay card. If they do not sign up, they are charged full out-of-pocket costs. Patient access can also be impacted and plays out in slower time to therapy. Some drug claims may be rejected, and members must seek coverage from unrelated third parties. Each additional process step can potentially delay initiating treatment.

Ongoing integrated support

Paul was recently diagnosed with **rheumatoid arthritis** (RA). He also has diabetes. Paul's doctor prescribes a new RA prescription.

STEP 1: Physician office

Automated prior authorization tools streamline the prior authorization process by providing specific employee information and cost. Plan sponsors receive lower unit costs with PBM cost levers.

STEP 2: Medication delivery and support

A patient care coordinator processes the first fill for RA medication and **connects him to a specialty pharmacist.**

Paul receives a **first fill and medication consult** for this medication, including how to inject, potential drug-drug interactions or side effects.

STEP 3: Seamless support

OptumRx variable copay solution seamlessly modifies the claim cost at the point of sale without requiring any benefit design modifications, reducing plan sponsor cost.

We synchronize all of Paul's medications—both traditional and specialty—making it easier for Paul to adhere to his medications.

Better patient experience and lower overall costs.

Optum Specialty Therapy Management embraces a **fully integrated approach at every step in a patient's care journey.** This approach yields a superior experience, timely access and better affordability. OptumRx supports patients across all of their therapies. We automate the experience where appropriate, keeping much of the administrative effort out of the patient's hands. We communicate with patients through our pharmacy, one patient at a time. Trust and transparency across the continuum are vital to aligning our patient experience. Our ultimate goal is to drive affordability and value, simplicity and access and to align interests and accountability—every step of the medication journey.

Myth #4: Plan sponsors get better economic value with a specialty carve-out.

Specialty carve-out vendors, and particularly coupon maximizers, claim their ability to deliver significant value in terms of reduced specialty drug spend. But plan sponsors must consider the full financial impact when deciding whether to carve out to a third party.

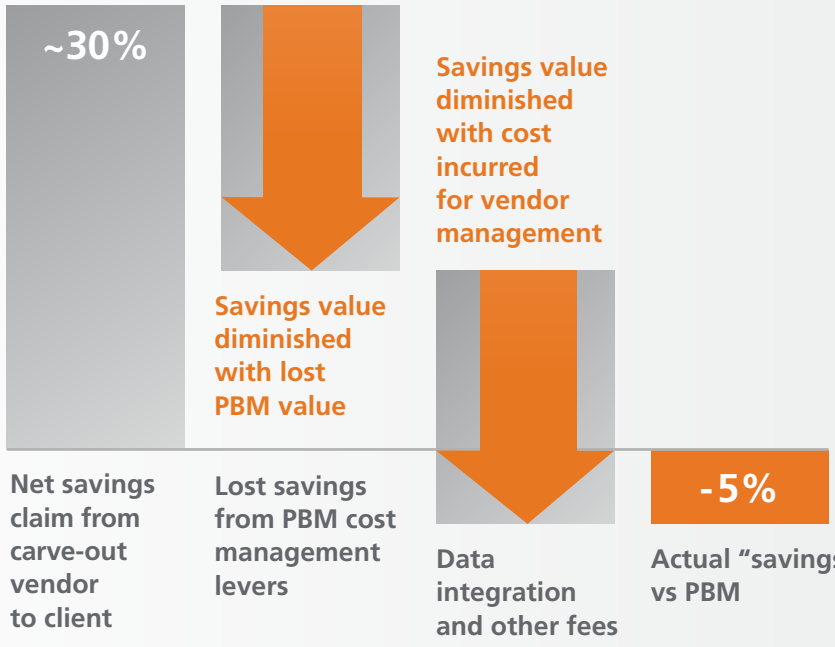
The reality is that quoted savings from these vendors do not include a "fully loaded" set of costs. Additional costs include fees and payments for the coupon maximizer services, lost benefit from PBM cost management levers and other integration/data exchange fees. **Figure 1** shows the impact of these additional costs against the quoted savings from these vendors.

Plan sponsors who carve out may also actually pay more for specialty drugs over the course of the year. For example, when the third-party funding sources run out, coupon maximizer contracts stipulate that the specialty drug coverage must be carved back into the PBM benefit. The plan sponsor would then be without the benefit of PBM cost management levers which were forfeited at the time of carve out.

We give plan sponsors the insights, guidance and flexible offerings that meet their needs. This includes building a strong clinical foundation and approach which drives to the **lowest net cost.** It also includes eliminating waste and neutralizing abusive pricing tactics by pharma manufacturers. We bring wide-ranging solutions and a holistic approach to the major cost drivers of both specialty drugs and complex cases.

Figure 1: Financial impact

Plan sponsor's quoted savings illustration versus actual "savings"



Savings estimates are approximate, illustration is based on actual plan sponsor examples.

We personalize care for each individual and bring price transparency, simple guidance and care into everything we do, from diagnosis to ongoing care.

One particular example of how we help with affordability is the **Variable Copay** solution, which balances cost savings with member needs. Our approach ensures that the member cost share is never greater than standard specialty tier copay, yet still maximizes available manufacturer dollars to reduce plan sponsor cost.

Our variable copay solution covers nearly 200 drugs which allows us to capture over 90% of available manufacturer dollars on top utilized drugs. Factoring program fees, the Variable Copay solution net savings is on par with the net savings of coupon maximizer programs, considering fully loaded costs. Last year our **plan sponsors saw an average of $800 specialty drug cost savings per impacted script.**[5]

For maximum flexibility, plan sponsors do not have to change their benefit design strategy to adopt the program. We can ensure that it will also align with the plan sponsor's rebate strategy, for a better net financial picture.

Conclusion

Plan sponsors must be diligent when working with carve-out vendors to ensure they are not just optimizing one dimension across the specialty management continuum. There is no silver bullet that will meet the challenge of high cost specialty therapies and the conditions they treat. Plan sponsors need a broad, flexible portfolio of strategies. These must properly evaluate the economic impact, clinical risk, the patient experience and your reputation to address this level of complexity. Coping with such a complex suite of challenges cannot be done piecemeal. It requires an experienced partner with an equally broad, flexible and far-reaching portfolio of solutions. OptumRx delivers integrated solutions that work together in concert to deliver value for plan sponsors, providers and patients.

References

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Contact your consultant or OptumRx representative to learn more.

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