



Weekly Checkup

Carved Out and Carved Up

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In the never-ending war between insurers and pharmaceutical manufacturers, the patient often gets the short end of the stick. The latest fight to pop up is no different and revolves around a relatively new concept, yet may prove to be another example of this general rule. The focus here is specialty carve-outs, also known as alternative funding programs (AFPs). These programs seek to reduce the costs of specialty drugs – costly prescription drugs for complex and chronic conditions such as arthritis, multiple sclerosis, and cancer – for patients and self-insured employers by shifting employees with specialty drug needs off employers’ plans and onto pharmaceutical manufacturers’ charity programs.

How does this work? There are two ways, and both involve contracting with a third-party AFP. One way is for the self-insured employer to mark certain specialty drugs as “nonessential,” which means the plan is no longer subject to cost-sharing caps under the Affordable Care Act. Next, the employer then raises the price of the copay for the beneficiary to cover more of the drug’s cost. The AFP then works to get the beneficiary enrolled in the pharmaceutical company’s copay-assistance program to either cut or eliminate the copay. The second way is for the employer to simply eliminate coverage of the specialty drug, and then the AFP works to get the patient on a pharmaceutical company’s patient assistance program – essentially charity care – to cover most, if not all, of the drug’s price. **In both cases, the pharmaceutical manufacturer is paying the employer/the employer’s pharmacy benefit manager for the drug, and the third-party vendor takes a payment - estimated at 20-25 percent.** So manufacturers lose money, employers get to save money on their benefits packages (some estimates place specialty drug spending at around 50 percent of drug plan costs), and the patient gets the drug at little-to-no cost. What’s the problem?

First, the savings potential for plans carving out benefits is unclear. A 2020 study in the Journal of Managed Care and Specialty Pharmacy examining spending on carve-in and

carve-out (but not specifically AFPs) beneficiaries with at least one of seven chronic conditions found that overall spending for beneficiaries with carve-in benefits was 4 percent lower than for beneficiaries with carve-out benefits. **Second, AFPs add yet another barrier between patients and their drugs, potentially disrupting care for the patients.** Patient groups also fear that this may be a way for companies to get expensive employees to look for other coverage or jobs. **Third, this practice drastically alters the mission of charity care programs and copay assistance programs, and it means that patients who really need the help may have to compete with people who would otherwise be insured and able to afford the drug.** It may even push pharmaceutical manufacturers to limit these programs: The Johnson & Johnson (J&J) Patient Assistance Foundation [has said](#) that starting in January it will no longer offer free medications to patients with insurance, specifically citing AFPs. J&J itself has brought a suit against one AFP, SaveOnSP, claiming that the AFP has cost J&J \$100 million.

These AFPs are a questionable practice at best, and some employers who use them may run into [legal issues](#) over compliance problems, especially when AFPs that can't secure the discounts look to unlicensed overseas pharmacies to fill prescriptions. **Policymakers should keep an eye on the situation while we learn more about these programs and their impact.** But something really doesn't feel right about how patients are getting tossed in the middle of yet another fight between insurers and pharmaceutical manufacturers.