



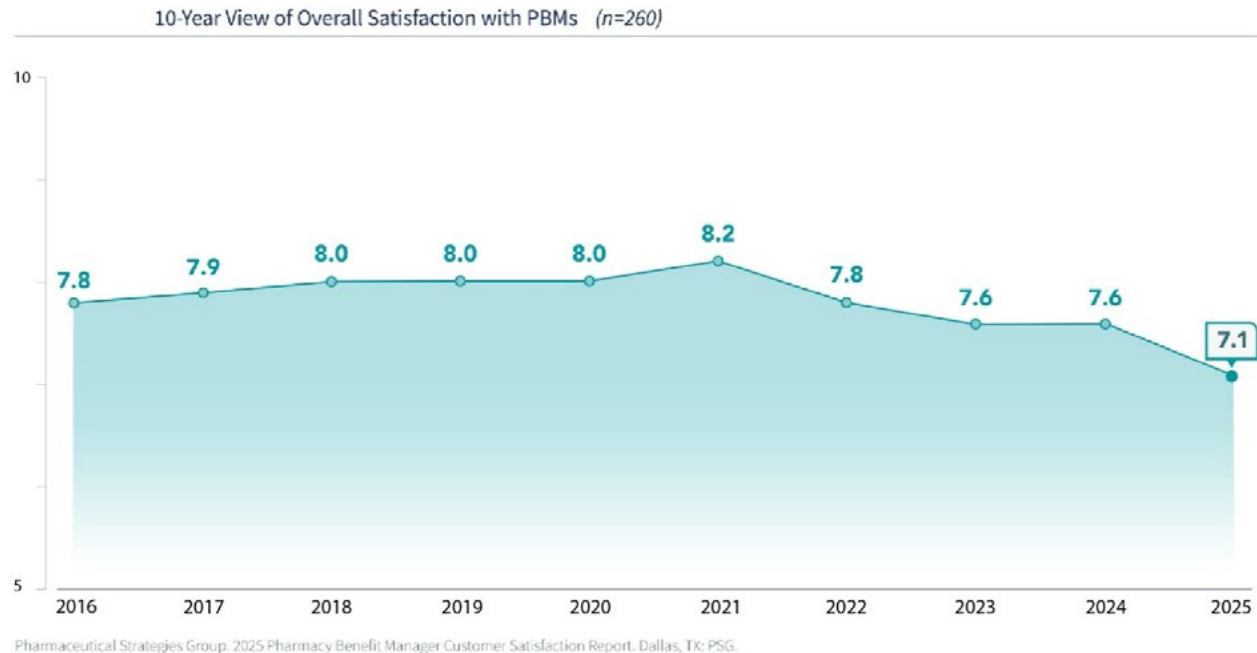
Direct-to-Consumer **Drug Sales & Rebate Cessation** Prompts *Market Shake-Up*

Written By Laura Carabello

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weeping changes to prescription drug purchasing may appear too good to be true. While the direct-to-consumer (DTC) models promise lower costs and greater availability, self-insured employers should be wary. The devil may well be in the details – particularly for the specialty drug spend, which is likely not to fit the new direct-pay model.

Amid years of legislative efforts to reform PBM practices and increase transparency, a cascade of initiatives and announcements for direct-pay may have unfolded, prompting many in the industry to respond with their own warning labels. Some have good-naturedly dubbed this trend “pharm-to-table.”



Source: *Pharmaceutical Strategies Group (PSG)*

MOVERS AND SHAKERS

A flurry of discount drug cards and online options emerged in 2025, but one of the first significant market disruptions actually came on the market in January 2022 -- Mark Cuban's Cost Plus Drug Company. This online pharmacy model aims to provide transparent pricing for generic prescription drugs by cutting out intermediaries like pharmacy benefit managers (PBMs) and applying a fixed markup.

The DTC model offers a transparent price that includes the drug's wholesale cost, a 15% markup and a flat \$5 labor fee, plus a \$5 shipping fee. Cuban has also reached a deal to sell a cheap, biosimilar version of Johnson & Johnson's Stelara, a widely prescribed treatment for chronic inflammatory and autoimmune conditions.

Now, the marketplace is readying itself for the 2026 launch of the TrumpRx model that involves a government-run website, TrumpRx.gov. This will allow consumers to buy prescription drugs at discounted rates directly from pharmaceutical companies, bypassing their insurance.

A fundamental feature of the cash-pay program is its "most-favored-nation" (MFN) pricing model, which requires drug makers to match or beat the lowest prices paid in comparable wealthy countries -- discounts of up to 80% off list prices. For consumers with existing plans that already have substantial discounts, there may be limited value to this model, while the greatest impact will be on uninsured or out-of-network patients.

But there is a dark side to this model, with some sentiment that direct-pay models are simply a way to placate government demands that pharma companies lower U.S. drug prices in line with what other countries pay. Dae Lee and Natalie Oehlers, pharmacy benefits law experts at Buchanan Ingersoll & Rooney, offer a new analysis with excerpts that include:

Pharmacies: TrumpRx could add to the already brutal pressure on brick-and-mortar pharmacies, with thousands of closures that leave "pharmacy deserts" in many regions.

Information: In the direct-pay approach, employers' lack of drug utilization information may hurt their ability to manage formularies or lists of covered drugs.

Hassles: Government-advertised discounts will make employees question why their employer-sponsored plan cannot deliver similar pricing.

The DTC model has its fair share of critics, as Ali Panjwani, founder and CEO of Merit Medicine, states, "DTC drug models may improve affordability and transparency, but they also risk eroding the pharmacy visibility employers need to design benefits that truly fit their workforce. When Rx purchases occur outside traditional claims channels, utilization data may become incomplete or delayed, leaving employers without a full picture of what conditions are prevalent, which therapies are being used and where costs are trending."

He stresses that the gap can lead to benefit packages that miss real member needs, such as inadequate coverage for chronic conditions or poorly structured specialty drug programs.

"Members may also lose deductible and out-of-pocket credit on DTC purchases," he continues. "Innovation in pricing must come with reliable data sharing, or benefit design and member outcomes are put at risk."

Many other manufacturer-sponsored cash-pay options are materializing or in the queue. Some manufacturers are offering new, branded direct-purchase programs that are more convenient and can save patients time and money with no direct connections to the patients' health plans – no hidden markups or fees and transparent pricing for patients and businesses:

- Eli Lilly, which became the first drugmaker to hit \$1 trillion in market value, is partnering with Walmart to expand access to Lilly's weight loss drug Zepbound, offered for pick-up at Walmart pharmacies nationwide by the end of 2025. Lilly has been providing all approved doses of Zepbound to cash-paying customers through its website LillyDirect, launched last year.

The drugmaker is rolling out a new model in early 2026 built on three core elements to make it easier for employers to provide access to its GLP-1 drugs for weight management: flexibility around benefit options for obesity care, allowing employers to design the benefits that work best for their unique workforces; a dedicated pharmacy network that makes it easier for employers to understand and track costs; bringing in third-party organizations to support employers in developing holistic weight management solutions. Novo Nordisk and Eli Lilly agreed to lower the prices for Ozempic, Wegovy and Zepbound when purchased through Trump Rx.

- Novo Nordisk also unveiled its own DTC NovoCare Pharmacy service and recently cut the cash price of its weight-loss and diabetes drugs Wegovy and Ozempic to \$349 a month (down from \$499). New cash-paying patients can get the two lowest doses for an introductory price of \$199 per month for the first two months of treatment. This offer is available until March 31, 2026.
- PhRMA, a trade group that represents companies in the biopharmaceutical industry, will be launching AmericasMedicines.com in January 2026, a new website to help patients more easily access these programs. This new website will allow manufacturers to list a wide range



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Lachelle Brown
Senior Member Advocate

of medicines and connect patients directly to available options prescribed by their doctor. Pharmaceutical manufacturers must make their own decisions to offer direct purchase programs, determine how they will work and if they want to participate in the program.

- Roche is considering a DTC for its multiple sclerosis, eye disease and cancer drugs.
- Pfizer and Bristol Myers Squibb are on the DTC pathway to sell their mega blockbuster blood thinner Eliquis, one of the drugs targeted by the U.S. in the first round of its Inflation Reduction Act-mandated price cuts. The companies unveiled a DTC program that allows uninsured or underinsured patients to buy the medicine online at a sharp discount to its current list price. Pfizer also joined TrumpRx, offering select drugs such as Eucrisa and Xeljanz at deep discounts.
- BlinkRx helps drugmakers with a service that promises to set up direct-to-patient sales programs in as little as three weeks.
- Amgen followed the DTC route with the launch of its AmgenNow channel, a new direct-to-patient program starting with Repatha® (evolocumab)
- Genentech is preparing a flu-season DTC program for Xofluza, showing that even acute categories are now testing patient-direct channels.
- Bristol Myers Squibb launched its own cash-pay portal with 80% discounts on Sotyktu.
- AstraZeneca unveiled 70% off Farxiga and Aircsupra.
- Novartis and Boehringer introduced price-slashing offers on Cosentyx and Spiriva Respimat.

Funding employee cash pay options will take planning. Dea Belazi, CEO of AscellaHealth, projects that employers might fund an HSA to pay for these products.

“They could easily put a few thousand dollars in an HSA, and the employee would get a \$250-a-month GLP1,” says Belazi. “The HSA would cover the whole year’s worth of the weight loss drug, and perhaps the federal government would raise the HSA limits from a few thousand a year to \$5,000 or \$10,000. I think that’s where this could go over the next year or two as we see more of these direct-to-consumer pharma programs. Employers may decide not to cover certain products, like GLP1s, and let these go through the cash model where the patients work it out directly with the doctor.”

What he finds interesting is when that does happen, the pharmacy benefit becomes centered on specialty medications.

“For AscellaHealth, that’s our wheelhouse as an organization that has all the bells and whistles, services and programs to serve all types of payers, including employers, health plans and PBMs,” he emphasizes. “It’s not GLP1s or diabetes medications. It’s ideal for the super high-cost drugs, complex conditions and diseases that require a high-touch service model. These drugs can’t be sold DTC; it’s too complex and expensive. This is where our focus is valued and what employers really need: the pharmacy benefit evolving to that of high-cost specialty therapies.”



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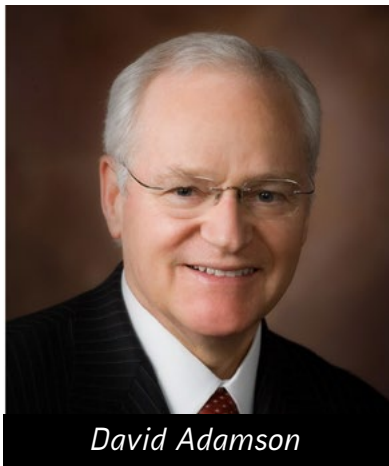


Bonafide services associated with every prescription, such as care coordination with physicians, member enrollment and administration, will have PBM fees as the system evolves into a more transparent model where the drug costs are closer to the true cost.

“I think that’s what is going to happen going forward,” he says. “Our new Group Purchasing Organization and the AscellaOne launch will have all these services so that employers and health plans can pick and choose the programs that best fit their needs.”

WOMEN’S HEALTH

One area that is expected to benefit is women’s health, since women continue to face long-standing coverage gaps and stigma. Many working-age women encounter delays or denials when trying to access necessary care, such as menopause support, hormone therapy or treatments for conditions such as endometriosis or migraines.



David Adamson

Dr. David Adamson, MD, founder and CEO, ARC Fertility, observes that many employer-sponsored plans either don’t cover hormone therapy or require step therapy or medical necessity documentation.

“ARC has provided direct sales to consumers in the fertility care market for 28 years and will continue that model even as we transition to a much higher proportion of our business being in the employer benefits market,” he says. “However, because of our innovative pricing model that makes family-forming benefits affordable for almost all employers by not having a PEPM and enabling them to choose the subsidy amount they provide to employees, some employees with less subsidy than meets all their needs will still choose to use our business-to-consumer purchasing model. This model brings steeply discounted cash prices to patients and increases the chances they can afford fertility care.”

ARC is following TrumpRx closely because the White House has stated it intends to provide high discounts for cash-paying patients through TrumpRx. “We will be very happy if we can help patients receive their medications at a lower price,” he adds. “ARC is very flexible and works with employers to design a family-forming benefit plan that meets their employee, business and financial goals.

THE FUTURE OF REBATES

Rebates are also in the crosshairs, following the blockbuster announcement in late October 2025 from Cigna that its Express Scripts pharmacy benefit manager, which is part of Cigna’s Evernorth Health Services business, will become rebate-free for many commercial health plans beginning in 2027. Fall-out from the public statement resulted in a pummeling from the stock market, and the company’s stock plunged more than 15%.

More importantly, industry observers began questioning if rebates would disappear altogether – although consensus is that it is not the case. Many project that employers will likely see higher PBM fees if a rebate-less world evolves.



Source: CIVHC

From 2021 to 2023, Drug Rebates and Total Drug Spending Increased

Across all payers, drug rebates rose 30%, and total prescription drug spending rose 24% when subtracting drug rebates received by payers.

“In an industry that is typically starved of any significant competition, the demise of rebates creates healthier competition,” says Christine Johnston, general manager, MacroHealth, Pharmacy Marketplace and co-founder of Foundational Pharmacy Strategies. “Employers should consider all their PBM options, but often those moving away from rebates prioritize cost management and clinical outcomes. This creates a healthier long-term payment structure that leads to healthier members and lower costs.”



Christine Johnston

While there is still a place for rebates, she maintains that employers should consider all options, noting, “The diversification of PBM types will lead to a better healthcare experience for all.”

An industry report from Drug Channels reveals crucial considerations why the Cigna announcement may be less revolutionary than it first appears, including:

Just another point-of-sale rebate program?

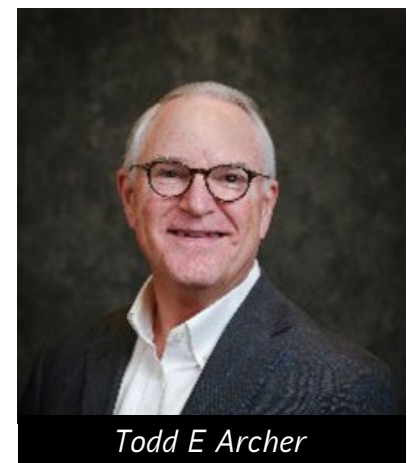
Evernorth’s “rebate-free pharmacy benefit” sounds remarkably like existing point of sale (POS) rebate programs, in which formulary rebates are applied as prescription discounts directly to patients at the pharmacy counter. POS rebates have existed for years, but adoption has been chronically low. Some states —including Arkansas, Indiana, and West Virginia—have even mandated POS rebates for certain insurance plans.

How many plan sponsors will actually adopt the rebate-free model?

Evernorth’s press release calls the rebate-free model its “standard” offering beginning in 2028 – but it is optional, not mandatory. Here’s the uncomfortable truth: Most commercial plan sponsors use rebates to offset general healthcare costs and reduce premiums, not to directly lower patients’ pharmacy costs for the patients whose prescriptions generated those rebates. The delay to 2028 presumably gives Cigna time to renegotiate contracts and persuade its clients to adopt the new model. Still, Cigna expects that only about half of its commercial book of business will transition by the end of 2028.

They also gave no indication that anything will change for Ascent Health Services, which manages rebate negotiations for Express Scripts’ PBM business, Prime Therapeutics, and several smaller PBMs. For those unfamiliar, Ascent is domiciled as an LLC in Delaware but based in Switzerland, which is well known for mechanical watches and...financial transparency.

Todd E. Archer, president, Concierge Third Party Administrator, sums it up nicely: “I have for years questioned the love affair the market seemed to have with drug manufacturer rebates. To me, drug rebates are like tax withholding: You pay more than you should, and at some time in the future, some of it gets returned to you, with no interest. Why not just pay what you should pay when the transaction occurs and avoid all the needless machinations associated with the process? Hopefully, the market is coming to its senses and moving away from this wasteful process.”



Todd E Archer

Application of Pharmacy Benefit Rebates in Employer-Sponsored Healthcare Plans, 2025

Item	Average cost for single person coverage ¹	Pharmacy benefit rebates ²	Net costs
Employer contribution to premium	\$5,089	-\$525	\$4,564
Employee contribution			
• Premium	\$2,339	-\$243	\$2,096
• Out-of-pocket costs	\$1,211	\$0	\$1,211
Total	\$8,639	-\$768	\$7,871

1. Figures show the total cost of healthcare for a single person covered by an average employer-sponsored preferred provider organization plan.
2. For 2025, Milliman estimated that pharmacy benefit rebates reduced allowed drug costs for the average person by 31% to 33%.
Source: Drug Channels Institute estimates based on 2025 Milliman Medical Index.

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A NEW ERA FOR PBMS

Employers face several challenges with PBM pricing transparency, primarily related to opaque contract language, lack of access to detailed cost data, non-disclosure agreements and hidden fees like "spread pricing," where they charge the employer a higher price for a medication than they reimburse the pharmacy, keeping the difference

as profit. These issues make it nearly impossible for employers to understand the true cost of prescription drugs and ensure they are fulfilling their fiduciary duties to plan participants.

THE SELF-INSURED EMPLOYER PERSPECTIVE

Belazi emphatically states, "No -- I don't think rebates are going away. What I think is happening is the intermediaries, like PBMs, are going to provide optionality: A new way of doing things with direct-to-patient programs or consumer programs vs. the traditional rebates."

He observes that Cigna and Express Scripts will provide the rebates upfront, at the point-of-sale, so that the employer doesn't have to wait for a check in the mail months later.

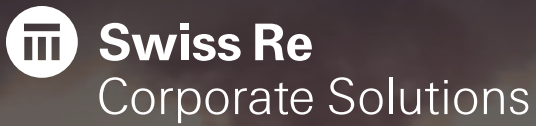
"As I understand it, the up-front discount is lower than traditional, but there is no rebate check 3, 4, 6 months down the road," he continues. My 25 years of experience in this industry tells me that the PBMs aren't necessarily providing more concessions because of this model. It's just moving the numbers around, giving it upfront versus later. And by giving it up front, there's usually a cost of money like interest rates."

As an example, Belazi explains that if the drug costs \$100 today, tomorrow it might be \$92 with the upfront discount.

"In the old model, there would be a \$10 rebate," he says. "The product would really cost \$90 if they had waited the three to six months for the rebate. But the problem is that the employers want their money now. For the PBMs to take risk on the rebates -- paying before they get it -- they will have to keep some of that to mitigate those risks."

Belazi deduces that whether it's the cost of money for interest rates or the drug company not paying for the rebate, the employer probably wouldn't get as much. But they would be getting upfront money faster, although they are going to miss getting those big rebate checks.

"That's the optionality," he resumes. "An employer group or a health plan or whatever entity is using the PBM service can now go and say, 'I want this version, or I want that version.' That's why I don't think rebates are going away. I think they're still going to be there because that is still the only mechanism and model to get those manufacturer discounts."



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Optionality and flexibility resonate for employers who seek to avoid the limitations of a rigid system.

Lori Daugherty, CEO, Rx Logic, shares, “As an independent claims adjudication technology platform that provides stakeholders across the self-insurance industry with multiple options for implementing a risk management strategy, RxLogic maintains a position of neutrality, being objective but not passive in the ongoing discussion of rebates.”

She reflects that while many organizations have expressed intent to phase out rebates, “...the underlying economic structure of negotiated discounts will likely persist. Drug manufacturers will continue to negotiate pricing in exchange for favorable formulary placement, though the transition to alternative models will be gradual and primarily driven by the largest market participants. This shift will not occur uniformly across all health plans and PBMs, and smaller, more transparent PBMs will undoubtedly continue to operate under traditional rebate structures.”

Daugherty points to the RxLogic independent role in the marketplace as the technology backbone for diverse segments in the pharmacy benefits landscape, adding, “We understand the significance of this change in how savings are applied rather than an end to rebates or negotiated price cuts. Our platform and client services team will support clients as they integrate their program offerings into an emerging DTC sales model.”

The new landscape is also spawning startup companies that say they can help address a critical gap in employer-sponsored health insurance when employers choose not to cover certain treatments. The pitch is that employers can pay less than they would if they covered the drugs through insurance, and, with a subsidy, employees could get the treatments at a lower cost than if they paid the full cash price on their own. RxSaveCard is one that is charging employers a set fee to help them set up this model, and Andel announced that it will launch a platform that will adopt a similar model for GLP-1 treatments and eventually for other branded drugs.

THE PHARMA PERSPECTIVE

Drug manufacturers are paying close attention to the ripple effect of the Cigna/ESI/Evernorth phase-out of the traditional prescription drug rebate model and transition to low net-cost pricing. Positive but cautious responses are reflected in the statements from PhRMA, the industry’s primary lobbying group, which called the announcement “a step in the right direction,” viewing it as a positive step toward transparency and lower patient out-of-pocket costs.

“I don’t think rebates are going away, but do I think we’re moving toward a system of more transparent drug pricing,” states Corey Belken, PharmD, principal – National Employer Team, Genentech. “There will still be a need for PBMs and pharmacy benefit consultants who understand the emerging landscape and the impact of these changes on employers and carriers. Their role is validated and embedded in the system with key services that include claims adjudication, Drug Utilization Review and Utilization Management, clinical review and much more.”

Belken believes that changes to the complex system of rebates are a key measure to achieving greater price transparency, adding, “The drive towards more transparency is a good thing for employers as well as benefit consultants. It will help to overcome the drawbacks of the current opaque system that often obscures the true cost of medications for plan sponsors and patients.”

But this transition will not happen overnight, as Belken projects the changes to evolve over time. He also weighs in on the trend toward direct-to-patient drug purchasing, noting, "This new model is very exciting for patients and employers, but the jury is still out on how it will align with specialty medications where total drug costs are beyond the financial reach of plan members."

Rob LaHayne, CEO and co-founder, Leap Health, views the vertical integration of these plans will also create friction, adding, "For instance, I'm on a maintenance medication that is covered by my insurer (Aetna/CVS) at a copay that is higher than what the drug costs if I pay out-of-pocket. If I want to fill it for mail order or a 90-day subscription, they require me to put it through CVS instead of my local pharmacy. Both of those dynamics are wrong."

He emphasizes that the direct pay model is inappropriate for all drugs, such as specialty or infusion therapies.

"As an infusion provider, we commonly deal with drugs that cost \$10,000+ per dose - not \$10,000 after markups and middlemen," he explains. "That's the price of the drug. Unless there is an employer-provided HRA program alongside the direct-pay initiative, there is no way your average consumer will be able to afford their specialty infusion medications."

Other advisory firms emphasize that only certain products are suited for cash-pay programs. In selecting products to make available on these platforms, they advise manufacturers to consider the coverage landscape, patient demand, and product pricing and price elasticity vs. inelasticity.

Furthermore, they point out that DTC programs often leverage third-party vendors to design front- and back-end program interfaces, disease education, telehealth, product distribution and pharmacy fulfillment. By investing in DTC platforms, they maintain that manufacturers can glean critical insights into patient behavior and adherence, which may otherwise be unavailable in a fragmented supply chain.

It is noteworthy that in the context of drug purchasing, many industry stakeholders use the phrase "direct-to-patient" vs. "direct-to-consumer." The latter phrase, they say, refers to TV and other media advertising spend, which skyrocketed in October of 2025. According to Fierce Pharma Marketing by iSpot.TV, the combined outlay for the

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top 10 pharmaceutical brands in October weighed in at \$307.1 million, far outweighing recent months' totals, which had not crossed the \$200 million threshold since June, but it also exceeds the record high of \$302.5 million set in January.

BOTTOM-LINE: WILL DRUG PRICES COME DOWN?

DTC programs promise to offer plan members a user-friendly interface that allows them to shop around for affordable prices for prescription medications. These platforms typically include telehealth services, prescription management and fulfillment/delivery services, empowering plan members to make their own decisions. While a new analysis from The Ohio State University suggests that DTC pharmacy models could challenge traditional prescription insurance, researchers conclude that for now, they're more disruptive on paper than at the counter.

There is consensus that DTC will likely upend the current chain of drug supply, payment and access. But several health policy and drug pricing experts (STAT; 8/2025) say they are unlikely to bring down drug costs for most people, as they are most beneficial for a small number of patients who lack insurance or have high-deductible plans:

"I just don't want it to be seen as, like, 'Well, now we've solved the problem because customers get to buy out of pocket. For the vast majority of Americans, they just simply do not have the means to do that.'"



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Craig Garthwaite, director of healthcare, Northwestern University's Kellogg School of Management.

"Even if patients have high-deductible plans, they may still be better off paying for drugs at the original, undiscounted prices so that they can meet their deductibles and get closer to their out-of-pocket maximums."



Stacie Dusetzina

Stacie Dusetzina, health policy professor, Vanderbilt University Medical Center.

"I think the drug companies are trying to do things out of the optics of looking good, like they're trying to make progress on drug prices without actually being willing to tackle some of the fundamental challenges of pricing in the system."

Ben Rome, assistant professor and researcher on drug pricing, Harvard Medical School.

Throughout the marketplace, concerns persist about relying upon voluntary deals and arrangements with manufacturers that are

focused too narrowly on the popular GLP1s, relegating other high-cost treatments – such as oncology medications – to remain unaddressed.

It is noteworthy that the ERISA Industry Committee (ERIC), a group for employers with self-insured benefit plans, says many of its members – large and small -- are questioning how their PBMs are addressing expensive "biologic" drugs like Humira.

Humira is a type of biologic medication that is typically administered as a subcutaneous injection and used to treat moderate to severe inflammatory conditions like rheumatoid arthritis, psoriatic arthritis, Crohn's disease and ulcerative colitis. ERIC reports that

employers are already forming relationships directly with biosimilar manufacturers.

MEMBERS NEED SUPPORT

With direct-pay solutions, members will not be totally on their own as the drug delivery method is agnostic to the need for support, education, monitoring and guidance for optimizing clinical outcomes. Many self-insurance stakeholders





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are calling upon modern pharmaceutical solution partners, including PBMs and consultants, to step up and provide this level of support, building DTC into their approaches without losing sight of clinical care.

Employers will require solution vendors to evolve and become partners in care, an integrated component of a broader strategy that lowers costs, improves member satisfaction and simplifies access. With the right partner, DTC can develop into more than a distribution channel -- it becomes a smarter, more connected model of care that turns every prescription into an opportunity to engage, educate and empower.

"DTC drug sales are rapidly transforming the pharmaceutical landscape by eliminating the need for traditional intermediaries to sell products," says Benjamin Takitch, Complete Captive Management Services (PharmD Candidate Class of 2026, University of Pittsburgh School of Pharmacy). "Many manufacturers have been implementing them for years. But current commercially insured pharmaceutical transactions typically include a significant cost based on a start point such as AWP, WAC, ASP, etc, and then great discounts are subsequently returned approximately 2 quarters later in the form of rebates or years later for outcomes-based contracting."

He observes that often, a high percentage of these reimbursements is retained by vendors rather than completely passed through to the actual payers. Other discounts off high price points appear through patient assistance programs and copay maximizer programs, which typically have prerequisites.

"DTC programs, including Mark Cuban's Cost Plus and TrumpRx, are intended to bypass these processes," he continues.

"By excluding the middleman, DTC sales to pharmacies and to consumers create opportunities to increase transparency and decrease cost, as long as eligibility through step therapy based on treatment guidelines, safety beyond marketing influences and efficacy measurements at defined intervals remain measurable outcomes monitored by pharmacists independent of manufacturers and providers."

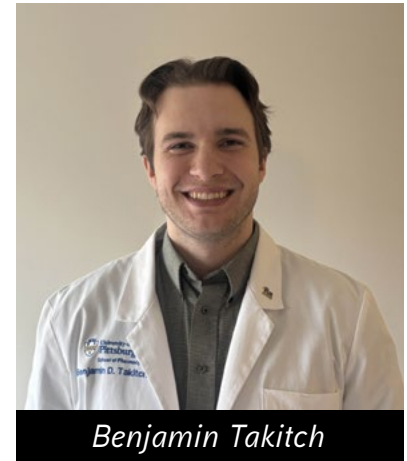
He quips the 'wait-and-see' will be: "Do we need to consider cost offsets if manufacturers do not extend specialty programs in the commercial space?"

NEW OPPORTUNITIES FOR MEMBER ACCESS, AFFORDABILITY AND DATA COLLECTION

DTP purchasing models emerge as a strategic imperative for a growing number of pharmaceutical brands. But for specialty drugs, which are projected to account for over 50% of employer pharmacy spending by 2026, they are evolving into sophisticated platforms focused on end-to-end patient care, not just a simple financial transaction.

Despite making up a small fraction of total prescriptions, their high cost for complex, chronic conditions or rare diseases means they drive a disproportionate amount of the overall drug budget vs. the more common, lower-cost medications.

DTP models for specialty drugs are focused more on enhancing the member experience and the treatment journey than on simple cost reduction, as Belazi stresses, "Specialty drugs often require unique handling, such as specific storage temperatures ('cold chain logistics'), which adds complexity to direct shipping that is less relevant for standard medications."





He explains DTP models for specialty drugs are likely to be more comprehensive, integrating digital services like care navigation, adherence support and communications to strengthen patient engagement.

“As the DTP model evolves, there is a growing need for improved access to patient data and behaviors,” says Belazi. “Accurate, timely data should provide actionable insights that can inform future product development and more targeted support programs.”

In this new environment, he emphasizes that stakeholders must maintain transparency and foster trust between the patient, the manufacturer and healthcare professionals.

“We can never lose sight of putting patients first,” he concludes. “A patient-centric approach to DTP prioritizes individual preferences, values and needs, leading to a more effective and coordinated care plan that respects a person’s physical, emotional and social well-being – regardless of the purchasing mechanism.” ■

Laura Carabello holds a degree in Journalism from the Newhouse School of Communications at Syracuse University, is a recognized expert in medical travel and is a widely published writer on healthcare issues. She is a Principal at CPR Strategic Marketing Communications. www.cpronline.com

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