Pharmacy Benefit News

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Specialty Spotlight

How To Afford High Priced Drugs

The pharmaceutical industry has begun to produce more innovative treatments for serious diseases that can extend life and often have fewer side effects than older treatments. However, such treatments are extremely expensive. High drug prices can translate to patient costs of thousands of dollars a year. Out-of-pocket prescription-drug costs rose 2.7% in 2014, according to CMS. Though many middle class Americans can get their out-of-pocket costs paid by drug companies or drug-company-funded foundations, some patients make too much money to qualify for assistance. Others are unaware the programs exist. Medicare patients, who represent nearly one-third of U.S. retail drug spending, cannot receive direct aid from drug companies. A quarter of U.S. prescription-drug users said it was difficult to afford them, in an August 2015 survey by the Kaiser Family Foundation. Drug companies, aware that costs borne by insured patients can limit sales, have stepped up their spending on programs to defray them, such as copay coupons. About 44% of commercially insured patients' prescriptions for specialty drugs involved copay coupons in 2013. Patients on Medicare are starting to feel some relief from out-of-pocket expenses through a provision in the Affordable Care Act that requires a gradual lowering of patient contributions. When the reduction is complete in 2020, the median out-of-pocket cost for Medicare patients taking oral cancer drugs will be $5,660 a year.

Wall Street Journal (12/31/15) Walker, Joseph

COMMENT:
Clearly, new approaches are necessary to pay for expensive medications. Subsidies, coupons, and patient assistance programs are some options. Debt financing is an option that is rarely discussed. Health systems could issue financial debt instruments, e.g., bonds or lines of credit, to pharmaceutical manufacturers. Hospitals already use similar options to lease or purchase expensive equipment. Value-based financial instruments are already being tested for pharmaceuticals that reduce hospital stays or complex surgeries. These instruments may have 5-10 year financing options to reduce upfront costs.

Payments over time and/or secured with mortgages provide other options for individuals to pay for care if they don't qualify for aid. Automobile and equipment purchasing offer other options for individuals to consider based on leasing or supplier financing of credit (i.e., pharmaceutical manufacturers).

All of this sounds good if people are covered by the same insurance for a long period of time, as for example, union members. However, if people change insurance often, then financing becomes more complicated. While we are not advocating any one option, it is too early in the process, it is necessary for individuals and health care systems to open the dialog and renew all options. Drugs may cost a lot, but we have to find a way to make them more affordable.

Find out more

Long Tern Statin Use Leads to Kidney Disease

An 8-year retrospective study of 43,438 individuals who were followed up for a median 6.4-year found an association between long-term statin use and increased risk of kidney disease. Ishak A Mansi of the University of Texas Southwestern and co-researchers write in the American Journal of Cardiology that compared with case-matched controls who did not use statins, statin users showed a 30%–36% greater prevalence of kidney disease. The study included data from 30- to 85-year-olds in San Antonio in 2003–2012. The most commonly prescribed statin was simvastatin, followed by atorvastatin. The drugs were taken for a mean of 4.65 years.

Medscape (12/21/15) Busko, Marlene

Commentary
This is a cohort study. Cohort studies investigate the cause(s) of disease. They attempt to find the relationship between risk factors and outcomes. Since cohort studies are planned in advance and then study a population over a period of time in the future, they are also known as observational studies. In this case, two cohorts, the study and the case-matched controls were compared to determine if the risk factor (long-term statin use) lead to the observed outcome (kidney disease).

The lesson to be learned here is that, while suggestive, a more controlled study is necessary. A controlled study selects patients to fix the impact of certain diseases, conditions and medications that may lead to kidney disease such that the administration of statins is the most probable rationale for the increase in kidney disease. In the absence of well-controlled studies, we may become more watchful and more selective in our therapeutic choices, but we may not withhold treatment when it is necessary.

Commentary Piece

What are some of the programs that retail pharmacy is implementing in 2016 that have the opportunity to change the health care landscape? Consider the following from the PwC Health Research Institute report and Drug Store News (1/11/16):

1. Consumer-Directed Healthcare: PwC found that 44% of employers will consider or offer high-deductible plan options within the next three years. Expect people in high-deductible plans to use more retail clinic health care, go to doctors less, and use more generic drugs or lower cost options.
2. Specialty Medications are going off-patent. Expect more biosimilars to enter the market to save money, but patients don't know what they are (67%).
3. Point of Care Laboratory Testing expands. Expect more clinical laboratory testing in pharmacies. Sonora Quest Laboratories is already in Safeway groceries.
4. Hospital Readmissions are due to medications. The top three reasons for readmissions are medication errors, adverse effects, and nonadherence. Expect more medication reconciliation and OTC use. Walgreens WellTransitions is touting such a program with a 46% decrease in re-admissions.
5. Mental Health is a problem for one-in-five adults in the US. Pharmacies like CVS Health are adding behavioral health to their Pharmacy Advisor clinical programs. The focus will be on gaps in care and adherence. Expect telehealth to be deployed to make these programs more efficient and to reach a larger audience using less resources and time.

All of these trends when added to the mobile technology advancements are driving the "retailization" of healthcare.

Fraud, Waste and Abuse™

FWA – Fraud, Waste, and Abuse – is not just a cost issue! FWA is not just a requirement for compliance with Medicare!

- Fraud is illegal
- Waste is a squandering of resources
- Abuse is a failure of the healthcare delivery system
- Health Plans, TPAs, and PBMs monitor for FWA. Is it enough? Do we wait for an event and then respond, OR do we make FWA a proactive management decision?

Pro Pharma has developed a management model (PP-FWA Management™) based on prospective education and retrospective surveillance.

Why manage FWA?

The key to the management approach to FWA is to identify high risk situations and to prevent waste and abuse through management initiatives

- The FWA management model is incorporated into current provider outreach and utilization review
- Providers are not antagonized as doing wrong

What's in it for me?

- Spend your time managing rather than reacting
- Spend more time on managing those issues that will result in change
- Place your emphasis on prevention
- Save money up front rather than trying to recover it
- Demonstrate the impact of your management approach through decreased risk and impact on provider PUPM (Per-Utilizer-Per-Month)

FWA can keep you up at night wondering where and when the next axe will fall. Waste and Abuse are endemic in all healthcare systems. Be proactive. Manage it!

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Pro Pharma Pharmaceutical Consultants, Inc. has assisted payer and providers for over 29 years to maintain quality while controlling costs.

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