Pharmacy Benefit News

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US Health Care Spend

Health care spending increased 5.8% from 2014 to 2015. Who paid for it?

- Private Insurance 33%
- Medicare 20%
- Out of Pocket 11%
- Medicaid (Federal) 11%
- Medicaid (State/Local) 6%
- VA/Military 4%
- Public Health Programs 3%
- Other Third-Party Payers 8%
- Nonprofit Investment 5%

What did we spend it on?

- Hospital Care 32%
- Physicians/Clinical Services 20%
- Prescription Drugs 10%
- Government/Insurer Expenses 8%
- Nursing Care Facilities 5%
- Research 5%
- Personal Care 5%
- Dental 4%
- Medical Products 4%
- Other Professional Services 3%
- Home Health Care 3%
- Public Health Activities 3%

Reference: AARP, 4/2017

Commentary:

In light of the many public and political discussions on health care policies, it is important to review some data to understand who pays for what. The arguments over the Affordable Care Act vs. American Health Care Act are targeted to a third of the spend and another 37% on Medicare/Medicaid spend. If Medicare and/or Medicaid are removed from the argument, then the issue is about 33% of the spend.

The real concern is over what we are spending the money on? Medications are about 10% of spend, but rising at 17% for specialty medications (about a 4 year doubling rate) that are heavily influencing which patients need hospitalization and which will be treated at home or in a physician's office. Hospital and physicians' services are largely contracted so their cost inflation is managed. Medical services and products are budgeted or contracted. Medications are not. As a result, cost inflation for pharmaceuticals is a "lightning rod" for cost control and oversight. Since medications are not contracted, Health Plans may pass a larger portion of the cost onto beneficiaries to maintain budgets.

Yet, if the medication spend continues to be around 10% of spend, then physicians as prescribers, and patients as payers, will have to accept a larger responsibility for finding affordable options. In any scenario, all stakeholders (Manufacturers, Physicians, Plans, State/Federal Governments, Hospitals, and Patients) will have to coordinate to find options to make health care affordable. The politicians can fight it out, but the onus will rest on the stakeholders as a whole.

Analytics at Work: A Real World Example

Best-In-Class

A client asked Pro Pharma how to measure pharmacy quality improvement so that their CFO and Financial Analysts could identify true savings.

Plan: Pro Pharma established a pharmacy program based on physician prescribing practices using a main intervention group, a control group, State Medicaid as well as a State Employee group for comparisons. The Pro Pharma approach was a monthly communication of actual physician prescribing, behavior modification program tracking trends in spend and per-utilizer-per month costs vs. Best-In-Class comparators that included over 70% of pharmacy spend. The reference group was formed based on similar Plan type, benefits, patient volume, diagnostic profiles, severity, physician specialty, and geography. State Medicaid and State Employees were used as additional comparators trended over the same time periods. The program continued for eight (8) years and was re-evaluated every year.

Results: Savings were quantified on a quarterly, bi-yearly and annual basis every year for 8 years. Annual trends were consistently less than 2% vs. national trends of 11%. The comparators were never less than 11+% trends annually, while the Medicaid and Employee Plans averaged 7% and 12%.

Learn More

Declining Drug Prices

Drug wholesalers like McKesson and Cardinal are already reporting lower earnings for 2017 through at least mid-2018. The rationale? At least one major reason is falling generic drug prices to low double digits. Why? There are more generics on the market due to faster FDA approvals and a price fixing investigation into the generic drug industry. How long will this occur? It is expected that by 2019 prices will be in the high single digits.

Reference: WSJ, 4/19/17

Commentary:
The above experience is based on the prices that the wholesalers charge their retail pharmacy customers, not on the

prices that they pay to manufacturers. The pricing pressure is on the "sell-side". The wholesaler-manufacturer "buy-side" is presumably controlling costs, while the sell-side is competitive and requires more discounts to keep their retail customers. Granted, this issue is focused on generic drugs. Yet, the cost of generic drugs needs to be low to anchor the increasing cost of new branded pharmaceuticals.

Generics can never compensate for all brand cost inflation, but generics provide an option for affordability for low income and

Corporate Alliance to Lower Health Care Spend

In 2016 an alliance of over three dozen companies -- including American Express, Johnson & Johnson, IBM and Macy's -- developed a plan to use group contracts to purchase prescription drugs through CVS Health and UnitedHealth Group; create a specialized physician network; and use IBM's Watson to analyze health care data. The group is called Health Transformation Alliance and is nonprofit. The goal is to combine the purchasing muscle of 38 companies to win lower prices than any individual could alone. Although all members may not participate due to better current contracts, the alliance expects to save an estimated 14-15% of total drug spend. Compare this to the 6.1% increase in health care spending by private businesses

vs. the 4.5% increase in government and household spending on health care (CMS).

Reference: WAJ, 3/8/2017

Commentary:
This alliance is taking the rein for reducing health care spend instead of waiting for the public sector. While the methodology is not new, it does emphasize principles that have been in use for years. The methodology targets concentrated purchasing on just

costs. With discount generic programs and lower cost generics, the retail pharmacy industry may provide the affordability that is crucial to make any pharmacy program work efficiently.

results for excessive cost procedures, centers of excellence and best-in-class providers/drug regimens, and predictions of patients requiring care for substantial risk diagnoses.

What is notable is that large employers have the skills and expertise so they don't need the public sector to solve all their problems. This alliance doesn't solve all problems, but it does show what can happen when some of the primary stakeholders get together and find their own solutions.

PRO PHARMA
PHARMACEUTICAL CONSULTANTS, INC.

PRODATA ANALYTICS

QMP

Quality Management Program™

The Quality Management Program™ has been instrumental in controlling drug spend and trend by:

- Maintaining Drug Cost Trend to Low Single Digit Inflation
- Managing Utilization (numbers of scripts per patient/year
- Minimizing Variance of Actual to Budget

Thereby improving quality-prescribing decisions for your members, without having to change your benefits.

Pro Pharma utilizes a multi-pronged approach to manage pharmacy costs through provider education, problem flagging, feedback on performance and patient education/involvement. The goal is to educate prescribers in clinical therapeutic decision-making and cost effective prescribing, which is consistent with managed care contracts. These programs can integrate effectively with Client/Health Plan and PBM drug-switching programs if currently in use or planned for by Client.

Bottom Line: Physicians will prescribe cost effectively when they are included in planning and implementation. Payers can expect to see performance improvement savings of 8-11%

Pro Pharma's Quality Management Program™ results have proven in markets nationwide to increase quality outcomes and decrease costs associated with managing the pharmacy and medical benefits

with prudent business principles to achieve cost contraction as a result of improved quality management.

Savings accrue from physician-accepted general education about evidence-based practice and information about the cost-effectiveness of competing medications.

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