Pharmacy Benefit News

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Co-Pays vs. Cost - Who Pays?

According to a recent Bloomberg report, several lawsuits are being filed against the major US pharmacy chains, CVS and Walgreens, for charging copays higher than the actual cost of the medication, while prohibiting the pharmacies from disclosing the lower cost alternative to consumers. The lawsuits stated that the difference in price is often pocketed by the Pharmacy Benefit Manager (PBM). Several other similar cases had been filed against UnitedHealth Group Inc., Cigna Corp., and Humana Inc.

Commentary:
Copayment, as a cost-sharing mechanism, was initially designed to manage consumer's utilization rather than as a profit mechanism for any parties involved. The issue here is transparency of drug pricing at the point-of-sale. With a lack of transparency, it is difficult for consumers to know the actual drug cost. Some benefits are designed such that the pharmacy can collect the whole copay regardless of the cost of the drug. Other benefit designs require patients to pay only up to the cost of the drug. Yet, how are Plans able to determine if patients are paying the correct copay?

Audits determine if copays are allocated correctly. However, on an ongoing basis, there should be a method to determine if a problem is happening. Pro Pharma and its subsidiary ProData looked at this problem and offer the following advice. We performed an analysis to search for instances in which consumer's copayments are higher than the cash price of the drug. Since there are several prices it was necessary to decide which price to use. The pharmacy submitted price, Usual and Customary (U&C), or paid amounts are not a costs as they include

Source: Feeley, Jef, and Jared S Hopkins. "CVS Health Is Sued Over 'Clawbacks' of Prescription Drug Co-Pays." Bloomberg.com, Bloomberg, 8 Aug. 2017, www.bloomberg.com/news/articles/2017-08-08/cvs-health-is-sued-over-clawbacks-of-prescription-drug-co-pays.

Analytics at Work: A Real World Example

What's In A Claim?

Problem: A Health Plan requested help in determining the extent of their problems in Pharmacy Claims Adjudication. The objective was to provide direction to their IT Department to minimize these problems.

Methodology: Pro Pharma and its subsidiary Pro Data Analytics formulated exhaustive digital analyses that were performed every month on the Plan's Pharmacy Claims Data. The analyses included eligibility, benefit checks for members and the Plan, pricing checks, benchmark comparisons, validation of bases of cost, and unrealized savings opportunities.

Results: The analyses identified potential issues in over 2/3 of the Invoice Subtotals. Each analysis was flagged as a problem for members and/or the Plan. The paid amount, percentage of the invoice and the solution to the problem were flagged so that the Plan could prioritize their action plans. Standard and Specialty Rx were included in the analyses so that all elements of the Pharmacy Benefit were identified and trended. As a result, the impact of interventions was trended for change to target.

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Commentary: Identifying Patients at Risk for Opiate Abuse

Problem: The increasing attention on the opioid epidemic in the US often centers on changing behaviors of patients and prescribers. However, data analytics can play a significant role in the current opioid crisis. We developed criteria to identify and flag patients who are high risk for opioid abuse or misuse using pharmacy data.

Solution: After extensive literature search, the criteria that Pro Pharma developed are for chronic nonmalignant opiate use are:

Antibiotics Are Curative, But When to Stop?

Growing scientific evidence challenges the long-held belief that stopping antibiotic treatment early would cause antibiotic resistance. While first promoted by the World Health Organization (WHO), such a claim lacks strong scientific support. In contrast, there has been sufficient evidence to show that taking antibiotics longer than necessary increases the risk of resistance. Therefore, it is best to treat infection with the shortest length of therapy that can clear infection while preventing recurrence. However, leading scientists and physicians are still looking for the ideal antibiotic course. The Center of Disease Control and Prevention (CDC) has

- Opioid prescriptions from ≥ 2 pharmacies over 3 months
- Opioid prescription from ≥ 2 physicians over 3 months
- High dose for short duration (> 100 Morphine Equivalent

Daily Dose for < 90 days)
- Concurrent benzodiazepine use
- Chronic opioid use (> 90 days of opioid for 6 months)
- Short term opioid use that lasted > 3 days
- Age 18 – 34
- Male gender

These criteria, or clusters of criteria, may be used in the Prior Authorization process. Since there are so many criteria available from multiple sources, it is hard to determine if some of the criteria are necessary and sufficient, or just necessary. Also, analysts can reach different conclusions based on the identification of different subsets of patients based on using all or only specific criteria. Ultimately, the deciding factor is the predictive capability of the metrics that leads to lower incidences of patients treated for opiate abusive usage or detoxification.

Outcome: Pro Pharma/ProData's goal was to alert payers and providers of early signs of potential opioid-related issues, in order to prevent abuse, misuse, or addiction from occurring. The criteria were developed and tested using 6-month pharmacy data from a public health plan. The results are ongoing and will be discussed in future issues of Pharmacy Benefit New issues.

CDC Guideline for Prescribing Opioids for Chronic Pain." Centers for Disease Control and Prevention, Centers for Disease Control and Prevention, 15 Mar. 2017, www.cdc.gov/drugoverdose/prescribing/guideline.html.

(For a complete list of citation, please contact Pro Pharma)

directed by a healthcare provider. (Ref. Wall Street Journal, New York, N.Y. 15 Aug 2017: A.9.)

Commentary: This article reminds us that there can be very little scientific evidence to support many common beliefs in medicine. For example, in the case of antibiotic use, there is lack of evidence about the proper duration of treatment for a given infection. Without knowing the appropriate length of therapy, the common treatment duration of 7 or 14 days puts patients at risk for unnecessary antibiotic exposure. This increases the chance of bacteria developing resistance. Overuse and inappropriate use of antibiotics are the two biggest contributing factors of the increasing antibiotic resistance issue. In contrast, the main concern with stopping antibiotic therapy prematurely is recurrence of the disease rather than resistance. Therefore, it is important to use antibiotics when they are needed.

The current state of the art is that some anti-fungal therapy has been reduced to one dose, and some categories of antibiotics may cure infections in 5 days vs. 7 to 14 days. It is also well known that there is a post-antibiotic effect that extends the activity of certain antibiotics that treat gram negative infections for more than 14 days. Alternatively, certain upper respiratory infections require at least two cycles of antibiotics to cure the infection, and certain bone infections require extended therapy beyond 14 days to reach poorly perfused areas. As a result, each type of infection must be addressed as to the optimal duration of treatment to prevent recurrence. An antibiotic stewardship program can also assist with choice of antibiotic and duration of treatment to ensure that both recurrence and resistance are minimized.

Reddy, Sumathi. "The New Conundrum About When to Stop Antibiotics." The Wall Street Journal, Dow Jones & Company, 14 Aug. 2017, www.wsj.com/articles/the-new-conundrum-about-when-to-stop-antibiotics-1502725463.

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