PRO PHARMA
PHARMACEUTICAL CONSULTANTS, INC.

Pharmacy Benefit News

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01 | Commentary: How Do Countries Achieve Universal Healthcare?

The uncertainty in Washington and the States over the provision of healthcare has opened the debate about a universal healthcare option. Buried in the discussion is how would the US deliver and finance care? The discussion has been rather vague with reference to the government paying everything.

However, is that the only option? It would be instructive to know how other countries do it. The Commonwealth Fund researched nineteen countries to find out how they did it. Three general approaches were evident in their study:

1.Public Insurance

-This is a single-payer model where government finances healthcare with tax revenues. The government contracts directly with healthcare providers. All healthcare is provided including mental health, dental and eye care. Additionally, there are no co-pays at point of service. About 10% of the population has private insurance from their employer providing faster access to specialists and elective surgeries.

-Model – United Kingdom's National Health Service

2.Private Insurance

-The government sets healthcare policy and regulates private insurance, but insurance and the delivery of care is left to the private sector. Everyone is required to have health insurance with a few exemptions. Low income people are

basic benefit package, but citizens must buy supplementary insurance for glasses and dental. There is a deductible, but it does not apply to primary care, maternity care, care for children, and home nursing care.
-Model – The Netherlands

3.Mixed Public-Private Insurance
-Government taxes support public and private insurance. Public financing supports three major non-profit insurance funds. The government manages these funds, since they negotiate with and pay providers. All citizens must be covered. Covered services include comprehensive care, prescription medications and diagnostic testing. There is a cost-sharing arrangement for doctor visits, inpatient stays, dental, and vision. There are exemptions for low-income people, those with chronic illnesses and disabilities, and care for pregnant women and children.
-Model – France

Interestingly, the private insurance model has similarities to the Affordable Care Act, while public insurance is the topic commonly referenced in discussions in the US. If federal or state governments move to adopt any of these models or similar alternatives, the discussion must include options such as those described above to ensure that all ideas are evaluated.

Source: medicaleconomics.com, 1/25/18

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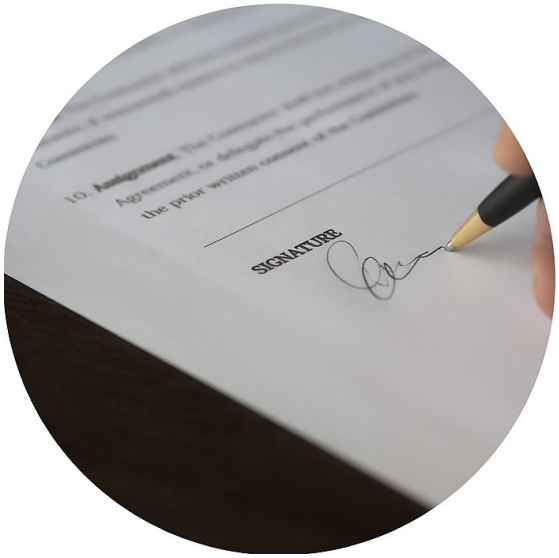

Problem: A client asked us to design a digital system for Request For Proposals (RFPs) that would be more efficient, easier to compare responses, provide in depth financial evaluations, and allow for reviewers to comment and exchange ideas. The goal was to project RFPs into the digital arena and to simplify comparisons to speed up the process and allow for faster and more efficient reviews.

Methodology: Clients always request more efficient and faster ways to move through the RFP process. We designed a digital format for RFPs that used fixed length responses accepted digitally. Questions were customized and focused specifically to the needs of the client as well as questions commonly used in the marketplace. The length of responses forces vendors to minimize marketing messages and provide clear and precise answers to RFP questions. The digital

hyperlinks to supporting documentation.

We added financial analyses from our library that allowed for comparative results and targeted filters to identify differences in the respondents. The RFP digital format also allowed for RFPs to be used for a multiplicity of uses including RFPs for PBMs, drug manufacturers, and clinical comprehensive medication review/medication therapy management (CMR/MTM) vendors.

Outcome: The digital RFP format was implemented and allowed for a two-week response rate, head-to-head comparisons, extensive financial comparisons, and more affordable budget impact due to faster turn-around-times. The RFPs were available 24-7 on the cloud so that the Review Team could review from any location. The client was extremely pleased with the in-depth level of explanations, understanding of the process, and outcomes

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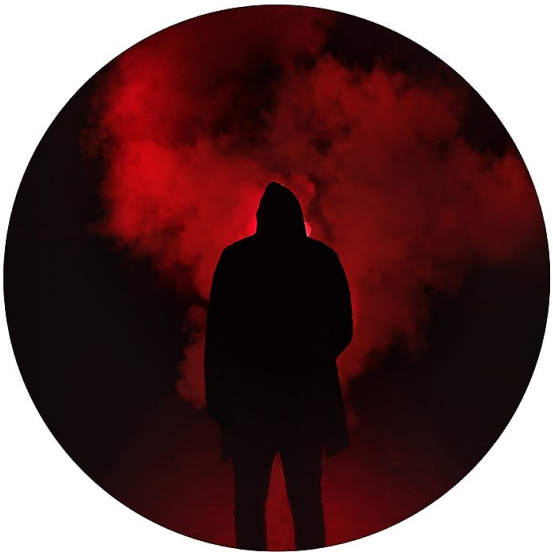

02 | Commentary: Firearm Injuries Cost Lives and Money

The horrific toll on human life should be enough to force action on gun control. There were 33,594-gun related deaths in 2014 (16.8% of all injury deaths) with mortality increasing by age from 6% under 18 years old, and 23.3% for 60 years or older. (Reference: Health Affairs, October 2017)

Nonfatal firearm injuries due to assaults ranged from 11% on head/neck to 35% on leg/foot.

What is not commonly discussed is that the victims of assaults, if they live, have a significant financial obligation. The total annual cost of initial hospitalizations between 2006 and 2014 was $734.6 million. This translated to an average of $5,254 emergency room charges per-person, and an average of $95,887 per-person inpatient charges.

The bottom-line, if one is still necessary, is that the victims pay with lives, money and distress. This is all one-sided on the wrong side of the equation.

Source: CDC, American Journal of Public Health

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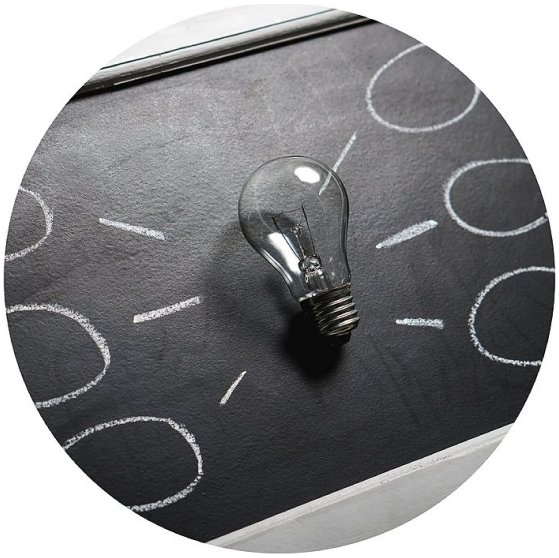
Press Release | Pro Pharma Announces New Find–Target–Fix Method



Pro Pharma Pharmaceutical Consultants, Inc., (dba Pro Pharma) a Pharmaceutical Consulting Organization which focuses on Data Analytical Expertise, announced a new method to identify and solve payer financial issueswith actionable results.

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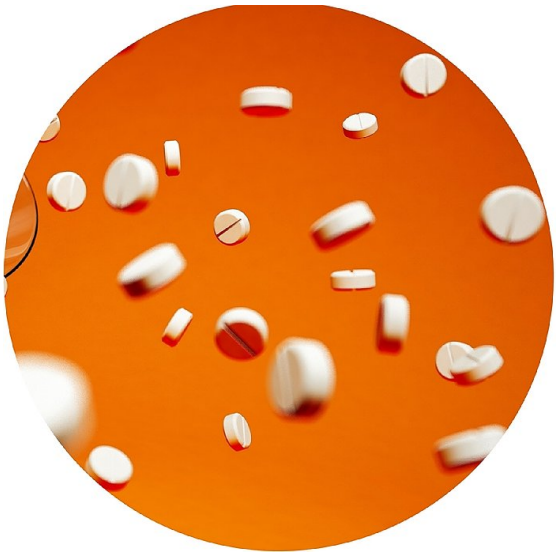

03 | Commentary: Unnecessary Opioids and Unnecessary Prescriptions

The opioid epidemic kills on average 115 Americans every day with about 40% of overdose death due to prescription opioids, according to the CDC. Much of this problem is due to large quantities of opioids prescribed for relatively painless surgeries and procedures.

The reason, “We heavily overprescribe, not intentionally, but because we don’t want patients to hurt, and what we do hurts.” (Dr. Lockett, Associate Professor of Surgery at the Medical University of South Carolina)

What can be done? Surgeons at the University of Michigan have taken action by forming the Opioid Prescribing Engagement Network (OPEN). This group is working to prevent overprescribing for acute care and short-term treatment for severe injuries with a focus on surgery and dentistry. OPEN bases some of their actions on studies that found that between 6% and 13% of patients who were not using opioids before surgery were still using them 3 to 6 months after surgery. An internal OPEN study (JAMA Surgery, June 2017) found that about 6% of patients receiving opiates for minor, or major, surgery became persistent users, i.e. getting at least one prescription 90 to 180 days after the procedure. These conclusions were further emphasized by a study at Johns Hopkins University

patients had left-over opioid medications.

While these studies and observations do not solve the opioid epidemic, they have lead to smaller prescription quantities. This is something that providers can easily fix if aware of far-reaching consequences.

Sources: WSJ, 1/30/18, A9

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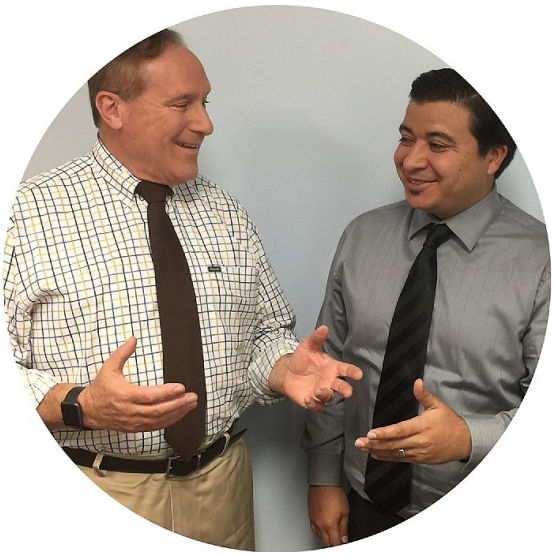

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Pro Pharma is a woman owned pharmaceutical consulting firm. Established in 1986, Pro Pharma's services are built on a foundation of data analytics, which are then communicated the client with results and recommendations.

Pro Pharma provides customized support to Health Plans, Self-Insured Employers, Physician Groups, and Workers' Compensation Companies, among others, both in the private and public sectors.

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