PRO PHARMA
PHARMACEUTICAL CONSULTANTS, INC.

Pharmacy Benefit News

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COMMENTARY | Are Employers and Plans Paying for Only Their Own Members?

The first test for all payers is to verify that they are only paying for their populations of employees or covered beneficiaries, and not for anyone that is not eligible. This is a simple test of the enrollment file with the claims. In our experience, frequent tests of Employer and Plan invoices indicates that there is a common problem where claims don't correlate with the enrollment file. Our experience shows that differences in subscriber numbers, patient names, dates of birth (DOB), member eligibility and termination dates, etc., often varies between the eligibility and claims information.

What to do? Patient identification used by the PBM Patient ID and Subscriber Numbers and those used by employers and Health Plans needs to be correlated and matched at least every month if not more frequently. Additionally, patient names, DOBs, eligibility and termination dates need to be correlated at least every month as well. If the benefit includes similar numbers with cardholder extensions for spouse and children, then this information also needs to be correlated. Correlation that can be verified is crucial to ensure that benefit dollars are applied only to those beneficiaries that are covered.

ANALYTICS AT WORK | Pre-

Certification of Specialty Medications at Work

Problem: One of our clients was concerned about comparing the medical versus the pharmacy specialty spend.

Their primary concerns were the location of service and applicable costs, as well as the overall gross trend of their per-member-per-month (PMPM) trends. Separately, the clinical group within the organization wanted to know if their clinical cost control methods were effective on a total Plan as well as on a per provider basis.

Methodology: We analyzed every specialty medication claim from both medical and pharmacy data for this client each month. All findings were filtered by location of service, PMPM, provider specialty, disease/condition, provider, etc.

The analyses reported overall performance and compliance with a series of outliers – e.g., unmatched diagnoses, medications without applicable genomic testing, dosage within labeled min/max ranges, quantities within expected usage, pricing vs. lowest cost, pricing in compliance with contracts, rebates, value of wastage, etc. For the clinical group, all claims were analyzed for prior authorizations (PAs) for formulary exclusions, efficiency of prior authorizations and step therapy, adherence by drug and by category, etc.

Outcome: Financial savings for our client were identified on average of 42-44% of paid amounts. Clinical analyses identified beginning compliance of 50% and cost control methods, including PAs at 60% efficiency. After the implementation of the new process, the compliance increased above 80% and clinical cost control efficiency was above 70%.

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COMMENTARY | Are Plans and Employers Paying for Generics When They Are Available?

Health Care Benefit Plans are generally bias to cover generic drugs when they are available. This ensures that the Plan beneficiaries pay the lowest cost or

copay for the most cost-effective medications. However, the way that PBMs, and often Plans, code drugs is frequently inconsistent. For example, medications available as a brand and a generic are known as “multisource” medications. These medications may be coded as either brand or generic requiring the Plan and the patient to pay higher costs and copays. Further, many drugs are available as over-the-counter (OTC), “store brand” and “private label” where a generic drug is repackaged as a “brand name” for a specific pharmacy or prescriber. The Pro Pharma and Pro Data experience is that multisource, OTC, store brand and private label are often paid as brands while the basic ingredients are generic.

Patients, Plans, and Employers should question the price that they are paying at the pharmacy. Plans and employers should question the methodology that is being used by the PBM to ensure that they are paying the lowest cost for medications, especially when they are available as generics from any manufacturer.

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COMMENTARY | Are Plans and Employers Paying for Refills When the Prescriber Is No Longer Available or a Covered Network Physician?

Prescriptions are written by valid prescribers who are still seeing the patient and continues to be a member of a Plan or Employer’s network. When a prescriber writes for multiple refills there is no guarantee that the physician will still be seeing the patient at each refill. Pro Pharma’s experience is that prescription files often have invalid doctor identification numbers, have doctors who have retired, are no longer seeing the patient, and sometimes have moved to other areas or States. When the claim has invalid information, no one knows who to contact for further information. When the doctor is retired, or no longer seeing the patient, then there is no one following the patient’s progress.

Transaction problems as above are fairly common. Plans and Employers should require PBMs, TPAs, and their own Plan, if applicable, to confirm on a regular basis that all prescribers are valid, the prescriber identification numbers are validated, and, most importantly that the prescriber is currently managing the patient. This is good medical practice, compliant with benefits, and ensures that benefit funds are being used appropriately.

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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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