PRO PHARMA
PHARMACEUTICAL CONSULTANTS, INC.

Pharmacy Benefit News

Issue #344 | February 21, 2019

COMMENTARY |

If Medicare Is Running Out of Money, Then Are Benefit Reductions Next?

The argument goes that the Medicare trust fund will run out of money in 2028. Is that true? Medicare financing pays for hospital, physicians and drug payments. Medicare funds come from two sources.

First, Financing for physicians and drugs comes from the federal government's general fund. Financing for the general fund is predicated on political decisions about how to use the general tax revenue.

Second, this leaves hospital financing covered under the Hospital Insurance Trust Fund. This trust fund is financed by a 1.45% payroll tax. Tax revenues built up a fund that could run out of money in 2028, if nothing else changes.

If the fund does run out of money, then what? The decision falls on Congress to make a choice. They have multiple options – (1) they could use income taxes to fund hospitals for physicians and drugs; (2) they could raise the payroll tax to 2.2%; (3) they could establish means-tests to decrease benefits; or (4) use a combination of these options.

As Merrill Goozner cites in Modern Healthcare (10/24/16) this is all predicated on the actuarial estimates published in the Medicare trustee reports. He further states that prior estimates have not been very accurate. For example, payroll tax

was $5,019 in 2015 when they were projected to be $6,644.

As an analyst, predictions are grounded in assumptions that undergo sensitivity tests to identify what would happen if the assumptions were modified. This is really a probability problem and subject to the economy, politics, social changes, and other variables. Predicting short-term is more accurate than long-term. Hence, budget shortfalls and predictions should be discussed carefully, and not thrown around like a political football.

ANALYTICS AT WORK |

Retrospective Audit

Problem: A common request these days is -- Can an audit help me to understand why costs are high, when my PBM is not helpful? At the same time other PBMs say they can help, but I am not sure if this is just marketing. A client contacted us for an expedited Retrospective Audit to determine the drivers of cost and the options available for change.

Methodology: Pro Pharma performed a Retrospective Audit including tests for eligibility, benefit compliance, brand and generic pricing, specialty pricing/utilization, benchmarking to national and local standards, and transparency in bases of cost. The Audit was expedited through the use of 100% electronic/digital analyses to facilitate quick turn-around time to significantly reduced Audit Costs, and available for desk and mobile devices.

Findings included potential problems with formulary claims that were coded as Brand when the Plan Expected Generics; problems with transparency such that AWP was inflated from national reference databases; specialty approved for total Rx without tests for FDA approvals, quantity, dosage and companion diagnostic tests; pricing above benchmarks, discount generic programs, Medicare/Medicaid when applicable, and patients paying more than cost of drug.

Outcome: The client used the findings to redirect coding options to include only Generic formulary options for multisource (especially timed-release products), OTC, store brands and private labels. They worked with the PBM to correct inflated AWP issues, and variances from Medicare and Medicaid. They moved specialty to Prior Authorization (PA) and improved criteria. They expanded the benefit to include payments for discount generic programs and removed zero-balance options. The result was normative pricing that was measurable and

future spend.

The client felt that they now had control, as they were equipped with a plan, an understanding of the drivers of cost, a solution for matching actual spend to expectations, and improved satisfaction.

Learn More >

COMMENTARY |

US Workers Take Bigger Out-Of-Pocket Costs Due to Health Care Deductibles

The Health Care Cost Institute (HCCI) published an analysis of 40 US metropolitan areas to determine the impact of high-deductible plans for employer sponsored health plans.

Their finding is that between 2012 and 2015 more workers were covered by high-deductible plans. According to economists, this trend is due to workers choosing plans with lower premiums, but workers with comorbid illness got less medical care. An additional finding was that gains in income were decreased by rising out-of-pocket spending between 2012 and 2015. As a result, company premiums covered less of the cost of health care than did traditional health insurance. Overall the high-deductible plans paid less for inpatient, outpatient, and prescription spending.

This data is of interest for the progress of employer sponsored health care spending. It might be argued that the 2012 to 2015 time-span is too short in that it does not cover the pre and post ACA period. It might also be argued that this is only for employee sponsored health plans and does not compare the impact of the ACA Exchanges on the employer sponsored health plans. However, what is interesting in the data is individual choice. People choose to pay less for health care in the short-term to preserve their fundamental needs. Long-term is not considered. This is a significant problem that needs to be addressed so that health care spending does not become a future catastrophe. Perhaps it is already here.

Trading lower short-term spending for long-term, high severity and high cost care is not a sustainable model!

Ref: WSJ, 9/1/17, B4

Watch or Listen to the Latest Episode

Discussion on Issues that Matter.

Watch the Latest Episode >

COMMENTARY |

Access, Coverage, & Affordability. What the Patient Wants!

One argument in the continuing debate about the Affordable Care Act (ACA), i.e., Obamacare, is the lack of subsidies to pay for the care of low income peoples.

The subsides were included in the ACA based on the Medicaid populations of each state. States that fully expanded Medicaid received greater subsidies to treat their Medicaid population. However, since subsidies have not been paid, there is less money to pay for the State's low-income population. A further result is that patients will use emergency rooms as sites for preventive and primary care. This impacts all patients who use the emergency room and urgent care centers for crises, as access is impacted for everyone. This situation is like pre-ACA times, but it is not an efficient or affordable method for receiving care.

What to do? Patients need coverage for their medical conditions and access to quality care. Unfortunately, the health care debate has revolved around affordability which is only one aspect of the problem. The real issue is to manage access, coverage and affordability at the same time. Managing people as populations, not as targets for payment, can lead to better options for global reform. The emphasis needs to be placed on the patient and not the method of payment.

It is necessary to anchor the coverage and access problems, in order to accomplish the population model. For example, people who are afraid of losing coverage, or have pre-existing conditions, or have behavioral health or substance abuse problems, need some assurance that coverage and access will be guaranteed. The patient population then needs to be grouped by health care need and severity so that appropriate quality care is provided to each group to accomplish this. When done efficiently, costs can be reduced.

Pro Pharma has had extensive client-related experiences over decades with this approach, but so have hospital systems like Aurora Health Care and Dignity Health, integrated care networks like Mayo and Cleveland Clinics, integrated managed care plans like United Healthcare and Kaiser Permanente, some individual provider groups, etc. The challenge is to expand the process across the entire health care system.

Where to we focus our efforts? First, focus on the patient. That focus drives the need. Second, focus on the data so that all providers (physicians, nurses, pharmacists, etc.) have the requisite information to manage their services. Third, focus on the long term. This is not a light versus darkness. It is an evolving process!

Learn More About Us >

ABOUT | Pro Pharma

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 to the client which provide 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.

Questions? Contact us at 1-888-701-5438

www.propharmaconsultants.com