PRO PHARMA
PHARMACEUTICAL CONSULTANTS, INC.

Pharmacy Benefit News

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COMMENTARY |

What Is the Transparency Goal?

The media is publishing a constant refrain of articles on price transparency for drugs. The common theme is to identify what the patient will pay at the pharmacy counter. From the patient's perspective this should be relatively simple. However, when experts get involved the concept of cost is interwoven with PhRMA's (Pharmaceutical Manufacturers) list price, one-time cost, cost per month, basis of cost, insurance price, cost after rebates, and/or cost after all rebates and discounts.

What all of this means is that the profession and all of its stakeholders have worked to make cost so complex that each element makes money off of the system. Each stakeholder is also altruistically trying to save money for the patient. How does this work? PhRMA issues list prices that no one pays and then negotiates discounts with hospitals and retail pharmacies for the volume that they purchase. PBMs (Pharmacy Benefit Managers) and some health plans negotiate further discounts called "rebates" of which the value of the rebates lowers overall drug cost and premiums for beneficiaries. As a result, everyone saves including healthy and sick patients. Medicare tried to simplify the situation by originally requesting that discounts and rebates, so-called direct and indirect rebates (DIR), be applied at the point-of-sale (POS). PBMs and others objected as the rebates are not known at POS. However, the war over DIR payments has become so extreme that the system is negotiating how to install the original concept and lower drug cost at POS.

means to compare prices across pharmacies with price checking that has become common for food, clothes, books, airfare, accommodations and insurance. Ultimately technology wins this game since digital solutions can form a price information exchange that is both national and international. The current goal is price comparison.

What we still don't know is whether all elements of the price are deducted at POS. We don't know if the system has changed or only been modified to provide a price at POS that can be compared. We don't know if all comparators are available, e.g., international vs. national price, or just too complicated to factor into the price comparison. Do all stakeholders now agree, or is everyone just waiting for the next cost war?

Ultimately, for patients, the real problem is that price does not always equal affordability.

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.

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 validated, low single digit point-of-sale trends, and a solution for analyzing 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.

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COMMENTARY |

Internationalism Brings Its' Own Rewards?

The drug market is international. Raw drug materials are manufactured all over the world. Israel is the largest manufacturer of raw materials for generic drugs. India is the largest manufacturer of raw materials for branded drugs. Countries such as China, India, South Africa, Brazil, etc., have their own drug industries supplying drugs to their own populations as well as to their customers.

What happens when the foreign manufacturers make defective products? The current issue is raw materials from China and India that are producing so-called angiotensin receptor blockers (ARBs) to treat high blood pressure, heart failure and kidney disease that contain potential cancer-causing materials adulterating the drug. While the risks are considered low, any risk is too much.

Since the sources of the problem have been recognized to cover most all ARBs, the ARB drug class has been removed from all pharmacy inventory. The recall is worldwide, so solutions are not available from other countries. Clearly, all stakeholders (wholesalers, hospitals, pharmacies, prescribers, insurance companies, PBMs, etc.) are affected, but most especially, patients. The FDA and similar groups in other countries besides the US are publishing interim limits of the potential risks of these cancer-causing materials. However, any amount will probably be considered too much.

important to realize that the growth of the drug market worldwide requires manufacturers to meet product safety standards for all markets. This is expensive and requires enough inspectors to cover manufacturers in all countries. Less rigid manufacturers will not, and cannot, survive.

Of interest is that the news is not presently discussing options. ARBs were originally marketed as a branded-name response to angiotensin converting enzyme inhibitors (ACEI). The ACEI category was essentially composed of generic medications that were extremely successful at lowering blood pressure, improving the failing heart, and slowed progression of kidney disease. Marketing claims for ARBs were largely based on an ACEI cough that was frequently over-diagnosed or incorrectly diagnosed.

Patients originally complained of the cost of ACEI and then of ARBs. Since both categories of medications are generic, no one seems to be complaining about drug price. The real price is the cost of the complication, namely cancer.

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COMMENTARY | Measles Kills. Vaccines Do Not.

In 1875 on the island of Fiji foreign sailors infected the population and killed one-third of the population. That is the same mortality as the “Black Death” in the 14th century that killed one-third of the population of Europe. Before 1963 when the measles vaccine was introduced, the World Health Organization reports that this “benign” disease killed an estimated 2.6 million children worldwide each year. In the US nearly 50K people were hospitalized every year with the measles virus and 400-500 people died every year according to the CDC. Measles can lead to pneumonia, encephalitis, blindness and a rare brain inflammation that kills 10-15 years after the initial measles infection. In 2017

available.

In 2018 Clark County, Washington fifty people were infected with measles. The disease has been confirmed in 10 states including California, Colorado, Connecticut, Georgia, Illinois, New Jersey, New York, Oregon, Texas and Washington. The disease is still spreading.

So, why don't people vaccinate? The stories are many… Vaccinations lead to autism; Greedy pharmaceutical companies are promoting vaccines for their own benefit; Natural immunity will protect kids; Injecting a foreign substance into a healthy individual makes no sense; Some kids still get measles even though they were vaccinated; My kids are safe even when others don't vaccinate their kids; There are horror stories all over the internet.

When individuals get vaccinated, they protect themselves and provide "herd immunity" for others. A high rate of vaccinations protects everyone from large outbreaks of disease. Even when a few get the disease, the symptoms are fewer and last shorter periods of time without causing large outbreaks. In Clark County, Washington only 77.4% of public-school children are vaccinated. The outbreaks are largely occurring in unvaccinated kids.

The worldwide population is afraid of earthquakes, hurricanes and tornadoes, meteorites hitting the earth, and other natural calamities. The history of polio, bird flu, Zika virus, disease outbreaks, skin eating bacteria, and other recent medical problems are examples of the consequences of disease spread, and in many cases, mortality. Yet, many of these same people argue over the value of vaccinations. The fundamental principles of science are active in all of these examples. If you believe in one, you must consider the impact of science on all of them.

Get vaccinated. What's better, vaccination or death?

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Pro Pharma provides customized support to Health Plans, Self-Insured Employers, Physician Groups, and Workers' Compensation Companies,

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