PRO PHARMA
PHARMACEUTICAL CONSULTANTS, INC.

Pharmacy Benefit News

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COMMENTARY |

Anti-Vaxers – Here Is the Data!

There is so much debate about vaccines causing autism, and the concerns of people to make their own decisions about their bodies, that it is hard to add anything to this debate. Humbly, we wish to add references from the professional data to provide some semblance of rationality to this discussion.

In 1998 Andrew Wakefield and 12 colleagues published a case study (12 patients) in ***The Lancet*** that measles, mumps, and rubella (MMR) vaccines may predispose patients to "autism". Subsequently the paper was retracted by 10 of the 12 authors. ***The Lancet*** completely retracted the paper in February 2010 in a small anonymous paragraph in the journal. Wakefield was exposed as guilty of fraud for falsifying facts and picking and choosing data that proved his case. He was also exposed as ethically violating the high standards of scientific research as he was funded by lawyers who were engaged by parents in lawsuits against vaccine-producing companies.

Subsequent studies debunked Wakefield and produced studies with data to support that there is no association between vaccines and autism. Remember that individual exceptions can always occur in science, since probability always allows for exceptions. But the presence of exceptions doesn't prove an association. It only proves that humans are different. The sad occurrence of someone who gets sick is why we try to prevent disease. Vaccines are the best tool at present for prevention.

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- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3136032/

What of the personal argument? Making your own decisions about what you do to protect your body seems to be obvious. What happens when your decisions impact the health of your children or other members of the community? Then you are making decisions for everyone. Your original argument is then used against you. If everyone can make their own decisions about their own body, then they cannot make decisions that impact everyone else.

More importantly, if you believe in the science behind earthquakes, storms, meteorites, sun spots, eclipses, disease producing genes, climate change, the ascent of man, infections, cancer, diabetes, autism, etc., then remember that each one uses the same scientific principles. If you believe in the science behind any of them, then you must believe in the scientific approach behind all of them! Remember, debate is at the heart of science, but it doesn't diminish the process. It leads to better results.

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 reduce Audit Costs, and was available for client desk and mobile devices.

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 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 |

Prescription Coupons – The Bane of Health Plans

Health Plans and Pharmacy Benefit Managers (PBMs) negotiate drug discounts with Manufacturers known as rebates. The rebates are based on moving market share to preferred drugs through tiering copays on the Plan formulary. The lower tiers require smaller copays, while the higher tiers require the patient to pay more in copay. Manufacturers who were not successful in getting their drugs on formulary, or were not preferred, lost market share and sales to the Plan's members.

Pharmaceutical Manufacturers developed a novel solution to the non-formulary or not- preferred option. They issued "copay coupons" to providers and patients that provided low out-of-pocket or no cost to patients to try their medications. The result was phenomenally successful especially for the high cost specialty medications. Patients used the copay coupons to obtain the Manufacturer's branded medications, thereby not complying with the Plan's formulary or the lesser expensive generic options.

the cost of drugs was not a limiting factor. However, when the coupon program ran out, then the patient was left with the total deductible and copay. Plans did not know how to respond for some time until they developed so-called "copay accumulator" programs in 2017. These programs ensure that the Manufacturer's payments are not counted toward patient deductibles and out-of-pocket copay maximums. The result is that both the coupons and the accumulator programs are highly controversial depending on whether you side with the Plan or the Manufacturer.

A poster at the last Academy of Managed Care Pharmacy (AMCP) meeting offered one solution to the dilemma. Integrated Care Partners presented a poster from Dr. Polomoff, et.al., that focused on educating providers about the cost of Manufacturer coupons. Their argument was that provider education including a video could show providers how to limit the use of these coupons thereby leading to lower drug costs and lower costs to their patients. Their education program lead to a 67% decrease in coupon expenditures. Separately, CMS announced that Plans offering ACA benefits on the Exchange can use copay accumulators to limit the impact of Manufacturers prices on patients. This is considered a win for Plans!

On the other hand, the State of Virginia banned "copay accumulator adjustments". The legislation requires that "***any payments made toward a patient's cost of care, including both a patient's own out-of-pocket payments and any copay assistance from Manufacturer coupons and other programs, count toward both the deductible and the overall out of pocket maximum payment***." This is considered a win for Manufacturers!

The bottom-line is that this is a controversy with no winners. This argument feeds into the general outrage over drug prices regardless of the source. One can easily see a situation where everyone loses. Until everyone focuses on the ultimate user/payer, i.e., the patient, and how they can afford their therapy, this will be an argument over competing for each group's share of the health care pie. Business School teaches a focus on the customer. All stakeholders need to take note!

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COMMENTARY |

Use Words and Concepts That Providers and Patients Don't Understand

Rebates, Medicare Advantage, biopharmaceuticals, biologics, biosimilars, QALYs, and standard therapy are just some of the jargon used in health care. The problem is that patients, and frequently providers (physicians, nurses, pharmacists, etc.), don't know what any of this means. Clearly, all professions have their own jargon. Health care and pharmacy are no different. Long complicated names for drugs and the use of Latin for disease names and conditions makes health care jargon even harder to understand.

What to do? Change the jargon, hardly! The fundamental problem is to use the terms whenever it can be couched in the context of "what's in it for me"? Put the term in the context of what it will mean for the patient or to the provider to prescribe. For example, rebates are for lowering prescription cost. Biopharmaceuticals are expensive, and they treat conditions that could not be treated in the past, but they save lives. Biosimilars are cheaper models of expensive specialty medications. QALYs demonstrate value for the cost.

We don't expect that the above examples will be acceptable to everyone, but we need to start somewhere. Tell me what's in it for me, and now we have a discussion!

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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 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.

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