PRO PHARMA
PHARMACEUTICAL CONSULTANTS, INC.

Pharmacy Benefit News

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In this issue of PBN we address some of the options that small employers are using to lower their cost of health care for their employees. The final commentary will consider other options used by health plans to lower cost and utilization.

COMMENTARY | HOW SMALL BUSINESSES COPE WITH THE RISING COST OF HEALTH CARE -- HSAs

Why is this an issue? According to the Kaiser Foundation, the typical individual employee's health care policy cost approximately $7,000 in 2018, and the average family premium was more than $19,000 annually. This was an increase of 5% over 2017, and about twice as much as inflation. The premiums have increased 20% since 2008.

How are small employers responding? The typical response is to ask employees to pay more in premiums (about 28% of total premium) or deductibles. The deductibles are included in 85% of covered workers, and these deductibles have increased by 55% in the last 5 years. To keep deductibles and premiums low employers have increased co-pays for workers. A second response is that only 47% of small employers with three to nine workers offer health-care coverage. However, in a low-unemployment environment healthcare is a requirement to attract sought-after employees.

alternatives are Health Savings Accounts (HSAs), Self-insurance, and Association health plans. (The self-insurance and Association health plan options are discussed below.) HSAs are like retirement plans for healthcare in that the HSA plans when coupled with a high-deductible healthcare plan allows employers and employees to contribute $3,500 for individuals and $7,000 for families annually. This is pre-tax for the plan, and employees can direct the money to investments like 401(k) retirement plans. Employees who are 55 years or older can add an additional $1,000. Different from retirement plans, however, employees can use the money to pay for approved out-of-pocket medical expenses and roll over any amount leftover to the following year.

ANALYTICS AT WORK | Pre-Certification of Specialty Medication

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 | HOW SMALL BUSINESSES COPE WITH THE RISING COST OF HEALTH CARE – SELF-INSURANCE & ASSOCIATION HEALTH PLANS

Self-insurance is a relatively new, but growing option for small employers. Why? Historically, small employers with 25-50 employees purchased fully funded insurance. The Affordable Care Act changed this scenario somewhat in that employers with more than 50 full-time equivalent employees had to offer affordable health care. The ACA mandate pushed employers with less than 50 employees to re-evaluate the fully funded solution. With fully funded insurance the employer is paying for all health care expenses regardless of whether employees use the benefits or not.

On the other hand, with self-insurance plan or its variants the employer pays for the employee's out-of-pocket costs up to an agreed maximum, and then stop-loss insurance pays for the rest. The result is that the employer is only paying for employees that actually use the benefit, so the costs are expected to be lower. This cost savings option has some traction in that the Employee Benefit Research Institute (ECRI) has identified that the number of employers with less than 100 employees who offer at least one self-insured plan increased from 14.2% in 2015 to 17.4% in 2016.

Association Health Plans are another option that was available in January 2019. The idea was for businesses to form associations and/or buying groups to buy healthcare from insurance companies who offer low priced plans with fewer essential benefits due to the size of the combined employee pool. However, some states follow the Department of Labor's ruling from 2018 and other states do not. Specifically, Pennsylvania and New Jersey have filed a lawsuit challenging the Labor Department's ruling for overriding the ACA's requirements. This places the Association Health Plans subject to political forces that can change with each election.

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COMMENTARY |

HOW SMALL BUSINESSES COPE WITH THE RISING COST OF HEALTH CARE – OPTIONS TO LOWERING THE COST

The above options for lowering health care costs are dependent on choices that the employer makes. What is interesting is that health care insurance plans have other options that may be available to self-insured employers, associations, HSAs and other benefits depending on how they implement their health care choices.

The choices of which we speak are directed to restricting networks of providers and comparing costs of care. Specifically, we are referring to:

- Centers of Excellence (COE)
- Best-in-Class providers (BIC)
- Comparative Pricing

If all providers are included in the prescriber, pharmacy or hospital networks, then the cost of care is higher due to the variability in cost and quality of care between respective providers. Geography, the demographics of the employee population, and employee choice are often drivers to keep networks broad. However, if networks are restricted by data and analyses indicating wide variance in care and cost, then options exist to provide high levels care at a more affordable cost to fewer providers. Health plans for a long time have identified Centers of Excellence for treating cancer, heart disease, surgical solutions, and other conditions to shift patients to these higher value providers. Plans have also compared individual providers within the same specialty, or subspecialty, to determine who provides the best outcomes. These Best-in-

encouraged to go to these providers for their specialty care. Group practices, patient care medical homes (PCMH) and others commonly use these options internally.

As the cost of medications, physician care, hospital fees, and service fees rise, the BIC and COE are becoming more attractive. The question is which providers can treat patients based on the total cost of care, and not just the cost of the medication; especially, when medication costs are astronomical. Further, the provider can be offered higher volumes of patients and negotiate more acceptable fees.

If self-insured employers, employees who chose how to pay for medical bills, and cooperatives like Association Health Plans employ make more restrictive choices, then the total cost of care is reduced. The bottom-line is that one option is probably not the cure for high medical costs. A portfolio of services is necessary using options from all sources in order to lower costs and improve care. As we tell our interns, the problem for health care providers and insurers is to provide the maximum effectiveness of care, at a minimum acceptable risk, and at an affordable cost. The difficulty is that all these elements must be managed at the same time! This is a solvable mathematical problem, but a very difficult social and medical problem.

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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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