A Dose of Reality

This article represents "commentary" and represents views of the authors. We welcome other opinions on the subject

Utilization review. Precertification. Medical case management. It seems as if health plans have been, for lack of a better word, micromanaging how medical care is sought and obtained by plan participants, for decades upon decades. It makes sense. Whether I'm a fully insured carrier or a self-insured plan sponsor, I know that a complicated pregnancy, chronic illness, cancer diagnosis, or any other number of conditions will seriously hurt – if not sink – my plan. So, it makes sense. It makes sense that I ask patients, providers and everyone else to check in. Give me a heads up. Let me know what's going on and put an independent team in place to identify the most effective, yet cost-conscious course of care. Everyone wins.

Meanwhile, we rail against hospitals whose charges multiply exponentially every year. World renowned periodicals take the "time" to publish magazines dedicated entirely to the "bitter" truth... that costs are out of control. In response, savvy self-insured benefit plans begin questioning everything about their medical program. They question their preferred provider organization (PPO) model; ("Does the discount matter, when it's applied to an arbitrary and excessive

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amount?" "Is it worth the peace of mind [and prohibition on balance billing] to stick with a network model, when I'm being contractually bound to pay more than [some interpret] my plan document allows?" "Should I consider putting my participants in the 'balance billing cross-hairs,' dump the network and just pay – out of network – rates I think are fair, based on external parameters [such as Medicare rates]?")

Yes indeed – from how, where and what care is obtained, to re-pricing and cost containment warfare – medical care (and costs) dominate the conversation these days.

Yet, as I examine plan spending, one thing becomes clear. The attention we pay to medical care, PPOs and hospital pricing, grabs almost all of the air-time, allowing what many would deem to be an outdated pharmaceutical "drug" acquisition process to plod along, unfettered and unchecked. As specialty drugs, implants and other devices – like the aforementioned medical care – usher in an age of skyrocketing costs, not enough attention is being paid to this area in dire need of improvement.

Industry experts have uniformly agreed that pharmacy costs are rising; increasing nearly ten percent (10%) each year, with a fairly certain projected "cost-trend-rate-increase" in 2016, already matching that prediction of 10% growth over the year prior. A 10% multiplier, applied year after year, may not scare you – until you learn that these drug costs already make up 25% of all healthcare expenses. Indeed, a recent study revealed that large employers spent – on average – almost a thousand dollars per covered life, on pharmacy costs in 2014.[1]

More than one industry ally has advised me that, driving significant portions of this trend are the oft mentioned "Specialty Drugs," "Compounds" and "Brand-Name Drug Price Inflation." Specialty and Compound drugs in particular, another expert tells me, accounts for between 25% and 35% of total drug spending. Further, the costs associated with specialty drugs is increasing at nearly double the 10% rate attributed to other drugs; meaning a 20% jump per year. Even more startling, more than 50% of drugs in the later stages of FDA approval are specialty drugs. When these meds hit the shelves, you can anticipate that the aforementioned trends will actually fall short of the reality. It's not all about new drugs, however; another industry expert shared data with me, evidencing the fact that prices of some existing medication have increased substantially, with some increases exceeding 47%. All of this adds up to a total pharmacy spend projected to double by 2020. *Ouch.*

So... I'll ask again. What are plan administrators doing about this? Need I remind you that, as fiduciaries of the plan, administrators have a duty to prudently manage plan assets; a fiduciary duty to protect the plan and its members from abuses, waste and fraud? One might argue that a fiduciary who fails to address this obvious problem of drug costs is drifting awfully close to breaching their duty; or – at least – making themselves a target for such accusations.

As we look at these apparently out-of-control costs, one must therefore assume that we're up in arms, scrambling to identify and implement solutions; right? Wrong! The same report referenced above also reports that eighty percent (80%) of employers agree or somewhat agree that their Pharmacy Benefit Manager (PBM) is sufficiently managing drug costs. I'm sure – if asked about medical expenses in general – the same respondents would be full of complaints. Yet, when we focus on drug costs which – as described above – are one of the (if not the) fastest growing drivers of plan expense, 80%+ of plan sponsors are satisfied. Someone isn't getting the memo!

PBMs are not necessarily the problem. The issue is that we – as an industry – don't recognize their role, limits and mission. People assume PBMs exist to contain drug costs. This is simply not the case (with a few exceptions).

Over the span of a couple decades, the role of PBMs has changed. Gone are the days where PBMs simply handled prescription billing. Today, plan sponsors contract with PBMs directly or through their third party claims administrator, to decide what drugs are covered, what the costs shall be and, as it relates to payment to pharmacies, the where, when and how much. Further, plans rely upon their PBM to set the participant cost-share and establish pharmacy networks. PBMs therefore serve many important roles; none of which are – first and foremost – dedicated to identifying cost containment opportunities.

Understanding the role of a traditional PBM, what they do to create revenue for themselves and recognizing the pros and cons of said arrangement, is the key to devising independent cost controls. Some plan sponsors think that they simply pay the PBM for the cost of any drugs actually dispensed and usually an administrative fee for managing the prescription drug program. Little do they know, but many other costs – and conflicts – impact the bottom line when it comes to prescription drug purchasing and distribution, above and beyond the problem of rising drug costs.

As we examine such arrangements

and relationships, we begin to notice that there are many different stakeholders involved and their interests often conflict. Whenever a plan administrator "turns over the reins" to a third party, so that spending is determined in large part by a stakeholder unrelated to the plan sponsor, we must ask what drives that stakeholder. What action (or lack of action) most benefits that entity? For this (and other) reason(s), most plan sponsors today prefer to maintain control of their plan and its spending.

The pharmacy supply chain, however, is especially complex; so that plan sponsors are at a disadvantage when attempting to manage it on their own. As such, PBMs are in a unique position to leverage their knowledge; providing many valuable services to these plans. Yet, with a lack of transparency, control over plan assets and incentives not aligned with containing plan costs, these organizations may not be driven to make reducing spending their top priority.

The costs of the drugs purchased are – as already referenced – exploding. Plans, however, are not only contending with the rising cost of the drugs themselves. They must also worry about lost refunds, PBMs pocketing spreads (the difference between what the plan pays and the pharmacy receives) and other revenue bolstering tactics, such as up-charging and therapeutic shifting.

PBMs are contractually tasked to complete a particular set of jobs. Rarely does that include reducing costs for the plan, no matter what. PBMs enter into contractual arrangements with other entities, to achieve their duties, even when those other entities may not share the same goals as the plan. For instance, PBMs may enter into contracts with retailers, where – in exchange for steerage – said retailers provide discounts to PBMs. Is that retailer the best option for the plan? Who knows?!?! Can we confidently say that said steerage is being driven with plan cost savings as the chief impetus? Not with any confidence; no.

A significant source of revenue for PBMs comes from drug manufacturers in the form of rebates. Brand-name drug manufacturers have the ability to financially incentivize PBMs to stimulate demand for their drugs; using discounts and rebates as a form

of compensation to PBMs. Meanwhile, few people know that there are at least two types of rebates: performance and access. Generally speaking, PBMs are only obligated to share performance rebates with the plan, meaning that drug purchasing, usage and other plan spending may not be producing the most cost-effective path for the plan, despite putting the greatest number of rebate dollars into the pocket of the PBM.

These and other contractual relationships may represent a conflict of interest for the PBM, because the PBM stands to gain additional revenue from parties with interests competing with those of the plan.

One last concern I have, whereby the status quo runs headfirst into (and against) efforts to contain the rising drug costs, relates to PBMs that own their own specialty pharmacy – and more importantly – handle the prior authorizations. Indeed, these particular organizations authorize themselves to buy drugs from their own pharmacy. Huh? Could you imagine if a hospital were in charge of pre-certifying procedures they will be performing?

Yet, most agree that PBMs still offer valuable services. If that is the case and we all agree that the cost of prescription drugs is skyrocketing, plans are obligated to: (1) implement programs either themselves, with third parties, or with their PBMs to make cost containment priority #1 and (2) recognize the limits and needs PBMs deal with – noting that if the plan wants to use a PBM, they may need to be flexible in their demands and expectations.

So, with these potential issues in mind, we next need to consider some actions we can take to avoid such conflicts, while still benefitting from many of the valuable services PBMs provide. If PBMs cannot be relied upon (and, in many instances, ought not to be relied upon) to reduce costs to the plan and manage drug utilization, the duty falls upon the plan fiduciary to do it themselves, or find someone who can do it for them.

First and foremost, the PBM (or someone else, providing oversight) should constantly evaluate medical necessity as it relates to the drugs being purchased. In other words, eliminate the "set it and forget it" attitude that tends to apply to medication purchasing. This is especially true with some of the most common conditions we see today. An industry expert and friend explained to me the outrageous waste he sees related to back injuries and conditions. According to him, 67% of all back surgeries are not medically necessary and too often the TPA just approves them. Worst of all? Most of them don't solve the problem!

Another ally in the battle against rising drug costs assured me that, to deal with this problem and ones like it, a savvy benefit plan must implement a program that involves evidence-based clinical care management – meaning they perform detailed analysis and identification of opportunities based on historical data, perform clinical review for appropriateness and cost effectiveness and continuously monitor diagnoses, treatment options and new therapy options, to ensure that the option that was best for both the patient and plan yesterday, is still the most impactful for the client as well as most likely to produce the best clinical outcomes today.

An exasperated professional said it best when he remarked that people are not even remotely up to speed on the cost of new drugs and therapies. There is, he said, a new therapy on its way that will cost benefit plans more than $1 million per year; (insert Dr. Evil laughter here). One of the hottest topics in our industry today is "price transparency for hospitals." How about transparency here? If a benefit plan's current arrangement would allow them to get slapped with a $1 million claim for the purchase of a drug or medical supply and they didn't have measures in place to provide early warning, stop payment pre-purchase and analyze the situation to identify any and all alternatives, they deserve what they get! With price inflation on current medication and a storm of high cost drugs brewing on the horizon, pipeline monitoring that allows for real-time actionable recommendations is a must.

Whether these measures are implemented by PBMs seeking to self-police themselves and counterbalance incentives to ignore cost containment, or, are provided by third party cost containment partners, the time to take drug costs seriously hasn't come... it's already been here for years. Act now or no amount of sugar will help this medicine go down. ■

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References

[1] *"The Prescription Drug Supply Chain 'Black Box' - How it Works and Why You Should Care For the American Health Policy Institute," By Henry C. Eickelberg - Managing Director - The Terry Group; 2015 American Health Policy Institute*