INNOVATIVE BENEFIT SOLUTIONS, INC.

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OUR SUMMER HOURS:

8:00 a.m. to 4:00 p.m.

Closed For July 4th Holiday

The End of Generic Drugs?

The generic drug industry, which supplies most of the drugs prescribed in the United States, is in crisis due to plummeting prices. The drug giants are refusing to develop certain drugs because there is no profit in it.

Teva Pharmaceutical Industries, one of the largest manufacturers of generic drugs in the world and number one supplier of generics in the United States, plans on laying off 14,000 workers as part of a global restructuring of its workforce, while closing about half its eighty manufacturing plants.

Many health care products including brand-name drugs routinely command big price hikes. Despite public perception that all medical costs are spiraling upward, this is not the case for generics. A deflation tracker developed by Evercore ISI Research shows generic drug prices are falling about 11% per year compared to brand-name drugs which are rising about 8% per year.

Approximately five years ago, middlemen in the drug delivery supply chain started to form buying consortia to gain more leverage over drug makers. The consolidation has become so extreme that just four groups now control 90% of drug buying in the U.S. and two of those four are joining forces to purchase generics, which likely will lower prices more.

This is leading some manufacturers to stop making some critically low-margin drugs. Endo International, makers of the popular blood pressure medication Lisinopril, decided to stop manufacturing it because the drug was no longer making enough money. Endo has stopped making 85 of its products and turning down requests to manufacture new generics due to similar price concerns. These would be generics sold through retail giants such as CVS Health, Target, Walgreens, and Walmart. Endo has cut its workforce in half to about 3,000 over the last eighteen months, as well as closing manufacturing facilities in Alabama, and North Carolina.

As you have read my opinions in the past there seems to be a theme that you should recognize by now; the makers of generics should look at using Amazon.com, FedEx, or United Parcel Service to get drugs directly to consumers.

Randall B. Marking
President

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Healthy Living

CVS TO LOWER Rx Costs?

CVS Health wants to make it easier for its pharmacists to find less costly drugs for its patients. The drugstore chain is introducing a system that will check for less costly alternatives, higher quantities at lower costs, and discounts. CVS hopes it can lower costs for its CVS Caremark customers and in doing so, make sure they pick up their prescriptions.

With drug costs rising and patients paying more out-of-pocket costs, consumers are frustrated by the difficulty of comparing the costs of drugs. The more expensive the drug, the less likely patients are to pick up their prescriptions. Most doctors and pharmacists are flying blind when it comes to price and value options on 15% of our medical dollar spend! Are you surprised?

Pharmacists are typically only able to see if drugs are covered and what the out-of-pocket cost would be. With the new system, they will be able to compare prices and see less expensive, effective alternatives in generic drugs or therapy. If they find a different option, pharmacists can call patients to ask if they would like to switch. If so, the patient can call their doctor to discuss writing a new script.

During the pilot program, CVS found that when given the opportunity, 95% of patients asked to switch and 85% of doctors make the switch.

How about that?

Creating a Comprehensive Financial Analytics Solution

Health care organizations are breaking down the old incompatible way of handling information and adopting agile visualization tools. A big change in the health care industry has complicated how providers measure and use financial analytics. As health care organizations start to move away from the traditional fee-for-service model, they are no longer able to rely on volume and payer mix to understand what drives their financial performance.

Accessing your data is the most important structure for health plan management and it all starts with your management team making analytics and data a strategic priority for your organization. While financial analytics once existed only in the finance department, there should be recognition that it needs more support from other areas of your organization. A cross-functional team includes members from finance, human resources, union representation, and employee representatives to bring much needed insight to your organization. Ultimately, having this team in place will make it easier to affect change across your business.

Opioids in the Workplace

By now you know the United States has an opioid crisis that is growing direr every day. New synthetic opioid drugs are more potent than prescription pills or heroin and more people are dying of overdoses.

Most employers are alert to the problem, but too many are still unprepared for it. Roughly 80% of employers do not have a drug-free workplace policy in place. All employers should have a drug policy where the drug tests check for major opioids, including synthetic ones, such as fentanyl and carfentanil. Traditional test panels do not cover many drugs, including heroin.

A strong drug-free policy should include the right to search workspaces for drugs, explicitly forbidding employees to show up high, banning possession, use, or distribution of drugs on the job, and perhaps setting up drug treatment plans for workers who test positive for opioids.

Train supervisors to spot signs of addiction and educate workers on the dangers of drug use. Encourage the addicted worker to seek help while directing them to where they can get the help they need.

In addition, work with your health insurer to curb opioid prescriptions and require plan members to try non-opioid medication before an opioid can be prescribed. Cover other non-drug approaches to relieving pain such as physical therapy and chiropractic treatment. Require those employees who do get opioids to fill prescriptions at one pharmacy so they cannot shop around for extra pills.

A Carve-Out for Specialty Drugs

If you are a self-insured health plan sponsor you have probably noticed that specialty drugs are an ever-increasing portion of your health care spending. If this is your organization, here is something you may want to consider.

Demand that specialty medications be paid through your pharmacy program rather than the medical benefit. In this way, your organization will be able to take advantage of deeper discounts through your Pharmacy Benefits Manager (PBM).

You can also connect employees with the PBM’s specialty pharmacy team. This team will provide assistance and information to the patients who are on specialty medications to improve adherence. The pharmacy team typically helps align the site of care to ensure that medications are being dispensed in a cost-effective setting.

For example: Hospital dispensed medications will cost three to four times more than in a providers office or at a patient’s home. It is all about cost and a better patient experience.

Obamacare Update

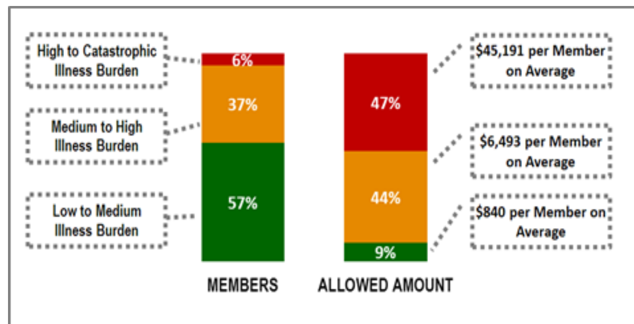
In April of this year, a new rule gives states more control to offer cheaper plans on Obamacare's Exchanges next year and ease the requirements on the health benefits that plans must cover as well as quality control. The rule could lead to less generous plans and less health care access.

Benefits won't have to be standard now, which will make shopping more difficult for individuals. The plans will be more complex and consumers will get less help when using the marketplace since states can cut back on staff that would aid shoppers in sorting through plan options. Insurers can spend less on medical care and fewer premium hikes will be reviewed. Starting in 2020, essential benefits can be redefined. For example, insurers could start capping how many days of rehab they offer or curb the drugs that they cover.

Under a plan by Gov. Scott Walker, Wisconsin will pay less than expected and reduce consumer costs within its Obamacare insurance markets by 5% next year. According to a private analysis done on behalf of the state Office of the Commissioner of Insurance, if Walker's proposal is approved by President Trump's administration, it would lower monthly premiums to a projected $721 per consumer per month next year, which is a little more than 5% less than the $762 per month being charged this year. State taxpayers would contribute $34 million, down from an expected $50 million under the proposal submitted by the Walker administration.

Health Plan Cost by Member Illness Burden

A relatively small percentage of health plan members drive a large percentage of health plan costs, however, this analysis of claims data from Mercer's database shows just how big the impact of high-cost claims really is. In the graph below, the first bar represents plan members and the second bar represents the plan cost.



Color coding matches the members to the cost they generated in a year. Just 6% of the members with high-to-catastrophic illness burden, generated nearly half the claims, which averaged over $45,000 per member. The next 37% of members with moderate-to-high illness burden generated 45% of claims, averaging about $6,500 per member. Meanwhile, the healthiest 57% generated claims averaging only $840 per member.

With these numbers in mind, think about whether your program strategy is reaching members all along the health spectrum. Understanding the impact of high-cost claims could keep you focused on your cost management strategy where it will have the greatest benefit. For the sickest plan members, intensive care coordination can improve patient experience and reduce the likelihood of a patient receiving duplicative or low-value services. Steering patients to centers of excellence can also result in higher quality and higher value care especially if bundled payments or other alternative provider reimbursement methods are in place. Expert medical opinion programs make it easier for employees to seek second opinions and advice about their treatment.

These are some of the steps employers can take right now to get closer to the goal of ensuring that the members with the greatest needs receive the right care, at the right time, and in the right setting. Ultimately, the best care is also the most cost-effective care.

Death by a Thousand Cuts?

Are American hospitals in trouble?

Are hospital executives inclined to shrug at the news of Apple setting up its own health clinics for employees? After all, the 84,000 people working for Apple in the U.S. are a collective drop in the bucket for a health care system with some 300 million patients.

It is true that Apple, J.P. Morgan Chase, and Berkshire Hathaway alone are not going to break the system, but it could be the rockslide debris setting off an avalanche to change the health care landscape. Will hospitals be determined to disrupt their own business model before outside innovators beat them to it?

Today's reality is that things are changing faster and the organizations that cannot keep up get left behind. It is a lesson that has been learned constantly in the private sector at an accelerating pace, whether with Blockbuster, Compaq, Kodak, or Sears.

It seems to me that hospitals need to look beyond how to save money and stay stable. They need to become agile and agility looks like the deceptively big predator circling them.

Amazon looks to be a giant company that tries to do everything, but in reality, online retail is the one thing it focuses very narrowly on and does it very well. It outsources almost everything else, not just to save money, but also to get the very best of what they need immediately. They are agile.

Are hospital executives asking how their medical staff can best care for patients? Are they forming partnerships that make that possible? Outside partners can help them to provide better cost effective care at a faster pace, which makes the patient experience and patient outcomes better. They are not there yet.

If there is one certainty about the Darwinian future of health care, it is that those able to harness the possibilities of focus and technology will eventually prevail. If hospitals don't figure it out quickly, Apple, Amazon, and Wal-Mart will.

Regardless of how this plays out, the results will be good for employers and their employees participating in employer sponsored health plans.

From the President

Miracles are Becoming More Expensive

One of the great things about living in America is that we invest in the development of new health care services and procedures. Often this investment translates into high cost claims.

In December of 2013, the FDA approved SOVALDI® *(Sofosbuvir) for the treatment of chronic Hepatitis-C, costing $1,000 a day per pill for an 8-12 week treatment that had total claims upwards of $80,000-$100,000 per treatment. A less expensive drug,* MAVYRET™ *(Glecaprevir and Pibrentasvir), was introduced in 2017. Depending upon the length of treatment it is still not exactly a bargain with prices ranging from $26,400-$52,000.*

We are on course to see new sources of high-cost claims coming down the track, for example:

- ***Artificial Pancreas Closed-Loop System:*** *monitors blood sugar levels and automatically dispenses insulin so a patient no longer has to manage their diabetes on a daily basis.*
- ***Gene Therapy:*** *There are 500 diseases that could be treated with gene therapy. For inherited blindness, gene therapy is a 45-minute procedure with an injection in the eye that has a cost of $400,000 to $500,000 per eye. Today, sixty million people in the world could be treated with gene therapy.*

There are many more examples of emerging therapies and technologies that have long lasting or lifetime value for a patient. It makes sense for society to have these treatments covered, but how will the employer plans handle the upfront costs? It would be shortsighted not to promote therapies in our benefit coverages that have lifetimes associated with them because an individual will likely not stay with the same employer for his/her working life.

For now, self-insured employers can undertake a deeper review of high-cost claims expense and consider new levels of stop-loss coverage especially as we expect the market to offer new stop-loss products in response to these trends.

The Prescription for Lower Drug Cost

Give President Trump credit. He realizes the U.S. is in a ridiculous place when it comes to drug pricing. We are paying way too much. The private market has proven incapable of dealing with these costs and our government has been unwilling to deal with it. All the while other industrialized countries have nowhere near the problem.

If we are looking for market-based solutions to the high cost of prescription drugs, we need to look no further than government run health care systems in France, Canada, Germany, Italy, Spain, and the United Kingdom who are out-marketeering the United States.

What these countries have in common is that they use a system called reference based pricing. While there are differences among them, they generally use the market to set a reference price for each prescription drug that also takes clinical results into consideration. It could be the lowest price from a range of alternative drugs in a class (Italy) an average of all of the drugs in a class (Germany), or an average of a group of the lowest priced players (Spain). The health care system then pays no more than the reference price for the drug in the class no matter which pharmaceutical company the consumer and their physician decide to use.

If a patient and their doctor want to pay more for an alternative drug because they think it will do a better job for a particular disease, they know all the prices and the comparative clinical outcomes upfront. If a drug company is truly able to innovate for an existing class of drug, that drug could be placed in a new class and innovation is still rewarded.

The value of referenced-based pricing is limited until there is more than one competitor in a class. Drug companies are still rewarded for blockbuster breakthroughs, but when a new player comes into the market in the same class, they compete based on both price and clinical outcomes.

How much more American could that be? Why does this have to be so hard?

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We are a privately owned insurance benefits firm specializing in the development, delivery, and implementation of employee benefits. Our primary focus is tailoring health care solutions for active and retiree populations. These solutions include our proprietary programs wrapped within a complete package of employee benefits and administration. We are a one-stop shop.

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