The Collective

The Oklahoma Business Collective on Health

At the intersection of business and health

February, 2024 Newsletter

Employers - Do You Really Understand Alternative Funding Programs?

Alternative Funding Programs (AFPs) are a hot, and often contested topic. Sometimes called a 'diversion plan, or a carve-out', they are run by 3rd-party vendors who push health plans to exclude specialty drugs with the promise of reducing pharmacy costs. The health plan deems the specialty drugs (some/all) as providing 'non-essential health benefits' and drops them from their formulary coverage then informs employees they must either enroll in an AFP or be 100% responsible for the cost of their medication(s). Affected employees instantly become uninsured for certain drugs in their employers plan.

During enrollment in an AFP, the employee is asked for their personal information, (including household size and annual income), to determine if they're eligible for any of the drug manufacturer's copay assistance programs, charitable assistance programs or international importation programs. The manufacturer then considers the uninsured employee for acceptance. (The ATF relies on the manufacturer to support the employee with one of their programs).

If an employee is accepted into a program, the manufacturer will cover the price of the drug(s). The plan sponsors incur no direct costs for these specialty drugs, and might capture the difference between a discounted drug cost and the fee the employer plan pays the 3rd party vendor. This 'cost avoidance fee' can be up to 30% of the value of the charitable funds provided to the employee (which is likely the full cost of the drug). If the manufacturer denies coverage, 3rd party vendors may seek drug sourcing outside the U.S. which could encroach on FDA regulations.

Justified because drug prices are too high? Or, another middleman strategy to extract plan dollars?

What are the unintended consequences for the employee?

Note: This is a generalization of how AFPs work. Individual plans may vary. (AFP's may also be referred to as Specialty Carve-outs or Patient Assistance Programs).

Source: Alliance for Patient Access

Find Out More

News You Can Use

Why Should Self-insured Health Plans Care About Value-based Payment Arrangements?

What is value-based care? A simple explanation: Quality over Quantity. The goal is to align

incentives to improve quality, i.e. achieve better health outcomes, and reduce costs.

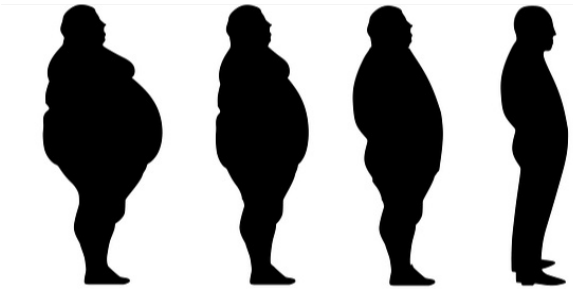
The structure of a value-based payment model can impact costs - either up or down. The four most common care arrangements differ in how they determine provider payments and the level of risk that is assumed. The models are: performance-based programs, bundled payments, capitation models and shared savings programs. Various factors can affect and influence costs within these payment models, such as provider networks. The best scenario for healthcare is that these value-based care models are part of a larger value strategy.

As healthcare organizations warm up to the idea of value-based care, CMS and commercial payers must choose which kind of arrangement they will offer to their provider partners. Understanding the difference in payment models will be important to future health plan discussions.

Source: HealthPayer Intelligence

Find Out More

Medical Minute



ARE COMPOUNDED WEIGHT LOSS DRUGS SAFE?

A new year - new resolutions to improve health. For many, goals are centered around reducing body weight. With the emergence of GLP1-based drug therapies like Wegovy (semaglutide) and Zepbound (tirzepatide), there's renewed optimism for success. There is also frustration due to the lack of access to these drugs, whether it's manufacturing shortages, the absence of insurance coverage or the out-of-pocket expense. Facing these barriers might just entice some folks to look for any available alternative - maybe through a medical spa or weight loss clinic who aggressively advertises the availability of these drug solutions at a fraction of the price.

Unfortunately, many of the available alternatives offered through these sources are compounded versions of semaglutide and tirzepatide. They are not what they are advertised to be. They are not the same as the drug provided by the manufacturer.

The FDA stated very clearly that, “Patients should be aware that some products sold as ‘semaglutide’ may not contain the same active ingredient as FDA-approved semaglutide products and may instead be the salt formulations.” Why does this matter? Simply put, the salt formulations have not been shown to be safe and effective and are not FDA-approved. Buyers may also get something they are not aware of and don't want - other active ingredients (which have been found in some compounded versions). If there is a health concern arising from the use of an alternative compound, pinpointing the cause could be difficult. There have also been reports that these counterfeits may pose serious health risks due to impurities or other non-pharmaceutical additives which can make their way into these products - there is no regulatory oversight. Recent lawsuits brought by manufacturers may stem the availability of compounded versions going forward, but In the meantime, caveat emptor - let the buyer beware...

Obesity Medicine Association Statement

Faux-zempic

What is Compounding?

Advocacy

"Ensuring Transparency in Prior Authorization Act." HB 3190

Prior authorization, or pre-certification, was designed decades ago as a health plan cost-control to prevent doctors from ordering expensive procedures or tests that are not indicated or needed. The objective - delivering cost-effective care.

Originally focused on the most expensive types of care, like cancer treatment, insurers now commonly require prior authorizations for many routine medical encounters, including basic imaging and prescription refills.

In December, the federal government proposed several changes that would force health plans to speed up prior authorization decisions and provide more information about the reasons for denials. Starting in 2026, these changes would require plans to respond to a standard prior authorization request within seven days instead of the current 14, and within 72 hours for urgent requests. The proposed rule is scheduled to be open for public comment through March 13.

Meanwhile, some states have passed, or introduced legislation into their own laws governing the prior authorization process. Oklahoma is currently reviewing proposed legislation, HB 3190. Introduced and read on 2/5/24, it was passed to Insurance on 2/6/24. Contact your legislator to learn more. *(KFF Health News 2/16/24)*

Note: PCMA vs Mulready is still being watched as it could set precedent for state laws preempting ERISA.

HB 3190

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