Employer Forum on Pharmacy Benefits & Specialty Drugs:
Oncology & Genomic Medicine

June 12, 2019

Meeting Summary

As more gene therapies come to market at a very high-ticket price, employers must weigh many factors when they consider what therapies should be included in their plan. Employers and other stakeholders gathered on June 12 to hear from industry experts and practitioners about:

- Perspectives on the challenges employers face in managing oncology and genomic medicine therapies
- Ways employers are disrupting medical and pharmacy benefits
- Impacts of health plan and PBM merger and acquisition activities on employers
- Politics and policies on the nation's cancer care delivery system
- How oncology care impacts health care waste and how integration and collaboration can improve outcomes
- New marketplace solutions and strategies that provide value and manage costs
- Access to no-cost resources to support plan sponsors

Welcome & Overview

Cheryl Larson, President & CEO, Midwest Business Group on Health

American Patients First (HHS Blueprint on Drugs)

Four major challenges we face:

1. High list prices and rising out-of-pocket costs – employers are paying that bill
2. Seniors/government programs overpaying for drugs due to lack of latest negotiation tools (employers are the real payers; we should have a voice about what is happening, and we need to get rid of the waste)
3. High/rising out-of-pocket costs for consumers (consistently see this with plan design)
4. Foreign governments free riding off American investments in innovation

- We can control some of these things, not others; MBGH National Employer Initiative on Specialty Drugs focuses on the things we can control

What Employers have told us:

- Want to pay for innovation from suppliers and manufacturers; much of current model is not working
- Need transparency about real cost, want suppliers to remove waste

- Need to stop spending money on low-value drugs to preserve resources that will pay for high-value drugs
- Want drugs on formulary to be based on clinical efficacy and safety, not rebates
- Suppliers need to tell us what they are paying each other and how they spend our money
- PBMs hide revenue streams (you are paying 10% - 40% more in your PBM contracts than you should be)
- There is a lack of PBM willingness to change and employers need disruption and transformation
- Easiest way to change this is through pharmacy benefits (low hanging fruit)
- Don't sign contract until you know where every penny is going
- Employers are not allied, have no common agenda to drive change
- Need to stand up and ask vendors for accountability; drive innovation or it will be driven for us

Employer Panel: How Will Pharmacy Benefits Legislation & Health Plan/PBM Merger & Acquisition Activities Impact Purchasers?

Moderator: Jason Parrott, Senior Manager Global Healthcare & Well Being Strategy, The Boeing Co.

- Jason Duhon, Healthcare Design Manager, Caterpillar, Inc.
- Kim Dwyer, Vice President, Inspera Health
- Sandra Morris, Principal, About Quality Benefits Design

- In January, the HHS proposed making rebates on prescription drugs paid by manufacturers to PBMs subject to the anti-kickback statute for Medicare part D and Medicare MCO plan sponsors; whatever legislation happens with these Medicare plans could move to commercial plan sponsors
- Proposed legislation states that it will lower prescription drug prices and out-of-pocket costs by encouraging manufacturers to pass discounts directly to patients by creating safe harbor for these discounts (also fixed-fee service arrangements between drug manufacturers and PBMs)
- Terms and conditions of rebate agreements between manufacturer and PBM are usually unavailable to employer plan sponsors
- This lack of information creates compliance risks for plans who must account accurately for rebates
- Lack of transparency creates potential program integrity vulnerability because compliance with program rules may be more difficult to verify

Question to panelists: How are rebates used by employer plan sponsors today?

- Most employers tend to take plan expenses for the year and plan recoveries (rebates, subsidies, etc.), subtract the difference, result is the premium
- The fear is if rebate streams are lost, leaves less money to go around
- Rebates are coming directly from utilization of plan assets and should be reinvested in the plan or in the actual prescription drug plan itself
- We still leverage rebates and use them to lower health plan premium contributions under our plan today

Question to panelists: Are we addicted to rebates? How can we turn this into a positive?

- Not addicted, but has a huge financial impact; is a factor in formulary management
- Sometimes to get best cost for a valuable drug, need to bring in something with a lower value; ties into our strategy
- If rebates go away, finance people will want to know how you will make up that income, what changes you will make to the plan to cover losses
- Have raised awareness but finance/accounting view this as revenue; unraveling this will be challenge as benefits buyers

Question to panelists: What timeline would an employer need to evolve passing rebates to plan participants? Make more palatable to employer plan sponsors?

- To make more palatable for us, after patient hits out-of-pocket limit, as payer we should retain that rebate
- If rebate goes directly to patient at point of sale, there won't be transparency, won't be able to track; HIPPA plays into it

Question to panelists: Do these vertical integrations create an environment for less transparency and disclosure in the health care arena, especially as relates to drug information (drugs dispensed through medical)?

- Designs that are value-based could operate better there, may be shared savings models (medical/pharmacy benefits are aligned, better management of whole patient)
- Solution is a value-based design where have some shared risks and some shared savings
- We'll lose our leverage on contracting – will be one big contract versus a PBM contract and a carrier contract
- These integrations create a market opportunity for small and mid-tier players who claim to be flexible and willing to work with employers

Question to panelists: Can you comment on your experience with eliminating payment for high cost/low value drugs?

- Employers have a fiduciary responsibility and a right to demand flexibility on terms and conditions that you want/need across your supply chain
- It's an ongoing journey to manage formulary in an appropriate way so members can still have access to adequate products in any category, while getting rid of the garbage
- When you do your next PBM RFP, you can leverage information from other employers to get best terms possible

Keynote: Understanding the Nation's Cancer Care Delivery System – Policy, Politics & Employers

Ted Okon, Executive Director, Community Oncology Alliance (COA)

- Cancer is big business; stakeholders include insurers/PBMs, hospitals, oncologists, diagnostic companies, IT companies; consolidation is a trend in cancer
- More people are being diagnosed, living longer with cancer
- Cancer drug prices are increasing and unsustainable, but are only 20% of the mix
- Cancer immunotherapy is the big deal now (pipelines); it's increasingly replacing chemotherapy as standard in cancer care
- Orals represent more than 60% of prescriptions in 2015 and this is increasing; there are more orals than chemotherapy injectable drugs right now
- It's not just about the drugs – site of care matters; prices soar as hospitals dominate
- About one-third of all outpatient volume for certain types of cancer treatments is now at 340B hospitals; 340B discounts are increasing in both scope and magnitude
- As long as a patient is in a hospital system, they will take a 340B discount; pharmacy gets some, hospital gets some; PBMs are included in this
- Old school tactics not working – prior auth, formularies, step therapies, copayment tiers; largely focused on drugs and interests are not aligned
- Need to think outside the box – the world is turning to value-based
- Contracting directly with providers/groups to align interests; directly with drug manufacturers, bypassing "active" middleman

Keynote: The Clinical Implementation of Precision Medicine

Precision/Personalized Medicine Today – Innovations in Cancer Genomics

Howard McLeod, PharmD, Medical Director, DeBartolo Family Personalized Medicine Institute, Moffitt Cancer Center; Chair of the Department of Individualized Cancer Management

- Definition: Emerging approach for disease treatment and prevention that takes into account individual variability in genes, environment and lifestyle for each person
- Trying to look at individuals because technology is there to sequence the human genome, do biomedical analysis, use large datasets (big data, leads to small data, leads to better decisions)
- It's an objective decision about a very important treatment for a very important disease - in cancer, getting it right has significant implications for the patient
- Around precision medicine, we're trying to determine what the patient needs in order to get the best value, disease control, cost and lower toxicity
- As you build a precision medicine strategy, think about ways of personalizing choices for your employees that would include DNA but also be ready to include the next thing proven to be useful; ready for a patient-information driven source
- Many therapies are starting to go across tumor types; the FDA is starting to approve drugs independent of origin of the cancer (considering the biology that is driving it)
- Trying to look at and balance the "neighborhood" as opposed to the individual tumor
- Costs appear to be lower in precision medicine because more purposeful and closer management

Stakeholder Panel: Genomic Medicine in the Real World

Moderator: Randy Vogenberg, PhD, Institute for Integrated Healthcare (IIH)

- Sheila M. Arquette, RPH, Executive Director, National Association of Specialty Pharmacy
- Howard McLeod, PharmD, Medical Director, DeBartolo Family Personalized Medicine Institute, Moffitt Cancer Center; Chair of the Department of Individualized Cancer Management
- Ted Okon, Executive Director, Community Oncology Alliance (COA)

- You will be hit by this in areas way beyond cancer – pregnancy, pediatric through geriatric care; plan and approach across your book of business not just for cancer (overwhelming now but way less than will be next year)
- Employers are in the driver's seat and need to negotiate with those administering benefits; need less rigid contract so can implement some of these new therapies

Question to panelists: Who should be involved in decisions around coverage with precision medicine and who is able to use the information?

- Need to function better as a team, change the way we think to get to best possible decision and effect total cost of care (versus unit cost of a drug)
- Employers should realize that science and technology can put employee or family member in a much better position in terms of outcomes, reduce cost – have to rely

on providers who understand that; can talk to employees about it, and then will have to take difficult step to weave into the benefit design (and who that arbiter is)
- We can do more in terms of personalized medicine, but on the insurer/arbiter front, easiest thing to do is no

Question to panelists: Who in charge and who can support employers in the future?
- Right now, the person who is least prepared is in charge – the patient; they need the tools to help them make decisions
- Employers need to ask questions, think about terms and conditions they're looking for, get educated about what they should be doing; it's your responsibility to make sure employees understand
- Seeing some mid-sized employers banding together around oncology navigators; helps with information, education and makes sure things of value are being done that fit in with the values of the employer

Employer Challenges & Marketplace Solutions: Where Do We Go from Here?

Denise Giambalvo, Vice President, Midwest Business Group on Health
Randy Vogenberg, PhD, Institute for Integrated Healthcare (IIH)

- Overall drug spend/trend will continue in low single digits, but specialty drug spend is growing in double digit pace
- Many self-funded plan sponsors regard drug benefits management as specialty drug management; those who are not doing this are getting further behind
- Study done by Rutgers H.O.P.E. Center for EPIC-HQF found that employers, in general, are not formally engaging in health care value assessment; with costs going the way they are, value is an issue employers will need to look at
- Existing measures e.g. productivity instruments, do not fit the real world/digital world employers live in
- About a third of cancer diagnostics/diagnoses being done today may be incorrect at the start; need to get it right the first time, reduce unnecessary treatment and testing
- How do we start looking at what is being provided and where the value is in what we are doing (not just cancer care)
- Not just managing pharmacy benefit, need to manage entire treatment with an integrated holistic strategy
- Think about diagnostic and treatment goals – make sure have the right genomic testing so you're doing the right therapy from the start; include demographics, population health is part of this

- National Cancer Institute estimated that in 2018, 1.7 million people would be diagnosed with cancer (this is big business)

- With more people surviving from cancer, not going away any time soon – it becomes a chronic disease
- Once patient is diagnosed, they're delivered a treatment path with many options; patient is overwhelmed, scared; they don't know where to go
- Northeast Business Group on Health recommend having a central person to support the individual, experienced in complex cancer care to help patient navigate the system
- National Alliance put forth a model that changes the paradigm – cancer-specific patient-centered medical home (PCMH)
- This comprehensive holistic approach delivers patient-centered care and improved access to clinical trials, shared decision making (including second opinion), tumor board, patient navigation and genetic counseling, plan for return to work, palliative care when needed
- Most important when improving upon cancer benefits you offer your population – put the patient in the center and consider their experience

Reactor Panel

Moderator: Kollet Koulianos, Senior Director Payer Relations, National Hemophilia Foundation

- Rachel Anhorn, PharmD, Director, Foundation Medicine Inc.
- Troy Ross, President & CEO, Mid-America Coalition on Health Care

Question to panelist: How does the profiling work?

- Comprehensive genomic profiling is for advanced cancer patients; this type of testing would be valuable for very few people
- Samples taken from tumor, sent to a central laboratory, DNA is analyzed, and a report is sent with findings
- If there is a biomarker or genomic alternation and there is a drug or clinical trial available, that information is sent back to the physician
- Patient does not receive this information, doctor does (patient can request it)
- Rights of Medication in cancer care = right test, right patient, right drug, right time

Question to panelists: Is this something employers would struggle paying for?

- Currently, there is a disparity of care – this type of testing is covered for Medicare and the VA; for commercial it is not consistent
- A good day for the purchasers of health care – the ability to take a high cost claimant and to help the individual, have opportunity to biopsy the cancer and know exactly what treatment to start with
- Fiduciary is: Once you know more, you must do more; have to do due diligence and document you've done this; have to think about the risk profile that might be created

Question to panelist: When we talk about the value of precision benefit design, do you think there is a disconnect with what that definition means if you're a provider, payer or patient?

- When we launch into any initiative, our executive committee has three strategic imperatives: 3-D thinking and data drives the decisions; seek expertise over experience; seek control over influence
- With that in mind, when looking at high cost oncology claimant, and you have genetic testing that will tell you how they will respond to available therapies – that checks all the boxes
- Value does have a different meaning to different stakeholders; at end of the day, decision-makers are humans, compassionate and will do the right thing and will pay for value, it's how we frame that value differently
- In oncology, if we help patients live longer, they will have an increased cost; want to prove to payers that this is worth it, people are worth it – and show how that value is applicable to each stakeholder

Employer Disruptors – Part I: How Employers are Shaking Up the Industry: Pharmacy Benefits

Moderator: Denise Giambalvo, Vice President, MBGH

- Chris Crawford, Chief Growth Officer, Health Strategy
- LG Hanzel, Principal & Vice President, Business Development, RxResults
- Thomas Traylor, GM Rx Solutions, Health Transformation Alliance

- PBMs provide a lot of services in the market – adjudicate claims, negotiate retail network, negotiate rebates, tell you what drugs to cover, etc.
- This is great if the value is there, but if you have the flexibility to shift responsibilities from PBMs to plan sponsors, you can achieve transparency, improve quality of care and reduce overall costs
- In the current model, the prescribing physician, who knows they have to get prior auth for a specialty drug, is contacting the PBM, who owns the specialty pharmacy; everything they approve generates revenue for the PBM and their specialty pharmacy
- Nothing illegal about this model – it's purely a conflict of interest; need to disrupt this model and take a different approach – find an opportunity to get an independent unbiased prior authorization with no financial relationship/interest
- A big frustration of employers in marketplace is who to trust
- Don't maximize rebates (chasing brand name drugs) – it isn't working; look at optimizing them and taking lower cost therapeutic alternatives
- Intent is not to deny claims, best way to control costs is the claim that never happens

- Combination of the contracts and the clinical component, which is based on evidence-based medicine, patient efficacy and safety of the drug

Question to panelists: Are specific disease states targeted or all specialty on medical side?

- We look at all of the specialty drugs that require a prior authorization (medical side and pharmacy side)
- We don't differentiate because we want to blend the medical and pharmacy benefits to focus on total cost of care – the reason we have the big data set
- We're marrying medical claims fee with pharmacy claims fee, looking at specific drugs and site of care; can see variations
- Look at site of service; make sure medical claims are appropriate (independent prior authorization); leverage all of it and go to the hospital and negotiate

Employer Disruptors – Part II: How Employers are Shaking Up the Industry: Health Benefits

Moderator: Cheryl Larson, President & CEO, MBGH

- Jason Duhon, Healthcare Design Manager, Caterpillar, Inc.
- Kim Dwyer, Vice President, Inspera Health
- Sandra Morris, Principal, About Quality Benefits Design
- Jason Parrott, Senior Manager Global Healthcare & Well Being Strategy, Boeing Co.

Haven is former Amazon, Berkshire Hathaway, JP Morgan strategy to revamp health care for their employees to do something about health care costs and lack of improvement

Question to panelists: How can we as employers learn from this model and implement similar strategies? What is already working in the marketplace, direction in the future?

- If all three can agree on plan design approach, how they contract and how they identify quality, they can look at total cost of care and outcomes by combining pharmacy piece; they will live the definition of value-based health plan
- Love what they are doing; employers need to get together in a room, innovate (not imitate), let data drive priorities
- They have to make sure they're building a system to help meet the needs of the patient; if they do that, will be successful – they understand consumerism
- There are a lot of progressive employers who are already testing things

Question to panelists: How do you think employers can learn from the HTA model and implement similar strategies?

- Would love to see more employers leverage objective independent consulting firms and dismantle the status quo that is ripe for disruption – across all stakeholders
- There's a lot of employer apathy out there, so most don't do anything – has to be overcome; the right leadership is being established to do that
- There's a lot of good work going on and if we don't do it, who will?
- HTA can bring best-in-class from other employers and build a solution; we can review and see if it's better or worse than what we're doing
- HTA brought a lot of big employers together – getting consensus is a challenge
- How do you get that many covered lives to come to consensus; HR weighs in on benefits so there are other things influencing how design benefits
- Wouldn't want any innovation or creativity to stopped or be stifled
- HTA trying to change health care delivery is wonderful; bigger is not always better

Question to panelists: Are any of you aware or currently doing anything disruptive or innovative you want to share with the group?

- It's relevant and important for employers to remember that members matter, flexibility and scalability matter
- Don't believe that any large employer can singlehandedly change the market
- If we can deliver a better member experience, better quality outcomes, and better affordability, then we have a compelling value proposition to bring forward
- First task in front of many employers is to attack contract terms and conditions with PBM contracts and create the flexibility you deserve (you are paying the bill)
- We cannot as employers continue to be apathetic and not take action; if not doing anything yourself, lend your support to those who are (members build membership)

Resources for Employers

From Midwest Business Group on Health (MBGH):

- Employer Toolkit on Specialty Drugs
- Drawing A Line in the Sand: Employers Must Rethink Pharmacy Benefits Strategies
- EmployRxEvolution – Collaboration with Health Strategies, LLC that offers an employer-driven solution that transforms today's pharmacy benefits marketplace

From Northeast Business Group on Health (NEBGH):

- Genomic Medicine and Employers booklet
- Improving the Cancer Patient Experience

National Business Group on Health (NBGH) – Oncology resources on their website

Join Get the Medication Right Institute – Their vision is to enhance life by ensuring appropriate and personalized use of medication and gene therapies

National Comprehensive Cancer Network (NCCN)