## MBGH Annual Employer Benchmarking Survey (2020/2021)

*Top Threats to Affordability of Employer-Sponsored Coverage*

- Specialty drug spend and high-cost claims are the top two threats.
- These are followed by specific diseases/conditions and the pipeline for high-cost gene therapies.

*Payment Reform Strategies*

- The majority of employers are addressing specialty drug management, centers of excellence and episodes of care – the top strategies.
- The next two strategies employers are engaged in are steerage within networks and onsite or near-site clinics.
- The vast majority of employers are not looking at price transparency services with member incentives, advanced primary care, bundled payments or reference-based pricing.

*Pharmacy Benefit Strategies*

- The top three strategies used by the majority of respondents are plan design steerage to lowest cost drugs, medication therapy management and utilization of authorized generics.
- More than half are removing low-value drugs from the formulary and using pharmacy benefit drug transparency/pass through pricing.

## Opening Comments

*Cheryl Larson, President & CEO, MBGH*

- Today's theme is managing the spend for high-cost therapies – specialty drugs today and in the future, orphan drugs for rare diseases (can be extremely expensive), and emerging gene therapies (there is a robust pipeline).
- How are employers going to pay for/cover these in the future?
- The top two answers from employers are:
  - PBM/carrier solutions that charge a PMPM to spread out the cost of the therapies over multiple years
  - Deferring payments over time
- The problem with these options is that it's just shifting costs; it doesn't change the cost, quality or efficacy of the drugs.
- It also allows intermediaries to continue their model of misaligned incentives.
- We are looking at performance-based contracts with intermediaries like PBMs. But most employers can't get their vendors to agree to this type of contract because it impacts how much money they make, including rebates.
- Another option we've talked about is outcomes-based contracting, which has potential. This has to occur primarily with the drug manufacturer, and they aren't quite sure how to do this (e.g. what should the patient outcomes be).

## Specialty Drug Landscape & Role of High-cost Drugs, Rare Diseases & Gene Therapies

*Dwight Davis, PharmD, Director, Evidence-Based Prescription Drug Program, University of Arkansas Medical School, College of Pharmacy*

## Evidence-Based Prescription Drug Program (EBRx) – Overview

- Can we continue to provide affordable and effective health care for the employees who have served us and make each individual company great? The current model is not sustainable.
- I'm coming to you today as a colleague with the same questions and concerns you have and to share what has worked in our model that could benefit you.
- EBRx is a service unit within the UAMS College of Pharmacy established in 2004 to construct/manage the Arkansas Medicaid Preferred Drug List.
- Parallel to that, we developed a relationship with the agency that oversees benefits for Arkansas State employees and public-school teachers.
- Recently, other state agency groups have recognized the EBRx model and wanted to be part of that umbrella (Arkansas State University, Arkansas State Police, Arkansas Municipal League and the University of Arkansas System.
- RxResults was formed in 2008 and they license the intellectual property that we develop and commercialize it in the private sector; they currently operate in 22 states. They are a great business partner, and they can address needs you might have if there's something here that could benefit your plan.

## EBRx Pharmacy Benefit Management Model

- To understand the model and approach we use, it's important to look at the pharmacy benefit and all the essential components that make up what's necessary to run the pharmacy benefit.
- The middleman (PBM) can add costs to the prescription benefit side; on the positive side, PBMs are essential in the claims processing aspect.
- **We all recognize there are slices of the pie that represent revenue streams for the PBM that you may or may not be aware of and may not be wholesome, effective or financially in your best interest.**
- It's not good or bad – it's just different; when a business partner has incentives not aligned with yours that can create stress and frustration.

- The state said to us, if this model isn't working, blow it up, redefine it, and design it the way you think it should work.
- We drafted an RFP and put it on the market; the big three never bid on it – it wasn't a good deal for them.
- **The RFP requested claims processing and a pharmacy network – the things they do and do well. We wanted to control or have some input on everything else e.g. clinical management, manufacturers rebate contracting (aligned with formulary), customer/member services and reporting/analytics.**
- We oversee **mail order pharmacy** but don't promote it – **it may be convenient, but we have not seen meaningful savings**. Arkansas is a rural state with a lot of independent practitioners so politically we don't do it.

## EBRx Services

- **Drug review process** – the **most critical and effective tool** we use in controlling drug costs at the point of entry; have a closed formulary (no drugs are covered until we add them to coverage)
- **Drug coverage/prior authorization criteria development** – for drugs authorized with criteria, we author those; they generally mirror clinical trials in which the clinical benefit was demonstrated
- Pharmacy benefit programming and coordination with the PBM
- Policy enforcement through the EBRx prior authorization call center/physician appeals management
- Other program design features – we do a lot of reference-based pricing; it is a very effective way to control cost
- **Manufacturer rebate management** – the rebate strategy is **lined up with the structure of our formulary** (not the other way around – we don't chase rebates)
- PBM contract review/relationship management

## EBRx Formulary Management Approach

- **All drug reviews consist of evaluation of the best current peer-reviewed published evidence using a general hierarchy**; we hire clinical faculty to perform these reviews (it's a subspecialty of pharmacy)
- **The objective is to get the highest amount of quality evidence and the lowest amount of bias**
- Sometimes with these rare diseases, you don't have the benefit of randomized controlled trials and must look at single arm trials with lower quality of evidence because it's an orphan disease and studies have not been done
- **Availability of evidence does not always align with FDA-approved product labeling**
- **We use the FDA approval as a data point – we adhere to the evidence**
- If evidence doesn't exist, we go back to the manufacturer and say, our plan doesn't pay for experimental therapy. If you want the patient to continue this therapy, you'll provide it. We're successful a large portion of the time.
- **A lot of oncology agents are low value, and we exclude a lot of them**; we continue to re-review as evidence changes and may change or alter coverage policies, but **we stick to overall survival data when making a coverage decision**.
- Of the 130 drugs evaluated by the EBRx P & T Committee during FY2020, 73% were recommended for exclusion from coverage.
- This amplifies the low bar the FDA has on the drug approval process.

## Additional Cost-Savings Approaches

- Coverage/prior authorization policies align, where possible and practical, with clinical trial designs demonstrating clinical benefit
- Rebate contracting aligns with formulary design
- Patient assistance funds are accessed, where available, through an accumulator program

## Specialty Accumulator Program – How it works

- We're using a specialty accumulator program for all our clients and **this one program is accounting for a savings of 10% of total Rx spend** (not just specialty).
- **We're determining what the copay assistance amount is and spreading it out over about 13 months and then assigning that number (the copay)** – programmed into the system – we're collecting that money off the top.
- **We're allowing the patient to save as well**
- We needed these requirements make this go:
  - Have an engaged PBM that will execute the program correctly and be flexible (this was key for us)
  - Determine the patient assistance amount and divide it over 13 months; make that your copay amount.
  - Use an automated mechanism to capture the real out-of-pocket costs – what the patient actually paid as opposed to the full copay amount. Your PBM has to have the functionality to true that up on the back end.
- **One thing that made this all possible was identifying a local specialty pharmacy that cooperated with us and are extremely flexible. They helped us design this program.**

## Current Specialty Drug Landscape

- **In general, specialty drugs account for approximately half to 1% of total prescription claims and greater than 50% of total plan spend.**
- The most common specialty categories are:
  - Immune modulators – treatments for rheumatoid arthritis, plaque psoriasis, Crohn's disease
  - Multiple sclerosis agents
  - Oncology/cancer agents
  - HIV/AIDS
  - Asthma/COPD
  - Endocrine/metabolic disorders

- **The new drug pipeline is consumed by specialty categories – we know this is what we have in front of us.**

## Role of Biosimilars

- **We have access to medical claims and we're able to enter into rebate contracts on these biosimilars – we've selected exclusive agents in all of these categories.**
- We've chosen one product and secured exclusive rebate contracts. **This has added a lot of rebate revenue and it's helped reduce the cost on the medical side.** It doesn't really show up on the pharmacy side but overall has been effective.
- None of the FDA-approved biosimilars are considered interchangeable.
- However, we've not gotten a lot of push back when we've selected an exclusive agent. If someone wants to go outside of that we have an exception process – prior authorization appeal process that could be managed to help reduce the number of non-formulary products that are being covered.

## Approved Gene Therapies

- We use the same process defined earlier to evaluate these drugs.
- They treat catastrophic horrific conditions – this gets your attention, and you want to make sure you're making the right decision and giving them something that will work.
- **Most of these drugs are excluded because the evidence has been weak or inconclusive; we will continue to look at these.**
- **The financing of these drugs also needs to be looked at.**

## Legislative Involvement is Essential for Payers

- Until I got into state government, I never thought this would make a difference.
- Make every attempt that you can to know and have relationships with legislators in your state and federal governments.

- **Educate them on what your company does and how your company impacts the economy, what your workers do, what your fears are.**
- It's essential to this whole process. **There is a legislative process going on outside of your building that could devastate your plan and you won't know about it until it's too late.**
- This year in Arkansas, 36 health care related bills were enacted. Most of these are well intentioned, but there will be components of what these bills addressed that could have severe unintended consequences.

## Drug Costs and Transparency

- One of the challenges we have is that physicians and patients do not know the cost of these drugs we are paying for.
- There is an overarching or popular benefit called the real time pharmacy benefit; over half of physicians using an EHR are seeing costs of medications but they're not seeing everything. Missing are:
  - Costs for existing medications not just new prescriptions
  - Total cost of drugs net rebates (patients pay total costs through premiums)
  - MD incentives to spend time considering lower cost alternatives
  - Patient incentives to move to lower cost drugs 40% of the time
  - Costs if the MD doesn't us an EHR
  - Robust alternatives – MDs won't spend time searching for alternatives
  - Training and support for MDs wishing to consider lower cost alternatives
  - Proven savings
- **State and federal governments are enacting cost transparency rules but government rulemaking lacks clear definitions and proven savings strategies.**
- There is no recognized market leader or strategy in savings from drug cost transparency

### Obstacles and Related Considerations

- **We have a lack of information and a lack of incentives** – no one is being paid to get their arms around this.
- Community pharmacies are in a high-volume low margin model where they're generating prescriptions just to keep the lights on.
- **Patients may or may not have incentives to switch to lower cost drugs.**
- **In addition to the real time pharmacy benefits, Gemini has developed a patented drug savings report delivered to the physician and the EHR for patients coming in that day so they can address existing medications.**
- It's also used through a portal by a managed care pharmacist at a health plan or an employer group to go in and pull drug savings reports and share them with patients and physicians.
- There are ways we can address the rising cost of pharmaceutical; we talked about specialty accounting for about 50% of spend, but let's not forget about the other 50%. There are a lot of savings to be picked up.

## Questions

***Can you confirm if your accumulator is not charging the member while saving money for the plan*** *– is the $5 copay in every case through the accumulator program?*

- **That is correct** – we've designed it that way. **Most are zero or $5; there is a small percentage of drugs that might be the maximum (around $20).**
- It was important to pass this piece onto the legislature – that we were in no way passing costs back to the patient or saving money on the plan at the expense of the patient.

*Are specialty drugs covered on coinsurance in your plan design and do you pass rebates onto the patient for specialty drugs?*

- Yes, they are covered; if the patient has a high deductible plan, the specialty drugs apply to that as well.

- Currently 100% of the rebates go directly back to the plan. We don't have the capability at this point to do point-of-sale rebates. The plan uses those rebates to reduce premiums.
- When the manufacturer sends the payment information back to us, we pass that completely so they can see to the unit (tablet or capsule) what those rebates were.
- They pay us to provide that service that 100% goes back to the plan and they can handle them however they want to.

*Would you consider the EBRx review process similar to the Institute for Clinical and Economic Review (ICER) approach?*

- **The chair of our P & T committee actually serves on the ICER panel and so we use a lot of the ICER information and cost effectiveness data in our decision-making process.**
- It's a data point, but we consider it – good process.

*What can employers do to eliminate rebates and transition to value-based contracting?*

- We've gone down that pathway but have no value-based contracts.
- **We've talked to several manufacturers about this and they appear to be unsure about how they want to structure a value-based agreement and what data elements would be required to make that effective.**
- We understand that rebates and the accumulator program is a shell game.
- We've taken the stance that we're going to play the game as long as it's offered.
- We don't want to shut it off and chase something else that might not replace the rebates.
- **Currently we've not found a good solution to follow the value-based approach completely – hopefully at some point we will.**

*What would be the right type of legislation for the top two issues – rebates and transparency?*

- We want to be careful what we want to be legislated – it's a double-edged sword.
- It can be heavy-handed and create some unintended consequences.
- The first step is allowing us the latitude to do the drug evaluation because that's where it all starts.
- **Ensuring the legislation will allow us to operate freely and use the best evidence that has been published to make good decisions and not mandate us into paying for drugs at zero copays without proven benefit.**
- **Most of the conversations on value-based contracts have centered on adherence, which means increased utilization, which means they win and you don't.**
- We want something more; **whatever the clinical outcomes are that a drug needs to demonstrate should be incorporated into a value-based agreement.**
- Price fixing would be a very slippery slope.
- I really don't know what the perfect legislation would be, but from the perspective of a self-funded employer group, if we could be given the latitude to do what we do currently I would be very happy. Every session challenges our existence, and you have to go and explain that over and over again.
- The pharmaceutical industry is the most powerful lobby in the world. They're going to continue to push these things – to gut the plans ability to effectively manage their costs.

*Do you contract directly with manufacturers for rebates or are you using a rebate aggregator?*

- **We contract directly with the manufacturer for every rebate contract.**
- We go out and pursue those individually **based on the design of the formulary** – we wanted a transparency and every penny accounted for.
- **It was built to pass a legislative audit and it has passed this without findings.**

- **We want to control the contracts directly for the core group drugs on our formulary.**

*Would international drug price benchmarks work to lower prices in the US?*

- **The only concern I have would be the unintended consequences because our health systems are different.**
- I think we have the best health care system in the world, with all the warts and scars. But the real answer is I don't know.

*What do you recommend to employers when pharmacogenomic testing confirms that the right drug is not indicated by our system?*

- **Anytime our approach doesn't match with something that is clinically appropriate we have an exception process; we evaluate that and make appropriate changes to the policy as evidence surfaces.**
- **We've had reports come in our call center** that the pharmacogenomics test was done, and **it indicates one of three antidepressants – it's never the generic**.
- Pharmacogenomics has a lot of "sex appeal" but **you have to look at the clinical relevance of all that** – we would vet that out in peer-reviewed data and have an exception process to deal with those situations.

*Can you explain the difference between RTBC and Gemini Drug Cost Transparency Tool?*

- Gemini refers to their product as Drug Cost Transparency Pricing (DCTP), which is their model of the real time pharmacy benefit.
- Most RTBC only shows the copay, so it's a limited amount of information – the physician doesn't see everything (e.g. total cost net of rebate, cost to the plan).
- Gemini's product shows it all. That particular service is delivered to the physician through the EHR at the time of prescribing.
- It's different name, same delivery but more information shared.

*What are the top things the average employer can do to work with their PBM to make a difference?*

- Size matters and that's a struggle. The good news? **Every employer group in your geographic area should be a part of this coalition and use your clout.**
- If you're a small employer, you can act like a huge one; it's like what we do with our state agencies.
- **Join forces as a group** – you have the mechanism to make such a difference just by consolidating and sticking with one voice.
- You'll have some individual differences, but **by and large your philosophy and DNA resonate across the organization.**

## Employer Panel on Leading Trends

*Moderator: Denise Giambalvo, MBGH*

- *Kim Foerster, Director, Pharmacy Account Management, Blue Cross Blue Shield of Michigan*
- *Demmy McBride, Manager, Health & Welfare Benefits, Ford Motor Company*
- *Darcy Sementi, Healthcare Manager, State Farm*

### Biosimilar Strategy: Success of a Partnership

*Demmy McBride, Ford Motor Company*

- Prescription drugs are a significant portion of our health care spend at Ford and about 22% of our total spend across the medical and pharmacy benefit.
- There are some alarming trends in this space, specifically with specialty drugs; they are the fastest growing area – they comprise 60% of our total Rx spend.
- There are very few scripts but much higher prices; because of the robust pipeline of specialty medicines, the utilization of these drugs is going to continue to grow.
- **The fact that prescription drugs, including specialty drugs, are delivered under both the pharmacy and the medical benefit further complicates**

**things for purchasers.** There are unique challenges addressing prescription drug spending under the medical benefit; one important area of focus for us is biosimilars.

- **Biosimilars are like generics but for biologic products.** Since they are designed to be highly similar to the brand name reference product, they can be clinically substituted. **They are often much lower in cost.**
- **Most of the reference products with biosimilars are delivered under the medical benefit** so health care purchasers must partner with our medical carriers (not just PBMs) on a biosimilar strategy.

### Kim Foerster, Blue Cross Blue Shield of Michigan

What is a biosimilar?

- **Biosimilars must go through the same FDA rigor as any non-biosimilar product.**
- **Studies and outcomes prove they have equal efficacy and safety for patients.**
- Biosimilar products still have to go through post-market surveillance to ensure continued efficacy and safety, just like any other drug.
- Biosimilars are a growing focus for us, and we're excited about the progress we've made with our strategies for biosimilars in partnership with Ford.
- It's important to point out that a biosimilar is not interchangeable with an innovator product compared with a generic which is interchangeable.
- When creating a biosimilar strategy, this requires a little more finesse in relationships with your providers, the member experience and the launch of the program.
- **Because biosimilars use live organisms to base the product on compared to a generic product which uses synthesized chemicals, you have to look at every strategy per biosimilar very differently and uniquely.**

### Biosimilar Program Expansion: Low Net Cost Strategy

- There are biosimilar strategies that are rebate driven – chasing the rebate.

- **We look at specific drugs that have biosimilar equivalents in the market and where can we pursue that lowest net cost strategy.**
- **You have to consider what the contracting relationships will be and what kind of improved discounts and rebates will you get.**
- A lot of this is determined by the volume of biosimilars available for any innovator product on the market and how you position it in your strategy, e.g. are you going to create parity? Every drug is different from a contracting standpoint.
- 29 biosimilars are approved in the US and 17 of those are for oncology drugs.
- **In 3Q20, two of the top 10 drugs by cost were innovator products with an available biosimilar.**

## Considerations

- Integration of pharmacy and medical benefits: **Look at whether the drugs are covered under both the medical and pharmacy benefits.**
- **Side effect profile**
- **Provider and member disruptions**: We are very sensitive to the member experience and disruption for our members.
- Overall savings: **The model you choose determines the opportunities for savings**
- Rebate savings
- Future biosimilar pipeline

## Biosimilar Program Case Study

- **Remicade represented about $140 million in spend from the medical side**; about 23,000 infusions annually – it was an easy target.
- Remicade had multiple biosimilars available on the market; **Inflectra (a Pfizer product) emerged as the leader in terms of pricing, contracting strategies and general market acceptance.**

- For this product we had to work very closely with our provider community; we were successful in our biosimilar launch because of provider relationships.
- We started long before program launch to get buy in from prescribers writing for Remicade to ensure they would support the strategy and to ensure a smooth transition to the biosimilar product.
- An approach focused on provider and member outreach was a big reason our program was successful.

### Demmy McBride, Ford Motor Company

- We had outstanding results overall with Blue Cross at the book of business level – across their HMO (91.3% transition rate) and their PPO (86.6% transition rate).
- Our results at Ford were even better – Ford HMO had a 100% transition rate and the PPO had an 88.1% transition rate.
- **Because of Blue Cross's thoughtful rollout strategy including engaging physicians in advance, not disrupting patients who were mid-treatment and a really strong communication strategy, we accomplished this with no noise from our membership.**
- **Since implementation in 2019 (starting with Remicade) and through April 2021** (after expansion of the program to include five additional biosimilar drugs) we have **achieved close to $5M in total savings**.

### Management: Biosimilars Preferred

*Kim Foerster, Blue Cross Blue Shield of Michigan*

*Side Note**: **We targeted Remicade not just because it was one of our highest spend drugs on the medical side; it was also because of the outcomes and success of Inflectra in the market.** We have been much slower in the US compared to Europe to have access to FDA approved biosimilar products because of the litigation that happens to protect patents.*

- We **incentivize our provider community** by adjusting the fee schedule payments for innovator and biosimilar products.
- After market share shifts and you've got the provider community to buy in, it's easier to consider an exclusive option or moving to a preferred option (the approach we have taken).
- **Rebates are important and the financial impact of rebates is definitely a consideration, but we don't chase the rebates.**
- We need to look at the whole picture to ensure whatever we launch into the market is the lowest net cost strategy that creates the least disruption.
- **We are member-centric so we allowed "grandfathering";** when we launched the additional four products, we looked at the approval – all of these drugs have PA requirements – so we extended the authorization for six months looking to transition all new members to the preferred product and ensuring members on current treatment could complete their treatment.
- If the treatment was to be renewed, we start them on the preferred agent, which in most cases is the biosimilar product.

## Recommendations: Employer/Plan Sponsor Perspective

*Demmy McBride, Ford Motor Company*

- **Work with a trusted partner**: Pharmacy benefits and strategies are very complicated and it's easy to feel discouraged as a non-expert in the space. Don't let that stop you from asking questions of your partners – **carriers, PBMs, consultants** – ask them to show you your data, understand where they are innovating on behalf of plan sponsors, and if you're not happy with what you're hearing, push them to do better.
- **Consider hiring an expert pharmacy consultant**; there is significant savings potential with biosimilars so it's an important topic to bring up with them.
- Equal member outcomes without member disruption.
- Member experience is really important and it's paramount for anyone who works with unions (we have 55,000 UAW-represented hourly employees). You can design these programs thoughtfully so as not to put the member in the middle.

- **Clear communication to members is critical to support smooth transition to preferred products.** Engage the provider community early in the process. The patients look to their physicians to reassure them.

### Recommendations: Blue Cross Blue Shield of MI Perspective

*Kim Foerster, BCBS MI*

- Understand the strategy/approach (rebate driven versus lowest net cost) and all the dynamics involved for each biosimilar.
- Consider member experience, provider-focused decision-making and grandfathering options.
- Clinically supported program – provide ample evidence to support the move to a biosimilar product and support a biosimilar strategy.
- Future value dependent on integrated benefits – it will be important to have alignment moving forward with whoever is managing your medical and your pharmacy benefits.

## Initiatives at State Farm

*Darcy Sementi, Healthcare Manager, State Farm*

### What was the challenge?

- Managing the pharmacy benefit can feel overwhelming.
- The pharmacy landscape is changing, represents a significant cost driver for employers and the supply chain is complex; there is a lack of transparency.
- Cost trends on the specialty side are concerning.
- **We were receiving guidance exclusively from the PBM and incentives were not aligned; we started looking for an unbiased approach that put State Farm at the center of the strategy with us looking out for the best interest of both our expenses, our members' expenses and our members' experience.**

## How was it solved?

- Our first initiative was to **hire a consultant to guide us** through the pharmacy space. We looked at those with a depth of pharmacy knowledge so we could stay ahead of the trends and everything happening in the space.
- Hiring a consultant preserved our ability to make our own decisions.
- We have 150,000 members covered on the plan and over $220M in spend; this was the reason we wanted to have a consultant with deep knowledge leading us through this space.
- Once we had a consultant hired, **we pursued a PBM RFP**. State Farm had not taken their PBM business out to competitive bid in more than 15 years.
- This was very critical to bring us up to speed, renegotiate contracts.
- **55% of our overall pharmacy spend is driven by less than 2% of our population**.

## What were the outcomes?

1. Specialty review/analysis
   - We did a deep dive into our specialty costs.
   - PSG was the consultant we hired and through their Artemetrx tool **we can see combined pharmacy and medical trend together**, which allows us to take a comprehensive approach with what we're going to do in the specialty space.
   - **One of the first priorities is around redirecting site of care.**
2. Review of PBM prior authorization process and decisions
   - **Looking at PA and utilization management criteria and what's happening in terms of approval rates, denial rates and some things that simply may not make sense.**
3. Pursing an overlay with an external partner or a member of our ecosystem to provide a white glove experience for the specialty users.
   - **We're looking at overlaying a concierge service for our specialty utilizers** in addition to the services that are part of our prior authorization and utilization management components.

4. **Renegotiated our PBM contract** with the help of our pharmacy consultant with significant financial improvements and revamped contract terms and conditions.
    - **Allows us the flexibility we need to manage the pharmacy space** as things change in the future and respond to what we need to serve State Farm as well as members.

### What were lessons learned and actionable takeaways?

- *Integrated Data:* **View into both medical and pharmacy specialty trends and utilization together so we can figure out where our priorities are**, what we need to tackle and where there are opportunities.
- *Vendor Partners:* **Engagement of vendor partners is imperative for success**; we use BCBS, HCSC as our primary TPA, Accolade as a concierge service for members and CVS is our PBM. We bring everyone to the table and have constant communication so that everyone understands what we're trying to accomplish.
- *Question Everything:* **If you don't understand something, keep asking questions** until you do. When you see opportunities, make sure you speak up.
- *It Takes A Village:* **Involvement of multiple individuals in analysis is important because people see things differently;** it allows us to question even more. Address culture change – balance things without disruption. Some outcomes are just in the best interest of our associates and not necessarily cost driven.

## Questions

*You are both relying on the expertise of others to direct you and your pharmacy decisions. How do you discern what information to listen to and what to table?*

*Response from Demmy*

- I am not an expert in pharmacy, so I absolutely rely on the expertise of our partners – our carriers, the PBM and our pharmacy consultant.

- The first step is always education. **I ask a ton of questions to deeply understand the problem they are trying to solve, what different options are available, what have they considered and what is their decision-making criteria.**
- I also want to understand both the potential upsides and downsides of anything we might do.
- **I always ask for data and expect our partners to be willing to peel back the layers of the onion for me.**
- If a partner feels strongly enough that a program is the right thing to do, I think they should stand behind it. So, **I ask for guarantees around the future success of the program.**
- Navigating health care is hard and benefits are complex. I always want to know what steps we can take together to create a smooth experience for members.
- If we decide something is the right thing to do, the question is when and how does it fit in with everything else we have going on with other strategic initiatives.

*Response from Darcy*

- Along with everything Demmy has shared, **we also lean heavily into our peers**. Other large employers are very willing to help or provide an opinion.
- Everyone is willing to share what they're learning and what they're seeing.
- When you're given a piece of advice, run it by your peers. This is the other element along with data and the experts that has been incredibly beneficial for me as I move forward with the strategy, we're pursuing at State Farm.

*How do you connect with your peers?*

*Response from Darcy*

- Through the Midwest Business Group on Health, the National Business Group; State Farm is a member of EHIR. These are the primary mechanisms.

- **It becomes a very close-knit community – we share emails, phone calls, LinkedIn; it's easy to get a hold of someone.**

*Response from Demmy*

- Coalitions, different client advisory boards; I've had a long career in health care and have met a lot of people along the way.
- **Building the network and taking advantage of it; we're always happy to share as well. It's a two-way street.**

*Question for Kim: When looking at a biological class, are you also considering site of service as a cost containment strategy?*

- **Site of care is a big focus for Blue Cross and there is a whole hierarchy strategy around site of care initiatives.**
- When we're looking at lowest net cost strategy specifically, the cost of administering a product that falls in the medical benefit is part of that overarching lowest net cost strategy.
- It's part of that calculation when you're saying, how much is the discount and how much is the rebate we're going to get? How much does it cost to administer the product on average?
- All of that is considered when you're looking at lowest net cost strategy.

*Question for Darcy: How many employees at State Farm manage your benefit?*

- We have a team of seven analysts that manage our entire ecosystem (150,000 lives). The majority of our time is spent on the medical side.
- We are in the midst of transitioning our data warehouse to Springbuck.
- We also lean heavily into PSG consulting's Artemetrx data warehouse specifically around our ability to manage medical and pharmacy in that space.

*Question for Demmy: Did Ford communicate with employees directly about the move to biosimilars?*

- We relied on Blue Cross to handle that communication directly to members.
- On the hourly side, we prepped our Union benefit representative working with our partners at the UAW to handle questions they may get from hourly employees.

*Were either of you able to find a benefits lawyer with experience in negotiating and finalizing your PBM contract?*

*Response from Darcy*

- Unfortunately, the answer is no. This is where we're leaning into a consultant in terms of negotiation and their expertise because this is such a niche area.

*Response from Demmy*

- We did an RFP and selected a pharmacy consultant last year (PSG).
- Now we're in the last stages of our RFP and we're absolutely relying on PSG's expertise as it relates to negotiating aspects of the contract.

*Question for Kim: Any thoughts on decreasing the out-of-pocket for biosimilars in comparison to the innovator drug when you have parity for the biosimilar and the innovator drug?*

- In our strategy for neupogen, the out-of-pocket is equal for the innovator product and its biosimilar that we are equally preferring so we did not.
- That would definitely be a consideration. Depending on your contract with the manufacturer, there are opportunities for further savings when you show preference for one product over another product.
- It's another consideration to make when you're deciding what model you're going to follow for your biosimilar strategy.
- It should be different for each biosimilar because they all have unique circumstances around them.

*Question for Demmy: What is the next thing for Ford Motor Company to tackle in their pharmacy benefit?*

- The RFP is a huge focus for us – we're in the final stages.
- Our relationship with our new pharmacy consultant includes not just the RFP and the implementation post-RFP; it also includes ongoing auditing, market checks, data analysis and ongoing pharmacy support.
- This is the first time we've hired a consultant to help us 24/7; we decided that pharmacy is complex enough – we can't bring in support just for an RFP, big projects or market checks.
- As it relates to the RFP, we are transitioning away from the traditional PBM contract and have included requirements for all our bidders, including our incumbent who is in the traditional arrangement today, related to transparency, control, flexibility, disclosure and audit ability.
- We're really excited about taking back control in the pharmacy space from the PBM under the new contract.
- The near-term focus is completing the RFP, executing the contracting, and implementing the new contract which could look different depending on who we select.

*Is there anything either of you heard this morning from Dwight that makes you want to dig deeper?*

*Response from Kim*

- It's nice to see that he's already addressing biosimilars and they're doing similar work that we did collectively with Ford. Their approach is a little different – ours is more focused on lowest net cost.
- I would be very interested in learning more on how they pursued their approach. With our sensitivity to member disruption, it wasn't an option for us out of the gate but would be something we'd be very interested in pursuing as part of our future strategy.

*Response from Demmy*

- Many of the things Dwight covered are on our radar and we've been in discussion with our partners.
- A topic he touched on that I'm passionate about is looking for opportunities to eliminate waste from the formulary wherever possible.
- Excluding no-value drugs, implementing other programs to address the big pharma schemes related to holding onto the brand drugs, bringing forward new drugs that don't add any value (they're just new combinations where generics are available), changing the packaging.
- We've been focused on this the past couple of years and will absolutely be part of ongoing discussions with our consultant and PBM.

*Has State Farm or Ford considered ICHRA (Individual Coverage HRA) as a potential benefit option for employee-sponsored health care?*

*Response from Demmy*

- Not for our active benefits, but it is something we've thought about for certain retiree groups.

*Response from Darcy*

- State Farm has not considered that at this point.

*Question for Kim: A participant saw the PR about Blue Cross Blue Shield of MI being part of five plan organization for-profit company called Evio. How is that work going to differ from your current cost containment strategies around specialty pharmacy?*

- We're excited about this opportunity to invest and partner more closely with the other Blues plans. It is very early stages.
- The hope is that collectively, the focus of the programs will be to complement the clinical initiatives we have out today; we're not looking to replace PBMs, build our own PBM or replace the contract relationships we have with our PBMs or other vendors we work with.

- It's looking at where there are opportunities to take real world evidence and build on that, improve the opportunities for value-based contracting – we have struggled with that.
- A lot of the requirements for value-based contracting are based on outcomes data that is difficult to get on a timely basis; we're hoping through this effort to create opportunities for value-based contracting.
- We're looking to be different, innovative and look outside of the box.

*Question for Kim: What strategies have you put in place for gene and cellular therapies?*

- This has been a big focus for us for years. We have our own P & T committee; we have been focused and prepared to address the pipeline.
- There are opportunities with some drugs that come to market where there are lots of other therapies in market you can rely on – you can see how the market responds then you may delay deciding where you're going to fit that into the formulary, drug list or utilization management.
- With a few products that are big hitters/blockbuster drugs treating rare diseases we had already done the reviews and studies; we have a huge population and within weeks of FDA approval of these we got a request for the drug.
- Just like with our biosimilar strategy, we are working with the provider community (the ones who are experts).
- Gene and cell therapies are a strong focus – we have separate P & T focus/effort specifically around the gene and CAR-T therapies so that we are prepared when they come to market.
- These products are astronomically expensive. So, we're working through the myriad options being discussed in the market on how to continue to afford to cover the cost of these drugs.

*Dwight briefly referred to therapy adherence in a negative light. How do Ford and State Farm look at therapy adherence?*

*Response from Darcy*

- We're looking at adherence specially with chronic conditions; we've been trying to look at adherence and cost with our data analytics team; BCBS has a health economics team that is trying to determine if adherence is having an impact.
- This is something we are just now looking at to determine what impact, correlation, causation we're seeing between adherence and overall medical expenses; primary focus is on the chronic condition space.
- I don't have a strategy around this other than to acknowledge that it's on our radar to determine what we should be doing about it.

## Achieving Outcomes through Specialty PBM & Medical Services Carveouts

*Amy Ball, PharmD, Chief Pharmacy Officer, Health Strategies LLC*

### Pharmacy Trend

- Overall pharmacy trends have been in the low single digits or negative in some cases over the last few years. Even in those situations, we've seen specialty drug trend continue to grow across our clients.
- **Most of our clients have a specialty drug spend of around 50% because we work with them to manage that non-specialty spend (and it has been driven so low).**
- Leading conditions that are driving the spend in specialty are inflammatory conditions, oncology, HIV and multiple sclerosis.
- **There is really only one non-specialty category that even competes with what's going on in some of the large specialty categories and that's diabetes.**
- Oncology and autoimmune disease are driving a lot of the spend on the specialty side.
- There are a lot of strategies you can look at to mitigate specialty trends including formulary management; distribution, channel and days' supply management; copay assistance programs; medical specialty management.

## Formulary Management

- Health Strategy has clients where we do full custom formulary management; that's making every single drug coverage decision.
- We offer clients a quarterly webinar where we look at all new drugs to market so all clients can take more control of their formulary management.

## Market Current State: PBM Controlled Formulary

- In this state, the **PBM is making all of the formulary drug coverage decisions**.
- Many times, the **incentive for those PBMs to add drugs to the formulary is driven by rebates.**
- Employers have no transparency to net cost. There are some PBMs that will give you true line of sight to your rebate so you can figure out your true net cost.
- A lot of times with PBMs you see **bundled rebates** where those **low-value drugs get automatically added to the formulary.**
- **Products with short patent lives are not preferred over the newer agents** because they're pushing that rebate strategy.
- **It's really important to begin to take more control over what you consider covered under your formulary.**
- When we get into PBMs creating and administering prior authorization criteria as well as owning the pharmacies where the drugs are being dispensed, you begin to create conflicts in the marketplace about whether the criteria are aggressive enough and whether they're being approved to make a profit because they're going to dispense the drug.
- There are ways to mitigate that – partners you can work with to help decrease some of that conflict of interest.

## Market Future State: Plan Sponsor Custom Exclusion

- **Employers make their own drug coverage decisions**.

- **We created three formulary philosophies** looking at how employers may want to consider making their own drug coverage decisions:
  - ***Low control decision makers***: Employers who are averse to member disruption but doesn't want low-value drugs with no added clinical benefits added to their formulary.
  - ***Medium control decision makers***: Employers who don't want significant member disruption, but they also don't want things like patent extension product, line extensions added if there's no clinical value or improved outcome.
  - ***High control decision makers***: Employers with full custom formulary, making aggressive decisions on a lot of the new therapies, especially specialty drugs, oncology drugs coming to market under fast-track approval.
- There is a way to manage your formulary and take more control without being a full custom formulary – evaluate all new to market drugs based on clinical efficacy and cost-effectiveness relative to other products already on the market.
- Making decisions on new drugs as they come to market – that's when you get ahead of the curve. You don't have numbers getting on those drugs, so you put a New Drug to Market block in place with your PBM so there is no negative member impact. It's sort of like a closed formulary.
- But you have to make those decisions quickly before the PBM puts those drugs on their formulary.
- Many of our clients are now involved in making those decisions for themselves and managing their formulary by taking over some of that control from the PBM.

## Why Formulary Management

- In the past, a lot of low-value drugs were coming to market in the non-specialty space. It's also important to manage your formulary as it relates to the specialty drugs.

- When you start looking at these therapies and everything that's coming to market, you have to look at it as a whole class as well.
- The FDA approval process includes the 505(b)(1) which is the traditional pathway, 505(b)(2) which is an accelerated pathway that allows you to base your efficacy and safety on the package insert of an already available drug on the market that is very similar.
- **If you don't have separate generic pricing in your pharmacy contract that is aggressive and guarantees that are aggressive, the PBM can price it in a way that makes it not price effective.**

## Distribution, Channel & Days' Supply

- Distribution options
  - **Use the PBM-owned specialty pharmacy**. If you do this, your contract needs to be very specific about the generic rates to make sure you have aggressive pricing in place.
  - **Carve out, under a direct contract, for specialty pharmacy distribution services.** You can do that on an AWP discount basis – ensure you have aggressive generic discount guarantees which will require pharmacies to give you their best rate on generic drugs. Otherwise you will pay a price similar to the brand drug even for the generic. Another option is cost-plus pricing; we can get very aggressive pricing on generic drugs and that is the same for specialty.
  - **Carve out your PBM services** completely to a separate PBM for specialty services.
- Channel management
  - **Look at an open specialty network** versus an exclusive specialty network.
  - **If you don't get the right language in your contract, you don't have the ability to determine what a specialty drug is.**
  - **If you retain that right, you can have that open network** where you send certain drugs to your specialty pharmacy that can be PBM-owned, carved out, etc., and certain drugs to your retail network based on where you get the best pricing.

    - **If you don't have that in your contract,** it's probably best to **go with an exclusive specialty network** because, generally, you will get better pricing. When the PBM owns the specialty pharmacy they're going to give you better pricing to use their pharmacy because dispensing of specialty drugs is a big profit margin bucket for PBMs today.
    - They won't give you as good pricing when you allow that to be an open specialty network and allow retail pharmacies and others to fill those scripts.
    - If you are bound by that contract, looking at an exclusive specialty network is not going to change your trend, but it will save some of your spend.
- Days' supply management
    - **Limiting fills to a 30-day supply is important**. A 90-day supply can help with adherence, but these are very, very high-cost medications, so we always recommend a 30-day supply.
    - Some PBMs allow a 90-day supply of some medications; depending on the turnover of your employee population that may not be a good thing for you.
    - Some of these drugs require a 90-day supply or greater because of their dosing frequency; that is absolutely allowed, but your PBM has to be able to do that correctly.
    - You have to make sure this is set up right so that when you're looking at your data, you're looking at it correctly.

## Copay Assistance Programs

- **Copay assistance has been one of the tools that anyone can access**; there are two different options for copay assistance, and you can employ one or both:
    - ***Variable copay program*** to access manufacturer copay assistance; allows savings for not only the member but also the plan.
    - ***True accumulator programs*** to ensure only the amount of true member out-of-pocket accumulates; if you don't have these programs in place,

when those members access copay assistance under a high deductible plan, there is no way for you to know that they have used that copay assistance program and the full amount of their calculated copay applies to their accumulator. It allows them to meet their deductible and out-of-pocket quicker and therefore the rest of their health care is free for the rest of the year. Employees know about these programs and know how to use them to get their health care for free.

- **Copay assistance has been extremely successful at lowering plan spend on specialty drugs.**
- In 2018, Reuters estimated that 17% of employers with greater than 5,000 lives were using a copay assistance program in their plan.
- More people are stepping into copay assistance programs and there are some real savings associated with that. About 40% are using accumulator and maximizers.
- We're seeing significantly more PBMs today offering these programs.
- We don't know how long these programs will last or when regulations will come into play to limit the utilization of these programs. For the time being they are there and they're very successful.

### Medical Specialty Management

- It is **estimated that half of the overall specialty drug spend is under the medical benefit;** there is a lot of opportunity for savings there, however there is often limited visibility to that data and utilization.
- **This will continue to grow as the pipeline continues to bring new high-cost therapies to the market for rare diseases and cancer.**
- The **Magellan 2020 Specialty Trend Report** showed a **14% net increase in PMPM trend for medical specialty drugs from 2018 – 2019** and their **five-year trend was 58%** from a PMPM perspective.
- This is definitely something that everyone needs to start considering and finding partners to work with around medical specialty.
- **Top drivers** of trend in medical specialty are **oncology and the oncology support meds, along with autoimmune diseases and the treatment of MS.**

- **Strategies to help mitigate** trends for medical specialty include **dose optimization, vial rounding, weight-based dosing, site of care, copay assistance and managing duplicate billing.**
- There is complexity when a drug crosses both the pharmacy and medical parameters and you've got to be able to **make sure a physician isn't double billing something that has been processed through pharmacy.**

## Client Trend History

- Health Strategy LLC client since 2009
- 2010 implemented custom formulary and new plan design
- 2011 moved to a new PBM after RFP process
- 2017 moved to a new PBM after RFP process
- 2019 moved to a two PMB model – specialty PBM carve-out with copay maximization

## Client Specialty Plan Paid Trend

- Client was not immune to the market changes
- New Hep C drugs in late 2014 – 2017 really drove significant trend
- Increase in new drugs approved for rare conditions (HAE, CF)
- Already managed a full custom formulary and made aggressive decisions on coverage
- Direct contract in place for specialty distribution since 2011; we were doing cost-plus pricing and carve out of the retail and mail order under direct contracts
- True out-of-pocket accumulator tracking program was put in place in 2016 (copay assistance tracking), before a lot of people were doing this
- The PBM at the time couldn't find a way to use manufacturer copay assistance to help decrease plan costs, so we needed the option to implement additional strategic ideas.

## Impact of Specialty Strategy

- In 2019, we **implemented specialty PBM carve out**; the PBM does not own its own specialty pharmacy and we already had a contract in place for distribution.
- We **put a focus on copay assistance** to help not only the members, but the plan decrease cost **resulting in a 25.5% reduction in plan paid PMPM spend**. We continue to maintain that in 2021.
- In 2020, we **implemented medical management of specialty drugs for non-oncology medications** and **delegated PA, copay assistance, site of care management, medical rebates and post-adjudication checking for duplicate billing, appropriate dosing, etc. to that specialty PBM.**
- In 2021, we **expanded the medical carve out** to include management of **HIV medications to access additional copay assistance and expanded medical management to include select oncology products and support products.**
- We're pulling as many levers as we can to maintain our flat to negative trend.

## Client Savings

- When we implemented the specialty PBM carve out, we had **virtually no noise and no issues.**

In 2019:

- Copay assistance drove the majority of our savings for the member and the plan. **We accessed $2.3M in copay assistance** just on specialty drugs (20% of the total cost of specialty drugs).
- Health Strategy vetted the way this PBM documents their clinical savings and how they take credit for that. The clinical savings are real and that has been impressive; **clinical savings were $950K (8% of total costs for specialty).**

In 2020: Specialty Pharmacy

- Copay assistance grew by $1M to $3.3M (24% of total cost for specialty)
- Clinical savings in 2020 were $2.7M (19% of total cost for specialty)
- Our total cost continues to go up, so we continue to have utilization of products, but we were able to lower our overall trend and copay assistance has had a big impact on that.

In 2020: Medical Specialty

- Half of the growth was from medical specialty drugs that moved under billing for pharmacy.
- We were able to access the medical side working with a TPA that is very flexible and willing to work with us.
- **We saved $564K in copay assistance; clinical savings was $352K.**
- **With site of care we saw $515K in savings**; still a lot of opportunity here.
- We **found limited issues with duplicate billing** (saved $88K on billing errors).

- This client has pulled many levers in managing their specialty spend and trend; all of these things are possible, and any client can do it.
- You may have to go to RFP to get the contractual rights to do some of these things; even if you can't, reach out to your PBM and make sure you're involved in copay assistance, especially around specialty drugs.
- With a simple change of your SPD you can get that program rolling.

## Questions

*Will the large PBMs ever waive their 25% fee for implementing copay coupon savings?*

- **Highly unlikely**. You can negotiate that.
- When you're talking about $1M if they're taking 25% you're still saving $750,000. Depending on the size of your plan, it's probably a good give at this point.

- As the potential for rebates lowers (as more generics come to market) it's another revenue stream for them; they're being up front about it and indicating what that percent is.
- Do I like 25%? No. But I don't see the big PBMs moving away from that.
- **When you work with some of the mid-level or small PBMs you can get a better percent;** you're getting access to the same copay assistance but at a lower fee.

*Do you have some large or jumbo employers that are working with mid-level PBMs? In the past we've had some concerns that they wouldn't administratively be able to manage their size.*

- **Yes.** It depends on what you want them to do for you. If you want the flexibility, you're going to have to go to a mid-level to get that.
- A lot of PBMs will tell you they'll give you that flexibility, but when you try to get things implemented, it's significantly harder.
- We have large employers (over 100,000 lives) that are using mid-level PBMs.

## Using Data to Find Where Savings Are Hiding in Your Pharmacy Benefits

Moderator: Cheryl Larson, President & CEO, MBGH

- *Antonio Ciaccia, CEO, 46brooklyn*
- *Jonathan E. Levitt Esq, Co-Founding Partner, Frier Levitt*
- *Tom Traylor, EVP, Business Development, Archimedes*

### Uncovering and Understanding U.S. Drug Price Distortions

*Antonio Ciaccia, 46brooklyn*

- We are a non-profit dedicated to making drug pricing data more accessible and understandable to the general public.

- We were bombarded by plan sponsors, lawyers, provider groups – everybody across the drug supply chain – because they were looking for answers. If we could diagnose the problem maybe we could cure the problem.
- We do work for state Medicaid programs, Medicaid fraud control units, law firms litigating in this space and we do a lot of research projects across the drug supply chain; we've also started working on some disruptive market-based solutions.

## The most basic and fundamental question: What is the price?

- The key is which price are we talking about? **There are a variety of layers**, benchmarks and proxies in the US drug supply chain that you can use to describe the price at any given moment.
- **Unfortunately for payers/plan sponsors, drug prices are proprietary and hidden**. Your (and a patient's) exposure to costs are derived from very complex contracting relationships that exist within the supply chain that are proprietary and not necessarily lending themselves to an efficient marketplace.
- **Prices are not objective, so they are prone to manipulation.**
- Unfortunately for all of us, the system is built on fake prices:
  - **List prices** for prescription drugs are **wildly overinflated** relative to actual cost.
  - **PBMs use those list prices (AWP) as the basis for their pricing guarantees** to pharmacies and plan sponsors.
  - **Brand name drugs have high AWPs that are offset by negotiated rebates and discounts that makes net prices much lower.**
  - **Generics have high AWPs** that are derived from brand drugs **that in no way reflect the actual prices pharmacies pay to acquire those drugs**.
  - In both regards, **the "actual" prices of both brand and generic drugs are hidden from the plan sponsor and patient.**

## The Fallout of Fake Prices

- A lot of our work started in Medicaid; we've started analyzing commercial and Medicare data as well.
- We rely on publicly available data, at least at the start of our research, to diagnose where we might find dysfunctional prices or obscenely high markups within the drug channel.
- In previous work, we relied on CMS state drug utilization data which is aggregated data showing what state Medicaid programs state-by-state across the country are being charged for every drug.
- In the **Florida Medicaid program**, we did a public records request and got **350 million claims worth of data** from their Medicaid program where we could see day-by-day, pharmacy-by-pharmacy, plan-by-plan, PBM-by-PBM exactly what the reported rate of reimbursement was for each pharmacy claim.
- **Over a five-year period**, for the **four largest plans** in the state Medicaid managed care program, **prescriptions for brand name drugs under $2,000 were being dispensed by pharmacies owned by the PBM or managed care plan.**
- When you look at **prescriptions over $2,000, a disproportionate share are being filled by PBM-owned pharmacies.**
- **When you aggregate all the data across the brand name drugs and analyze the AWP discount at traditional community pharmacies versus PBM-owned pharmacies, you see that it is more expensive to fill these prescriptions at PBM-owned pharmacies than traditional community pharmacies.**
- This is a concerning trend – if they are fulfilling the actual dispensing of the drug, what incentive do they have to provide you a better rate?
- **They will tell you they're trying to lower their premiums; I will tell you they might make more money downstream than upstream.**

## The Fallout of Fake Prices: Generic Drugs

- In the US, every drug has multiple, different prices.
- Average Wholesale Price (AWP) and Wholesale Acquisition Cost (WAC) are unilaterally set by the manufacturer, not dictated by competitive market forces.
- National Average Drug Acquisition Cost (NADAC) is based on a voluntary national survey of pharmacy invoice costs and is dictated by competitive market forces.
- **Alabama Actual Acquisition Cost (AAC) is based on a mandatory survey of pharmacy invoice costs and is dictated by competitive market forces.** Ohio Medicaid is pursuing their own AAC survey under PBM redesign.
- Most of you have an effective rate guarantee – some sort of aggregate discount off AWP.
- Over time, as the number of manufacturers entering the marketplace increases, the benefits of generic competition are throttling the real price of that drug down to zero over time.
- **As more manufacturers enter the marketplace, they seek to gain market share not by lowering the sticker prices of the drug but by raising it over time.**
- When you see your "AWP – X" contract, you need to **ask yourself, what is AWP?**
- Routinely, PBMs have language in their contracts that allows them to pick the sourcing of the AWP.
- Regardless of whether you have an ironclad definition of what source AWP is derived from, **remember that different drugs have many different prices – the exact same generic drug could have a massive delta between the lowest AWP per unit and the largest one.**
- **AWP is designed to increase over time**; **PBMs cannot claim they are working to lower drug prices and then use a benchmark designed to increase them.**
- All the major PBMs are linking generic drug costs to the one benchmark in the system that is actually inflating over time rather than deflating.

- Because the system is built on fake prices, PBMs are able to use the high, top- level price and move money around underneath it.
- Spread pricing is when a PBM pays the pharmacy one rate, bills a different rate and pockets the difference.

### *Spread Pricing Hits Home in Ohio*

- **An Ohio Medicaid audit revealed $244M in spread pricing from Q2 2017 to Q1 2018;** the spread equated to 31.4% of gross generic spending in Ohio Medicaid managed care.
- They were still making money off rebates, specialty drug transaction fees; but just on spread pricing over $6/prescription in this program.
- As a result of these findings, in the **first settlement a company that owned a number of subsidiary PBMs was forced to pay $88M to Ohio and have set aside over $1.1B to settle over alleged overcharges.**

- **When a PBM has conflicts of interest in the fulfilling/dispensing of drugs, you can no longer trust that they have your interests at heart.**
- Your PBM, not acting as a fiduciary, can set margins however they want in the pharmacy marketplace – this presents a unique opportunity to find savings.
- This problem is even more significant in the specialty marketplace.

### Jonathan E. Levitt, Frier Levitt

- I founded a health care and life sciences law firm 21 years ago; we represent plan sponsors and many different stakeholders including specialty pharmacies.
- I am a trial lawyer; **I get to take depositions and ask PBMs questions about data.**
- The three biggest plans are owned by CVS Health, Cigna and United.

- **Cigna owns Express Scripts, one of the giant three PBMs; United Healthcare owns Optum, Humana owns a PBM and Aetna is owned by CVS Health which owns Caremark.**
- The **top three PBMs process nearly 80% of all prescription claims** in the country and the **top six PBMs process 95%.**
- **Where there is such consolidation, there is an opportunity for the PBMs to take advantage of spread pricing, rebate arrangements and paying their wholly owned pharmacies more money.**
- The Federal Trade Commission (FTC) is an agency of the Federal government that helps address competition in the marketplace.
- There is a **new commissioner of the FTC** who made statements in May saying: The FTC stood by and watched as the PBM industry consolidated to three main giants. **The secretive kickback practices of so-called rebate walls between pharmaceutical companies and PBMs are worrisome. Large rebates create a wall around lucrative products in ways that squelch out competitors.** PBMs are incentivized to select higher list prices for drugs instead of lower list prices for their formularies in order to collect a higher rebate.
- He said that the **FTC and Congress must take concrete steps to address the conflict of interest embedded in the PBM industry**.
- **Self-funded plans don't need to wait for legislation**; they can act on their own and negotiate better contracts with PBMs.
- **Each PBM now owns a rebate aggregator,** and they don't want people to know about them. Do you as plan sponsors know what your contract says about rebate aggregators?
- When one of the plan sponsors goes to retain a PBM for its Medicare, Medicaid or self-funded plan business, they don't go out to bid – these are no-bid contracts.
- What does this mean to the cost of Medicare, Medicaid and self-funded plans? What about the cost to the patient?

## What is a Rebate Aggregator and why should a health plan care?

- Every PBM owns a rebate aggregator. What are the dangers?
- Have your inhouse counsel and benefits team look at your pharmacy benefits services agreement. **Does your contract tell you that the PBM you've retained has the right under the agreement to delegate services to a rebate aggregator?** If so, hire another company.
- **Does your contract tell you that the rebate aggregator they are going to hire is owned by the PBM?**
- The rebate aggregator collects rebates, takes a large part of those rebates and puts it in their pocket, then gives the balance to the PBM. The PBM then tells you they're going to give you 95% of the money they collected.
- **The PBM is not telling you that they own the rebate aggregator and just took a huge amount of money out of the system.**
- We tested this theory – **in our case the rebate aggregator took more than 50% of the manufacturer paid rebate dollars out of the system and put it in their pocket**.
- This is going on in Medicare, Medicaid and for the commercial space self-funded plans.

## Origins of a Costly Problem: Poorly Negotiated Pharmacy Benefit Services Agreements

- Across the country there is a growing awareness by plan sponsors that there is something wrong with the way PBMs are adjudicating the pharmacy benefit.
- A lot of this has to do with spread pricing, paying their own wholly owned specialty pharmacies more money and rebates.
- We need to do a better job negotiating the ability to audit the plan and have the ability to get health care data about pharmacy benefit transactions.
- Key contract terms that all health plans should know:
  - PBMs loosely define "rebates" – get an actual rebated versus a fixed rebate
  - Broad and vague "rebate exclusion"
  - Specialty pharmacy definition and "exclusion" from rebate guarantee

- “Flat Rebates” negotiated in advance:
- “Rebate Guarantee” provisions do not actually guarantee 100% pass through
- Plan sponsor’s rebate audit rights are limited by PBMs

## PBMs Masked Arrangements are Harmful to Patients

- The net price is the price the manufacturer receives after all discounts – 340b, rebates, off-invoice discounts.
- The gross-to-net bubble describes the difference between that gross price (AWP) and the net price. The total value of pharmaceutical manufacturers’ gross-to-net reductions for brand name drugs spiked to $175B in 2019.
- A piece of that belongs to each plan sponsor on this call today; you need a contract that better allows you to audit the PBM and get a bigger piece of those rebate dollars.

## Specialty Drug Carve-Out: Employer Experience

*Tom Traylor, Archimedes*

- From the perspective of large/jumbo employers, we knew about spread pricing and conflicts of ownership when the PBM owns fulfillment; we knew there was a conflict in chasing rebates and that you end up with a higher cost drug, and that there was a conflict in terms of rebate aggregators that are offshore companies and you could say there was a 100% pass through but some of it was staying with that aggregator; we knew that we’d rather get zero dollars of rebate for a drug that shouldn’t even be dispensed to begin with.
- How do we use that information and the data we have to move these large/jumbo employers’ benefit forward as we focus on taking more control?

## Challenge: Why Specialty PBM Carve-Out

- The US represents 7% of the world’s population yet it’s 50% of pharma’s revenue.
- Specialty was outpacing everything else in health care in terms of trend.

- *Employer Headwinds: Pharma*
  - Some drugs are extraordinarily impactful and help people tremendously and some are not worth the price they are being sold at.
  - An unfortunate side effect of the ACA was getting rid of lifetime maximums; overnight specialty drug pricing went through the roof.
- *Employer Headwinds: FDA*
  - Heavily pharma-funded
  - Drugs approved with limited evidence, specifically in the specialty space
  - Fast-tracking is a growing challenge
- *Employer Headwinds: Physicians*
  - Physicians want to do the right thing, but may not understand or be on the cutting edge of what's happening in terms of new drugs to market (clinical practice is 17 years behind the science)
  - They don't know the price of drugs
  - Reimbursement can influence prescribing
- *Employer Headwinds: PBMs*
  - Financial interests are not aligned when they can push a drug through their own pharmacies or specialty fulfillment and make a lot more money
  - Hidden pricing and revenue sources; PBM is incentivized to fulfill the drug, not to control it
  - Siloed management

## Employer Decision: Focus on Trend

- Set the foundation – required significant leverage and RFP negotiation to get all of this sitting in one contract
  - 100% transparent and pass through so we knew exactly what the pricing was and knew what we were getting
  - Drug level rebate reporting
  - Employer controls the benefit
- Edits/Carve Outs
  - Value-based coverage
  - Formulary management

    - Direct to retail contracts
- Specialty Focus
    - High-cost case management
    - Full specialty PBM carve out
    - Medical specialty carve out
    - Integrated approach across pharmacy and medical

## Results: Set up the specialty carve out

- *Unbundle the Conflict*: Eliminate the fact that the PBM owns fulfillment and carve out retail; 2% - 12% savings opportunity
- *Don't Chase Rebates*: Look at exclusions, look at the "stupid" drugs and focus on lowest net cost; for one jumbo employer, one contract edit was an $87M return. There is a lot of opportunity to look at formulary management.
- *Largest Impact and the Future:* Carve out specialty across PBM and medical; specialty is the highest trend in health care; 40% - 60% of your spend, now becoming chronic use; covering new drugs to market (75% of drugs in the pipeline are specialty drugs).

## Results with Carve Out

- After moving specialty out from a big three PBM to Archimedes, we saw an average savings of 26% - 51% across a large sampling of large employers (the average was 30% - 40% consistently minus the outliers).
- 40% was in clinical management, 60% in non-clinical
- The 46% - 53% prior authorization change rate comes down to absolutely eliminating waste.
- If you separate out the pitfalls that you find in these massive vertically integrated organizations where they own fulfillment, you will put yourself in a position where you can put carve out in your contract and use it as leverage and you will find a tremendous amount of opportunity.

## Questions

*What is it going to take for the system to change, especially among the most egregious practices? Will it be driven by employers? Legislation? Disruptive lawsuits?*

*Response from Tom*

- The first thing that needs to happen is a complete evaluation of how we buy drugs to include looking at quality adjusted life metrics in terms of new drugs to market or the current high spend drugs.
- It behooves every employer to immediately go out and do an RFP on your medical plan and on your PBM and say, you won't make to finalist unless you allow me to carve out.

*Response from Antonio*

- A lot more transparency is needed. We were only able to unlock the spread pricing in Ohio because we were able to squeeze knowledge out of publicly available data. This data is very imperfect.
- We can do a lot more to create more data transparency, which is what unlocks a lot of the dysfunction that is embedded in the contracts in the first place.

*Response from Jonathan*

- The litigation that's going to happen against the big players/PBMs that are all doing the same things is like the tobacco/asbestos litigations of decades past.
- MBGH has done an amazing job and your organization is really on it.
- The individual benefits leaders at the self-funded plans need to have a better understanding of what is contained in their contracts.
- Do you have the ability to audit the PBM? What does your contract say about rebates? Do you get all of the rebates? Does the PBM hire a rebate aggregator?

- There is a massive change happening in the industry and I don't believe a lot of legislation is needed. **You just need to negotiate better contracts.**

*Do you have any thoughts on fiduciary and what employers need to do to ensure they are covered?*

*Response from Jonathan*

- A fiduciary means that a partner, for example your PBM, is acting in your best interest not theirs.
- If you look at some of your contracts, the PBM says they are not acting as fiduciary. But under ERISA and some state laws, employers are fiduciary with respect to its agents (employees), so **self-funded plans have a duty to audit and negotiate better contracts.**
- Your employees are paying a copay based on that list price of a drug, not the other price.
- **If state legislation would say PBMs are fiduciaries in our state, that would change things.**

*Response from Antonio*

- The lesson here is that **PBMs are not looking out for your interests**, they're looking out for their own.
- It's something you have to recognize and until they are forced to act in your interest, expect them not to.

*Response from Tom*

- Demand 100% pass through and 100% transparency. Have it fully auditable.
- Separate fulfillment from actual management of it; it's not going to get you to full fiduciary, but it will eliminate as many conflicts as possible.

*Why aren't we doing more together? Do you think it makes sense for us to start collaborating more in meaningful ways to get the message out?*

*Response from Antonio*

- **We've got to break down the silos.** I think the consulting world, the broker world, employers and the provider community should all be huddling together to acknowledge the massive gap between them and the need to eliminate it.

*Response from Tom*

- When I went out with over two million lives to do an RFP with multiple employers, I definitely made it further than if I was doing it with a few.
- However, **there are mid-tier PBMs that are kicking the pants off of the big boys because they are getting to the lowest net cost through appropriate clinical usage and they've unbundled the conflict.**
- **I'd love to see a bunch of employers come together out of this and move forward.**

*Response from Jonathan*

- There are different stakeholders – there are manufacturers, wholesalers, plan sponsors, PBMs and providers.
- Each stakeholder has their own challenges in working together.
- Anti-trust rules limit providers; there is a growing awareness with plans and over the next year or two organizations like MBGH are going to help bridge that gap.

## Employer Panel

- *Darin Hinderman, Global Health Strategy, Manager Total Rewards, Caterpillar Inc.*
- *Jason Parrot, Senior VP, Enterprise Growth & Partnerships, Vida Health*
- *Sherri Samuels-Fuerst, Vice President, Total Rewards, Sargento Foods*
- *Tom Sondergeld, Director, Digital Awareness, Employer Health Innovation Roundtable*

*Many of us today were surprised to hear about groups like repurchasing organizations that are not transparent; they could be hiding rebates and you can't audit them. There are also health purchasing alliances that are more transparent and auditable. Please give us your feedback on this.*

*Response from Jason Parrot*

- From an employer self-funded, self-insured side, over the last three to four years I looked at everything to try to figure out how we could create a new construct that would remove all the misaligned incentives.
- We just said enough is enough – we decided to construct our own framework that is going to set the rules of the road for the PBMs and ultimately moved forward with an RFP and invited a bunch of PBMs to play ball.
- The key was they had to fundamentally agree without deviation to all our established terms and conditions, definitions, flexibility, control, audit ability rights without restrictions, definition of rebates – that was imperative to us.
- There was a lot of language that had to change and for us; as fiduciary, we had to take back control.
- More and more employers that are self-funded are moving away from the traditional spread pricing models because it doesn't make sense and moving to an acquisition cost model.
- We are setting the terms and conditions around the rights to audit any rebate aggregator or any GPO. If we don't, we're perpetuating the status quo.
- We learned through our RFP that there are established PBMs out there that don't want to deal with this type of construct.
- They don't want to bid on the business because it's going to be disruptive to their model and the revenue they could potentially bring in for their shareholders. There is too much downside financial risk.
- **Employers have the choice today – if you don't want to deal with the status quo with the contracts you have in place, you can make that pivot.**

- Find a proven advisor or consultant that understands what needs to get done. Run your due diligence to make sure you partner with someone who is independent, objective and not on the take from the PBMs financially.
- Demand in your RFP what rules and definitions you want and then move on to the financial phase and get the pricing.

*Any comments on GPOs versus HPA?*

*Response from Jason Parrot*

- GPOs are alive and well and that's not going to change any time soon.
- There is an alternative that can create their own employer-driven construct to take back that control and do what is the best interest on the self-funded employer side.

*Response from Tom Sondergeld*

- Group Purchasing Organizations (GPO) are typically done by health care entities; hospitals do them and now pharmacy benefit managers have started.
- They formulate an organization that is run by them but is separate; they buy en masse on behalf of the PBM – **the GPO is built by the PBM.**
- **They get to follow all the FTC rules and regulation around group purchasing organizations which make them not auditable.**
- They will come to the table and say they will save you money and they will.
- What they're then doing is keeping a bigger part of the spread and rebates that are now coming through the GPO as part of their revenue. That get passed back to the PBM.
- You as a buyer feel like you're getting a good discount. But in transparency rules, you're not getting it all.
- I**f you don't want to get 100% of your transparent benefit, it's a great solution.**
- **Health Purchasing Alliances (HPA) are typically formed by the buyer.**

- The employer joins an HPA and they buy medications or the health solutions together for that group.
- **They are auditable because the group defines the rules**, all the money in savings is passed back to the group members, they are not run by the PBMs – they can't be. They can join an HPA, but it's run by the employer.
- Most PBM contracts allow the employer to carve out portions of their pharmacy to other solutions like an HPA. So, an HPA could actually run a lot of your pharmacy benefits through your PBM.
- Check your contract to make sure you understand whether or not this is possible.

*Do the GPOs also include the pharmacy benefits offered by the consultant houses. Are those GPOs as well, with the same types of rules?*

*Response from Tom Sondergeld*

- Consulting houses have a harder time creating a GPO on their own.
- They are probably more likely to create or participate in an HPA.
- **Consulting houses are creating their own pharmacy consulting benefits solutions by partnering with the PBMs and bringing savings to the table in a consortium or coalition model.**
- They can be more transparent because the consultant is managing that contract. **What is not transparent is how much the consultant is getting from that piece.** Everybody gets a piece of the pie.

*Response from Darin Hinderman*

- I was unaware of GPOs until our discussion a couple of weeks ago.
- My first reaction was it's awesome if you can add a middleman to a middleman.
- It's an ideal situation for a PBM. We were starting to make inroads and they got scared – more companies were getting audit rights and are demanding transparency. So what does a PBM do? Figure out another way to hide the revenue stream (GPOs).

- **The PBMs have discovered a way to move money around based on how they purchase drugs that's not even based in the US and is not auditable.**
- This creates one more reason to move away from traditional models and even traditional PBMs, especially those that participate in these types of arrangements.

*Response from Sherri Samuels-Fuerst*

- We belong to an HPA coalition in Milwaukee, we're fully transparent and have full audit rights.
- We joined the HPA to reduce our administrative fee because that's all we pay with our PBM; we were staying with the same PBM, same pass through, totally transparent so we joined them for that reason.

*Any comments on where we need to go to reduce the waste and the egregious practices so we can offer the best price for these really high-cost gene therapies?*

*Response from Jason*

- There's no answer today. There are self-insured, self-funded employers that are covering these high-cost gene therapy and specialty products and they're invested in phase IV (real world evidence); we're hoping to see long-term durability and efficacy out of this but only time will tell if this holds up 10 years from now.
- I'm optimistic that these are promising cell and gene therapies that can be life changing and life altering.
- Many large/jumbo employers (like Boeing) have been covering these products from day one; there are small and mid-tier companies that simply can't afford it.
- So, you have two classes: the haves and have nots. Some of the have nots are doing it out of choice – they don't think it makes sense yet because it's not cost effective, and they don't have the data and evidence to show long-term effectiveness. And how do we fund it?

*Response from Darin*

- Employers are going to get a wake-up call; over the past 10 years we've funded the move in specialty pharmacy through the erosion of brands on the traditional benefit side.
- **We've not seen as significant a move in our pharmacy spend as we will see in the next 10 years**; our traditional pharmacy spend has gone from 40% generic utilization to 90% - everybody's has.
- We've funneled almost all of those cost savings into the specialty products that have come about since then. We're no longer going to be able to pull from that piggy bank.
- **The specialty drugs that are already launched and those in the pipeline are going to be direct impacts to our budgets**; we're going to have to start justifying the cost of these to our CFO.
- We have to put a script limit on these new therapies from a clinical efficacy perspective – are they the right thing for a certain disease state.
- We're going to have to use stringent clinical criteria for these medications that come out and only for the people who strictly qualify for them. Then you hope they work.
- If you allow the PBMs to set the clinical criteria, they're going to get approved because that's in their financial best interest.
- Employers taking over the clinical data, the clinical criteria and the clinical decision making is going to be even more pronounced in the coming years to help modify or limit the people who get these medications.

*Response from Sherri*

- For **small to mid-sized employers**, which a lot of us are, we don't have the expertise or resources to take over that clinical data.
- **We're going to have to lean on our consultants or brokers and make sure it's not the fox watching the hen house** even though we're a fully transparent model.

- We've always had a PBM consultant. Our broker consultant pharmacy benefits expert works in concert with me, our medical director at our onsite health and wellness center when necessary, and our PBM pharmacy (P & T).
- We work collaboratively on things because we don't have the manpower internally to do it ourselves.
- We need to get out in front of this before the horse is out of the barn.
- If the "big bad employer" doesn't cover it, word gets out especially in smaller communities. With the talent war going on right now, you are not going to be the employer of choice.

*Response from Darin*

- **We have a solution for small and mid-sized employers through MBGH right now and it's RxEvolution.**
- **The clinical backbone is already built** – cost-plus pricing models, formulary management, clinical decision making – all of it is built.
- **It's an awesome opportunity for small and mid-sized employers to band together**, come into one solution and have the clinical backbone that every large employer has.

*Response from Tom*

- The whole space needs to have a refocus. There's so much concentration on transparency when transparency hasn't been defined.
- Every time we try to uncover the next new leaf of transparency, something is created that hides more transparency.
- The middleman exists to be the middleman – in a democratic economy, they take money.
- As long as you have that structure and **until you get somebody who just charges a price for processing claims, you have to get everything else out of the way**.

- **Coming out of COVID will bring a lot of surprises to cost in the medical plans and in pharmacy benefits** where people didn't receive care and are now going to get care. We've all started to see that, but we haven't.
- **I think we're going to see it en masse in 2023** and we need to be prepared for it.
- In that will come the need to address cost pressures – pharmacy is one place where it exists, and we need to look for it and uncover all the places it exists.

*Comments from Cheryl*

- Coalitions like MBGH have never had major PBMs as members because they know how disruptive we are.
- We've seen the exodus of big health plans from coalitions because the big guys recognize that they don't want to make less money (unbundle what they've created).
- Those collaborative opportunities for real change aren't possible because they are hunkering down – that concerns us.

*What should we be focusing on – legislation? Employers pushing the envelope? Disruptive lawsuits?*

*Response from Tom*

- The landscape in DC is such a mess – you can't even get crucial things passed. I don't know if legislation will be the thing. The government initially focuses on Medicare and Medicaid and employers usually follow or the laws and regulations get extrapolated onto self-insured plans.
- **Employers need to be the voice – we're self-insured and it's our fiduciary responsibility to manage our plans on behalf of our members.** You can't pass that responsibility on to somebody else.
- We have the duty to pretend that our members are us and should fight for that in every contract and negotiation we have.
- We shouldn't be timid – **we should be demanding, forceful, creative and innovative.** That's our duty and responsibility.

- **We've seen more movement from self-insured employer involvement than we have from any regulatory involvement except for ACA.**

*Response from Sherri*

- **The contract is just one part – how do we make sure the drug manufacturer is making a fair profit but that the patient also gets the care they need?**
- Is there a way for us to do things through a 340b? For rare and genetic diseases, especially for small and mid-sized employers who can't afford it, is there any state assistance or opportunities like that?
- We have done direct contracting for 340b through Hemophilia Treatment Centers for a specific hemophilia case.
- **For a high-cost case we have right now, we're working together with the health plan and PBM – we try to have the health plan case manager work with the family.**
- We have to solve those problems because ultimately, we're not going to be able to afford health care for all of our family members on our plan because of a small percentage of those claims.
- **It's multi-faceted – how do we get upstream and downstream working together?**
- **It's also working one-off for these rare genetic diseases and having some plan language built around that** e.g. if there are centers of excellence like Hemophilia Treatment Centers for hemophilia. That may help mitigate some of the cost and get you the right pricing as well.

*Response from Darin*

- Over the years, the employer groups have been out there and the opportunity to disintermediate the PBM model is there. We've been talking about this for years.
- Still employers have just not felt the need or want to go down some of these roads because it's too hard, I don't have the staff – you hear all the excuses.

- **There are so many opportunities in the industry today that weren't there before to save money, to adjudicate a better plan, improve sustainability of the plan and affordability to your members.**
- **It's up to employers now to do this because that's what changes the industry.**

*Comments from Cheryl*

- The program MBGH offers is agnostic to what PBM you use — if they don't agree to what you want to do, you walk away from them. We're going to find a PBM that will. You're not alone in that process.

*Do you believe when PBMs say they provide pass-through retail pricing, they are passing through rates from a different contract with retail pharmacies – one that refers to pass through but for employers?*

*Response from Darin*

- They have multiple contracts and they go through multiple channels. They have employer-only pricing.
- Every contract is different for every single vendor, every single situation. It's in their financial interest to create that.

*Response from Sherri*

- Before we changed to our current pass through in 2010 we were with one of the large three and I had done some analysis – we called it the "fleecing of America."
- They were up charging even for generics.
- We now have a great partner.

*Is it difficult to determine what a "fair profit" is? What is a fair profit?*

*Response from Tom*

- The difficulty with profit is that it's defined by the company that is producing the product and has a revenue to achieve for their shareholders or their leadership.
- A PBM has a need to establish a profit. The problem is how they get to it.
- **They should just say, we're going to charge you this fair fee and that's all we're going to charge you (like a transparent PBM does).**
- Everything else is 100% pass through instead of trying to keep a piece here and there, widen the spread on AWP, create a MAC pricing list so they can keep more, create a GPO and share some of the profits, do something with rebates. How is that transparent? Technically the rebates belong to the plan, not the middleman.
- Profit is misnomer – I think they need to be transparent on what their margins are, what their operating costs are and then I can help them determine what their price should be as a self-insured employer.
- It should change based on the size of the employer.

*Response from Sherri*

- Supply and demand are going to determine profits and what they can charge if they can get away with it.
- We're in that full pass through so I go up the chain and go to the drug manufacturer and what's a reasonable profit.
- The bigger challenge is with these cell and gene therapies and what they cost. What we pay to our PBM and the rebates are nothing compared to what these are going to cost us. How do we mitigate those costs? The true cost is upstream much further than an admin fee or a rebate.
- **We need to be careful what we ask for.**

*Response from Darin*

- Profit margins of pharma companies are between 9% - 10%; for pharmacies that dispense the drugs, profit margins are less than that (3% - 5%).
- Profit margins for PBMs are in the 30% - 38% range on average.

- **Those making the most profit by margin is the PBM industry and they are just the middleman – they do not provide value into the system.**
- The value comes from the people who make the medications, the wholesalers who move them, and the pharmacies – the people who dispense them and get them to our people.
- Everything else is behind the scenes in adjudication and making sure your insurance works correctly.
- Where you place the value is not where the profit margins are and that's why more should be exposed on the PBM side to understand what the profit margins should be and how we should reimburse them.

*Comments from Cheryl*

- We've been talking for years about direct contracting with manufacturers. I think it makes sense to consider doing this with these high-cost gene therapies.
- When we go out to bid it is an opportunity to address this.

*Any comments on this?*

*Response from Darin*

- We've talked about direct contracting with manufacturers, but **we can do cost-plus pricing and direct contracting with our pharmacy partners already and move away from the AWP model. This is a good first step.**
- When you talk about contracting directly with manufacturers, that is hard. They won't do it for one drug – they need a portfolio of products. In this case you may be adding drugs to the formulary that you don't want.
- Going directly to pharmacy partners and setting up cost-plus models on acquisition cost plus is a great solution.
- It moves you out of the AWP model and gets you back to what they're paying for the drug and giving them a fair profit.
- That's already built – through RxEvolution you can take advantage of cost-plus pricing and move away from AWP. That's where I would start.

## The Cost of Insulin: Has Legislation Had an Impact?

*Judy Hearn, Director of Membership Initiatives, MBGH*

- The average price of insulin has skyrocketed in recent years, tripling 2002 – 2013, then doubling between 2012 - 2016 which made this essential medicine unaffordable for many.
- This can greatly impact the health and well-being of people with diabetes, whether they have type 1 or type 2 diabetes.
- Insulin rationing (taking smaller doses or skipping doses all together) is becoming more common than our health system would like to admit.
- State legislatures across the country reacted by setting maximums on monthly insulin copays to resolve the affordability facing many of those who require insulin every day.
- At least 16 states have enacted these limits; the Illinois legislation was effective January 21, 2021, and their maximum copay is $100/month.
- In comparison, Medicare part D plans have set a $35/month maximum copay.
- The vast majority of state legislations only cover those plans that are fully insured or state Medicaid plans.
- What about the uninsured employers who have self-insured plans?
- ERISA has an exemption for self-insured plans, so you are not subject to state legislation and the mandates they may put in place.

### What can you do as a self-insured employer about insulin affordability?

- **If you offer a high deductible health plan, there are options on how to treat coverage for insulin.**
- In July 2019 the **federal government updated guidelines for HDHPs to include adding insulin and other glucose lowering agents to the**

**preventive drug list** which allows coverage for those medications before reaching that deductible.

- Having to reach the deductible before getting access to drugs such as insulin can have a major impact.
- Many employers have said that state legislation has not impacted their decisions on pharmacy benefits in general and/or making insulin more affordable.
- **Many of you already have drug copay maximums as part of your regular drug benefits. Make sure that insulin is among them.**
- There are multiple forms of insulin and many PBM formularies restrict which insulin is available to your covered population.
- **For a person with diabetes requiring insulin, having to change from one product to another can wreak havoc on their health. Whenever possible, offer all of the different forms of insulin on your formulary.**
- Keeping individuals compliant with their insulin and other medications is critical to their health and to the health of your bottom line.

### Action Steps for Self-Insured Employers

- Centers for Medicare and Medicaid Services guidance is to cap insulin copays at $35 for a range of access.
- Ensure all insulins are on your formulary
- Review your formulary for insulin placement; understand where it is and what the costs are.
- For cost sharing, place insulin on the lowest price tier possible, reduce the copay, or reduce the coinsurance.
- Consider allowing the use of copay cards.
- For value-based design strategies, if you add a care model for achieving lower HbA1c you can lower the cost share for compliant individuals or remove the cost share. These programs can allow engaged members with diabetes to receive their insulin at a reduced cost or for free.
- Annual contract reviews with your PBM and your medical carriers are really essential.

- For performance guarantees, make sure you're doing a true-up at the end of the year and that you're auditing them.

### More Information

- Remember to check out MBGH's Diabetes in the Workplace Toolkit for information and resources.

## Midwest Health Purchasers Collaborative Partner Update

*Denise Giambalvo, Vice President, MBGH*

**These are our trusted partners** – all have been fully vetted through an employer advisory board and they're available to you at a reduced rate as an MBGH member:

- Carrum Health
- Day Two
- RxResults
- Inspera Health
- Health Strategy
- Shortlister

### Carrum Health 2020 Outcomes: The new standard for Centers of Excellence

Results from an employer study from RAND based on Carrum's COE platform:

- Surgeries that were in these claims were for spinal fusion, total joint replacement, and bariatric weight loss surgery.
- 30% of unnecessary surgeries were avoided; there was an 80% reduction in complications and readmissions
- They drove the proven savings through ROI for their mature clients and had greater than 45% savings per procedure versus market.
- The patient experience resulted in a 96 Net Promoter Score and 90% were engaged on the mobile app.

- The lead researcher from RAND stated: Both employers and patients can see immediate and significant savings on completed surgeries while getting high quality care from the top hospitals around the country.

### Day Two Diabetes Management Program: One Year Outcomes

- They have precision nutrition in place.
- Outcomes after one year include a drop in A1C (1.0+), time in range increased 69%, weight loss average was 11lbs+, 88% were engaged, there was a 34% decrease in medication.
- Energy and sleep quality improved, stress was reduced (as was hunger) and the Net Promoter Score was 87.
- They are moving people with type 2 diabetes into remission and having great success.

### Inspera Health: Engagement Leads to Outcomes

- Inspera works with people who have multiple chronic conditions.
- Members with baseline A1C above 7 saw a 14% drop; decrease of 9% in BMI (baseline greater than 30); there were also decreases in blood pressure, glucose and LDL.
- This is a whole health approach so there was great improvement in mental health which improved by 43%; improved care gaps by 83% and had a 94 Net Promoter Score.
- After 12 months, 84% were still engaged; they recommend 12 – 18 months minimum in their program.

### 2020 Shortlister Connect Stats

- This is a platform to help you find and vet out vendors (it's an RFP process).
- 137 employers used Shortlister to research vendors and issue RFPs (10 MBGH members).
- 3,500 vendors are available in the platform, the largest database of unbiased and objective information on vendors in the benefits and insurance space.

- 22 million lives out to RFP through Shortlister in 2020
- Our members who have used Shortlister have been very pleased with the results; they have greater confidence when they contracted with the finalist.

### Health Strategy: 2020 Pharmacy Benefits Consulting Outcomes

- They are part of RxEvolution
- They have $50B in pharmacy spend currently under management; 30 self-funded employer groups and 10 national/regional health plans.
- More than 30 clients are supported with customized formulary management.
- They have conducted 15 pharmacy benefit management RPF procurement processes.
- Launched Rx Marketplace with 13 PBMs, making it easier for the midsize employer to go to RFP and get a response in less than a month.
- Six clients were supported with a specialty PBM carve-out arrangement.
- Ten PBM market checks were completed and five PBM contract renewals negotiated.

### RxResults: Formulary RxGuidance Results

- This was spun out of the evidence-based prescription program directed by Dwight Davis at the University of Arkansas College of Pharmacy. They provide formulary Rx guidance.
- Year one to year two, there was a 46% decrease in plan paid, 66% decrease in average plan paid per script; 10% increase in generic utilization; 49% decrease in member paid per script.
- They offer Specialty Rx Guidance and have an independent P & T committee to set clinical criteria and run independent prior authorization on all specialty drugs.
- They had $1.7M in prior authorization savings (99 prior auth results for specialty medications over a 24-month period).

## New to Market: A Better Rebate Solution

- This is an opportunity for us to build on what Dwight Davis has already started at the College of Pharmacy through the evidence-based prescription program.
- We are working with Health Strategy to identify PBMs in advance who will participate in the program; RxResults also has a total solution to put in place.
- This is an opportunity to go direct to manufacturer to get the right drugs to your member at the right time for the right price for all the right reasons (meeting all of the clinical criteria).
- This is about setting the formulary then talking to manufacturers about rebates for those drugs.
- We'll be ready to fully launch in 2022.

## Employer Case Study: Employee Population & Medical Design At-A-Glance

- Total of 8,815 employees (average 11,000 members)
- They had tried many different plan design strategies including copay, predictable cost to steer towards generics; coinsurance with lower minimums and maximums to steer to preferred brand name; no separate deductible; mandatory maintenance.
- They changed PBMs and had a more restrictive formulary, eliminated outlier drugs and had a lower employee subsidy for the dependent portion of total medical contributions.
- After going out to RFP and choosing to go direct, the PBM they chose is with their health plan/carrier.
- Their anticipated savings over three years was $7.855M
- Have total transparency; their current admin fee is 2/3 less; 100% of identifiable rebates are coming back; have increased flexibility so they can pull more levers.
- In 2021 they removed the outlier drugs and adopted the Performance Select Drug Formulary with minimal disruption and $636K in annual savings.

- Net PMPM increases from 2017 – 2019 have dropped; in 2020 they saw a 7.4% decrease in their PMPM.

## Next Steps

- Restrictive formularies: Adopting PBM's Performance Drug list, their most restrictive with $223,000 additional savings
- Reviewing the resulting PBM supplied restricted formulary with independent Rx consultant and further restrict the formulary
- Will proactively review drugs in the pipeline to gain an understanding of possible impact on pharmacy plan
- Supply their own specialty drugs
- Investigated but eliminated the possibility of direct contracting with a pharmacy