Employer Forum on Pharmacy Benefits & Specialty Drugs

Managing Drug Spend for High-Cost Therapies

June 23, 2021

MBGH
Midwest Business Group on Health
Catalysts for Change in Health Care & Benefits

Welcome and Overview

Cheryl Larson

President & CEO

MBGH

Catalysts for **Change** in Health Care & Benefits

Midwest Business Group on Health

Since 1980 – One of the nation's leading and largest non-profit coalitions of HR/health benefits professionals

4M+ Lives – Represent more than 135 mid, large & jumbo self-insured public & private companies

$12B+ – Annual employer member spend on health care

Community of Your Peers – A sharing and friendly environment to help you collaborate, benchmark and learn

Trusted Source – Helping benefits professionals find solutions to better manage the cost of benefits and the health of employees and families

Upcoming Programs – register at mbgh.org

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July 13 – 11:30AM to 12:30PM CT

Microbiome….The Future of Diabetes

July 14 – 9:00AM to 10:30AM CT

***Employer-Only**: Executive Briefing on The National Diabetes Prevention Program: Managing the Risk of Prediabetes*

August 3 – 10:00AM to 12:30PM CT

Purchaser Expectations for Providers, Payers & Suppliers

Save the Date!

May 4-5, 2022 – *We're back in person!*

MBGH 42nd Annual Conference: JW Marriott, Chicago

New MBGH Website

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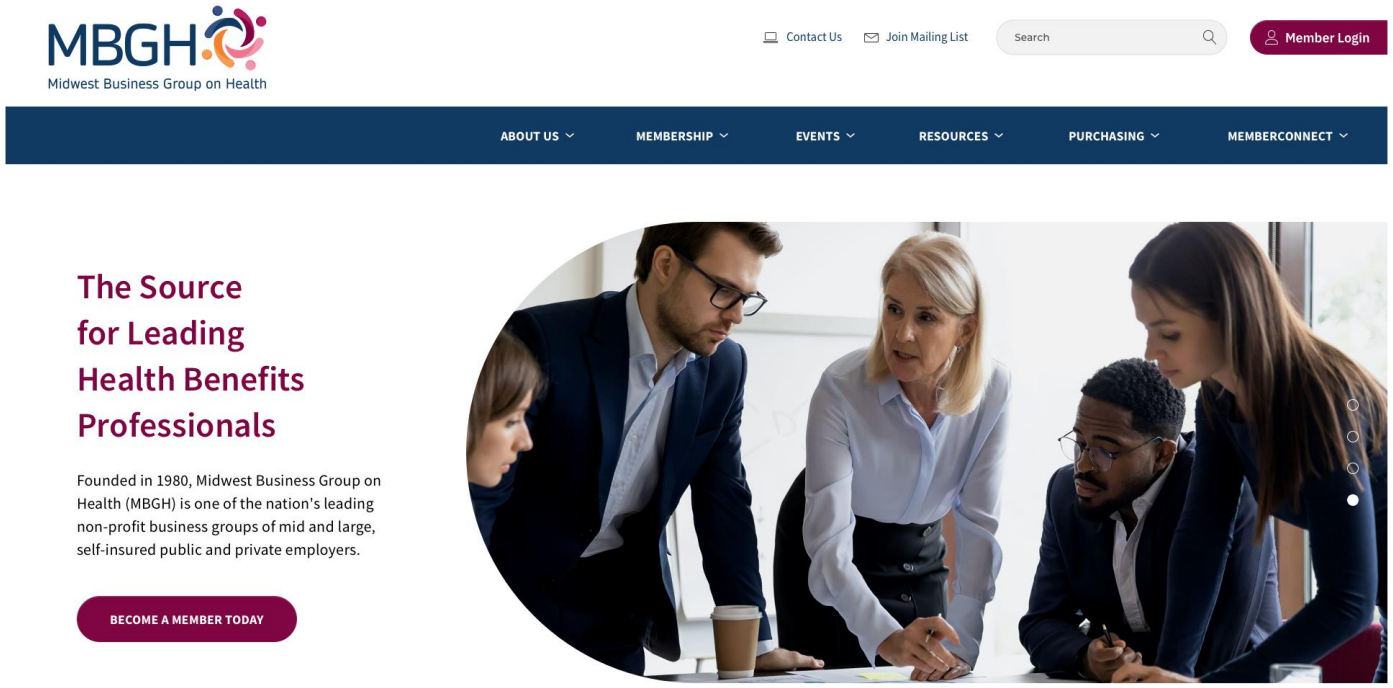

Employer Resources

Benchmarking Surveys | Program Summaries | Action Briefs | Turnkey Toolkits | Covid-19

Employer Toolkits

Midwest Business Group on Health

Coming Soon

Employer Member Benefits

Roundtables

Peer-to-peer meetings for employer members to share and learn from each other on leading topics, pandemic-related actions and best practices

member connect

Platform for REAL-TIME employer benchmarking, sharing best practices and gathering insights from your peers!

Posted a question for the first time, and I just want to tell you all how easy it is to use and what a wonderful tool it is. I love it! *MBGH Member*

Benchmarking Surveys

Quickly learn what other employers are doing in benefits and connect to dig deeper

2021 topics: Engagement Vendors; Managing COVID in India

Community-Based Initiatives

- Vaccine Hesitancy
- Improving Mental Health in Chicagoland
- Promoting Employer Awareness of Cancer Prevention
- COVID-19 Long-Haulers

Partnerships

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American Benefits Council

IBI INTEGRATED BENEFITS INSTITUTE

catalyst FOR PAYMENT REFORM

ebri.org Employee Benefit Research Institute

THELEAPFROGGROUP

PBMI Pharmacy Benefit Management Institute®

WELCOA WELLNESS COUNCIL OF AMERICA

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HRCI® Accredited Program

HR Certification Institute® (HRCI®) Continuing Education

- Activity/Program ID: 557663
- Employer Forum on Pharmacy Benefits & Specialty Drugs: Managing Drug Spend for High-Cost Therapies
- Credit Hours Awarded: 4.75 HR (General)

For questions, contact Cristina Evans cevans@mbgh.org

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Stay Connected with MBGH!

Share today's learnings on social media including Twitter and LinkedIn

Use these Hashtags:

#mbghevent
#specialtydrugs
#pharmacybenefits
#healthcarecosts
#highcosttherapies

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member connect

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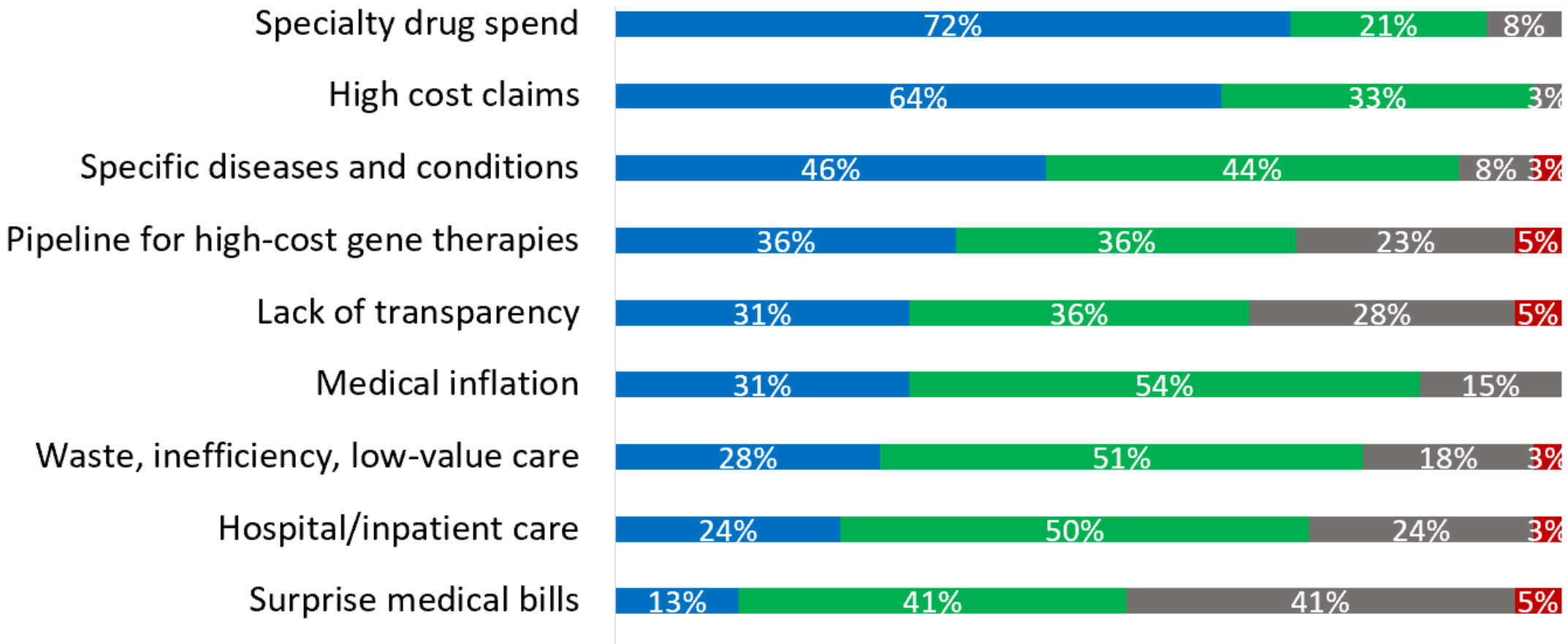
MBGH Annual Employer Benchmarking Survey

2020/2021

Midwest Business Group on Health

Catalysts for Change in Health Care & Benefits

Top Threats to Affordability of Employer-Sponsored Coverage



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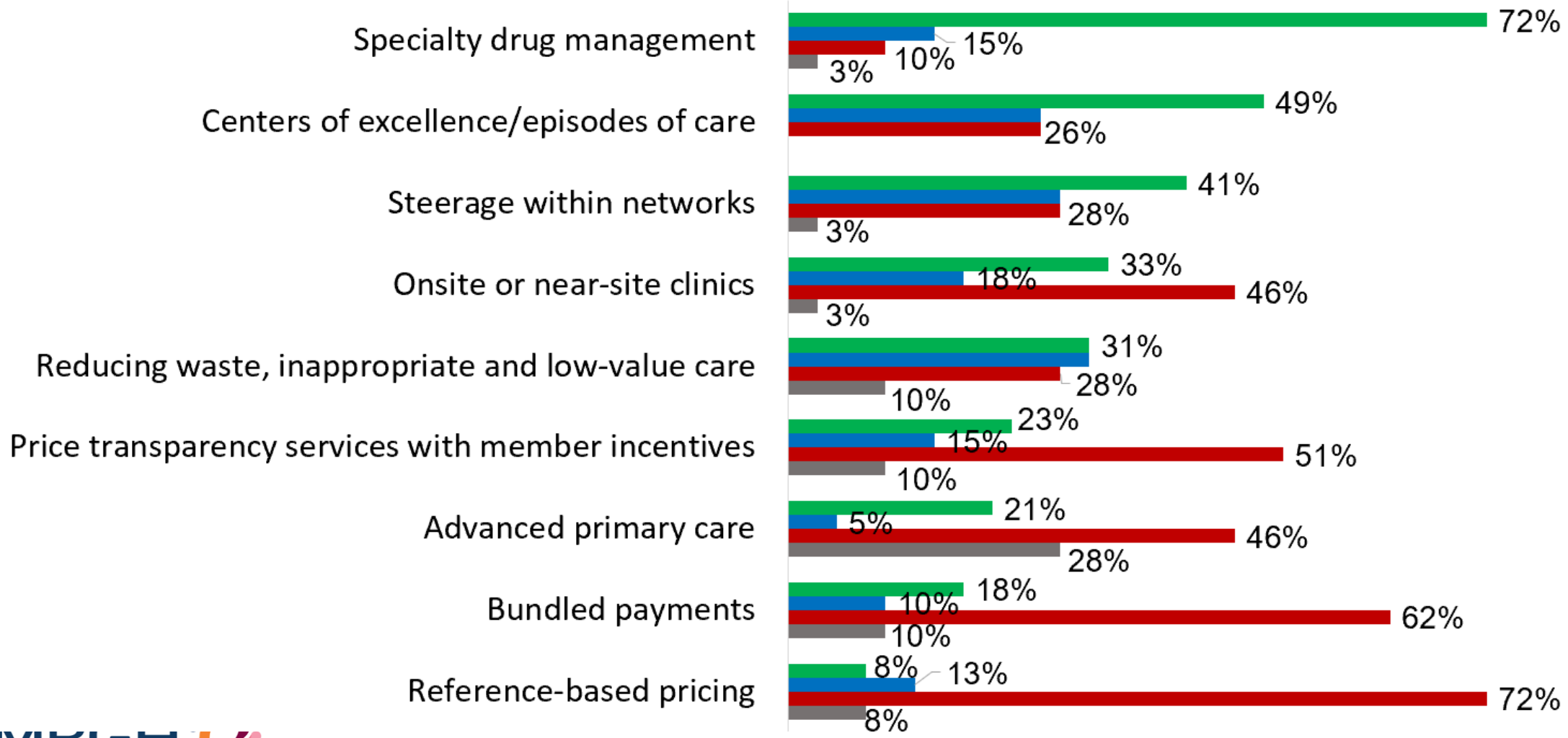
Payment Reform Strategies



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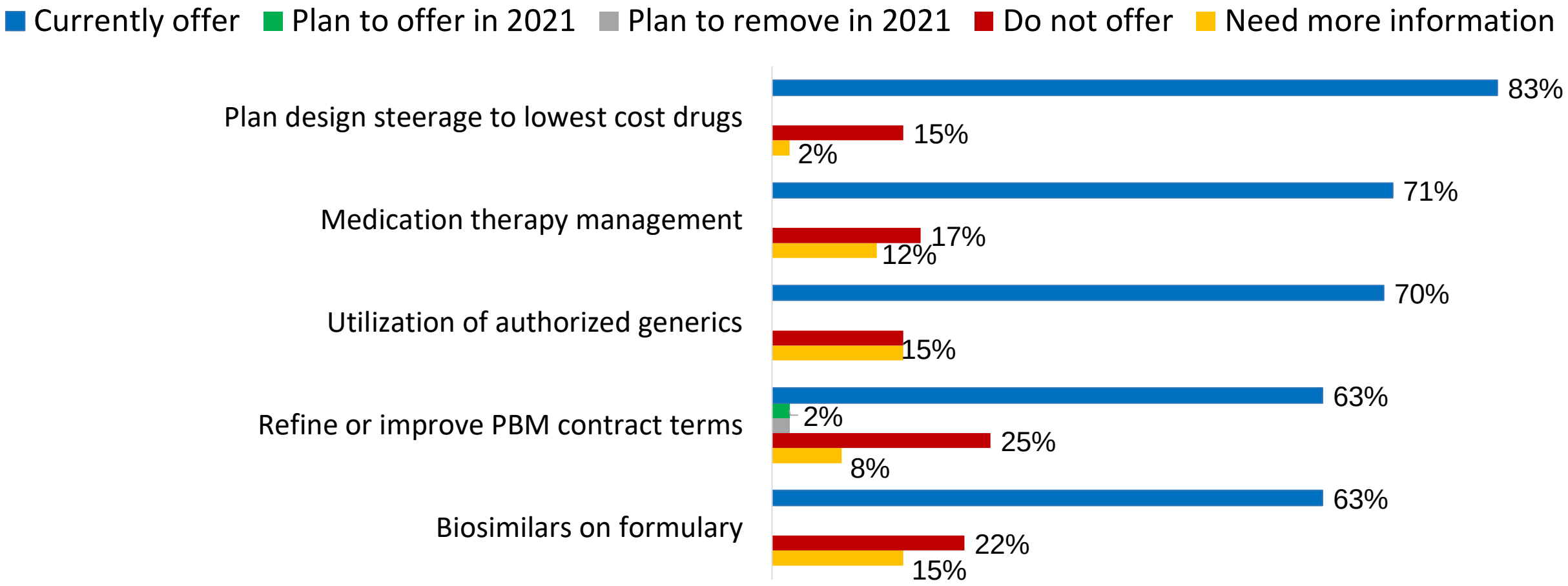
Pharmacy Benefit Strategies



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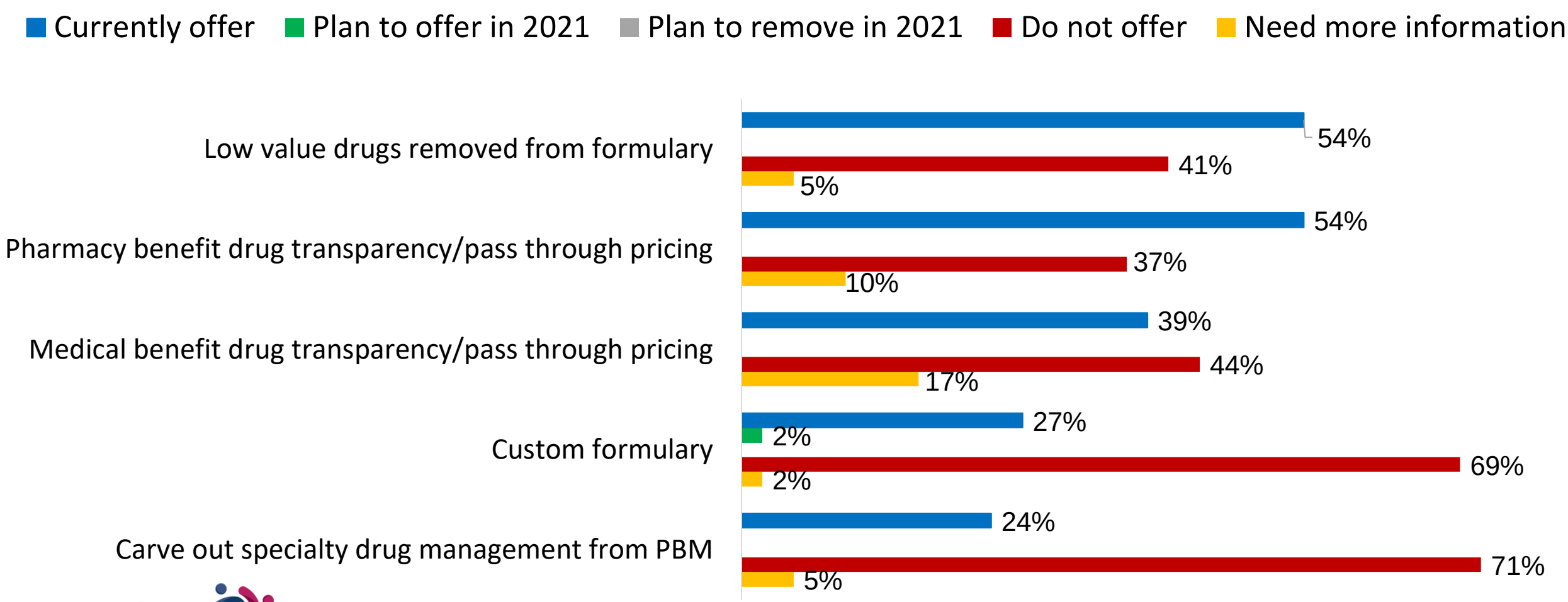
Pharmacy Benefit Strategies



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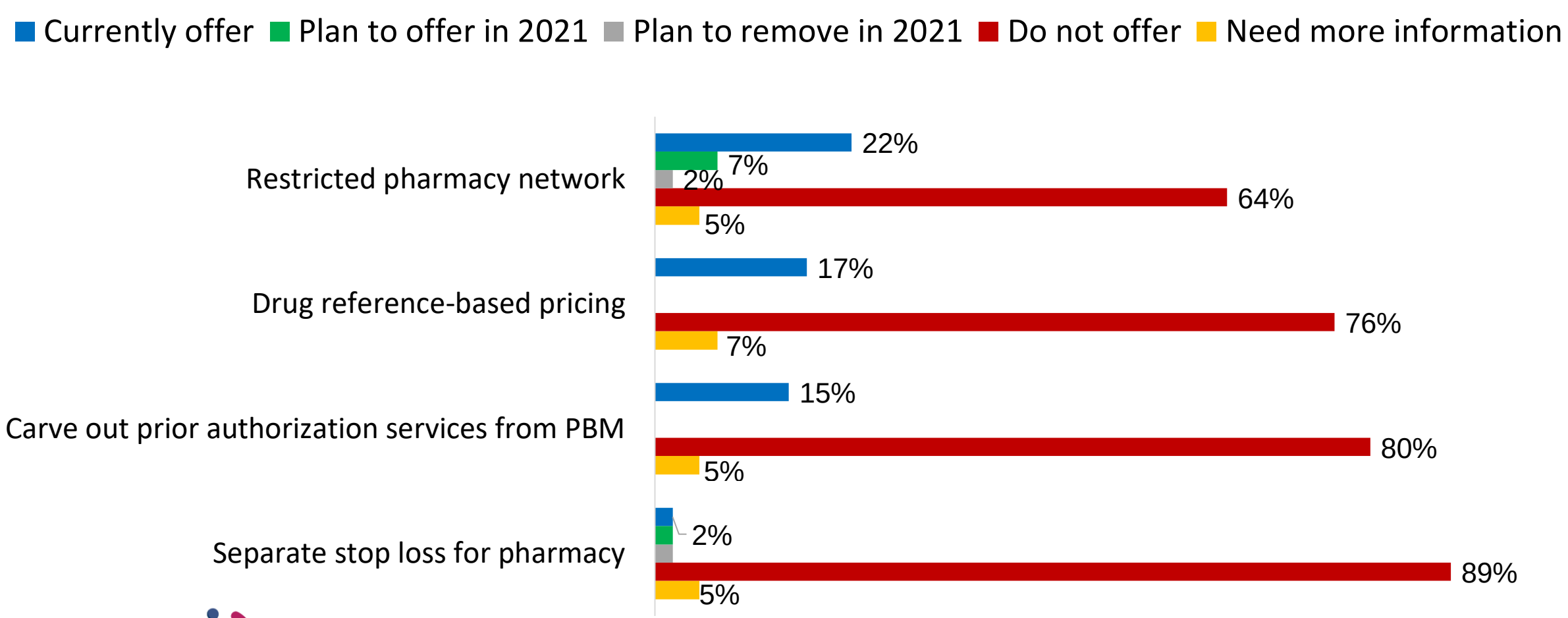
Pharmacy Benefit Strategies



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National Employer Initiative on Specialty Drugs

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- Employer Advisory Council of large self-insured employers
- Employer Benchmarking & Action Briefs
  - Coming Fall 2021 – Emerging Coverage Strategies for High-Cost, Rare Disease & Gene Therapies
  - 2020 – Precision Medicine in Pharmacy Design: Pharmacogenomics & Pharmacogenetics
  - 2020 – Transforming Pharmacy Benefits: The Role of Biosimilars'
  - 2018 – Drawing a Line in the Sand: Employers Must Rethink Pharmacy Benefit Strategies…… Middlemen continue to add to the cost of drugs
- Employer Online toolkit – www.specialtyrxtoolkit.org
- Annual Forum on Pharmacy Benefits & Specialty Drugs
- Annual Multi-stakeholder Meeting for Project Stakeholders
- National educational presentations

National Employer Initiative on Specialty Drugs
Employer Focused, Employer Driven
MBGH

Employer Perspectives

We shouldn't be saying we're not covering a drug because it's high cost, especially if there's no other solutions. The drug must be considered appropriate by the FDA, medical societies and data. We're willing to look at other options.

There will be a time and place for these therapies, but it may not be through the health plan. We could do a carve-out or something that people can opt into – a whole separate medical plan similar to a voluntary benefit with a third party. We can't continue to bring risk onto balance sheets if we know the cost of the drug may out-strip profit.

We need longitudinal evidence and that's often lacking along with a lot of uncertainty. We've seen wide variability in contracting from plans across the US when comparing one to another; decisions on what to cover out of the gate or negotiate a better deal or wait.

It would be a rare instance where we're going to stop covering a drug unless the cost per year was more than our company made in revenue that year.

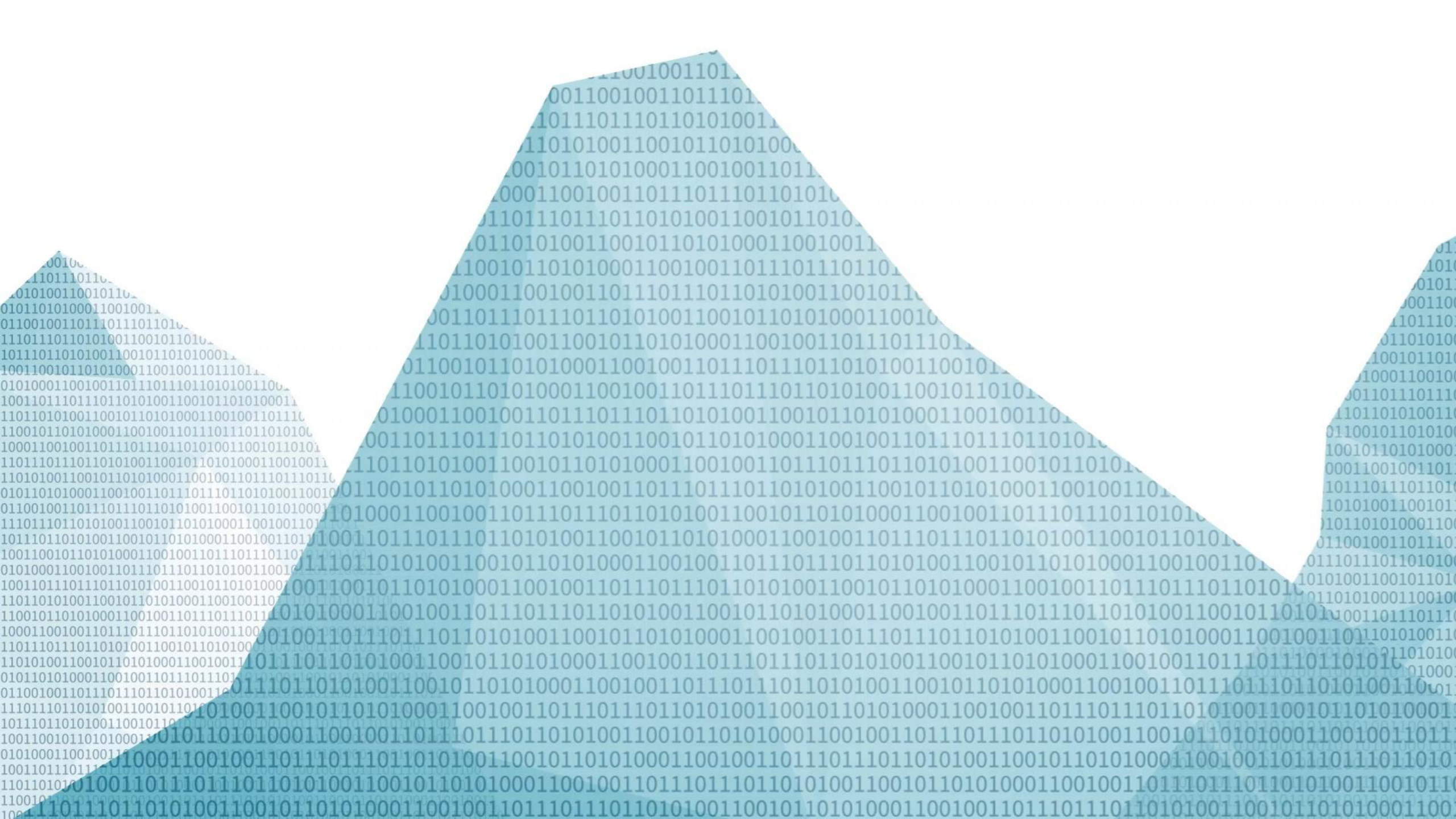
More employers and insurers are unwilling to cover these drugs and those willing are pulling all levers on UM and PA to ensure the right product at the right time and which drugs work and don't work.

Certain regions have a large mark up and wide differences with high-cost therapies and mark-ups the providers apply (they have the right to do this in contracts with health plans and take it to the fullest extent). This is waste within the system we have to address.

Employers don't want to play God and they have fiduciary responsibility. The tipping point is when cost hits over that threshold and it makes you stand up and take notice; that's when we become aggressive. We must do whatever we can to advocate for the patient while finding every avenue possible to mitigate cost.

In the end, employers need to identify new ways to pay for high-cost drugs

a word from our sponsor



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

Dwight Davis PharmD

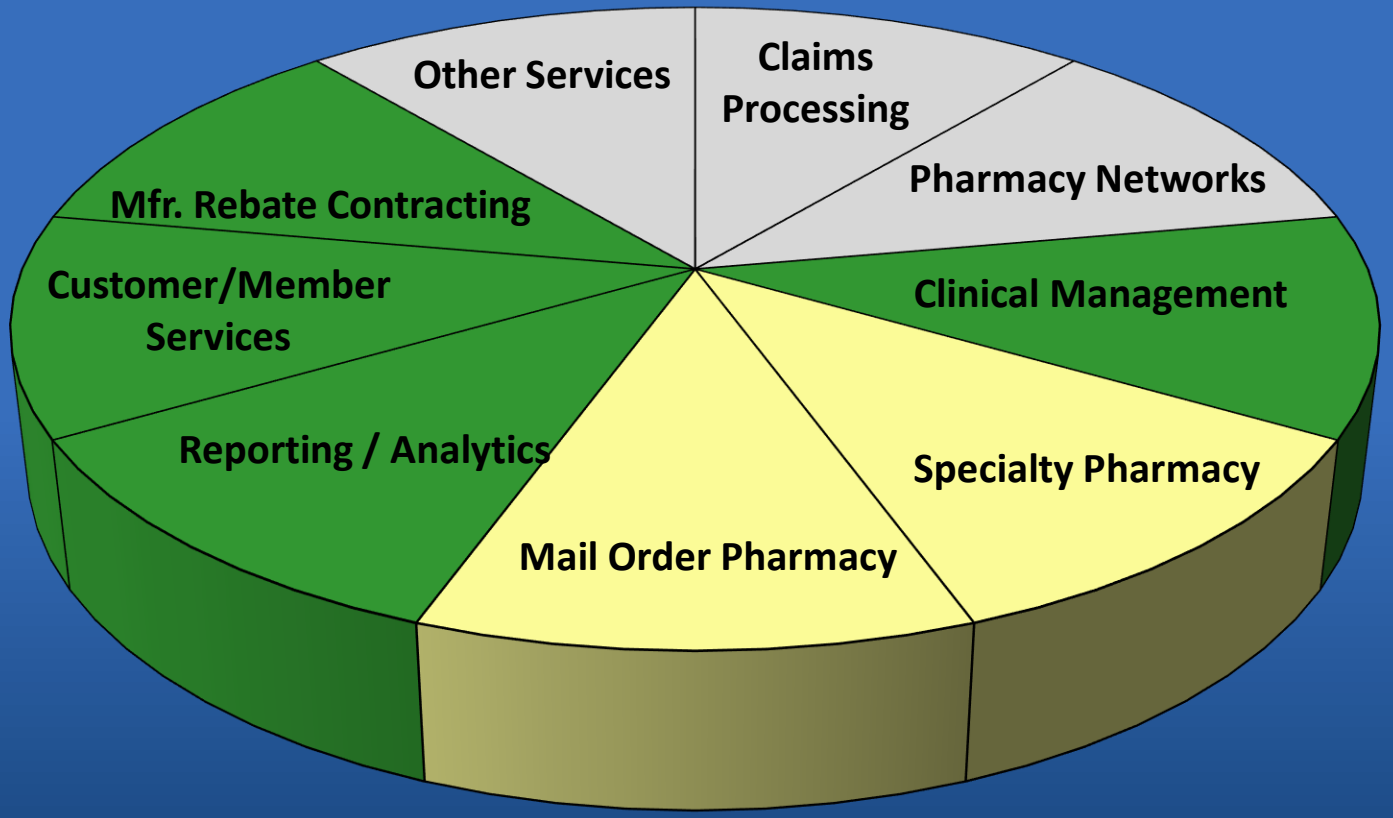
Director, Evidence-Based Prescription Drug Program

UAMS College of Pharmacy

Evidence-Based Prescription Drug Program (EBRx) - Overview

- EBRx is a service unit within the UAMS College of Pharmacy
- Established in 2004 to construct/manage the Arkansas Medicaid Preferred Drug List (PDL)
- Additional partnerships:
  - Arkansas Employee Benefits Division (EBD) – State Employees / Public School Employees
  - Arkansas State University
  - Arkansas State Police
  - Arkansas Municipal League group health and workers compensation plans
  - Public Employee Claims Division (state workers compensation plan)
  - University of Arkansas System
  - RxResults

EBRx Pharmacy Benefit Management Model



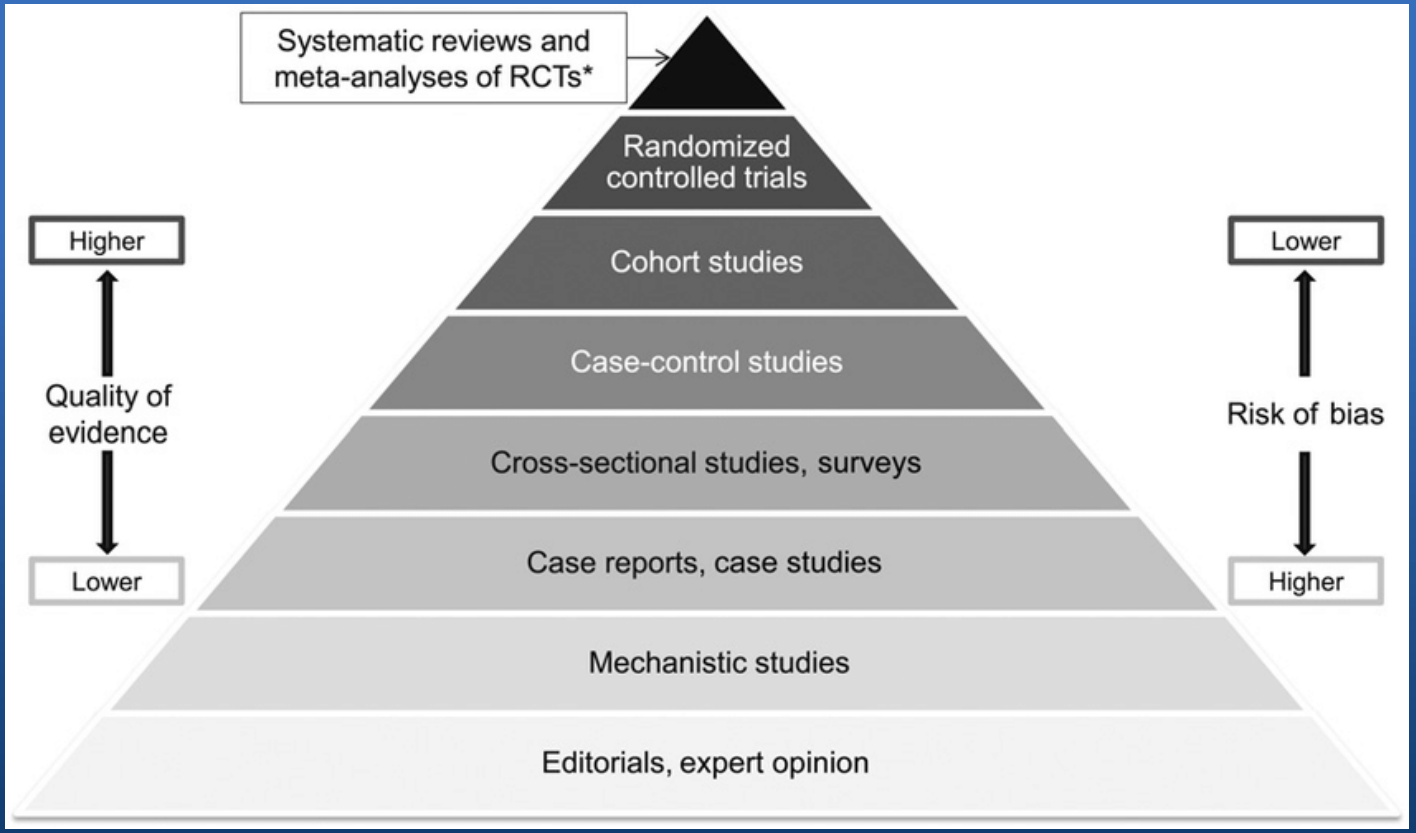
Green – EBRx Services
Grey – PBM services
Yellow – PBM services overseen by EBRx

EBRx Services

- **Drug Review Process** - through the EBRx Pharmacy and Therapeutics Committee – includes new and existing drugs, traditional and specialty drugs and those distributed through community pharmacies as well as some medically administered.
- **Drug coverage / prior authorization criteria development**
- **Pharmacy Benefit Programming and Coordination with the PBM**
- **Policy Enforcement through the EBRx Prior Authorization Call Center / Physician Appeals Management**
- **Other Program Design Features** (e.g. reference-based pricing, etc.)
- **Manufacturer Rebate Management**
- **PBM contract review / relationship management**

EBRx Formulary Management Approach

- All drug reviews consist of evaluation of the best current peer-reviewed published evidence using the general hierarchy below.
- Availability of evidence may not align with FDA-approved product labeling.



Examples of Low-Value drugs based on critical literature review

- Exondys-51 – excerpt from the package FDA label / package insert

> _____ INDICATIONS AND USAGE _____
> EXONDYS 51 is an antisense oligonucleotide indicated for the treatment of Duchenne muscular dystrophy (DMD) in patients who have a confirmed mutation of the DMD gene that is amenable to exon 51 skipping. This indication is approved under accelerated approval based on an increase in dystrophin in skeletal muscle observed in some patients treated with EXONDYS 51 [see Clinical Studies (14)]. Continued approval for this indication may be contingent upon verification of a clinical benefit in confirmatory trials. (1)

- HP Acthar® Injection – compared to low-cost injectable corticosteroids
- Hyaluronic Acid knee injections – compared to saline injections
- Multiple oncology agents – progression-free survival with little to no overall survival benefit
- Selected diabetes agents (e.g. Januvia®, Onglyza®) – no cardiovascular benefit

Summary of the EBRx Pharmacy & Therapeutics (P&T) Committee

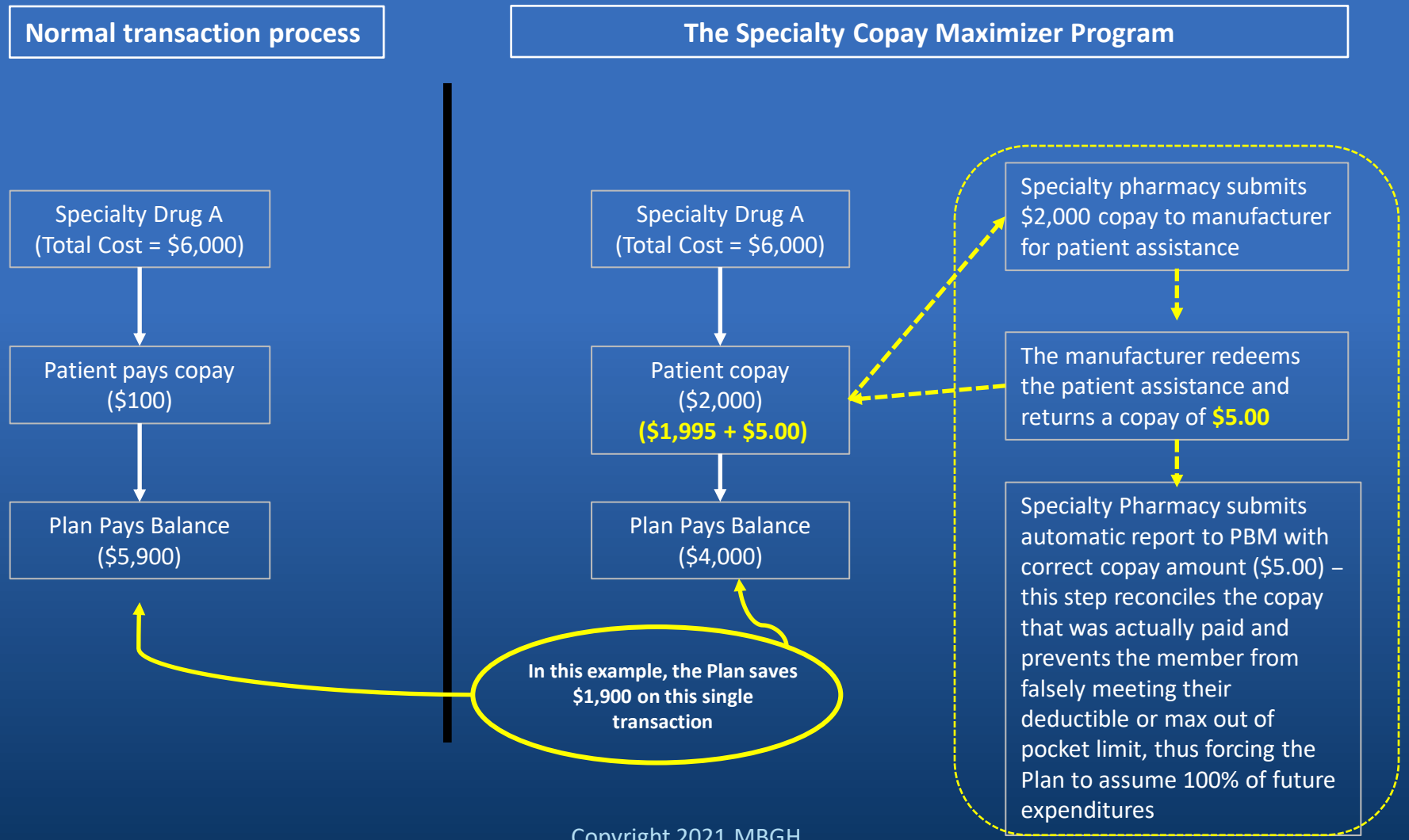
	Drugs Reviewed - CY2020			
EBRx Recommendation →	**Cover w/o Restrictions**	**Cover w/PA**	**Exclude**	**Total**
# Drugs Reviewed	10	25	95	130
% Drugs Reviewed	7.70%	19.20%	73.10%	100%

Of the 130 drugs evaluated by the EBRx P&T Committee during CY2020, 73% were recommended for exclusion from coverage.

Additional Cost-Savings Approaches

- Coverage / Prior Authorization polices 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



Current Specialty Drug Landscape

- In general, specialty drugs account for approximately 0.5% - 1.0% of total prescription claims and > 50% of total plan spend.
- The most common specialty categories are:
  - Immune Modulators – treatments for rheumatoid arthritis, plaque psoriasis, Crohn's Disease, etc.
  - Multiple Sclerosis Agents
  - Oncology / Cancer Agents
  - HIV/AIDS
  - Asthma/COPD
  - Endocrine / Metabolic Disorders
- New Drug Pipeline is consumed by specialty categories (e.g. oncology agents, orphan drugs, gene therapies)

Role of Biosimilars

Innovator Drug	Biosimilar(s)	Indication(s)
Remicade® (infliximab)	Renflexis, Inflectra, Avsola	Rheumatoid arthritis, Crohn's Disease
Neupogen® (filgrastim)	Nivestym, Zarxio	Neutropenia
Neulasta® (pegfilgrastim)	Fulphila, Nyvepria, Ziextenzo, Udenyca	Neutropenia
Avastin® (bevacizumab)	Mvasi	Cancer, macular degeneration
Herceptin® (trastuzumab)	Kanjinti, Trazimera, Ontruzant, Herzuma, Ogivri	Cancer
Rituxan® (rituximab)	Riabni, Ruxience, Truxima	Multiple sclerosis, rheumatoid arthritis
Epogen®, Procrit® (epoetin)	Retacrit	Anemia

Note: Currently no FDA-approved biosimilars are considered interchangable without the prescriber's approval.

Misc. Approved Gene Therapies

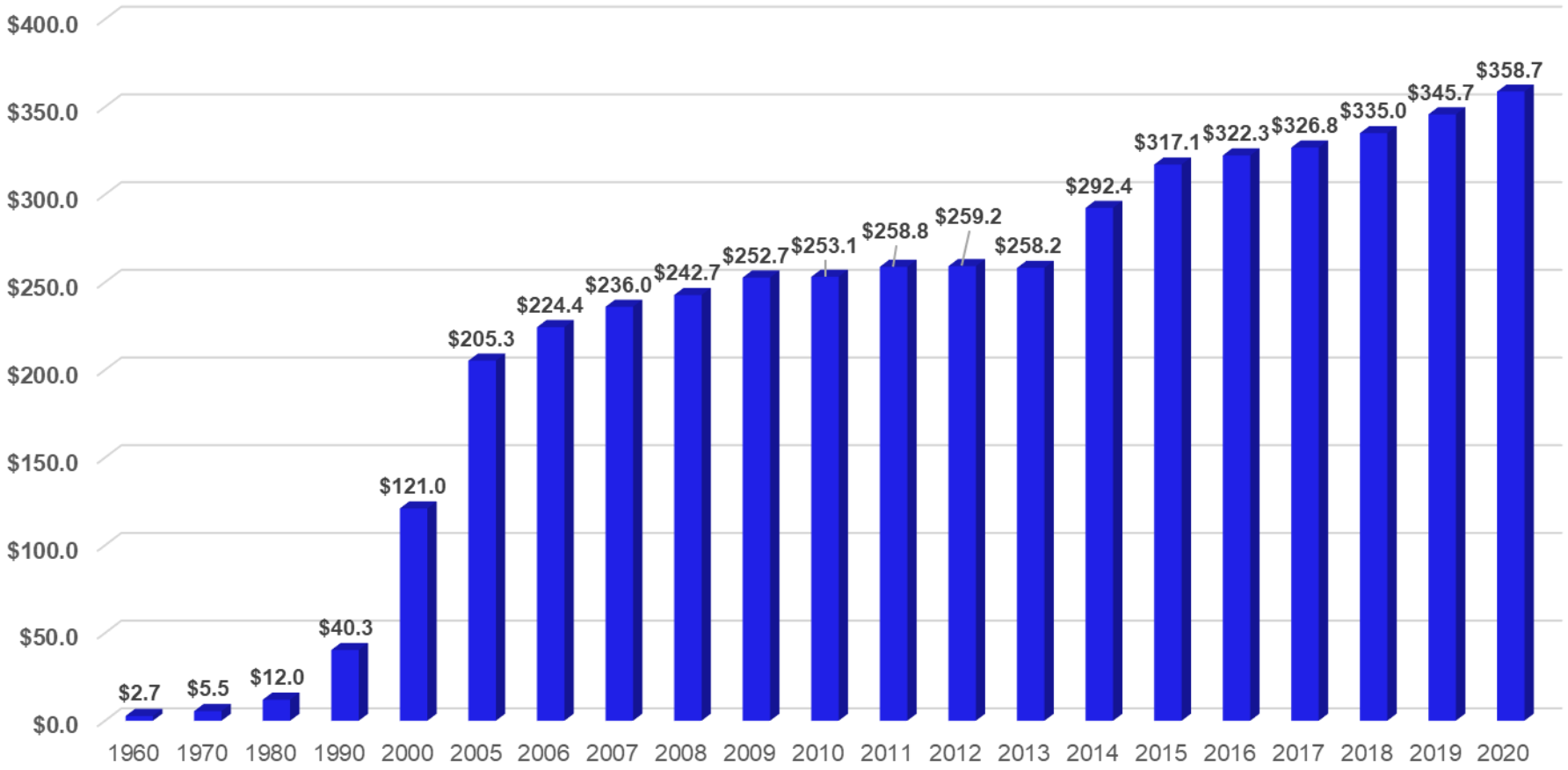
Tradename:	Generic Name:	Indication:
Breyanzi®	lisocabtagene maraleucel	Relapsed or refractory large B-cell lymphoma
Imlygic®	talimogene laherparepvec	Unresectable cutaneous, subcutaneous, and nodal lesions in patients with melanoma recurrent after initial surgery
Kymriah®	tisagenlecleucel	For the treatment of pediatric and young adult patients (age 3-25 years) with B-cell precursor acute lymphoblastic leukemia (ALL) that is refractory or in second or later relapse. Adult patients with relapsed or refractory (r/r) large B-cell lymphoma after two or more lines of systemic therapy including diffuse large B-cell lymphoma (DLBCL) not otherwise specified, high grade B-cell lymphoma and DLBCL arising from follicular lymphoma.
Azficel-T®	laviv	Indicated for improvement of the appearance of moderate to severe nasolabial fold wrinkles in adults
Luxturna®	voretigene neparvovec-rzyl	Biallelic *RPE65* mutation-associated retinal dystrophy
Provenge®	sipuleucel-T	Metastatic castrate resistant (hormone refractory) prostate cancer
Tecartus®	brexucabtagene autoleucel	Relapsed/refractory mantle cell lymphoma
Yescarta®	axicabtagene ciloleucel	Relapsed or refractory large B-cell lymphoma
Zolgensma®	onasemnogene abeparvovec-xioi	Spinal muscular atrophy – Type 1

Legislative Involvement is Essential for Payers

- During this year's 93rd General Assembly in Arkansas;
  - 36 bills became law related to healthcare
  - Although the vast majority of bills were well-intentioned, some had potentially devastating financial consequences for health plans.

ACT	Description
97	Requires healthcare insurers to base step therapy protocols on clinical practice guidelines or published peer-reviewed literature.
965	Requires a healthcare insurer to include cost-sharing amounts paid by the enrollee or on the enrollee's behalf when calculating an enrollee's contribution to cost-sharing requirements
1104	Prohibits a pharmaceutical manufacturer from providing a manufacturer discount of an insulin product unless provided directly to the end user in a coupon card. Requires the discount to be processed prior to submitting a claim to healthcare payer.
1105	Authorizes healthcare providers to make a determination in the best interest of the enrollee to bill the healthcare payer or pharmacy benefits carrier; prohibits payers and pharmacy benefits carriers from placing certain requirements on enrollees

Prescription drug expenditure in the United States from 1960 to 2020 (in billion U.S. dollars)



Source: CMS.gov – only includes retail sales

Drug Costs and Transparency

- Over half of US physicians are seeing patient costs for drugs at prescribing for some of their patients. Missing are:
  - Costs for existing medications not just new prescriptions
  - Total cost of drugs net of 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 use 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

Related:

1. **State and federal governments are enacting cost transparency rules (CMS 4180, CA/AB752).**
2. **Government rulemaking lacks clear definitions and proven savings strategies.**
3. **There is no recognized market leader or strategy in savings from drug cost transparency.**

Obstacles and Related Considerations

Obstacle to Drug Cost Savings	Possible Policy Response
Not all payers/PBMs provide cost transparency	Raise the bar for Medicare plans beyond CMS-4180
Payers show few lower cost alternative drugs for MDs	Use more prescriptive language defining “alternatives” beyond CMS-4180 and CA AB 752
Payers do not show total drug costs net of rebates	Use More prescriptive language defining “costs” to include total net of rebates in CMS-4180 and CA AB 752 and similar legislation
Patients lack simple means to identify lower cost options for existing medications.	Mandate simple means (web, mobile, on-demand in mail, etc.) for patients to request a list of lower costs alternatives to existing medications similar to CMS-4180 and CA AB 752 and similar legislation
Patients lack incentives to move to lower cost drugs 40% of the time	Promote shared patient savings for lower cost drugs similar to lower cost providers in CMS-9115-F
MDs lack incentives to lower drug costs	Support reimbursement for time spent considering lower cost alternatives to existing medications
MDs lack training and support for MDs to consider lower cost alternatives- some have no EHR	Support PharmD reimbursement for consulting with MDs to identify lower cost alternative medications
There are few recognized market leaders showing savings from cost transparency	Blue Shield of CA appears to have made the most progress in delivering results and savings

Some Plans are Delivering Results

blue california

Blue Shield of California's Innovative Drug Cost Transparency Initiative Provides $20 Million in Prescription Savings

Nonprofit health plan's collaboration with Gemini Health empowers medical providers, patients to make informed decisions on more affordable prescriptions

By Carrie Kirby | October 15, 2020

One in four patients say that they or a family member have skipped filling a prescription because they could not afford it, according to the California Medical Association .

When patients forgo medication it's understandably distressing for medical providers, who know that a patient's wellness – even their life – depends on following the treatment plan. And the problem is only getting starker. U.S. drug spending hit $335 billion in 2018, more than double spent in 2002, according to the Centers for Medicare and Medicaid Services.

Questions?

Employer Panel on Leading Trends

Denise Giambalvo

Vice President

MBGH

Kim Foerster

Director, Pharmacy Account Management

Blue Cross Blue Shield of Michigan

Demmy McBride

Manager, Health & Welfare Benefits

Ford Motor Company

Biosimilar Strategy
Success of Partnership

Demmy McBride
Manager, Health & Welfare Benefits
Ford Motor Company

Kim Foerster
Director, Pharmacy Account Management
Blue Cross Blue Shield of Michigan

WHAT IS A BIOSIMILAR?

Reference Product

A reference product is the single biological product, already approved by FDA, against which a proposed biosimilar product is compared

Biosimilar Product

A biosimilar is a biological product that is highly similar and has no clinically meaningful differences from an existing FDA-approved reference product

Meets FDA's rigorous approval standards	Safe option for patients	Effective option for patients
✓	✓	✓
✓	✓	✓

A biosimilar is approved by FDA after rigorous evaluation and testing by the applicant

Prescribers and patients should have no concerns about using these medications instead of reference products because biosimilars:

- Meet FDA's rigorous standards for approval
- Are manufactured in FDA-licensed facilities
- Are tracked as part of post-market surveillance to ensure continued safety

Blue Cross Blue Shield Blue Care Network of Michigan

Strategy: **Lowest net-cost preferred**

- Each reference product and its biosimilar products are reviewed individually, case by case, to determine lowest net-cost based on drug pricing and available rebates
- Biosimilars are typically 25% or more lower net cost than brand name innovator drugs (drug cost + rebates)

MARKET

- 29 Biosimilars approved to date
  - 17 oncology biosimilars launched to market (from five oncology innovator drugs)

TOP DRUG SPEND

- In 3Q20, two of the top 10 drugs by cost were innovator products with an available biosimilar
  - Rituxan ranked 7th
  - Neulasta ranked 8th
  - Avastin ranked 12th
  - Herceptin ranked 16th
- Remicade ranked 1st in 2019

MODELS

- Parity
- Preferred
- Exclusive

CONSIDERATIONS

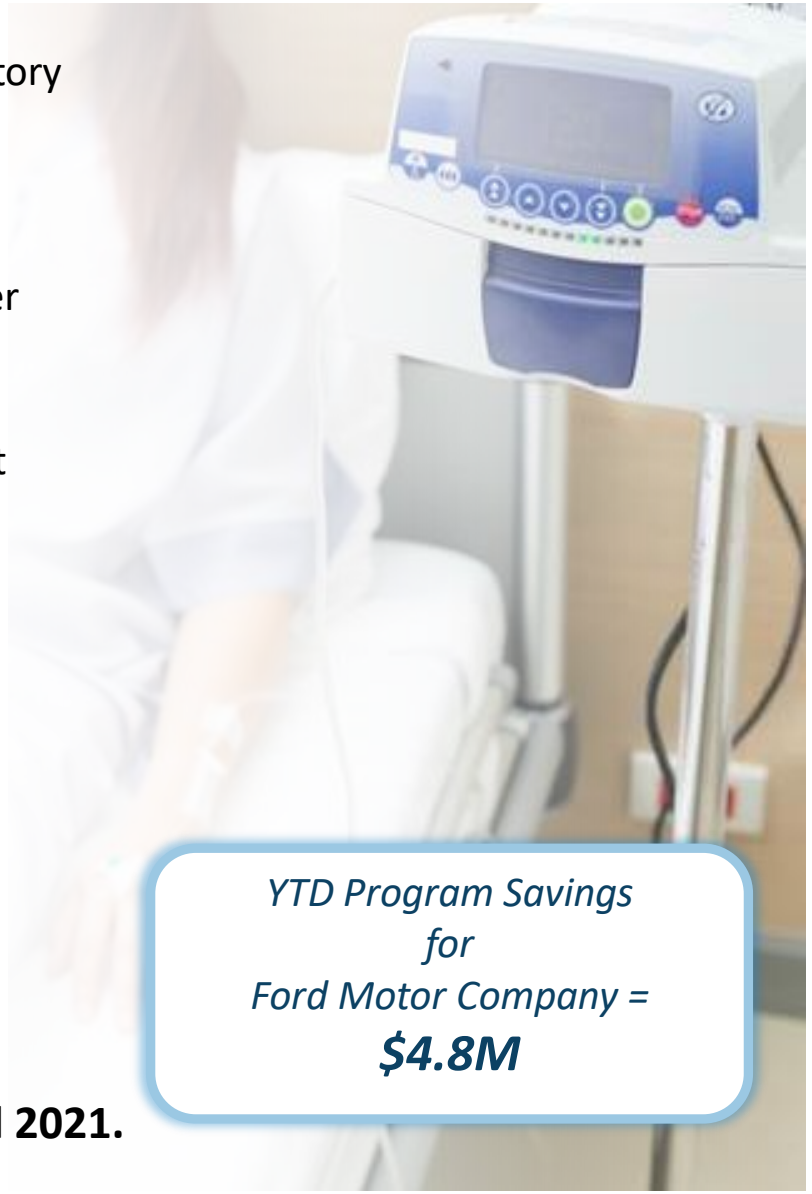
- Integration of Pharmacy and Medical Benefit
- Side Effect Profile
- Provider and Member Disruption
- Overall Savings
- Rebate Savings
- Future Biosimilar Pipeline

BIOSIMILAR PROGRAM CASE STUDY

Blue Cross Blue Shield Blue Care Network of Michigan

- Infliximab (innovator brand name Remicade) is used to treat a number of chronic inflammatory conditions such as rheumatoid arthritis, ulcerative colitis, and psoriasis
- Infliximab is the highest spend medical drug in total allowed amount for Blue Cross (~$140 million annually for all commercial LOB), with about 23,000 annual infusions
- The FDA has approved several infliximab biosimilars. Inflectra (Pfizer), launched in December 2016, has emerged as the leader in terms of pricing and contracting strategies, and general market acceptance.
- In 2019, implemented an imfliximab biosimilar preferred strategy requiring new and current utilizers of Remicade to convert to infliximab biosimilar.

Ford Benefit Plan	Infliximab Transition Rate
Blue Cross Blue Shield of Michigan HMO	91.3%
Blue Cross Blue Shield of Michigan PPO	86.6%
Ford HMO	100%
Ford PPO	88.1%



YTD Program Savings for Ford Motor Company = ***$4.8M***

Program now expanded to Herceptin, Neulasta, Avastin, and Rituxan in 2020 and 2021.

Blue Cross Blue Shield Blue Care Network of Michigan

Management: biosimilars preferred

What

- Adjust fee schedules payments for innovator and biosimilar
- After market share shifts, consider preferred biosimilar products

Why

- Currently rebates offered on both reference and biosimilar products
- Promote lowest net-cost products

Who

- Members new to therapy will receive a biosimilar
- Members currently in treatment are uninterrupted; allowed to complete treatment course with brand/innovator (up to 6 months approval)

FORD MOTOR COMPANY BIOSIMILAR PROGRAM RECOMMENDATIONS

Ford Motor Company

- ✓ Work with a trusted partner; you don't need to be the expert
- ✓ Significant benefit cost savings opportunity
- ✓ Equal member outcomes without member disruption; don't put the member in the middle
- ✓ Member communication is critical to support smooth transition to preferred products

Blue Cross Blue Shield of Michigan

- ✓ Understand the strategy; rebate driven versus lowest net cost
- ✓ Consider member experience; provider focused decision-making and grandfathering options
- ✓ Clinically supported program
- ✓ Future value dependent on integrated benefits

Questions?

Next Presentation at 12:40 PM CST!

Achieving Outcomes through Specialty PBM & Medial Services Carveouts

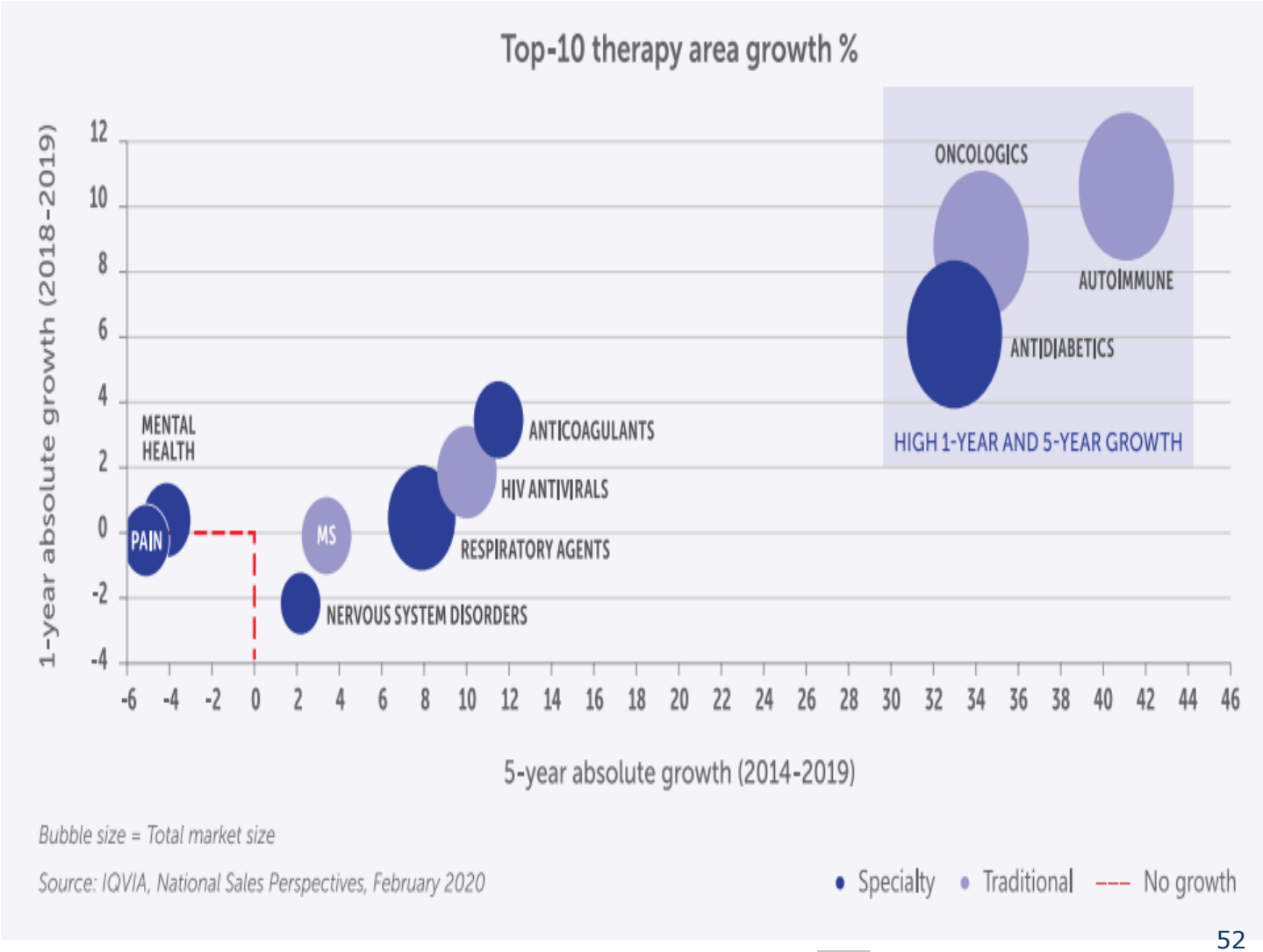
Amy Ball, PharmD

Chief Pharmacy Officer

Health Strategy LLC

Pharmacy Trend

- Overall pharmacy trends have been in the low single digits or negative, but Specialty Drug trend continues to grow
- More than 50% of plan spend is for Specialty Drugs
- Leading conditions driving plan spend in Specialty; Inflammatory conditions, Oncology HIV and Multiple Sclerosis
- Strategies to mitigate Specialty Trend
  - Formulary management
  - Distribution, Channel & Days supply management
  - Copay assistance programs
  - Medical Specialty management



Formulary Management

Less control → More control

Market *Current* State
PBM Controlled Formulary

- **PBM makes all formulary drug coverage decisions**
- **Many times incentive for PBM to add drugs to the formulary is driven by rebate**
- No transparency to true net cost
- Bundled rebate contracts allow patent extension type products to be covered on the formulary in preferred status
- Products with shorter patent life are not preferred agents and newer agents are chosen as preferred for longer term rebate contracting
- **PBM creates and administers prior authorization (PA) criteria**
- No real incentive to create aggressive criteria, especially when PBM owns retail, mail and or specialty pharmacy

Market *Future* State
Plan Sponsor Custom Exclusions

- **Employer makes own drug coverage decisions**
- This could be a full custom formulary or a partial custom formulary
- **Evaluate all new to market drugs**
- Clinical efficacy and cost-effectiveness relative to other products already on the market
- Generally, little to no impact on rebates or rebate guarantees because no utilization and no market uptake data
- Ensures Low clinical value products, like patent extension products, are excluded from the formulary
- No negative member impact, if New Drug to Market block is in place with PBM

Formulary Management

- Recent Specialty Brand and Generic launches in MS
  - Kesimpta – is a CD20-directed cytolytic antibody, same MOA as ocrelizumab (Ocrevus)
    - Indicated for the treatment of relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease in adults
    - Kesimpta is the 15th disease modifying drug the FDA-approved for RRMS
      - 4th agent for self-administered SubQ injection
        - interferon beta-1b (Betaseron/Extavia), interferon beta-1a (Rebif), glatiramer (Copaxone/Glatopa)
    - Benefit of being self-administered, ***but more than twice as much as Ocrevus***
      - Kesimpta - $135K first year due to loadig dose, $100K annually thereafter
      - Ocrevus – IV infusion – 3 infusions year 1 (1st does split in half and given 2 weeks apart) and Every 6 months thereafter – annual cost $~67K
  - Bafiertam (monomethyl fumarate) - approved via the 505(b)(2) pathway, and bases its efficacy and principal safety data in the PI upon Tecfidera's trials: Tecfidera's prodrug form is not systemically detectable following administration, so Bafiertam achieved approval on the basis of bioavailability equivalence to the monomethyl fumarate levels attained post-Tecfidera administration - $84K per year – oral therapy
  - Vumerity – oral therapy - $100K/year - approved via the 505(b)(2) pathway via Tecfidera – prodrug of dimethyl fumarate
  - Generic Tecfidera (dimethyl fumarate) - $12K a year and Brand - $120K a year

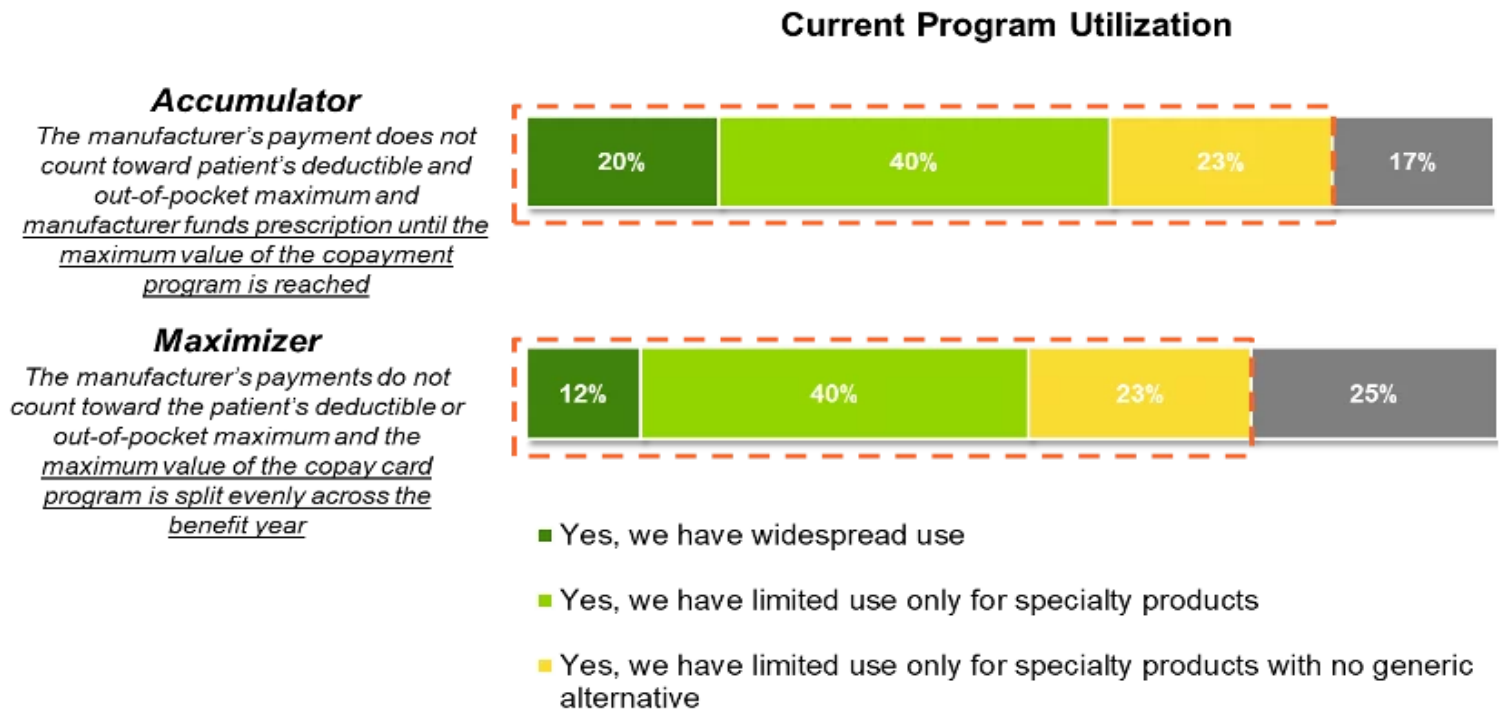
Distribution, Channel, & Days Supply Mgmt

- Distribution options
  - PBM owned Specialty pharmacy
  - Carve out direct contract with Specialty pharmacy for distribution
    - AWP discount
      - Ensure there is an aggressive generic discount guarantee
    - Cost Plus pricing
  - Carve out of PBM services to a separate PBM for Specialty Pharmacy Services
- Channel Management
  - Open Specialty network
  - Exclusive Specialty network
- Days Supply management
  - Limit fills to a 30-day supply
    - Some drugs will require a 90 day or greater days supply based on dosing frequency

Copay Assistance Programs

- Manufacturer copay assistance programs used to lower member and plan spend
  - Variable copay program to access manufacturer copay assistance
  - True accumulator programs to ensure only the amount of true member out of pocket accumulates
- Copay assistance programs have been very successful at lowering plan spend on Specialty Drugs
- In 2018, Reuters estimated 17% of employers with > 5K lives were using a copay assistance program in their plan
  - Significantly more PBMs offer these programs today

Figure 1: Current Utilization of Co-pay Mitigation by Sampled Commercial Lives



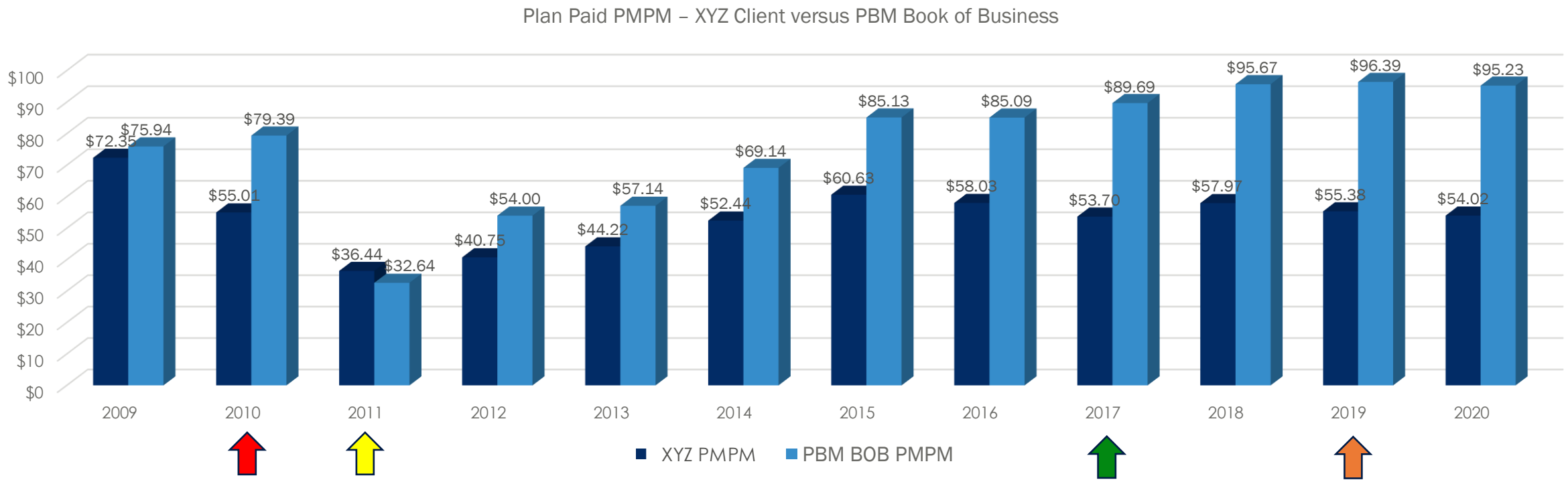
Source: Guidehouse Primary Research Analysis (2020), N=16 representing 65% of commercial lives adjusted to 100%

Medical Specialty Management

- It has been estimated that half of the overall Specialty Drug spend is under the medical benefit
  - There is often limited visibility to that data and utilization
- This will continue to grow as the pipeline continues to bring to market new, high-cost therapies for rare disease and cancer
  - Magellan 2020 Medical Specialty trend report showed a 14% increase in PMPM trend for medical specialty drugs and a 58% trend from 2015 to 2019 in the commercial population
  - Top drivers of these trends were Oncology and oncology support agents, drug for auto-immune disease, and significant growth in Ocrevus use for MS
- Strategies to help mitigate trends for Medical Specialty include
  - Dose optimization
  - Vial Rounding
  - Weight-Based dosing
  - Site of Care
  - Copay assistance
  - Managing duplicate billing

Client Trend History

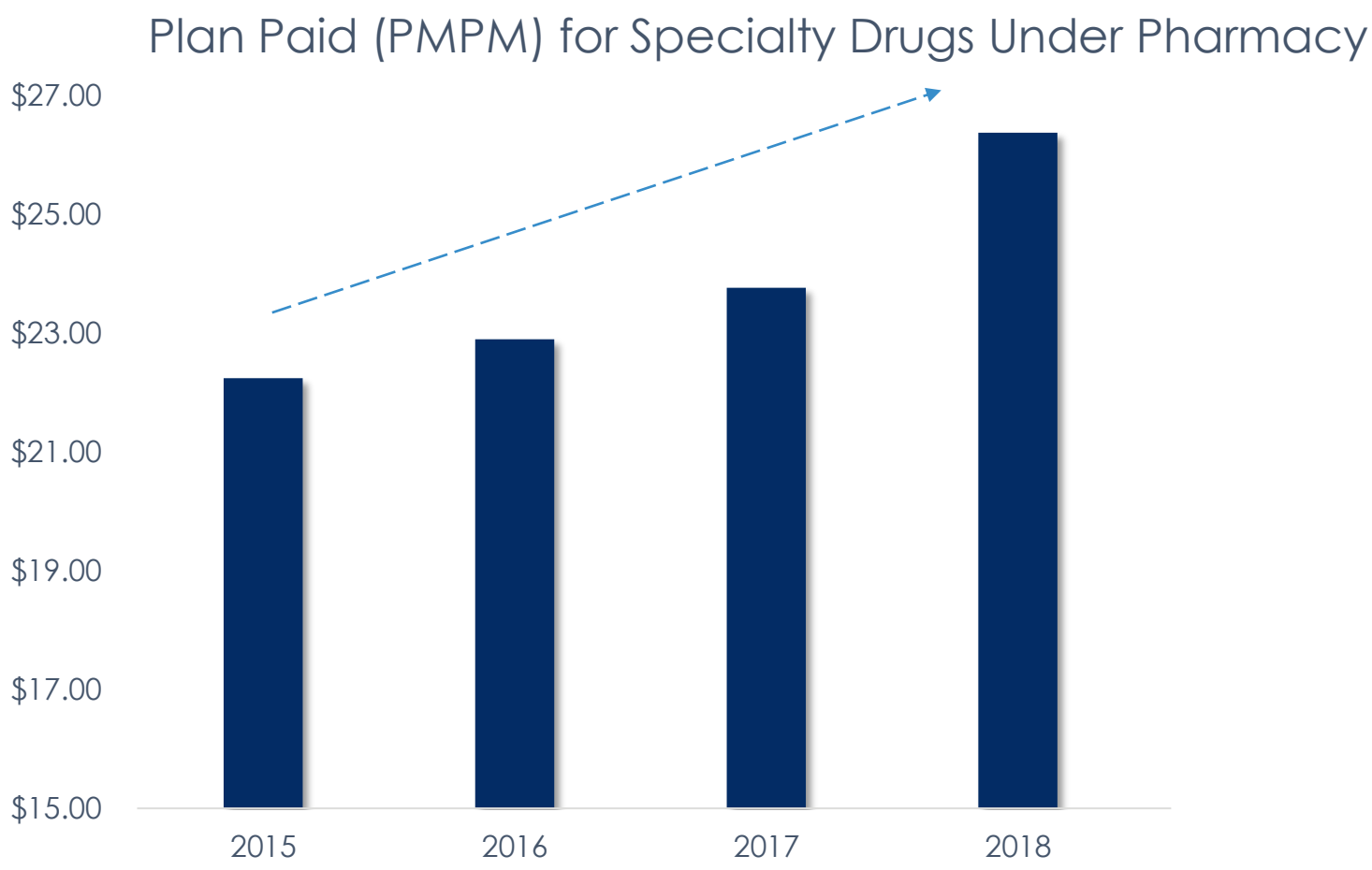
- HSLLC client since 2009
- 2010 implemented custom formulary and new plan design
- 2011 moved to new PBM after RFP process
- 2017 moved to a new PBM after RFP process
- 2019 moved to a two PBM model – Specialty PBM Carve-out with Copay maximization



HEALTHSTRATEGY

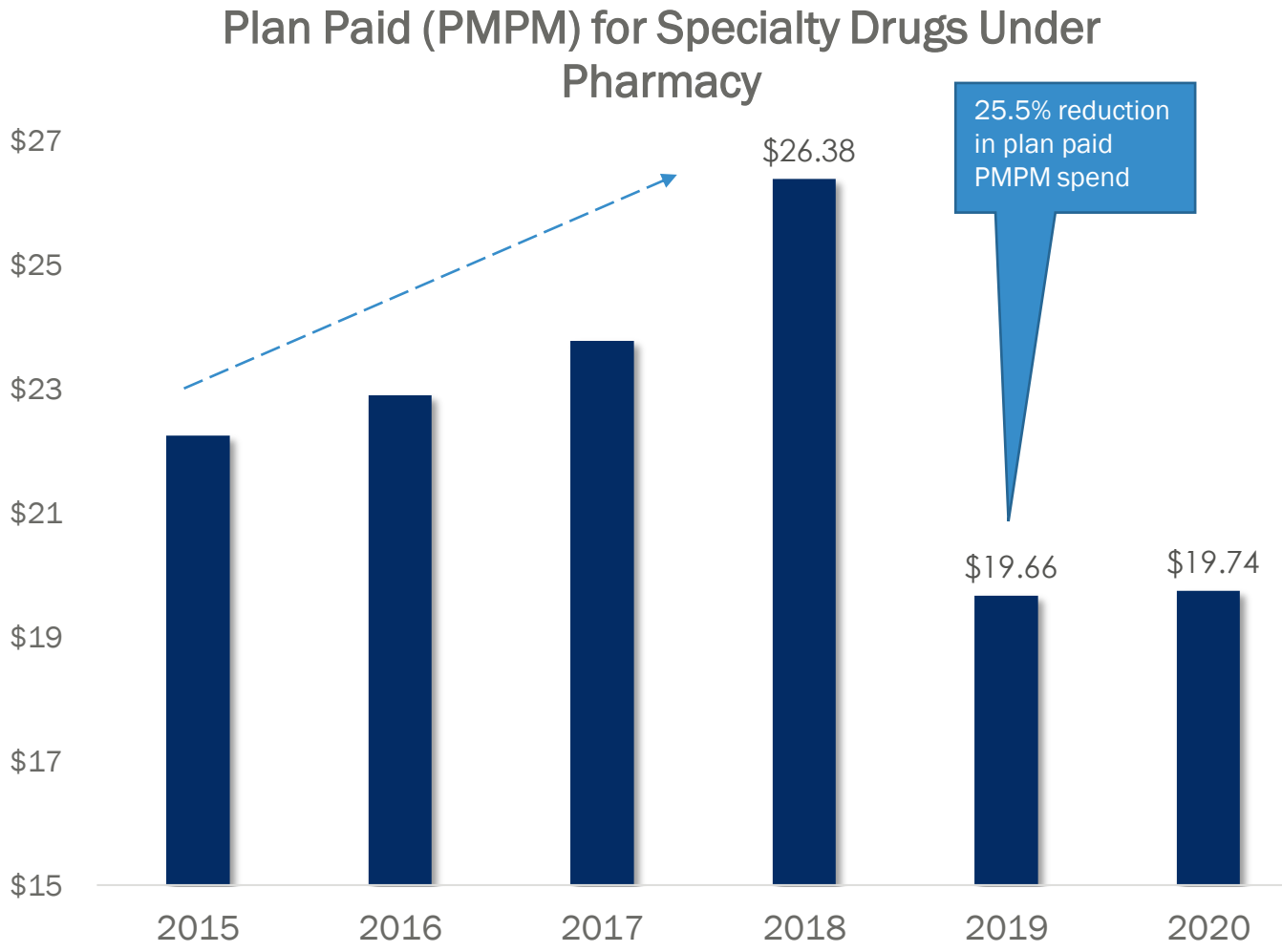
Client Specialty Plan Paid Trend

- 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 – i.e. HAE, CF, etc,
- Already managed a full custom formulary and made aggressive decisions on coverage
- Specialty pharmacy direct contract in place since 2011
- True OOP accumulator tracking program was put in place in 2016 (Copay assistance tracking)
- Needed additional strategic options



Impact of Specialty Strategy

- 2019 - Implemented Specialty PBM carve-out
  - PBM that does not own its own Specialty pharmacy
  - Focus on copay assistance program that helped the plan and the members decrease cost
- 2020 - Implemented medical management of Specialty Drug for Non-Oncology meds
  - PA
  - Medical Copay Assistance
  - Site of Care
  - Medical Rebates
  - Post adjudication checks for duplicate billing, appropriate dose billing post PA, etc.
- 2021 - Expanded pharmacy management to HIV medications to access additional copay assistance
- 2021 - Expanded medical management to include select Oncology products



Note: Select medical specialty drugs were carved out to pharmacy in 2020 and are reported separately

Client Savings

- Virtually no member noise when Specialty PBM carve-out implemented
- Copay assistance drove the majority of savings
  - Savings for plan and the member
- Clinical savings vetted by HSLLC
- Copay assistance grew almost $1M in 2020
  - ½ of that growth was from Medical Specialty drugs moved and billed under pharmacy
- Clinical savings grew significantly in 2020
- Copay assistance for Specialty drugs billed under medical
- Site of Care savings was good, but more opportunity
- Client uses a TPA that does a very good job so billing error findings were limited

2019

Specialty Pharmacy

- Copay assistance - $2.3M (20% of total cost for Specialty)
- Clinical - $950K (8% of total costs for specialty)

2020

Specialty Pharmacy

- Copay assistance - $3.3M (24% of total cost for Specialty)
- Clinical - $2.7M (19% of total costs for Specialty)

Medical Specialty

- Copay assistance - $564K
- Clinical - $352K
- Site of Care - $515K
- Billing Errors - $88K

Using Data to Find Where Savings is Hiding in Your Pharmacy Benefits

Cheryl Larson

President & CEO

MBGH

Antonio Ciaccia

CEO

46brooklyn

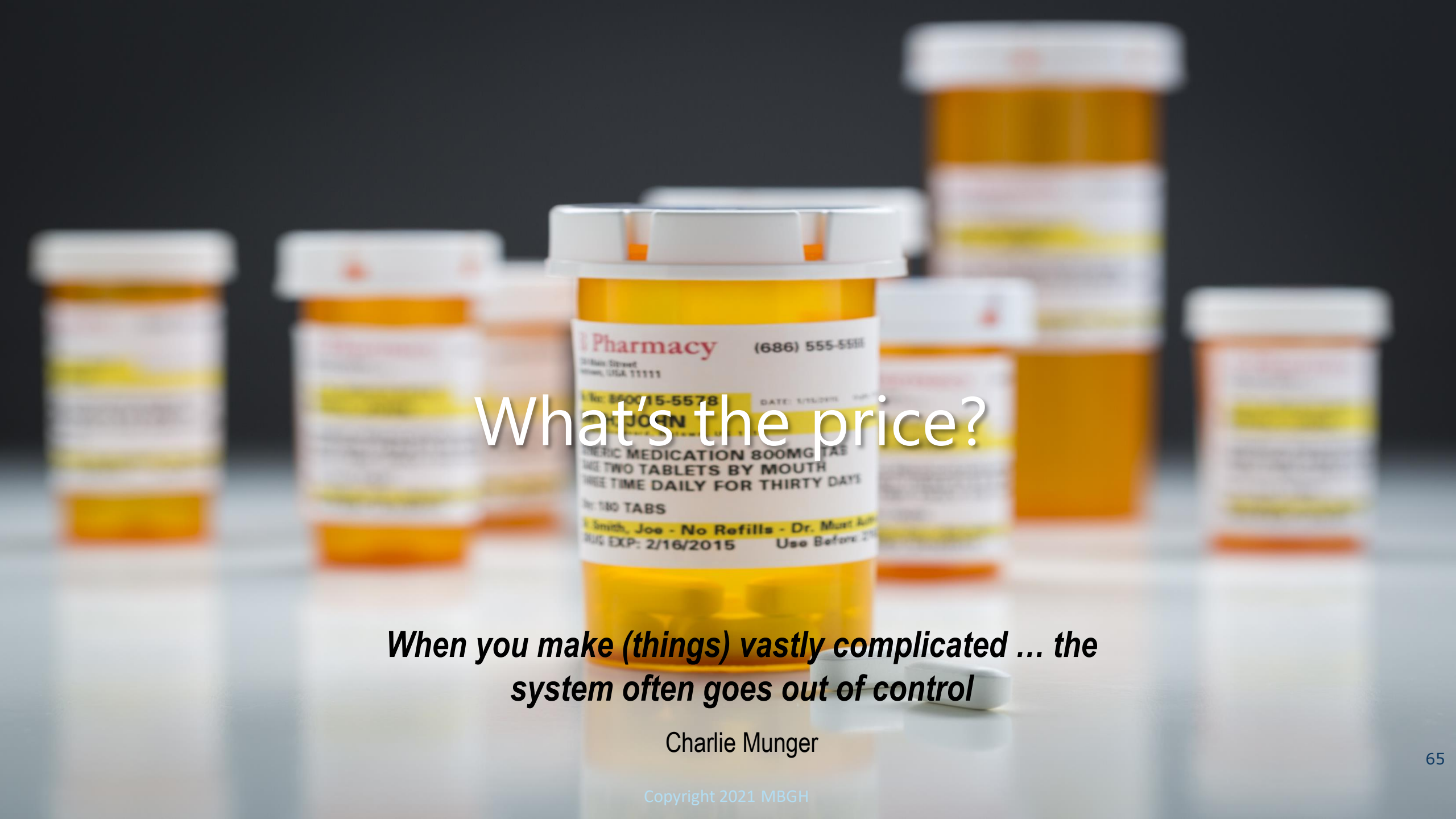
Uncovering and Understanding U.S. Drug Price Distortions

Antonio Ciaccia

Chief Strategy Officer and Co-founder

June 2021

3AXIS Advisors



What's the price?

When you make (things) vastly complicated … the system often goes out of control

Charlie Munger

Which price are you talking about?

MANY PRICES AVAILABLE FOR DRUGS IN THE U.S.

Drug prices are…

The system is built on “fake prices”

- List prices for prescription drugs are wildly overinflated relative to their 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 make those net prices much lower.
- Generic drugs have high AWPs (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.**

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The fallout of fake prices: Brand specialty drug steering

- 3AA data analyses suggest the proliferation of specialty drug "steering," which is the pushing of particular medications to insurer/PBM-owned (affiliated) pharmacies.
- To gauge steering, 3AA divided the small commercial dataset 2018 brand drug claims into those above and below $2,000.
- 3AA found **insurer/PBM-owned pharmacies are filling an overwhelming number of the expensive medications and a small fraction of the cheaper brand medications**.

Percentage of Brand Drug Claims Filled by Affiliated Pharmacies

Small Commercial Payer Dataset (2018)

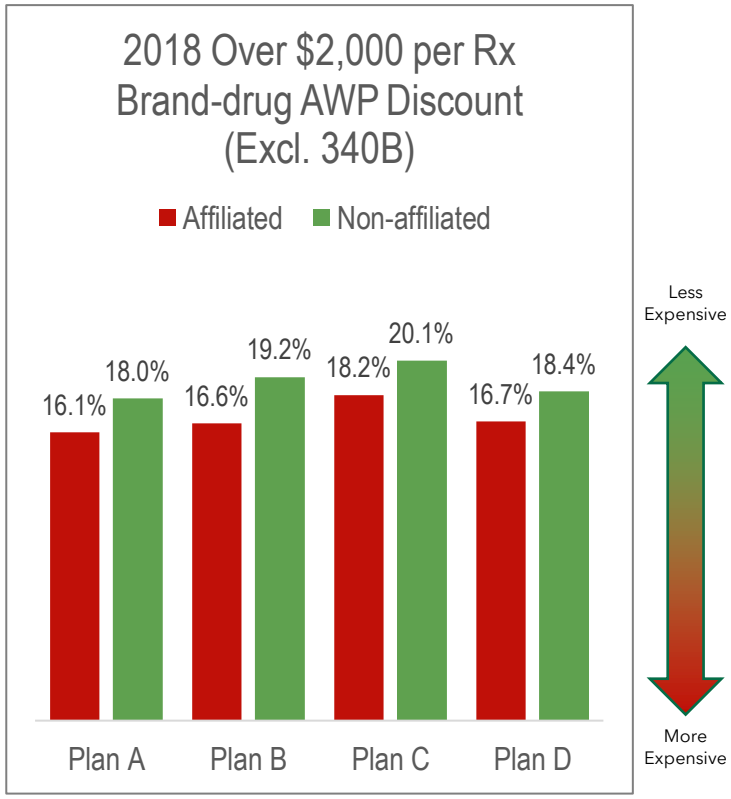
	Cost < $2,000 per claim	Cost > $2,000 per claim
Insurer #1	5%	75%
Insurer #2	38%	85%
Insurer #3	21%	68%
Insurer #4	5%	81%
Insurer #5	3%	93%
Total	**16%**	**76%**

69

The fallout of fake prices: Brand specialty drug differential pricing

Percentage of Brand Drug Claims Filled by Affiliated Pharmacy
Florida Medicaid Managed Care Claims Data (excl. 340B)

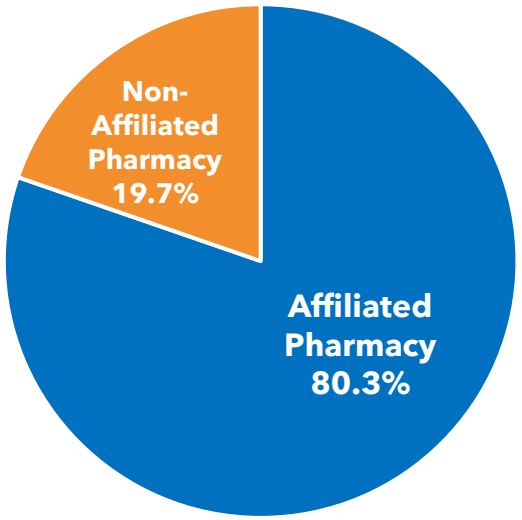
2018-19	Under $2,000 per Rx	Over $2,000 per Rx
Plan A	0.6%	60.2%
Plan B	0.4%	53.0%
Plan C	0.3%	18.2%
Plan D	0.2%	44.9%

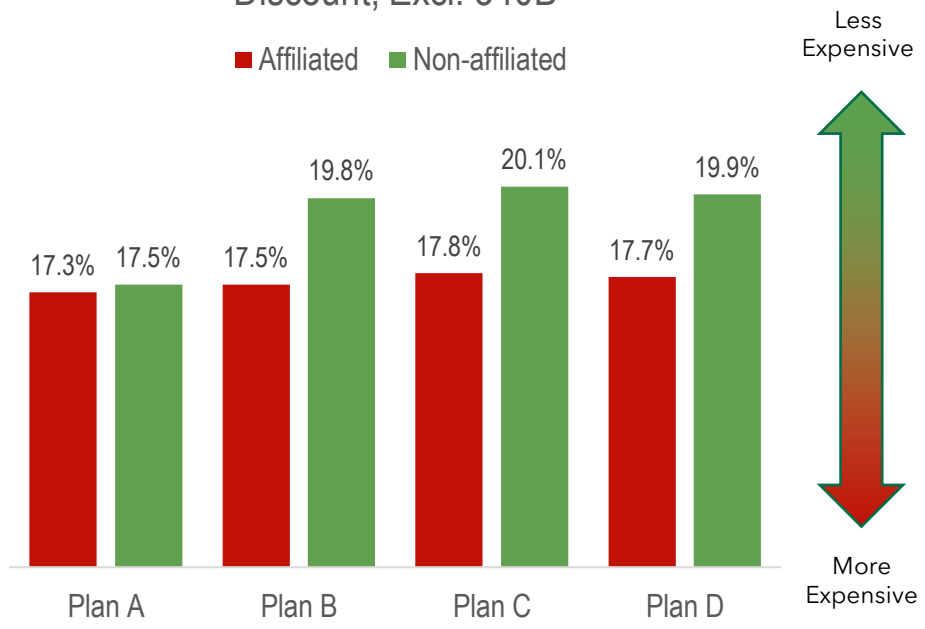


In Florida, specialty drugs are not only steered to affiliated pharmacies, but they are also more expensive at affiliated pharmacies!

https://www.3axisadvisors.com/projects/2020/1/29/sunshine-in-the-black-box-of-pharmacy-benefits-management

The fallout of fake prices: Humira differential pricing



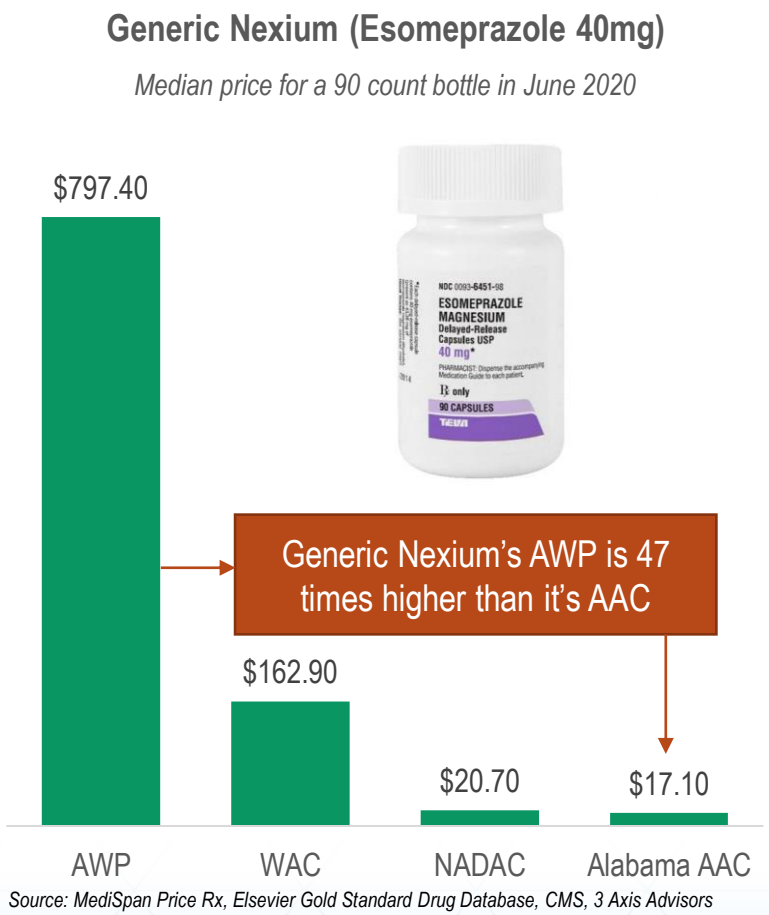


If Florida Medicaid would have recognized the non-affiliated pharmacy cost on the claims within the affiliated pharmacies, over $1.5 million in savings would have been realized on Humira alone.

https://www.3axisadvisors.com/projects/2020/1/29/sunshine-in-the-black-box-of-pharmacy-benefits-management

The fallout of fake prices: Generic drugs

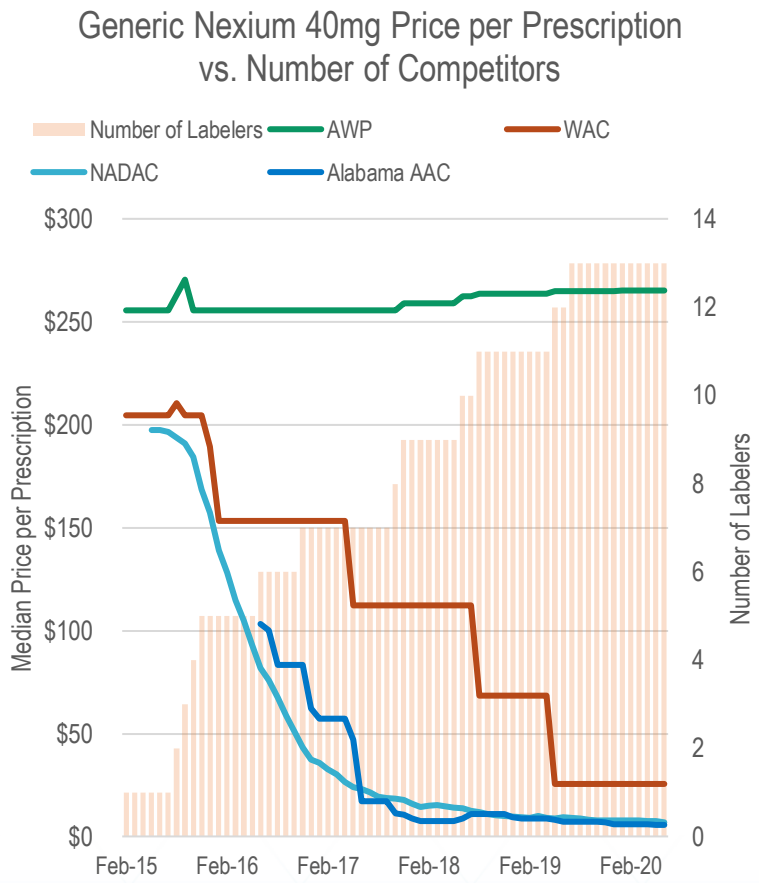
- In the U.S., every drug has multiple, different prices
- **Average Wholesale Price** ("AWP") and **Wholesale Acquisition Cost** ("WAC") are both unilaterally set by the manufacturer
  - Not dictated by competitive market forces
- National Average Drug Acquisition Cost ("NADAC") is based on a voluntary national survey of pharmacy invoice costs
  - Is dictated by competitive market forces
- Alabama Actual Acquisition Cost ("AAC") is based on a mandatory survey of pharmacy invoice costs
  - Is dictated by competitive market forces
  - Ohio Medicaid pursuing their own AAC survey under PBM redesign



Source: MediSpan Price Rx, Elsevier Gold Standard Drug Database, CMS, 3 Axis Advisors

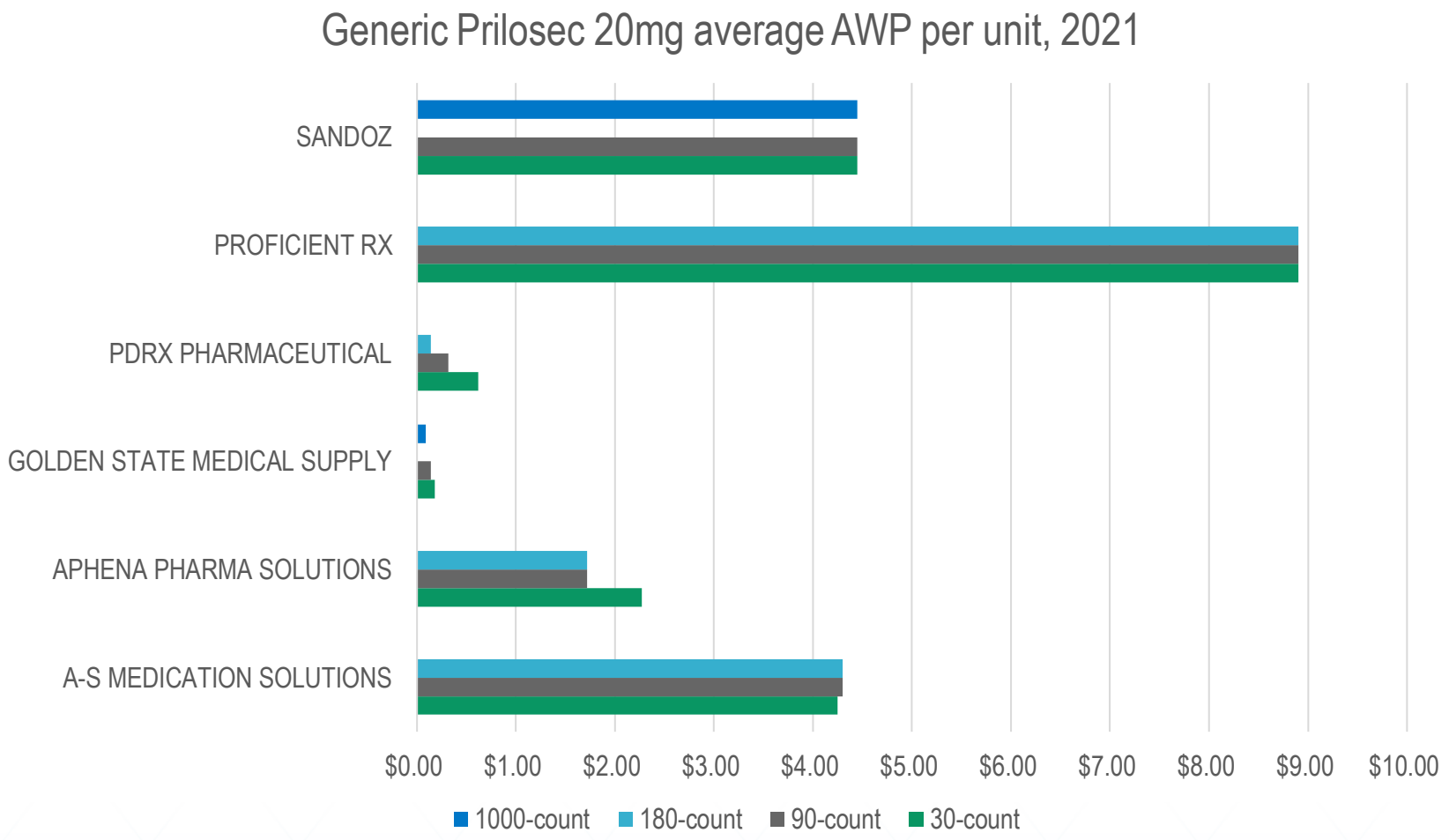
AWP is a thoroughly broken drug pricing benchmark for generic drugs

- This chart shows another problem with AWP
  - **Not only is it wildly inflated, it does not decline with increased free market competition**
- The **light orange bars** (right axis) show that the number of competitors producing this drug went from one in Feb 2015 to 13 today
- The **light blue line (NADAC)** and **dark blue line (AAC)** show that as more competitors came to market, the price drops precipitously
  - NADAC is down 96% from May 2015
- The **brown line** shows that **WAC** declines with increased competition, but not nearly as responsively as surveyed pharmacy invoice costs
  - Remember, WAC is set by the drugmaker, not the marketplace
- Lastly, the **green line** is **AWP**. This price benchmark is completely immune to the effects of competition, ***increasing*** since the drug's launch



Source: MediSpan Price Rx, Elsevier Gold Standard Drug Database, CMS, 3 Axis Advisors

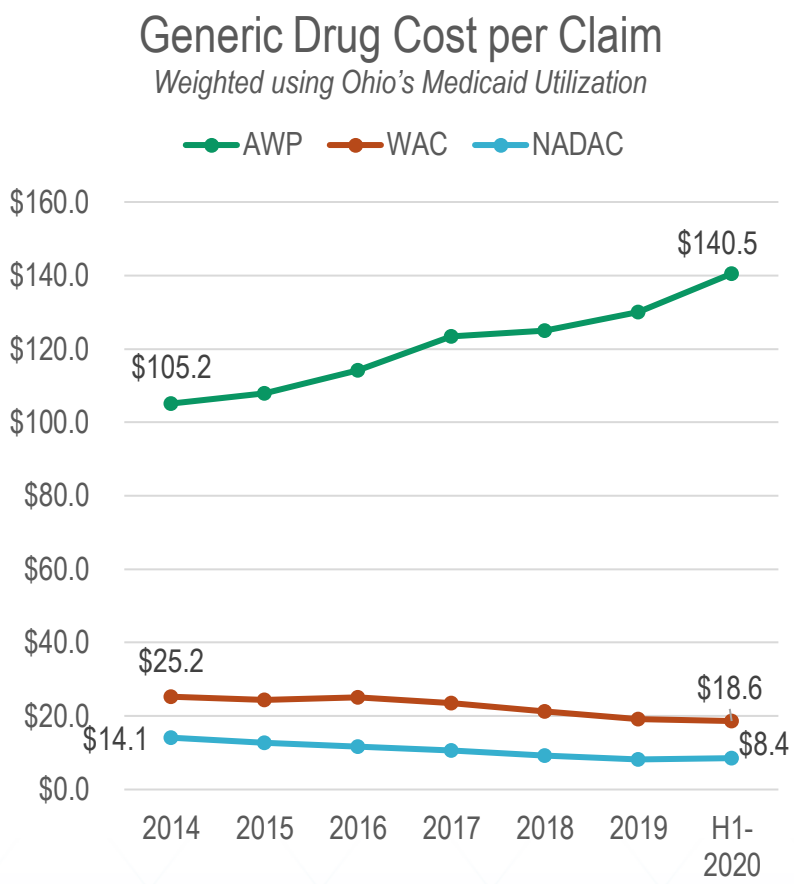
Which AWP is the AWP?



AWP is designed to increase over time for generic drugs

- We calculated pricing for ALL generic capsules and tablets dispensed in Ohio Medicaid
  - Total of $2.6 billion in drug spending between 2014 and H1 2020*
- The true cost of generic drugs (**NADAC, light blue line**) has declined by **40%** over 5.5 years, to $8.40 per claim
- Against that backdrop, the **AWP** of the exact same collection of generic drugs has increased **34%**, from $105 per claim to $141 per claim
  - The lack of market-based pricing, combined with more expensive drugs coming to market naturally pushes AWP up over time

PBMs cannot claim they are working to lower drug prices and then use a benchmark designed to increase them



Source: MediSpan Price Rx, Elsevier Gold Standard Drug Database, CMS, 3 Axis Advisors

* This is the total Medicaid spending between Q2 2016 and Q1 2020 on generic drugs with a published NADAC

Actions speak louder than words

PBMs PIN THEIR CLEINTS' DRUG COSTS TO BOGUS AWP PRICES

Contract Pricing from PBM A

RETAIL	Traditional
NETWORK	National Network
BRAND	AWP -17.75%
GENERIC	Generic Effective Rate 01/01/2019 - 12/31/2019: AWP -81.75% 01/01/2020 - 12/31/2020: AWP -82.25% 01/01/2021 - 12/31/2021: AWP -82.75% (MAC & Non-MAC Combined)
NON-MAC GENERICS	AWP -25.00%
DISPENSING FEE	Brand & Generic $0.50 per Claim

Contract Pricing from PBM B

	Retail 30 Pharmacy Network
Retail Pricing	
Brand Drugs	Lower of U&C or AWP minus 17.0% plus $1.15 dispensing fee
Generic MAC Drugs	Lower of U&C, Contractor MAC plus $1.15 dispensing fee
Non-MAC Generic Drugs	Lower of U&C or AWP minus 17.0% plus $1.15 dispensing fee
Effective Overall Generic Guarantee (ingredient cost)	AWP minus 82.00%

Contract Pricing from PBM C

Type of Guarantee	Participating Pharmacy	Mail Service Pharmacy	Claims Excluded
Brand	AWP – 17.50%	AWP – 24.75%	OTC, compounds, Member Submitted Claims, Subrogation Claims, vaccines, Specialty Products, biosimilar products, long term care pharmacy claims and products filled through in-house or 340b pharmacies (if applicable)
Generic	AWP – 81.00%	AWP – 84.50%	OTC, compounds, Member Submitted Claims, Subrogation Claims, vaccines, Specialty Products, biosimilar products, long term care pharmacy claims and products filled through in-house or 340b pharmacies (if applicable)

Contract Pricing from PBM D

1 - 83 Day Supply Component	
Minimum Brand Effective Rate (AWP Discount) Guarantee:	AWP minus 15.25%
Minimum Generic Effective Rate (AWP Discount) Guarantee:	AWP minus 79.00%
Maximum Brand Claim Dispensing Fee Guarantee:	$1.35
Maximum Generic Claim Dispensing Fee Guarantee:	$1.35
84 - 90 Day Supply Component	
Minimum Brand Effective Rate (AWP Discount) Guarantee:	AWP minus 16.77%
Minimum Generic Effective Rate (AWP Discount) Guarantee:	AWP minus 79.00%
Maximum Brand Claim Dispensing Fee Guarantee:	pass-through
Maximum Generic Claim Dispensing Fee Guarantee:	pass-through

How PBM generic drug pricing arbitrage (a.k.a. "spread pricing") works

- PBM signs contract with payer/client guaranteeing a discount to AWP for generic drugs
  - Example: AWP – 82%
- PBM signs contract with pharmacy/PSAO* with a more aggressive discount to AWP (or no guarantee at all)
  - Example: AWP – 89%
- PBM sets different "MAC"** rates for client and pharmacy to meet its separate guarantees, adjusting frequently, and truing up afterwards if necessary
- PBM locks in a percentage of AWP – the spread between what it charges its client and what it pays the pharmacy
  - Example: 7% of AWP
  - 7% of Ohio's weighted average generic AWP is $9.87 per claim – almost as much as Ohio's professional dispensing fee for its pharmacies!
- **Levers to increase PBM profits in this business model:**
  1) **Increase the gap between client's discount and pharmacy's discount**
  2) **Choose a benchmark price that is naturally designed to increase: AWP**

* Pharmacy Services Administration Organization

* Maximum Allowable Cost: a proprietary PBM benchmark for generic drug ingredient cost that can differ from one client to the next, and one pharmacy to the next, and need not have any relationship to actual acquisition cost

Spread pricing hits home in Ohio

Ohio Medicaid audit revealed $244 million in SPREAD PRICING from Q2 2017 to Q1 2018

Spread pricing = the difference between the reimbursements paid to pharmacies and the rates reported back to the payer; PBM retains the difference

Ohio's state Auditor David Yost conducted his own audit, and found that spread equated to 31.4% of gross generic spending in Ohio Medicaid managed care

Legal notices in the Ottumwa Courier showed how much Wapello County paid CVS's Caremark drug benefits unit. Photographer: Marisa Gertz/Bloomberg

The Secret Drug Pricing System Middlemen Use to Rake in Millions

By Robert Langreth, David Ingold and Jackie Gu
September 11, 2018

Not everybody reads the legal notices inside the Ottumwa Courier. But in January, Iowa pharmacist Mark Frahm noticed something unusual in the paper.

Press Releases · Ohio Auditor of State

Auditor's Report: Pharmacy Benefit Managers Take Fees of 31% on Generic Drugs Worth $208M in One-Year Period

Geographic Price-Spread Disparities Found in Medicaid Pharmacy Payments

Thursday, August 16, 2018

Columbus - Ohio's Pharmacy Benefit Managers (PBMs) charged the state a "spread" of more than 31 percent for generic drugs – nearly four times as much as the previously reported average spread across all drugs, according to a new report by Ohio Auditor of State Dave Yost.

https://www.axios.com/data-showing-pbm-medicaid-drug-price-manipulation-1533059892-c2a97bcd-8874-42c2-a161-503e89666678.html
https://www.bloomberg.com/graphics/2018-drug-spread-pricing/ https://ohioauditor.gov/news/pressreleases/Details/5042 https://stories.usatodaynetwork.com/sideeffects/cost-cutting-middlemen-reap-millions-via-drug-pricing-data-show/

The first domino falls

- June 14, 2021: Ohio Attorney General Dave Yost announces the first major victory over PBM overcharges
  - Centene agrees to settle case over alleged prescription drug markups that were found in 2018 to be more than $11 per prescription under the plan.
  - $88 million to Ohio
  - $55 million to Mississippi
  - More than $1.1 billion set aside for other states
  - First and largest settlement in the country secured by a state attorney general against a PBM

- "I will accept an apology note that has a dollar sign and many zeroes after it." - Yost

The Columbus Dispatch

Sports Entertainment Lifestyle Opinion USA TODAY Obituaries E-Edition Legals

Centene's $88 million deal with Ohio comes on top of $1.1 billion set aside to cover other U.S. lawsuits

Darrel Rowland The Columbus Dispatch

Published 6:03 a.m. ET Jun. 14, 2021 | Updated 8:29 p.m. ET Jun. 14, 2021

View Comments

Video: Attorney General Dave Yost announces PBM settlement

Ohio Attorney General Dave Yost announces a settlement against Centene, a pharmacy benefit management company. *The Columbus Dispatch*

One of the biggest lawsuit settlements in Ohio history should send a message to all pharmacy benefit managers and health-care companies taking advantage of patients and taxpayers: "Everybody's accountable," says Attorney General Dave Yost.

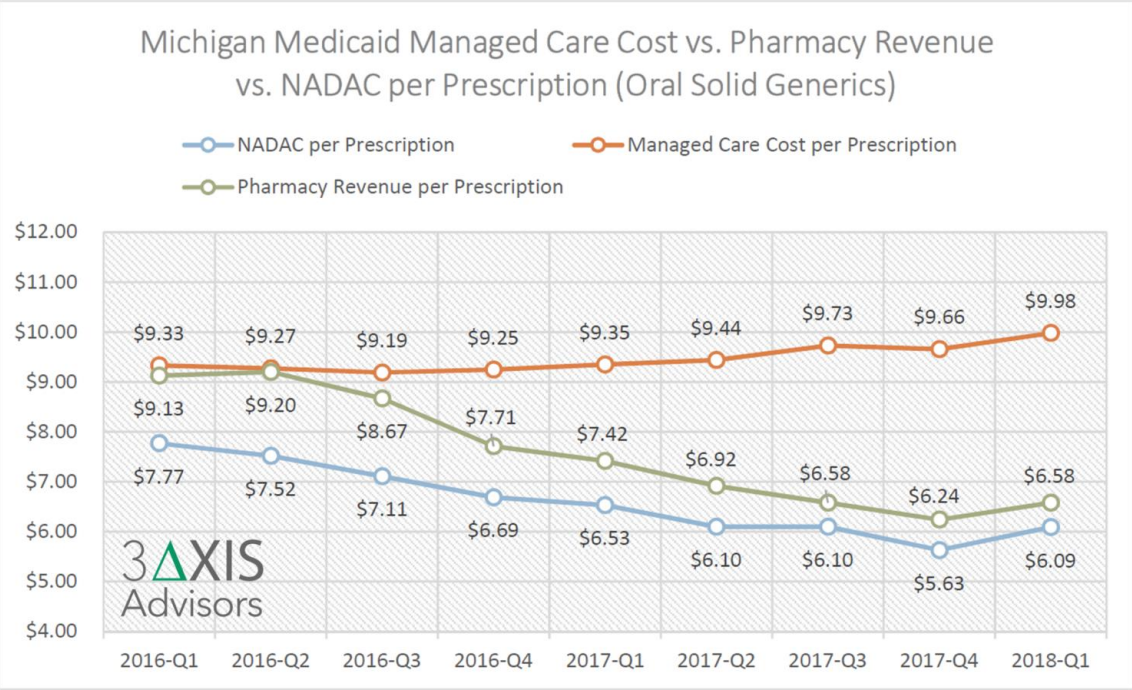
https://www.dispatch.com/story/news/2021/06/14/centene-to-settle-ohio-medicaid-lawsuit-attorney-general-dave-yost/7679946002/

Ohio isn't alone

3AA analysis of Medicaid managed care pharmacy claims in Michigan showed:

- Drug costs going down
- Pharmacy margins going down
- PBM spreads going up
- State costs going up

Spread pricing allows pharmacy-affiliated PBMs to shift traditional pharmacy margins to the PBM side of their enterprise.



https://www.3axisadvisors.com/projects/2019/4/28/analysis-of-pbm-spread-pricing-in-michigan-medicaid-managed-care

National backlash against spread pricing

LOGIN

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An Inside Washington news service

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Monday, November 30, 2020

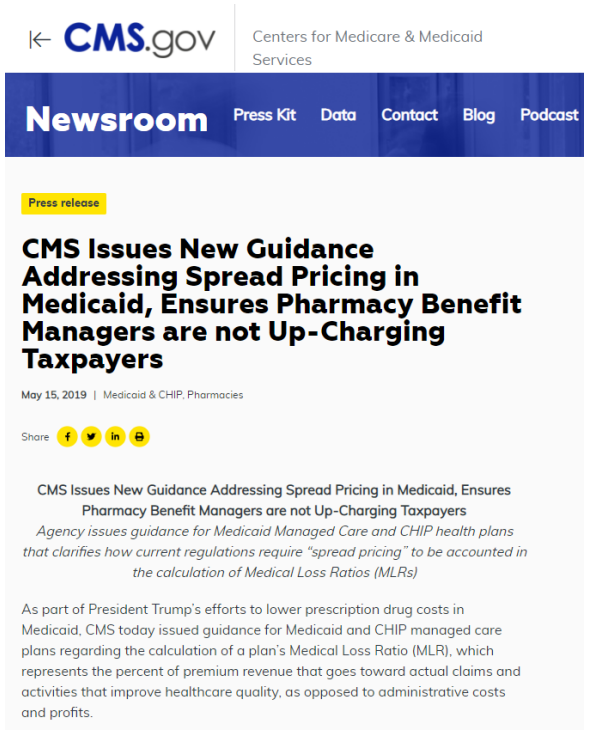
Inside Drug Pricing

Maryland Bans Spread Pricing Following Report On The Practice's Cost

By John Wilkerson / January 17, 2020 at 5:08 PM

Tweet Share

The Maryland Health Department will ban spread pricing in its Medicaid program next year after an audit found the practice cost the state $72 million in 2018, which at $6.96 per claim appears to be the biggest spread margin per prescription spread reported to date, according to 3 Axis Advisors. The department will mandate that Medicaid managed care plans use a pass-through pay model that requires PBMs to charge the exact amount they pay for prescriptions and dispensing fees. There...



CMS.gov | Centers for Medicare & Medicaid Services

Newsroom Press Kit Data Contact Blog Podcast

Press release

CMS Issues New Guidance Addressing Spread Pricing in Medicaid, Ensures Pharmacy Benefit Managers are not Up-Charging Taxpayers

May 15, 2019 | Medicaid & CHIP, Pharmacies

Share

CMS Issues New Guidance Addressing Spread Pricing in Medicaid, Ensures Pharmacy Benefit Managers are not Up-Charging Taxpayers

Agency issues guidance for Medicaid Managed Care and CHIP health plans that clarifies how current regulations require "spread pricing" to be accounted in the calculation of Medical Loss Ratios (MLRs)

As part of President Trump's efforts to lower prescription drug costs in Medicaid, CMS today issued guidance for Medicaid and CHIP managed care plans regarding the calculation of a plan's Medical Loss Ratio (MLR), which represents the percent of premium revenue that goes toward actual claims and activities that improve healthcare quality, as opposed to administrative costs and profits.

UNITED STATES SENATE COMMITTEE ON FINANCE

MENU

SEPTEMBER 23,2019

Grassley op-ed: Let's prescribe a dose of common sense: End spread-pricing in Medicaid

Let's prescribe a dose of common sense: End spread-pricing in Medicaid

By Senate Finance Committee Chairman Chuck Grassley

Americans from coast to coast disagree about plenty of issues. As a U.S. senator, I know at least one issue that unites all Americans: Drug prices are too high.

The soaring cost of prescription medicine has struck a nonpartisan nerve. Sticker shock is hitting consumers at the pharmacy counter and socking it to taxpayers who foot the bill for government health programs. While most Americans agree the U.S. healthcare system provides the most innovative cures and quality care available in the world, they also know the delivery system is too complex, too secretive, too confusing and too expensive.

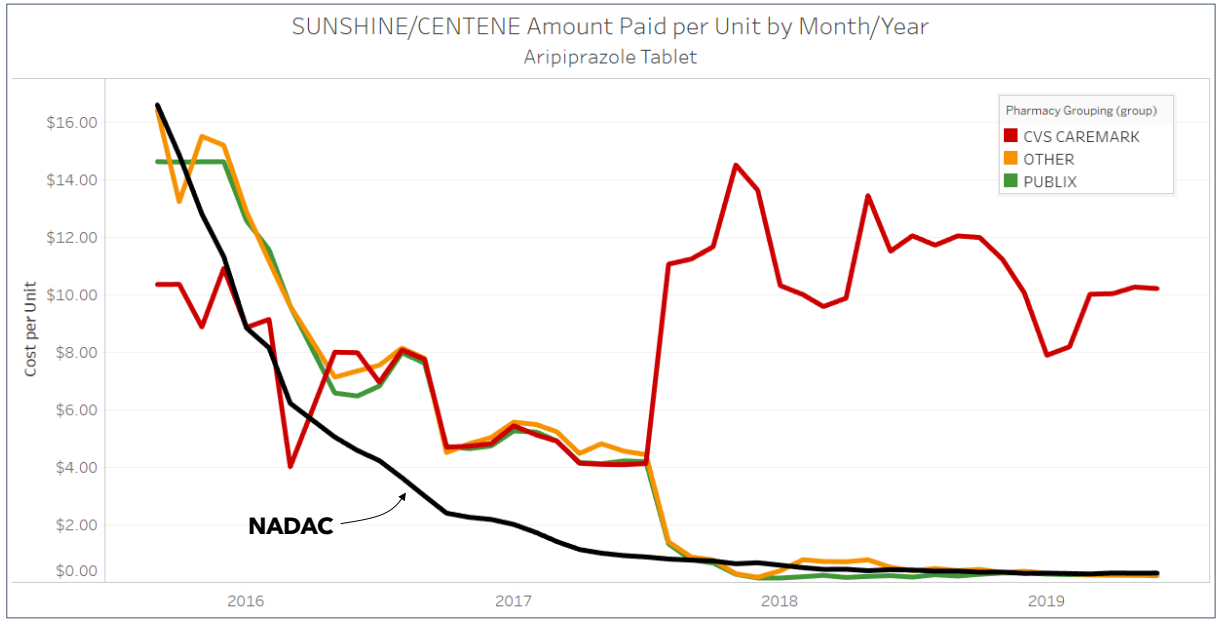
Complicated formulas along the pharmaceutical supply chain let drug manufacturers, wholesalers, retailers and pharmacy benefit managers hide behind a thicket of obscure payment arrangements to bilk public health insurance programs, including Medicaid.

Differential generic drug pricing hits a post-spread world

In 2017, Caremark joined Envolve (owned by Centene) as the provider of Sunshine's (owned by Centene) PBM services in Florida

The same month, Caremark dramatically increased the rates reported on claims dispensed at its affiliated CVS pharmacies on generic Abilify - Florida Medicaid's #1 spend generic antipsychotic drug

At the same time, it dramatically reduced the rates paid to all other pharmacy groups in the state.

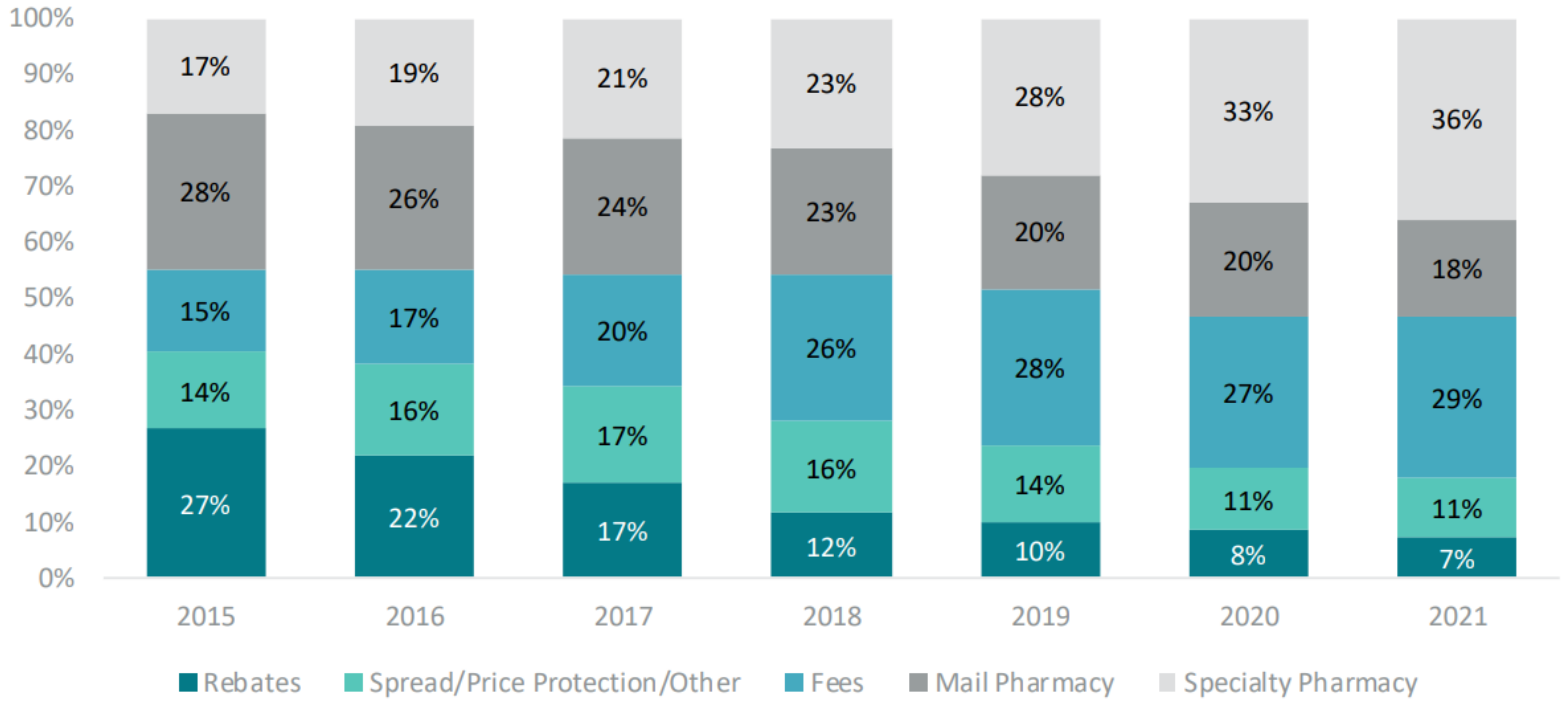


Overall, in 2018, 94% of the margin (revenue above acquisition cost) reported on generic drug claims by Sunshine/Centene was reported on claims dispensed at CVS pharmacies!

https://www.3axisadvisors.com/projects/2020/1/29/sunshine-in-the-black-box-of-pharmacy-benefits-management

As “spread” and “rebate” scrutiny grows, PBM focus turns to fees and specialty

Fig. 4: PBM Gross Profit by Profit Pool (CVS, CI/ESI, OptumRx): PBM Profits Have Shifted from Rebates & Spread to Fees & Fullfillment



Source: Nephron Research

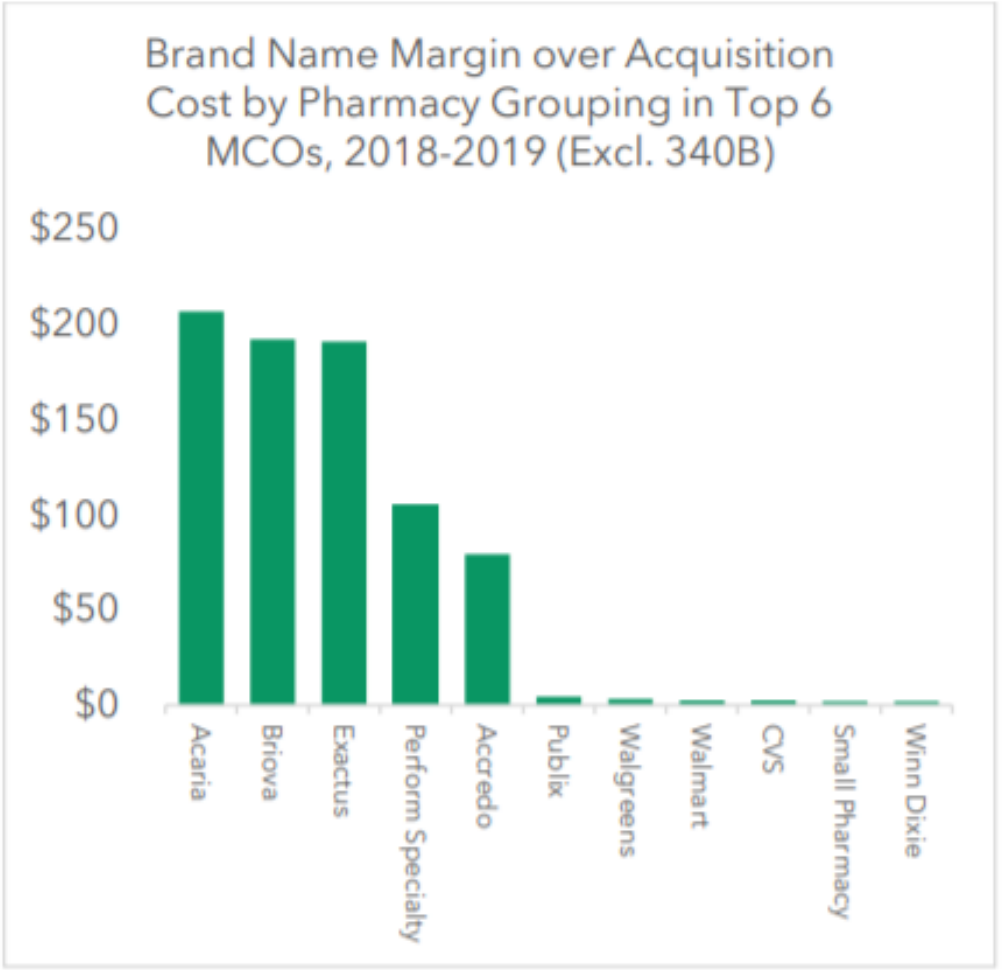
PBMs are steering specialty drugs, and then overpaying themselves on them

- 3 Axis has investigated specialty pharmacy steering and drug mispricing for small commercial payers
- We found that “cheap” generic drugs were filled at pharmacies affiliated with a PBM/Health Plan only 11% of the time, with a $26 profit to the pharmacy
- Meanwhile, “expensive” generic drugs were filled at pharmacies affiliated with a PBM/Health Plan 51% of the time, with a $3,448 profit to the affiliated pharmacy
- Employers have no way of knowing if they are getting fair prices for specialty drugs as the PBM is removing all pharmacy competition

Small Commercial Payer Analysis		
	<$1,000 per claim	**>$1,000 per claim**
Percent of generic drug claims filled at affiliated pharmacy	11%	51%
Gross profit per generic drug claim	$26	$3,448

Florida Medicaid MCO specialty pharmacy experience highlights the distortions

- When comparing margins over NADAC in our Florida Medicaid analysis, it was overwhelmingly apparent that PBM-owned pharmacies received significantly more margin per prescription than traditional community pharmacies
  - Example: For Sunshine/Centene, 95% of all generic Gleevec 400 mg claims were filled at Acaria, Centene's wholly owned specialty pharmacy, at a Margin over NADAC of $4,399 per claim



https://www.3axisadvisors.com/projects/2020/1/29/sunshine-in-the-black-box-of-pharmacy-benefits-management

Differential generic drug pricing & steering

In Ohio, after spread pricing was eliminated and "pass-through" pricing was implemented in Medicaid, PBMs began overpaying pharmacies on specialty drugs, which PBMs tend to steer through their own pharmacies.

This enabled PBMs to margin-shift dollars from spread to specialty medications filled at their affiliated pharmacies.

These problems persist today, but are by no means unique to Ohio and by no means unique to Medicaid programs.

Special prices

CVS Caremark already was charging a healthy price markup in providing specialty prescription drugs to some Ohio pharmacies through the Medicaid program in 2018. But when the state removed the pharmacy benefit manager's "spread pricing" revenue stream in 2019, the prices went way up — far above the National Average Drug Acquisition Cost maintained by the federal government. The move by CVS' PBM presumably benefited the company greatly because it requires many specialty drugs to be bought from CVS' own pharmacies. The prices below are per pill.

Specialty drug	2018 price for Ohio	2018 US avg price	2018 markup	2018 % markup	2019 price for Ohio	2019 US avg price	2019 markup	2019 % markup
SILDENAFIL 20 MG TABLET	$3.45	$0.24	$3.21	1,338%	$3.90	$0.16	$3.74	2,338%
IMATINIB MESYLATE 400MG TAB	$120.00	$83.00	$37.00	45%	$270.00	$14.50	$255.50	1,762%
ENTECAVIR 0.5 MG TABLET	$5.70	$4.21	1.49	35%$	30.00$	1.86	$28.14	1,513%
CAPECITABINE 500 MG TABLET	$7.40	$5.40	$2.00	37%	$29.00	$3.33	$25.67	771%
TACROLIMUS 5 MG CAPSULE	$2.20	$2.86	$(0.66)	-23%	$3.50	$1.52	$1.98	130%
OTEZLA 30 MG TABLET	$51.00	$49.88	$1.12	2%	$58.00	$54.75	$3.25	6%

SOURCE: DISPATCH ANALYSIS OF MEDICAID PRESCRIPTION DATA FROM SOME THREE DOZEN OHIO PHARMACIES

Reference: https://www.46brooklyn.com/research/2019/4/21/new-pricing-data-reveals-where-pbms-and-pharmacies-make-their-money; https://www.dispatch.com/news/20190430/ohio-medicaid-officials-to-crack-down-on-pbm-specialty-drug-practice

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Rise of the effective rates

In Michigan, after spread pricing was eliminated, pharmacy reimbursements started rising (100%-125% increase under OptumRx and CVS/Caremark).

We later learned from pharmacies that much of the increased payments were clawed back.

In a pass-through pricing model, plan sponsors lose auditing visibility once reimbursement hits the pharmacy.

By overpaying at the point of sale, and clawing back excess payments later, PBMs have shifted spread to post-adjudication and out of sight from plan sponsors.

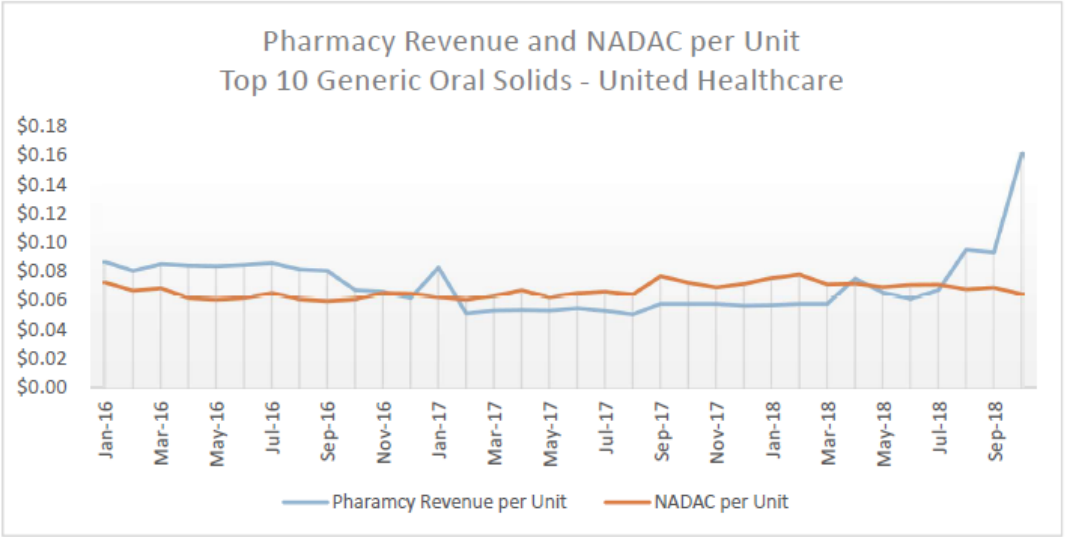


Table 8 - OptumRx and CVS/Caremark Rate Changes, July 2018 to October 2018

	OptumRx	CVS/Caremark
Total generic drugs in sample	1,096	989
Number of drugs that experienced a per unit increase in pharmacy revenue between July 2018 to October 2018	992 *(91% of total)*	785 *(79% of total)*
Average % change in per unit drug reimbursement	105%	125%

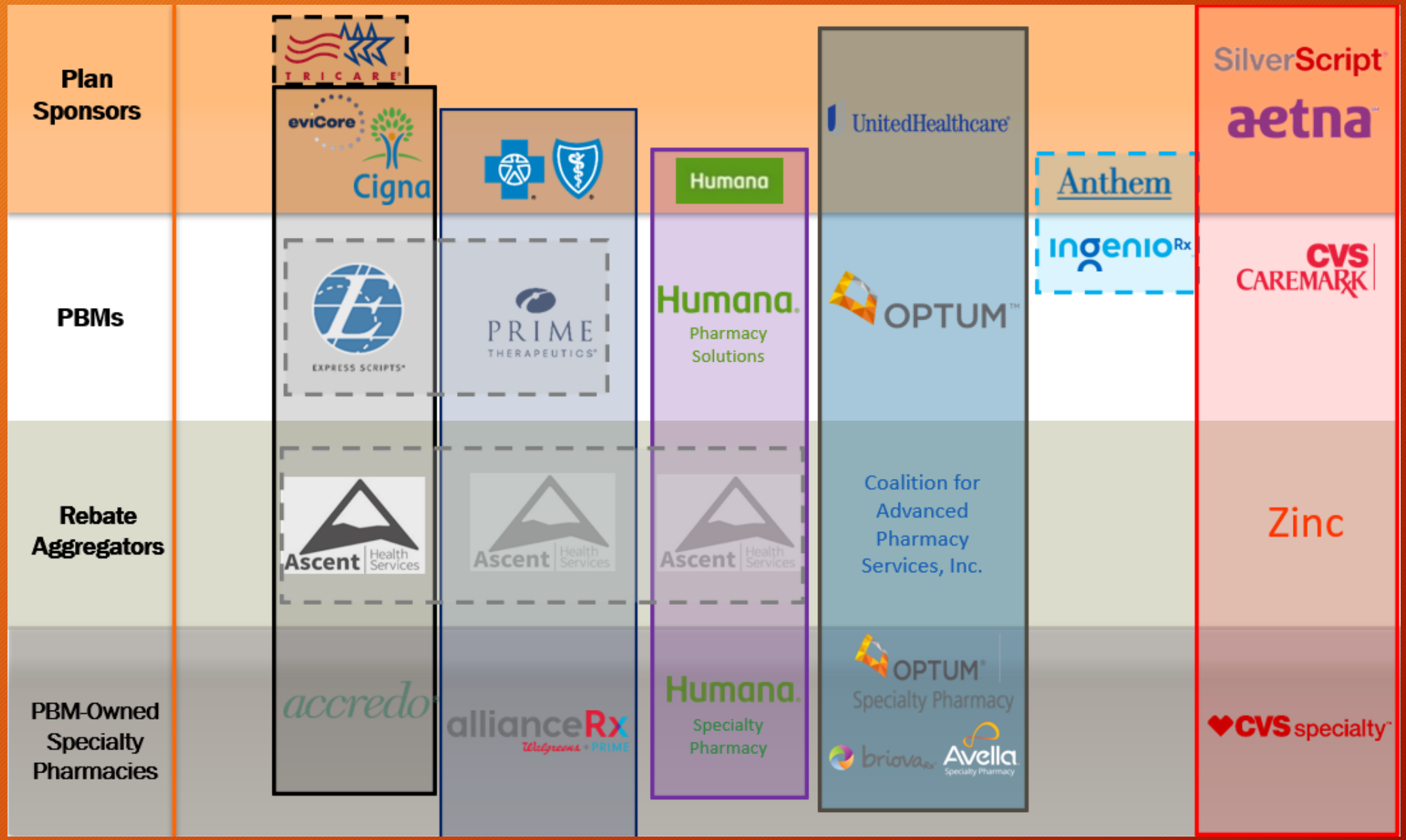
Reference: https://www.3axisadvisors.com/projects/2019/4/28/analysis-of-pbm-spread-pricing-in-michigan-medicaid-managed-care

87

Jonathan E. Levitt, Esq

Co-Founding Partner

Frier Levitt



What is a "Rebate Aggregator" and why should a Health Plan care?

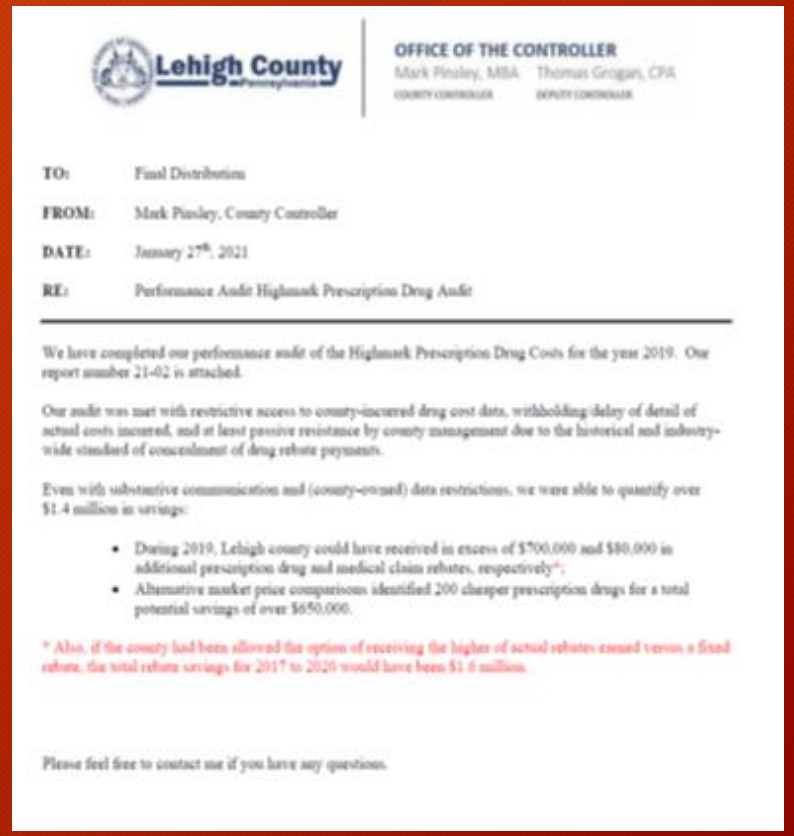
- Every PBM now owns a rebate aggregator
  - Express Scripts owns Ascent Health Services, located in Switzerland
  - Caremark owns Zinc Health Services
  - OptumRx owns Coalition for Advanced Pharmacy Services
  - Prime Therapeutics has an alliance with Express Scripts
- What are the dangers of Rebate Aggregators?
  - Frier Levitt Settlement against PBM owned by publicly traded company
  - Broward County versus OptumRx

$6.5M

$833K

Origins of a Costly Problem: Poorly negotiated Pharmacy Benefit Service Agreements

- Key Contract Terms that all Health Plans should know:
  - PBMs loosely define “rebates”
  - Broad and vague “rebate exclusion”
  - Specialty pharmacy definition and "exclusion" from rebate guaranty.
- "Flat Rebates" negotiated in advance:
  - Lehigh County is a cautionary tale.
- "Rebate Guarantee" provisions do not actually guarantee 100% pass thru.
- Plan Sponsor’s rebate audit rights are limited by PBMs.



Lehigh County Pennsylvania

OFFICE OF THE CONTROLLER

Mark Pinsley, MBA, County Controller — Thomas Grogan, CPA, Deputy Controller

TO: Final Distribution

FROM: Mark Pinsley, County Controller

DATE: January 27th, 2021

RE: Performance Audit Highmark Prescription Drug Audit

We have completed our performance audit of the Highmark Prescription Drug Costs for the year 2019. Our report number 21-02 is attached.

Our audit was met with restrictive access to county-incurred drug cost data, withholding/delay of detail of actual costs incurred, and at least passive resistance by county management due to the historical and industry-wide standard of concealment of drug rebate payments.

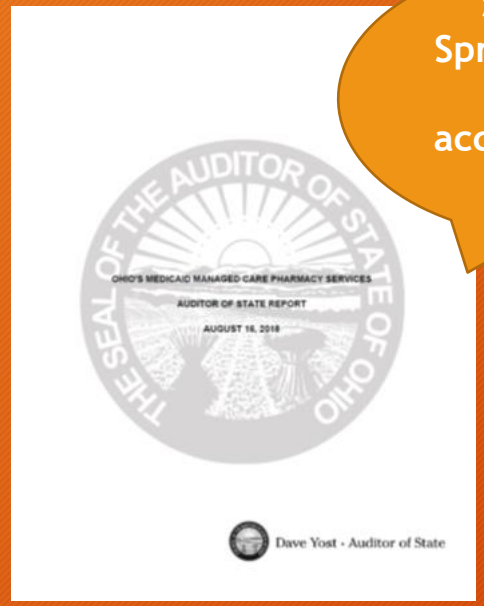
Even with substantive communication and (county-owned) data restrictions, we were able to quantify over $1.4 million in savings:

- During 2019, Lehigh county could have received in excess of $700,000 and $80,000 in additional prescription drug and medical claim rebates, respectively*;
- Alternative market price comparisons identified 200 cheaper prescription drugs for a total potential savings of over $650,000.

* Also, if the county had been allowed the option of receiving the higher of actual rebates earned versus a fixed rebate, the total rebate savings for 2017 to 2020 would have been $1.6 million.

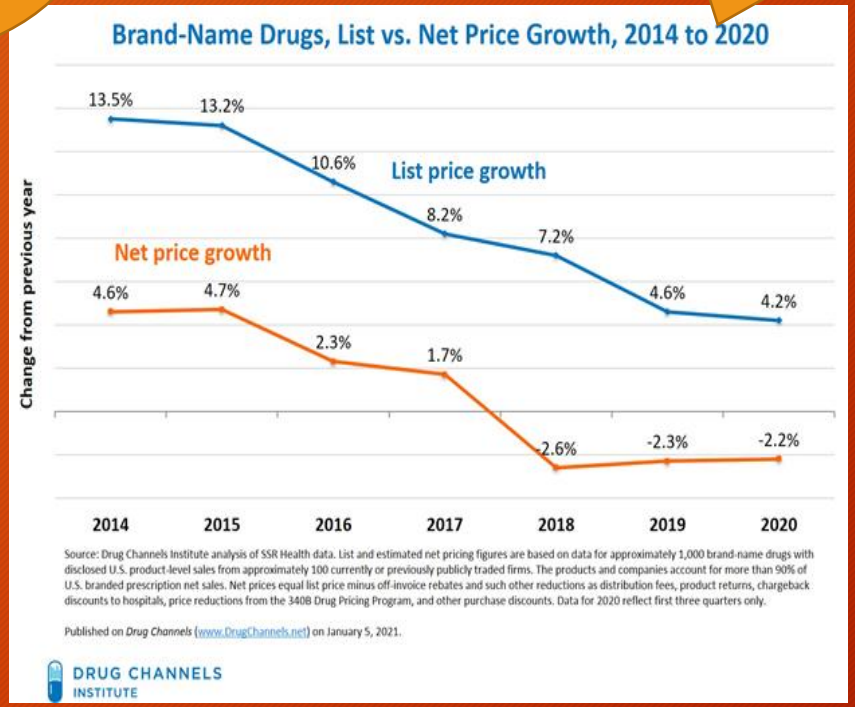
Please feel free to contact me if you have any questions.

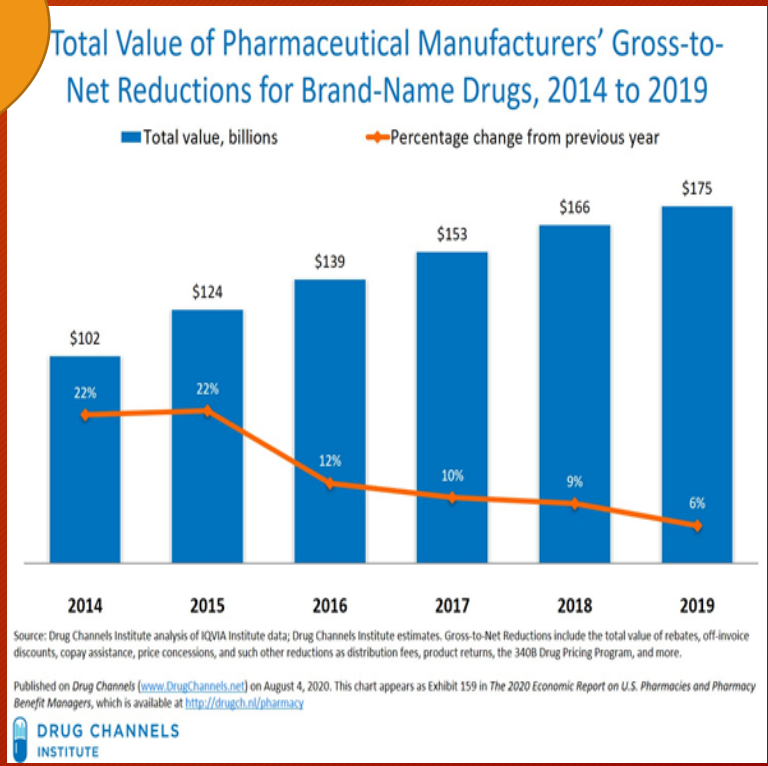
PBMS MASKED ARRANGEMENTS ARE HARMFUL TO PATIENTS



$225M in Spread Pricing (W/O accounting for rebates)

Gross-to-Net Bubble Spike to $175B in 2019.





Questions?

reliance|rx®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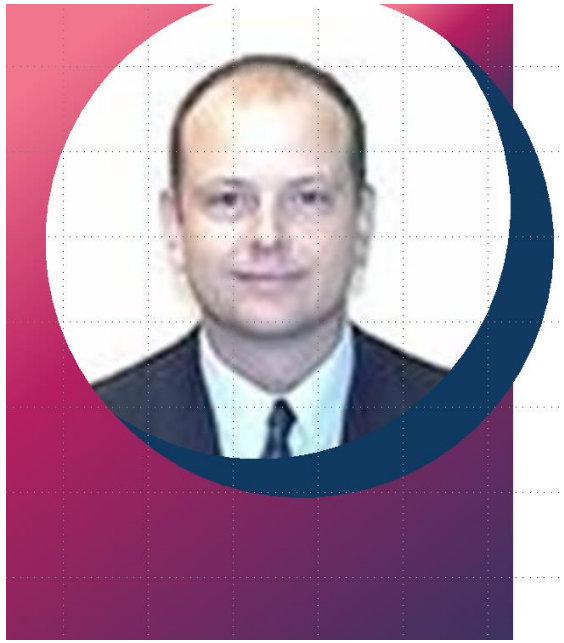
reliance|rx

We'll be back at 2:50 PM CST!

Employer Panel



Darin Hinderman

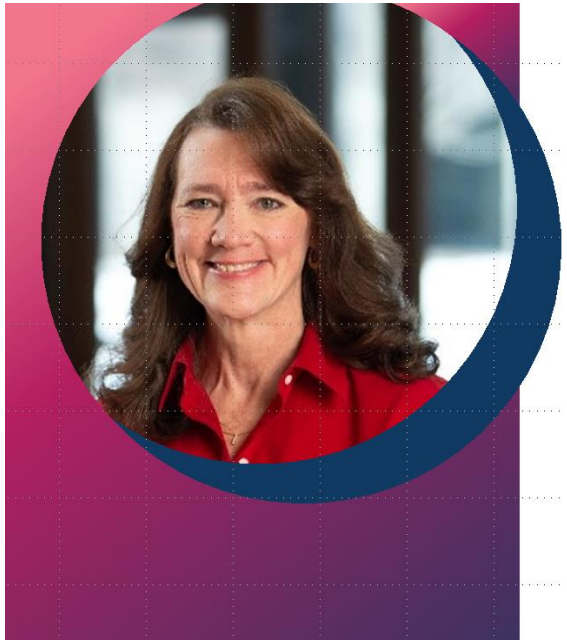
Global Health Strategy Manager-Total Rewards

Caterpillar Inc.

Jason Parrott

Senior VP, Enterprise Growth & Partnerships

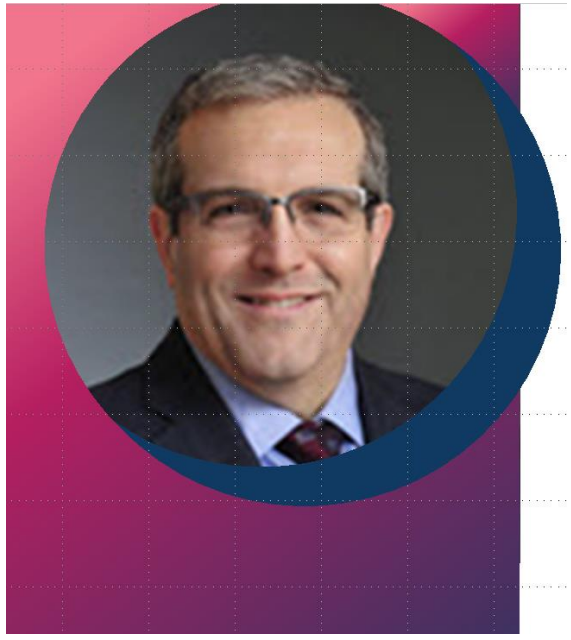
Vida Health



Sherri Samuels-Fuerst

Vice President, Total Rewards

Sargento Foods



Tom Sondergeld

Director Digital Awareness

Employer Health Innovation Roundtable

The Cost of Insulin: Has Legislation had an Impact?

Judy Hearn

Director of Membership Initiatives

MBGH

State Legislative Impact on Cost of Insulin - What do employers need to know?

Effective 1/1/2021 insulin copay caps at $100/month for IL patients using a state-regulated insurance plan

No impact for:

- Self-insured plans under ERISA
- Uninsured

HDHP in place?

- Include all insulin types on your drug list (standard formularies may exclude some)
- Insulin should be exempt from the deductible for best affordability, then cap the coinsurance or copay

Midwest Health Purchasers Collaborative Partner Update

Denise Giambalvo

Vice President

MBGH

MHPC
Midwest Health Purchasers Collaborative

MIDWEST HEALTH PURCHASERS COLLABORATIVE
TRUSTED PARTNER

MBGH
Midwest Business Group on Health

carrum health

DAY TWO

RxResults℠
Evidence-Based Risk Management

inspera health
Healthy employees. Healthy business.

HEALTHSTRATEGY

shortlister

CarrumHealth

2020 Outcomes: The new standard for Centers of Excellence

Commitment to quality

30% of unnecessary surgeries avoided*

80% reduction in complications and readmissions*

+

Driving proven savings

>4x ROI for mature clients (voluntary model)

>45% savings per procedure vs market*

+

Delightful experience

96 Net Promoter Score

90% Mobile app engagement

* *Source: RAND Corporation analysis of Carrum Health results data. Funded by National Institute on Aging. Published March 2021.*

Program: 1 Year Outcomes

1.0+ Drop in A1C

69% Time-in-range

11+ lbs Weight Loss

88% Engagement

34% Medication

64% Energy

44% Sleep Quality

48% Hunger

36% Stress

87 NPS

inspera health

Engagement Leads to Outcomes

A1C 14%
For members with baseline A1C above 7.0

BMI 9%
For members with baseline BMI > 30

Blood Pressure 5%
For members with baseline BP (Sys) > 120

Glucose 25%
For members with baseline Glucose above 125

LDL 9%
For members with baseline LDL > 101

Mental Health 43%
For members measuring at risk using the SF36v2 instrument

Care Gaps 82%
Average baseline of 3.3 open Care Gaps

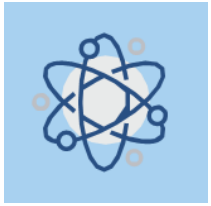
NPS 94
2020 Net Promoter Score

12 mo. Engagement 84%
70% engagement at 18 months

2020 Shortlister Connect Stats

137 Employers use Shortlister to research vendors & issue RFPs

10 MBGH members



3,500 Vendors available in the Shortlister platform

Shortlister is the largest database of unbiased & objective information on vendors in the benefits and insurance space

22,000,000 lives out to RFP through Shortlister in 2020

Access unbiased ratings & reviews of vendor performance and feedback from employers like you

Pre-negotiated discounts available from most of the top well-being vendors

HEALTHSTRATEGY

2020 Pharmacy Benefits Consulting Outcomes

$50B Pharmacy Spend Currently Under Management

40 Self Funded Employer groups and
10 National/Regional Health Plans

Launched Rx Marketplace™ with 13 PBMs Selected

Efficient RPF process, including PBMs selected to participate based on upfront agreement to HSLLC contract terms, conditions and definitions, while providing customized client pricing bids

>30 Clients Supported with Customized Formulary Management

240 New Rx benefit drugs evaluated
107 designated as low clinical value and recommended for plan design exclusion

6 Clients Supported with a Specialty PBM Carve-Out Arrangement

15 Pharmacy Benefit Management RFP Procurement Processes Conducted

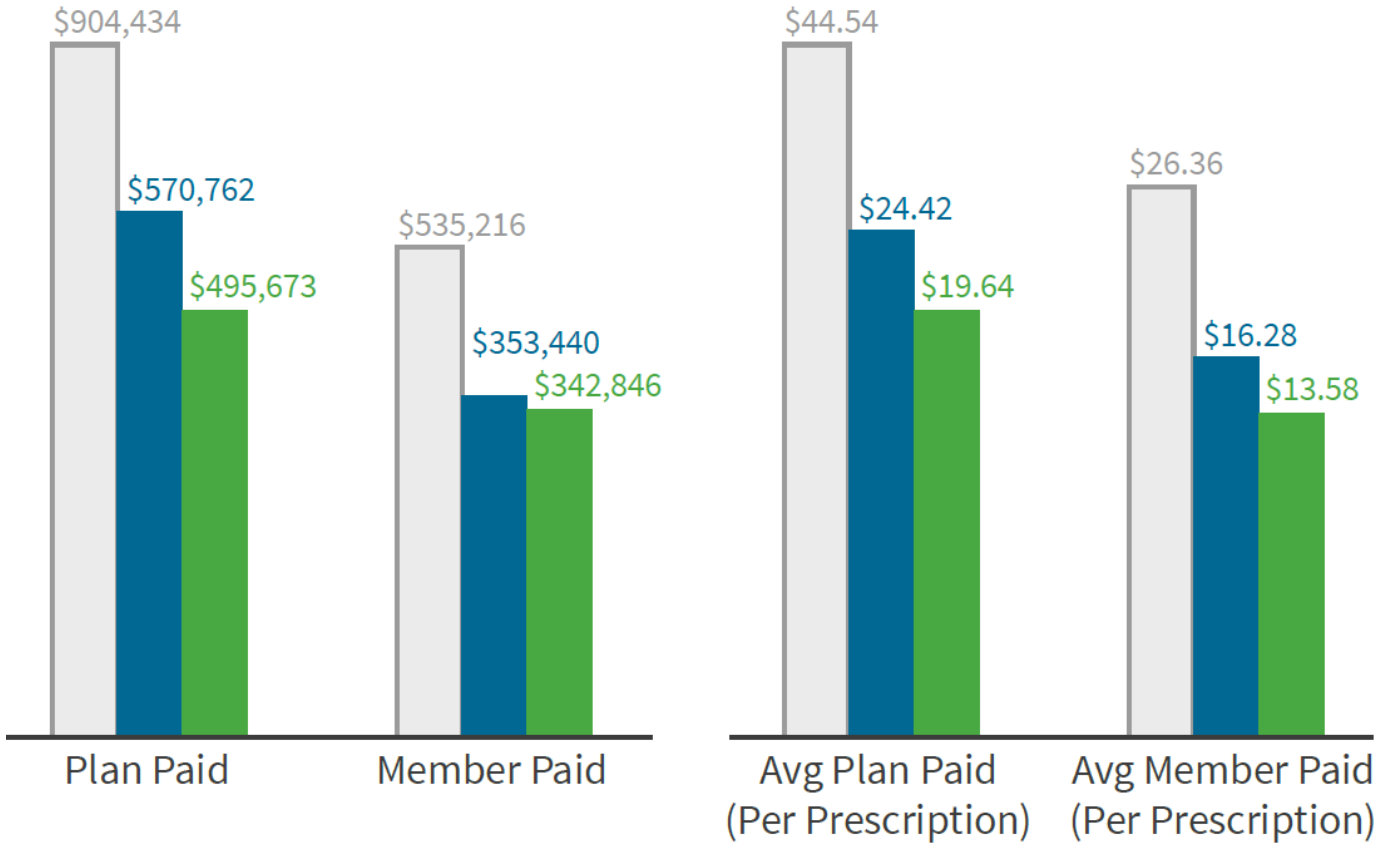
Resulted in new direct (non-coalition) contracts ranging in cost avoidance savings of 8-20% depending on baseline PBM deal and rigor of the contract definitions and pricing conditions

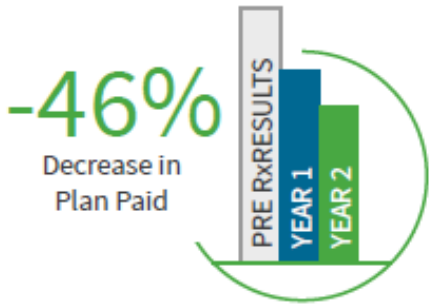
10 PBM Market Checks completed

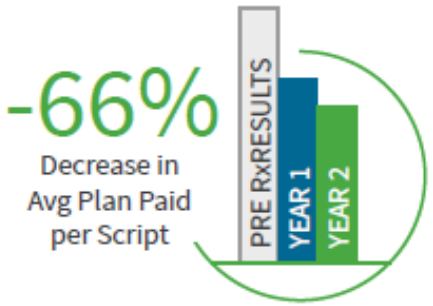
5 PBM Contract Renewals Negotiated

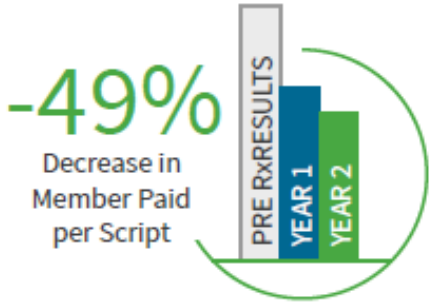
Contract value captured ranged from 3-8% of total drug spend

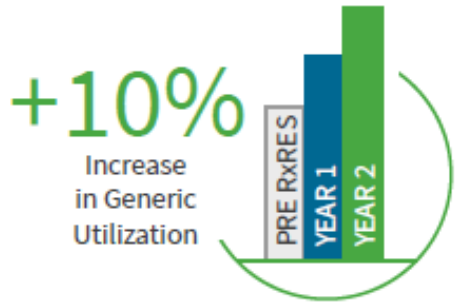
Formulary RxGuidance Results | Targeted Drug Classes









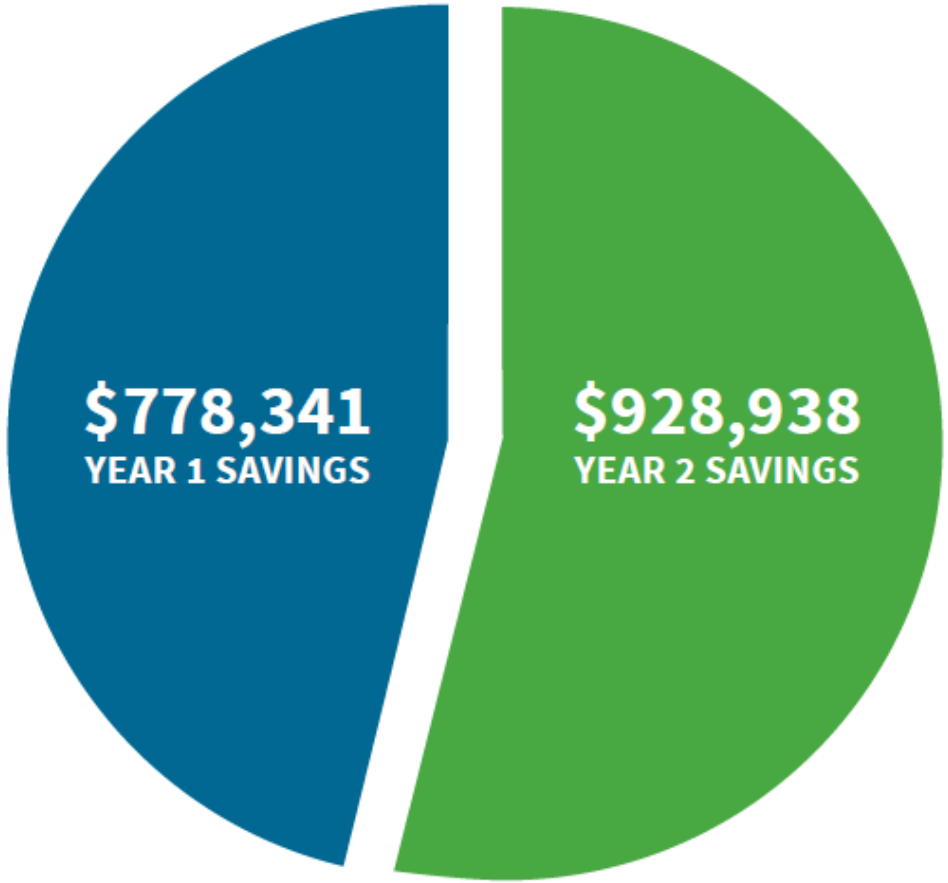


Specialty RxGuidance Results | Independent Prior Authorization

$1.7M

prior authorization savings

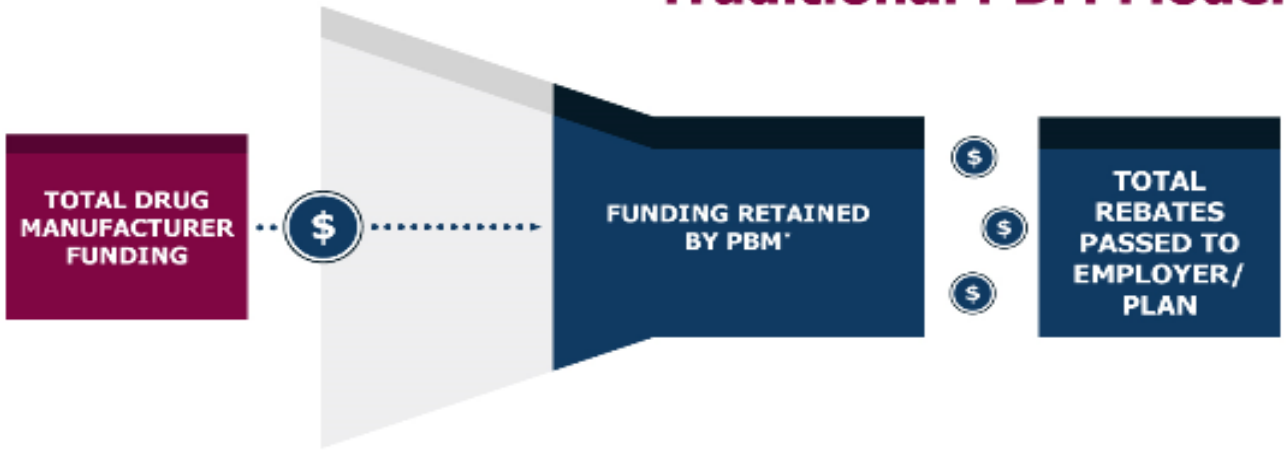
99 prior authorization requests for specialty medications over a 24 month period.



NEW TO MARKET:

A Better Rebate Solution

Traditional PBM Model



*Administrative fees negotiated with manufacturer, such as formulary compliance initiatives, clinical services, therapy management services, education services, medical benefit management services, and the sale of non-patient identifiable claim information.

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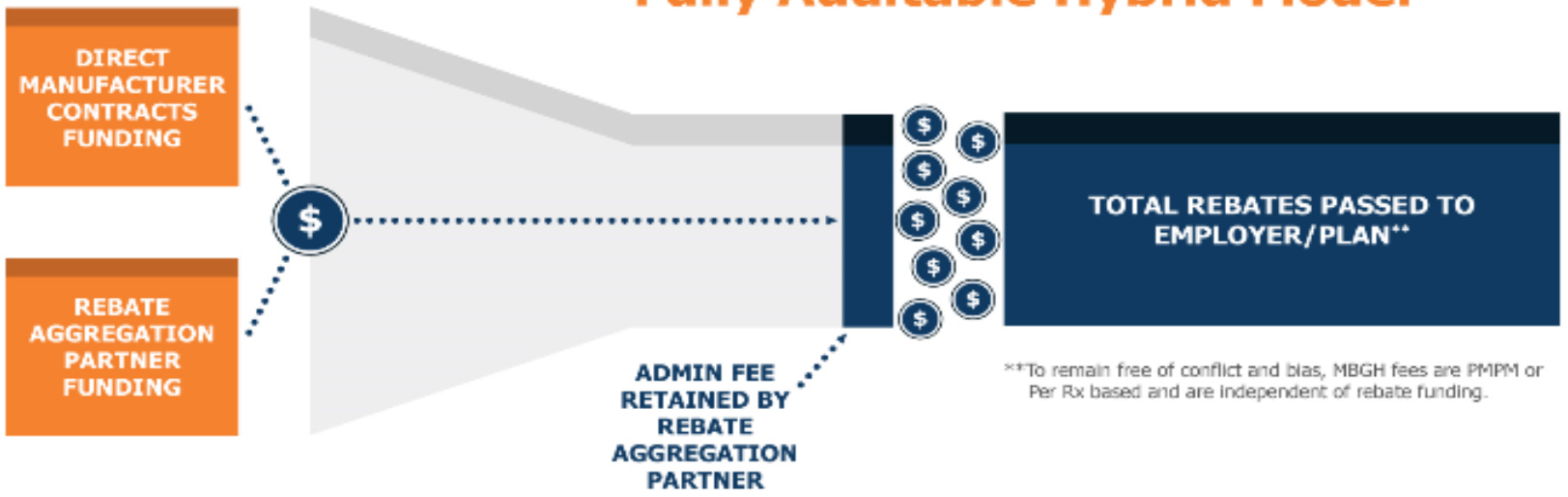
Midwest Business Group on Health

Fully Auditable Hybrid Model



**To remain free of conflict and bias, MBGH fees are PMPM or Per Rx based and are independent of rebate funding.

Employer Case Study

Midwest Business Group on Health

Employee Population & Medical Design At a Glance

- 8,815 total employees
  - 88%; 7,555 are benefit eligible
  - 70%; 5,244 of benefit eligible take medical
  - Average 11,000 members
- Offer two plans (EPOs) with almost identical plans

	Exclusive EPO EEH network	Extended EPO BCBSIL network
Annual Deductible	No deductible for prescription drugs	
Annual Out-of-Pocket Maximum	Separate out-of-pocket maximum from medical: $2,000 Individual, $4,000 family	Included in medical out-of-pocket maximum
You Pay	Generics $12 retail up to 30-day supply $24 mail order or retail 90-day supply Preferred Brand Names 20% ($45 Min/$75Max) up to 30-day supply 20% ($80 Min/$160 Max) mail order or retail 90-day supply Non-Preferred Brand 30% ($75 Min/$105 Max) up to 30-day supply 30% ($160 Min/$225 Max) mail order or retail 90-day supply	

Past Design Strategies

- Copay; predictable cost to steer towards generics
- Coinsurance with lower minimums and maximums to steer to Preferred Brand Name
- No separate deductible
- Mandatory Maintenance
- Changed PBMs
- More Restrictive Formulary; eliminated the outlier drugs
- Lower employee subsidy for dependent portion of the total medical contributions

Employer Case Study: Current Strategy

Midwest Business Group on Health

Engaged in 2019 with MBGH's EmployeRxEvolution to optimize PBM Contract

- Focus outcomes at the lowest unit cost
  - **Anticipated savings of $7.855M over 3 years**
    - $2,390,750 yr. 1, $2,684,512 yr. 2, $2,779,743 yr. 3
    - Indirect impact; allowed the introduction of salary banding at no cost to the organization
- Total transparency
  - Discovered a consulting fee buried in the PBM fees
    - The PBM was part of our Benefit Consultant's Cooperative
  - Current transparent fee is 2/3 less
- Employer Directed Contract Language
  - 100% of identifiable rebates are coming back
    - 28% or $5.3M n 2020 v. 24% or $4M in 2019
- Increase flexibility

In 2021 - Removed the outlier drugs and adopted Performance Select Drug Formulary

- Minimal disruption
- $636K in annual savings

Results – Net Paid PMPM increases:

- 2017 - $101.28
- 2018 - $103.91; 2.6% increase
- 2019 – $108.18; 4.1% increase
- 2020 – $100.18; 7.4% decrease

Employer Case Study: Next Steps

Midwest Business Group on Health

- Restrictive Formularies
  - Adopting PBM's Performance Drug List which is their most restrictive
    - $223,000 additional savings
- Review the resulting PBM supplied restricted formulary with our independent Rx Consultant and further restrictive the formulary
  - To discover Rx not as economical or effaceable as low-cost alternatives
- Will proactively review drugs in the pipeline to gain an understanding of possible impact on our pharmacy plan
- Supply our own Specialty Drugs
- Investigated but eliminated the possibility of direct contracting with a pharmacy
  - Not viable currently

Questions?

Thank you!