



Midwest Business Group on Health
The Source for Leading Health Benefits Professionals

Employers' Forum of Indiana

Strategies to Address High Drug Prices

January 10, 2018

MBGH: *Representing the Employer Perspective*

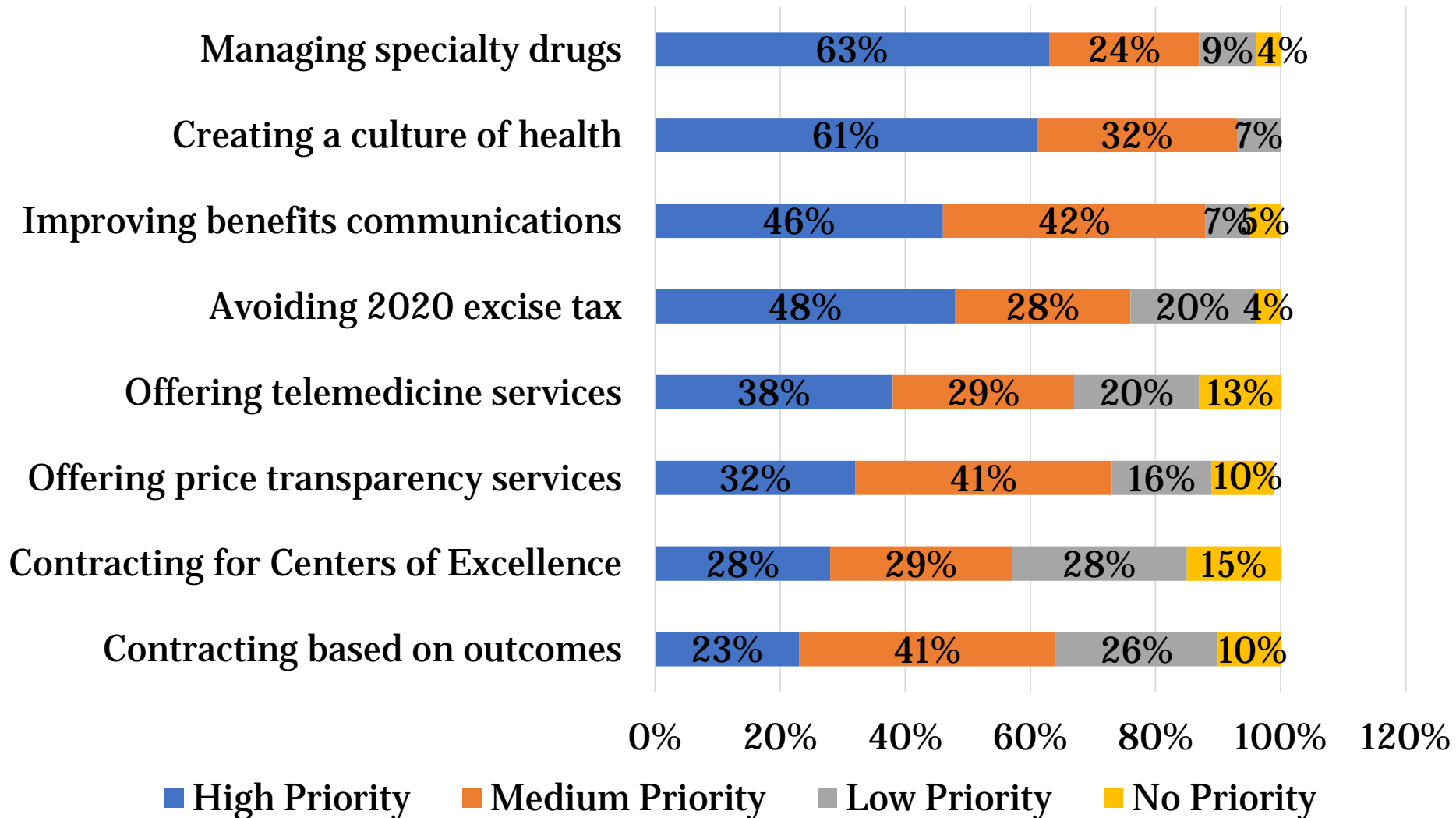
- Since 1980 with more than 130 members providing coverage to over 4 million lives and spending over \$4.5 billion on health care each year
- Members consist of mid to large companies, including coalitions, hospitals, health plans, pharmaceutical manufacturers, wellness vendors, consultants and professional associations
- Activities focus on the Employer – as the Purchaser – Perspective
 - Education, networking and benchmarking
 - Health benefits research, toolkits and demonstration pilots
 - Community-based initiatives on health improvement, patient safety and quality outcomes
 - Buyers groups and health benefits service offerings

MBGH Members



2016 Annual Employer Survey

Health Benefits Management Priorities – 2017-18





National Employer Initiative on Specialty Drugs

Employer Focused, Employer Driven



INDUSTRY NEWS CONTACT LOGIN

National Employer Initiative on Specialty Drugs

Employer Focused, Employer Driven
A project of the Midwest Business Group on Health

INDUSTRY OVERVIEW MANAGING YOUR STRATEGY TOOLS & RESOURCES

Today's health benefits professional needs to make critical and informed decisions to better manage the higher cost of specialty drugs.

This Toolkit provides guidance, knowledge and access to no-cost resources to support plan performance and cost management efforts, and includes ideas to optimize specialty drug use in the medical and pharmacy benefit, make informed decisions on benefit coverage approaches and address PBM transparency issues on pricing, rebates and contracting.

GET TOOLKIT ACCESS GET TOOLKIT UPDATES

Industry News
The Summer of Cardiology Blockbusters?
FDA approval (pending) of heart failure drug sacubitril/valsartan (Entresto)

Latest Employer Resources
• Results of 2013 National Employer Survey
• Employer View of Benefits

- Employer-driven research project began in 2010
- Advisory council of large self-insured private employers
- Annual benchmarking survey
- Online toolkit – www.specialtyrxtoolkit.org
- Annual Forum on Pharmacy Benefits & Specialty Drugs
- Annual multi-stakeholder meeting with coalitions, employers/purchasers, specialty pharmacies, PBAs, manufacturers
- National educational presentations

National Employer Initiative on Specialty Drugs – www.specialtyrxtoolkit.org

- Employer-Driven Research with Coalitions
 - Employers' Health Coalition – Arkansas
 - Employers Health Coalition – Ohio
 - Florida Healthcare Coalition – Florida
 - Healthcare 21 – Tennessee
 - Mid-America Coalition on Health Care – Kansas
 - Midwest Business Group on Health – Midwest
 - Northeast Business Group on Health – New York, New Jersey
 - Pittsburgh Business Group on Health
- Collaborative efforts to create a smart PBM RFP for medical and pharmacy



National Employer Initiative on Specialty Drugs — www.specialtyrxtoolkit.org

- [Checklist for PBM Contracts](#) – Criteria for inclusion in a PBM contract to drive high performance and determine if your vendor is delivering results
- [Checklist for PBM Audits](#) – Types of benefit assessments/reviews commonly conducted and what elements should be included in a pharmacy benefit audit
- [Checklist for Designing Specialty Drug Benefits](#) – Key elements to address when developing a specialty drug benefit and contracting strategy
- [Checklist for Site of Care Management](#) – Guidance to determine if a site of care strategy is beneficial for your company
- [Education Strategy for Consumers](#) – Communication strategy for employees/plan members offering tools and resources, along with strategy implementation and measurement recommendations

PBM Contract Checklist

Use components of this checklist when contracting with a PBM for pharmacy benefit services, including biologics/specialty drugs.

General Contract Provisions

The following terms are clearly defined:

- Generic drug
- House generic drug
- Single source generic drug
- Brand drug
- Multi-source brand drug
- Specialty drug
- Compound drug
- Average Wholesale Price (AWP)
- Contract year
- Claims
- Dispensing fee
- Drug interchange
- Losses
- Maximum Allowable Cost (MAC)
- MAC list
- Plan design document
- Usual and Customary (U&C)
- Retail Pharmacy Network
- Retail 90
- Definitions provided for all dispensing channels

National Employer Initiative on Specialty Drugs – www.specialtyrxtoolkit.org

A new MBGH report on ways that PBMs are significantly adding to pharmacy benefit costs and what employers can do about it

Ways that PBMs generate revenue:

- Retain the rebate
- Keep the spread
- Keep drug distribution in house
- Claw back patient copay
- Use direct and indirect remuneration (DIR) claw backs at the pharmacy
- Lock out new drugs
- Require price protection rebates from the manufacturer



Drawing a Line in the Sand: Employers Must Rethink Pharmacy Benefit Strategies



Throughout this report, you will see commentary from health benefit professionals, speakers and others who participated in MBGH educational programming in 2017. Look for this icon

Middlemen continue to add to the cost of drugs

Health care reform continues to drag on with Washington's inability to address rising costs with rational health care policy. This lack of direction negatively impacts the market, and employers – as the largest purchasers of health care – can no longer afford to sit on the sidelines. One area of the health care value chain ripe for transformation is pharmacy benefits.

Organizations like the non-profit Midwest Business Group on Health are partnering with progressive employers, key industry leaders and employer coalitions across the country to improve the effectiveness,

efficiency and value of pharmacy benefit programs to influence affordability and transparency.

This report offers a call to action on the key issues and important steps public and private employers can take to:

- ▶ Understand how today's pharmacy benefits model, with multiple parties in the middle, contributes to higher costs in the supply chain
- ▶ Identify ways to work with intermediaries to reduce unnecessary costs and drive efficiency

Employers are caught in the middle with specialty drugs

Biologic and specialty drugs have the ability to change the face of treating disease. Every year, there is an increasing number of these drugs being produced for rare and chronic diseases or previously untreated conditions. The high cost of specialty drugs has become an increasing concern for employers, as plan sponsors. In 2016, MBGH members cited "managing specialty drugs" as their #1 priority.

Although employers value the knowledge, skills and resources provided by Pharmacy Benefit Managers (PBMs), there is growing concern about their revenue streams which are increasing the costs of specialty drugs. Employers are caught in the middle

unless they take action to change the paradigm. This report outlines some of these challenges and provides employers with important recommendations.

In addition, MBGH created an online employer toolkit as part of its National Employer Initiative on Specialty Drugs – www.specialtyrxtoolkit.org – to support health benefits professionals in making critical and informed decisions to more effectively manage specialty drug costs. The toolkit offers no cost tools and resources, including those linked to the titles below.

PBM Contract Checklist: Criteria for inclusion in a PBM contract to drive high performance and determine if your vendor is delivering results.

PBM Audit Recommendations: Types of benefit assessments/reviews commonly conducted and what elements should be included in a pharmacy benefit audit.

Checklist for Designing Specialty Drug Benefits: Key elements to address when developing a specialty drug benefit and contracting strategy.

Checklist for Site of Care: Guidance to determine if a site of care strategy is beneficial for your company.

Consumer Education Strategy: Communication strategy for employees/plan members offering tools and resources, along with strategy implementation and measurement recommendations.

Employer quotes from report

Manufacturers can tell you what they charge the wholesaler but they can't talk about rebates with the PBM because of required confidentiality clauses between the two.

When you pay a PBM a PMPM fee, any revenue or rebate derived by adjudicating your formulary should get passed back to you. PBMs have lots of ways to hide revenue streams so it doesn't always happen. Transparency standards have been in place for a long time but you still need to negotiate with suppliers.

We don't talk to employers about the concept of fiduciary responsibility; in this health care environment, employers will have to make ethical decisions about which drugs to cover that will require making difficult choices.

Employers haven't felt there is a problem with pharmacy benefits and have been told by consultants and partners that everything is under control and they are getting the best deal possible. We want to trust our partners, but don't know what questions to ask or what to include in the RFP. Employers need help!

Today, employers are not allied and have no common agenda (to drive change). The people you're buying benefits from know it. You have to stand up and ask (your vendors) for accountability.

Include questions in your RFP that ask intermediaries what they have been paid by partners in the supply chain (and indicate they will be audited – you have a fiduciary duty).

Employer quotes from report

Don't accept the status quo. There is a lack of (PBM) willingness to change and employers need disruption and transformation. The easiest way to do this is through pharmacy benefits. If one PBM doesn't want to play, there are others waiting.

A properly designed, full pass through, transparent PBM/PBA is clean, audit-friendly and the best option for legal compliance, but most PBMs don't want to sell you a transparent contract. Traditional contracts are much more profitable.

Don't sign a contract until you know where every single penny is going.

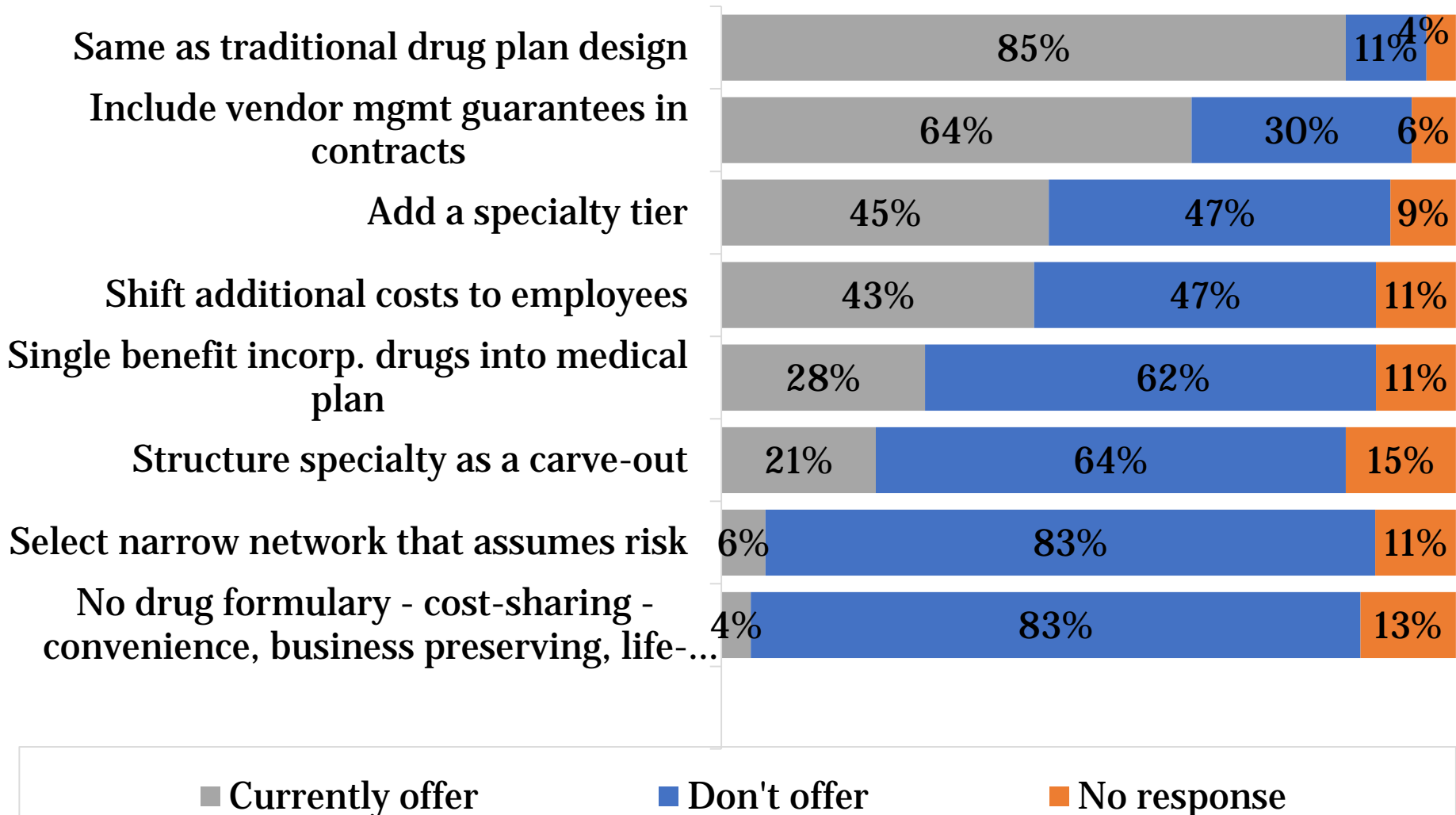
Formularies are mostly based off cost savings not clinical outcomes and most employers don't know how to ask the PBM the right questions. Contracts also need to be reworded.

Our "suppliers" don't share contracts or disclose fees. Employers are starting to notice and wondering why they are paying so much. We need to ask intermediaries what they are paying each other and how they spent the money."

We learned we are only getting 70% of our rebate dollars. We need to review our PBM contract language and if necessary, change it to demand more rebates get passed through.

5th Employer Survey on Specialty Drugs

Plan design strategies currently offered



5th Employer Survey on Specialty Drugs

Current versus Future plan design strategies

- **45% increase** in considering a narrow network to assume the risk
- **45% increase** in considering “no drug formulary” with employee cost sharing based on:
 - Lifestyle enhancing drugs (diet aids, ED, cosmetic) – *no coverage*
 - Convenience drugs (acne, HRT, non-sedating antihistamines) – *50/50 split*
 - Business preserving drugs (chronic diseases) & Lifesaving drugs – *low employee cost share*
- **41% increase** in structuring specialty as a carve-out
- **34% decrease** in using traditional plan designs

5th Employer Survey on Specialty Drugs

Key Issues - Strongly Agree or Agree

- 80% - Cost trend management is a top priority
- 71% - New and innovative solutions are needed
- 68% - Prior authorization is critical to managing trend
- 66% - Quantity limits are critical to managing trend
- 57% - Concerned about number of specialty drugs in pipeline
- 53% - Limitations and exclusions are critical to managing trend
- 51% - Rebates are critical to cost management

Employers, as Plan Sponsors and Fiduciary

ERISA doesn't just apply to retirement; as plan fiduciary it is the employer's duty to know how employee premiums are being used to fund care

- Drug distribution channels are very complex and employers need to hold everyone in the supply chain accountable
- Understanding these channels and the impact of intermediaries or “middlemen” in adding to the cost of the drug is an important first step



Value Chain & the Middleman

- “In the US, \$15 of every \$100 spent on brand-name drugs goes to middlemen; largest share (about \$8) goes to pharmacy benefit manager. In other developed countries, only \$4 out of every \$100 goes to middlemen.”
- “The drug-pricing system is completely broken (and) for the first time PBMs are in the crosshairs.”
- Health Transformation Alliance – PBM efforts will focus on reducing “redundancies and waste in the supply chain”

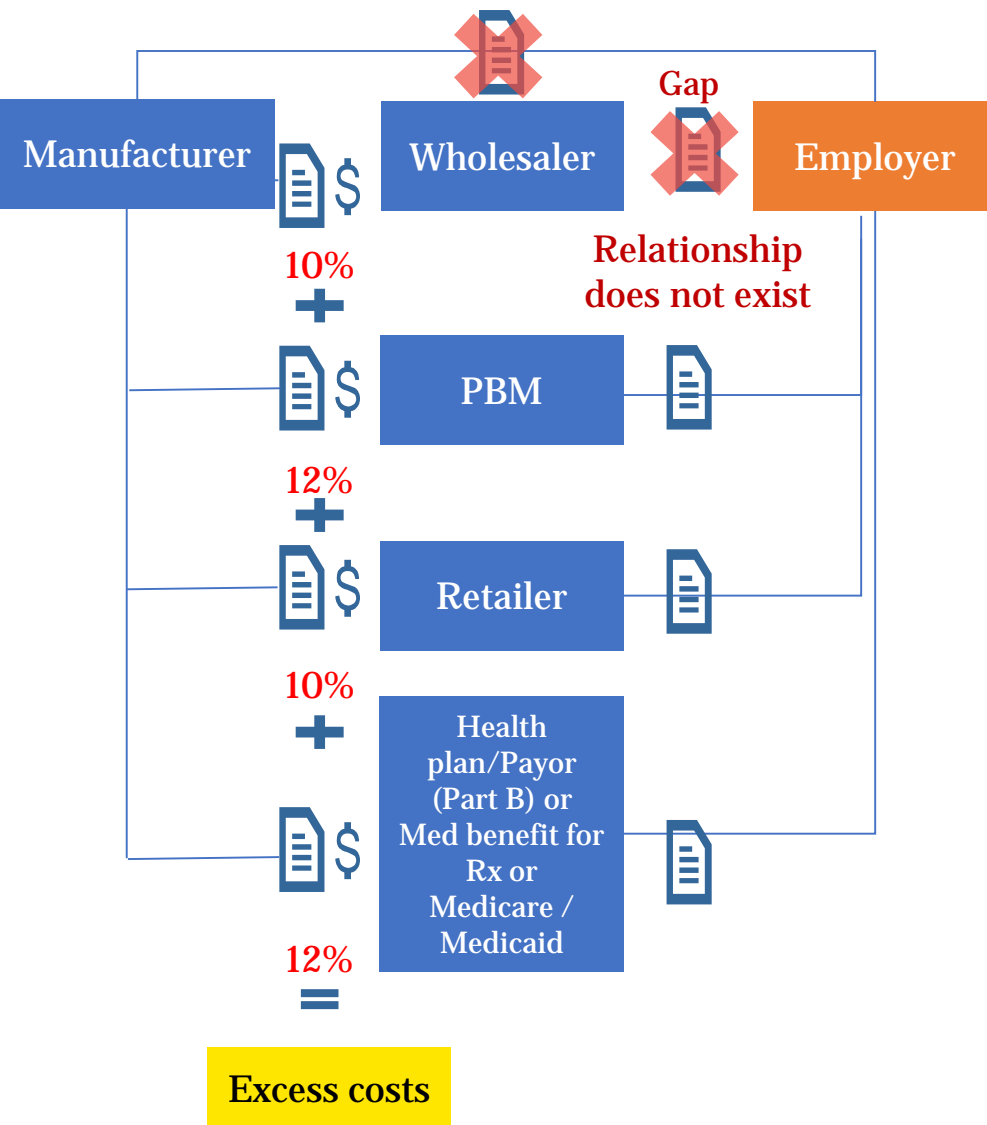
30—40% of an employer’s total premiums can be impacted by middlemen and this is not reflected in administrative expenses

Quotes: <https://www.bloomberg.com/news/articles/2017-03-03/drug-costs-too-high-fire-the-middleman>



Contracting universe in the value chain

Gaps for Employers



Challenges

- Employers are not a party to contracts between intermediaries so they **have no visibility** to fees and rebates paid by manufacturers or between parties to handle the transport and hand-offs of the drug
- Drug prices are marked up at every handoff point, increasing costs
- Drug prices are also “arbitraged” (e.g. buy and sell) which further increases costs

Pharmacy Benefits Middlemen

- Few opportunities exist for employers to impact the actual cost of traditional and specialty drugs
- Middlemen's lack of transparency for certain drug costs, contracting strategies and unpaid rebates continues to play a significant role in adding to the already high claim costs of specialty drugs
- Who are the primary middlemen impacting employer costs?
 - PBMs
 - Drug Wholesalers
 - Drug Distributors



Pharmacy Benefits Middlemen

PBMs

- PBMs are virtually unregulated and many want to know – How they function? What deals do they cut? How do they generate revenue? What specific services to they perform?
- PBM contracts are known for being opaque and difficult to interpret
- Three PBMs control 70-80% of the prescription drug benefit transactions – ESI, CVS, OptumRx
- Ongoing consolidation and vertical integration is reducing competition instead of enhancing it
- State legislative efforts focused on PBM fiduciary standards to “put customers’ interests ahead of them” has been beaten back in court; so have other efforts to change the way the system works

Employer Strategies

Caterpillar – Serve as their own prescription coordinator

10 years ago, saw dramatic increases in drug costs; estimated that as much as one-quarter of their \$150M drug spend was being wasted

- Devise own drug formulary with internal physicians and pharmacists based on clinical efficacy; not rebates
- Negotiate directly with retail pharmacies – Walgreens, Walmart, Kroger
- Promote use of generics and discourage use of expensive heartburn and cholesterol medicines

Results:

- Save tens of millions of dollars each year (\$5-\$10M on cholesterol-lowering statins alone)
- Drug spending dropped their per patient/per prescription costs

Employer Strategies

See Employer Journey – www.specialtyrxtoolkit.org

Procter & Gamble – Value-based design with no drug formulary; shares the values of the outcomes between the consumer and the employer

Lifestyle-Enhancing – Used primarily to enhance one’s ability to perform/ achieve a lifestyle related activity/goal

- Diet aids, ED, Cosmetic
- *All or the greatest amount of cost is assumed by the consumer*

Convenience – Produce outcomes not directly associated with the preservation of life or the normal functioning of body systems essential to life; or medications with one or more less costly treatment alternative that results in similar clinical outcomes.

- Non-sedating antihistamines, acid reflux, progesterone, testosterone, toenail fungus, certain sedatives
- *The consumer and the employer at least share equally in the cost*

Employer Strategies

See Employer Journey – www.specialtyrxtoolkit.org

Procter & Gamble – Value-based design with no drug formulary; shares the values of the outcomes between the consumer and the employer

Life-Preserving – Directly associated with the preservation of life or functioning of body systems essential to life

- Typically largest group of meds - Treatment of conditions such as infections, pain, seizures, depression and cancer
- *Employer assumes the greatest amount of cost*

Business-Preserving – Used to treat controllable chronic health conditions resulting in the highest levels of lost work time and long-term disability

- Typically the second largest group of meds - Treatment of conditions such as hypertension, high cholesterol, diabetes and asthma
- *Lowest level of consumer cost share or no cost*

Employer Strategies

Value Based Benefit Design – Uses incentives and disincentives to design health benefits that can support employees/plan members to:

- Encourage use of a provider or specific health care service, test, or drug that is shown to be more effective or provide higher quality than other options
- Discourage behaviors or the use of health care services, tests, drugs and providers when the evidence does not justify the cost or their use

Reduce employee cost sharing for certain drugs to get employees to participate in DM program

Reduce employee cost sharing for chronic disease drugs

Waive employee cost sharing for certain drugs to get employee to participate in DM program

Require employee to complete health risk assessment to be eligible for benefits

Waive employee cost sharing for chronic disease drugs

Employer Recommendations

- Use transparent/pass through PBMs or PBAs that remove the spread between the amount paid by the plan and the amount paid to the pharmacy
- Guarantee PBM contracts:
 - Disclose all financial flows, including all PBM revenue streams – margin pricing, formulary management fees, data sales
 - Pass-through all pharmacy discounts, rebates, pharmacy spread, retail and mail-order discounts **so that the true costs – not just the price – are known**
- Ensure that price protection rebates that PBMs require from the manufacturer are disclosed and passed through; these rebates are often worth more to the PBM than traditional rebates
- Require that PBM contracts exclude use of copay claw backs at the pharmacy

Employer Recommendations

- Use performance-based PBM contracts with penalties for not meeting goals and incentivize for improved outcomes for drugs and related treatments
- Negotiate directly with retail pharmacy networks for dispensing and patient care services
- Determine if there is value in allowing PBMs to have drug distribution in-house vs. via retail/specialty pharmacy – contracts often demand this and it is very profitable for the PBM; alter benefit design accordingly
- Exercise full auditing rights in PBM contracts, including the handoff between supply chain partners and how they get paid between contracts (the part we can't see) and make sure the PBM does not control what companies you can use to audit them

Things to watch for and know about...

- The term “cost savings” is often used by PBMs but how can we know if there are cost savings if we don’t know what we are actually paying
 - Employers need to know the cost of a drug at the point of service, not just a price that has no direct relevance to the claims cost
- Transparent and pass through models are worth learning about with many vendors offering these services and several coalitions with similar models – Arkansas, Nevada
 - Ask one of the big 3 to offer a transparent model and your costs will go up 30%
- Be aware of the a handful of new drugs coming to market at “net cost” or using outcomes or value-based contracting
 - Genentech - MS drug – Abbvie - HepC drug – no rebates being paid to PBM and often at less cost than older drugs
 - Merck – pediatric oncology drug – outcomes-based pricing
- Future potential of direct contracting with manufacturers; strategies to address PBM safe harbor issues through innovative purchasing mechanisms

Thank you!

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