Be the Boss of your Drug Spend: Take Control!

Employers' Forum of Indiana
September 25, 2019

PBGH
PACIFIC BUSINESS GROUP ON HEALTH

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PBGH Mission:

To be a change agent creating increased value in the healthcare system through purchaser collaboration, innovation and action, and through the spread of best practices

Employers Center of Excellence (ECEN)
Purchaser Value Network (PVN)
Value based programs to address low value care, maternity, pharmacy
Payment Reform
Meaningful Measures/Common ACO Measures
Accountable Pharmacy
Mental health/Primary Care integration
Benefit design best practices

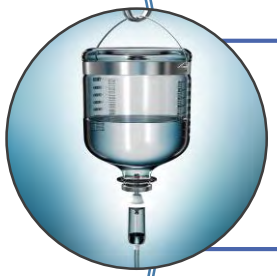
Influence CMS Policy
Health Care Payment Learning and Action Network (HCPLAN)
Health Care Transformation Task Force (HCTTF)
Antitrust advocacy
Pharmacy policy
Measurement/transparency

Intensive Outpatient Care Program (IOCP/AICU)
Practice Transformation
California Quality Collaborative (CQC)
Maternity Transformation
Patient Reported Outcomes (ICHOM)
Measurement/transparency

Agents for Change
PBGH Members - Partial List

Today's Agenda

Waste-Free Formulary



Specialty Drugs (particularly Biosimilars)

Accountable Pharmacy

Waste Free Formulary Study

The Commonwealth Fund

NEWSROOM TO THE POINT LOG IN SEARCH

Affordable, quality health care. For everyone.

Topics Publications & Data Experts Grants & Fellowships About Us

What's Trending: Medicaid Work Requirements High-Need, High-Cost Patient Personas Non-ACA-Compliant Health Plans

Reducing Wasteful Spending in Employers' Pharmacy Benefit Plans

August 30, 2019 | Lauren Vela

ABSTRACT

- **Issue:** Large self-insured employers and other health care plan sponsors are concerned about rising prescription drug costs. Formularies developed on their behalf by intermediaries like pharmacy benefit managers (PBMs) and health plans can ensure drug safety and support negotiating with manufacturers. But

Toplines

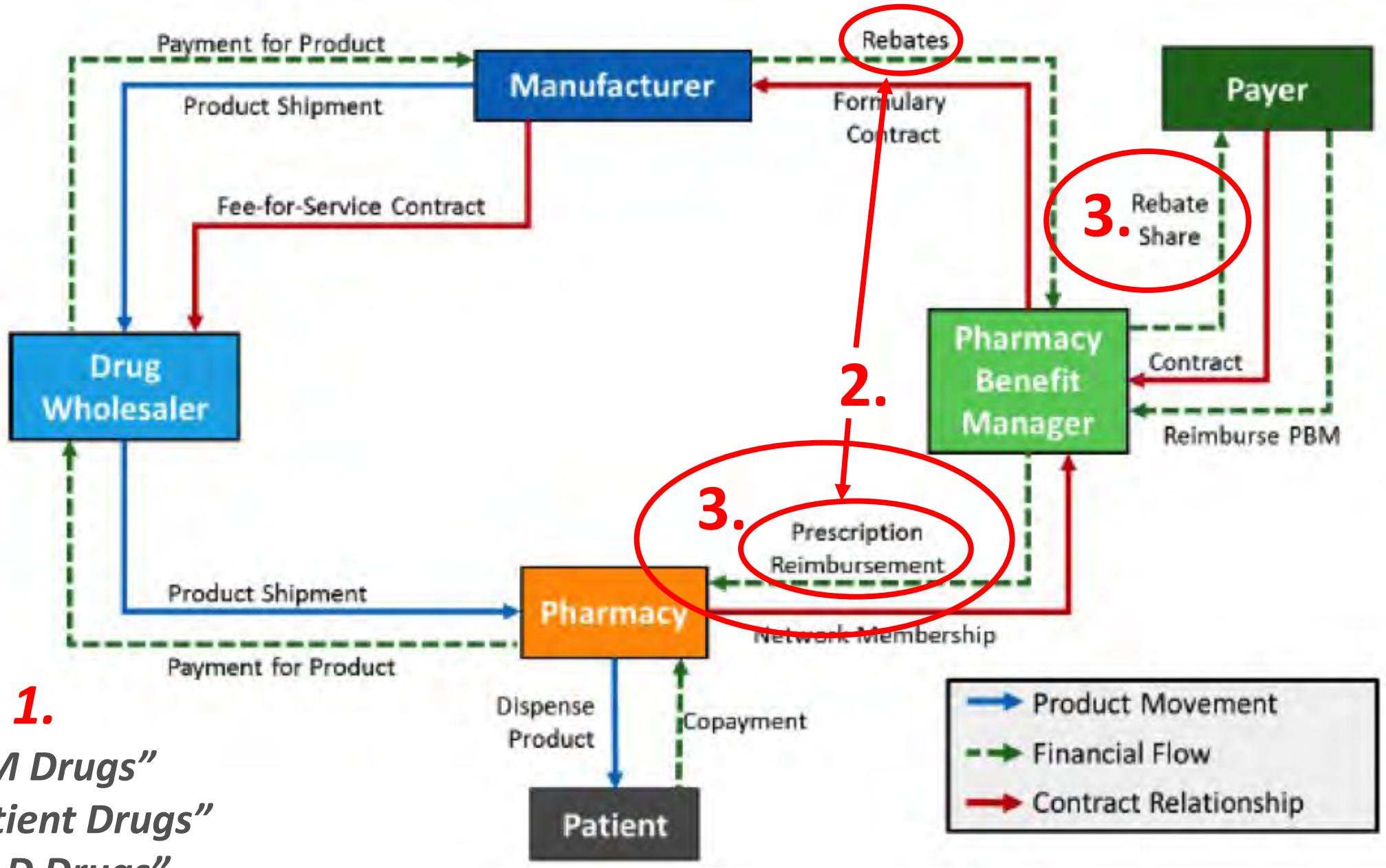
Pharmacy benefit plan sponsors could lower drug spending and out-of-pocket costs for enrollees by reducing the use of high-cost, low-value drugs

1. Is there substantial waste on the formularies of large, self-insured employers?
2. Would doctors prescribe to a common, waste-free formulary?
3. Would employers adopt a common waste-free formulary?

Why do we have so much waste in our formularies?

- Industry efforts and profit models encourage the utilization of unwarranted higher priced drugs.
  - PBMs- hidden rebates, AWP spread
  - Manufacturers—"Me too" drugs (re-marketing "old" drugs), "combo drugs" OTC equivalents, and brands. Marketing efforts: direct to physician detailing, direct to patients advertising, coupons, etc…

- ***We have one screwed up drug supply chain system with many parties making much money***
- ***Nothing will change until the entities paying the bill (employers in the case of ESI) change it***



1.

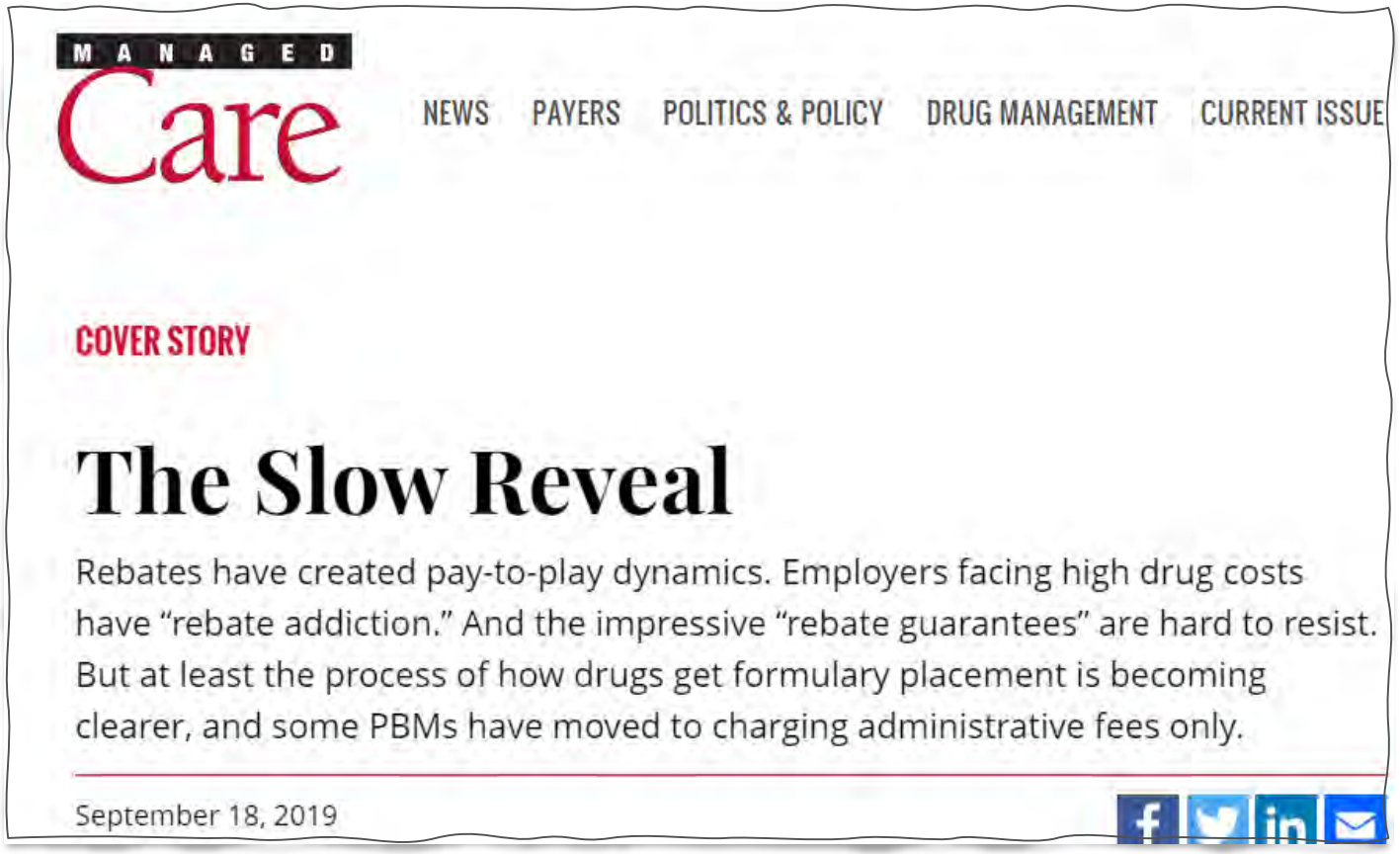
"PBM Drugs"
"Outpatient Drugs"
"Part D Drugs"

Take-Home Message

"When an vendor is negotiating on behalf of their client, but accepting monies from the party with whom they're negotiating that their client doesn't know about, that's not a discount, that's a kick-back"!!!

Why do we have so much waste in our formularies?

- Employers' focus and concerns
  - Consultant trust
  - Rebate addiction - as opposed to overall cost per member per month (PMPM) and outcomes
  - Member inconvenience and disruptions



MANAGED Care

NEWS PAYERS POLITICS & POLICY DRUG MANAGEMENT CURRENT ISSUE

COVER STORY

The Slow Reveal

Rebates have created pay-to-play dynamics. Employers facing high drug costs have "rebate addiction." And the impressive "rebate guarantees" are hard to resist. But at least the process of how drugs get formulary placement is becoming clearer, and some PBMs have moved to charging administrative fees only.

September 18, 2019

1. Yes, There is Waste

15 Data Donors submitted data (4 ESI, 8 CVS, 3 Optum)

2,543,907 claims evaluated of which 6% were wasteful, consisting of 868 different drugs

Data was limited, assumptions were conservative

Estimated savings of this data set was $63.3 million

Represented 2.8% to 24% of total PBM spend (for 9 data donors for whom we knew total spend. 10-24% for 7 of the 9. Two of the 9 had already begun managing their formulary.

- No controversial drugs (.01% specialty)
- Only considered if excluding the drug saved ≥ 25%
- Savings had to apply across formularies, i.e. specific formulary "deals" were excluded
- Case study-based assumptions about patients' behavior
- Savings were 11% less than comparative case studies due to conservative assumptions

Eight Drugs Account for 23% of the Savings

Drug	Patients*	Scripts	Savings
MetFORMIN HCl ER (MOD & OSM)	291	1,049	$ 3,472,137
Dexilant	842	3,170	$ 2,282,770
Duexis	190	428	$ 1,638,284
Mometasone Furoate	1,244	3,151	$ 1,323,248
Absorica	267	512	$ 1,279,028
Solodyn	259	622	$ 1,265,560
Esomeprazole Magnesium	1,390	4,201	$ 1,017,398
Jublia	362	645	$ 980,287

* Patient counts and member IDs from two data donors were not included in the data set. Script counts from all data donors are included.

2. Yes, Physicians would adjust prescribing patterns…

TO THE POINT
Quick Takes on Health Care Policy and Practice

How Physicians Can Help Reduce Wasteful Drug Spending

September 5, 2019 | **Lauren Vela**

Could prescribing practices designed to maximize both efficacy and cost-effectiveness reduce wasteful prescribing and save money? Physicians we interviewed said yes, and that the key to altering their prescribing practices would be to give them easy access to information, including the cost to patients and total cost of drugs, at the point of care.

There is ample room to reduce drug spending. We analyzed prescription drug data from 15 large, self-insured employers (including 13 members of the Pacific Business Group on Health), to identify prescriptions that may be wasteful — that

Toplines

Physicians say the key to prescribing higher-value, lower-cost medications is to give them easy access to information, including the total cost of drugs and the cost to patients

Physicians support the idea of

Toplines

Physicians say the key to prescribing higher-value, lower-cost medications is to give them easy access to information, including the total cost of drugs and the cost to patients

3. Will employers remove waste?

REMOVING WASTE FROM DRUG FORMULARIES

A practical guide to help er
remove waste from drug fo
and achieve savings for co
and employees while maint
member satisfaction

Coming Soon!

APPENDIX 2. Demonstration List of Wasteful Drugs, Less Expensive Therapeutic Alternatives, and Per-Unit Savings Potential

- The table compares high-cost wasteful drugs with their less expensive therapeutic alternatives.
- The large difference between the prices of the wasteful drugs and the therapeutic alternatives indicates that, even when discounts and rebates are accounted for, the therapeutic alternative will still offer savings as compared to the wasteful drug.
- The total savings obtained from removing each wasteful drug from the formulary will depend on the utilization levels. Removing a wasteful drug with high utilization may provide great savings even if the price of its therapeutic alternative represents a low per-unit discount.

	Wasteful Drug			Less Expensive Therapeutic Alternative		
	Brand Name & Active Ingredient	Main Indication	Unit Price[1]	Therapeutic Alternative[2]	Unit Price[3]	Per-Unit Discount[4]
Multi-Source drugs: high-cost branded or generic drugs for which less expensive options are available						
1	**Gleevec** (imatinib	Leukemia and gastrointestinal tumors	$112.37	**Generic Imatinib**	$4.09	96%
2	**Auvi-Q** (epinephrine auto-injector)	Acute allergic reactions	$2,940.00	**Generic Epipen**	$247.01	92%
3	**Penlac External** (ciclopirox solution 8%)	Toenail fungus	$204.93	**Generic ciclopirox external solution 8%**	$8.02	96%
4	**Carafate** 1g tablets	Duodenal ulcer, short term treatment	$4.88	**Generic Sucralfate** 1g tablets	$0.33	93%
5	**Vanos External** (Fluocinonide 0.1% cream)	Itching of the skin (Pruritus)	$32.82	**Generic fluocinonide** 0.01% cream	$0.54	98%
6	**Prenate** (prenatal multivitamins) - multiple preparations e.g., Prenate DHA, Prenate Star, et	Nutritional supplement for pregnancy	$9.19	**PreNata** (Chewable tablet	$0.10	99%
7	**Nexium Capsule Delayed Release** (esomeprazole magnesium)	Gastroesophageal reflux disease	$10.04	**GoodSense Esomeprazole Oral** (Capsule, delayed release)	$0.25	98%
Fixed-Dose Combination ("Combo Drugs"): drugs with two or more ingredients in one pill costing substantially higher than the individual ingredients in separate pills The examples below also reflect drugs for which over- the-counter (OTC) options are available						
8	**Duexis** (ibuprofen + famotidine)	Pain in osteoarthrosis and arthritis	$33.10	**Generic ibuprofen** (OTC) + **Generic famotidine** (OTC)	$0.58	98%
9	**Vimovo** (Naproxen + esomeprazole)	Pain in osteoarthrosis and arthritis	$49.64	**Generic naproxen** (OTC) + **generic esomeprazole** (OTC)	$0.38	99%
10	**Zegerid** (Omeprazole + Sodium bicarbonate)	Gastroesophageal reflux disease	$132.27	**Generic omeprazole** (OTC) + **sodium bicarbonate** (OTC)	$0.60	99.5%
11	**Percocet** (Oxycodone + acetaminophen)	Acute Pain	$28.10	**Generic oxycodone** (Rx only) + **acetaminophen** (OTC)	$1.44	95%
12	**Primlev** (Oxycodone + acetaminophen)	Acute Pain	$22.10	**Generic oxycodone** (Rx only) + **acetaminophen** (OTC)	$1.44	93%
Me- too drugs: immaterial tweaking of a particular ingredient results in a "new" more expensive drug that adds no clinical value as compared to the less expensive original version.						
Example 1: Difference in the salt or chemical form of the active ingredient						
13	**Dexilant** (dexlanzoprazole)	Gastroesophageal reflux disease	$11.30	**Generic lanzoprazole**	$0.30	97%
14	**Aplenzin** (bupropion hydrobromide)	Smoking Cessation, Major Depression	$165.56	**Generic bupropion hydrochloride**	$16.0	90%
Example 2: Difference in the formulation: cream vs. lotion, capsule vs. tablet, packet vs. capsule, etc						

And, btw…where HAVE your consultants been?

Be the Boss of Your Drug Spend: TAKE CONTROL!

Today's Agenda

Waste-Free Formulary

Specialty Drugs (particularly Biosimilars)

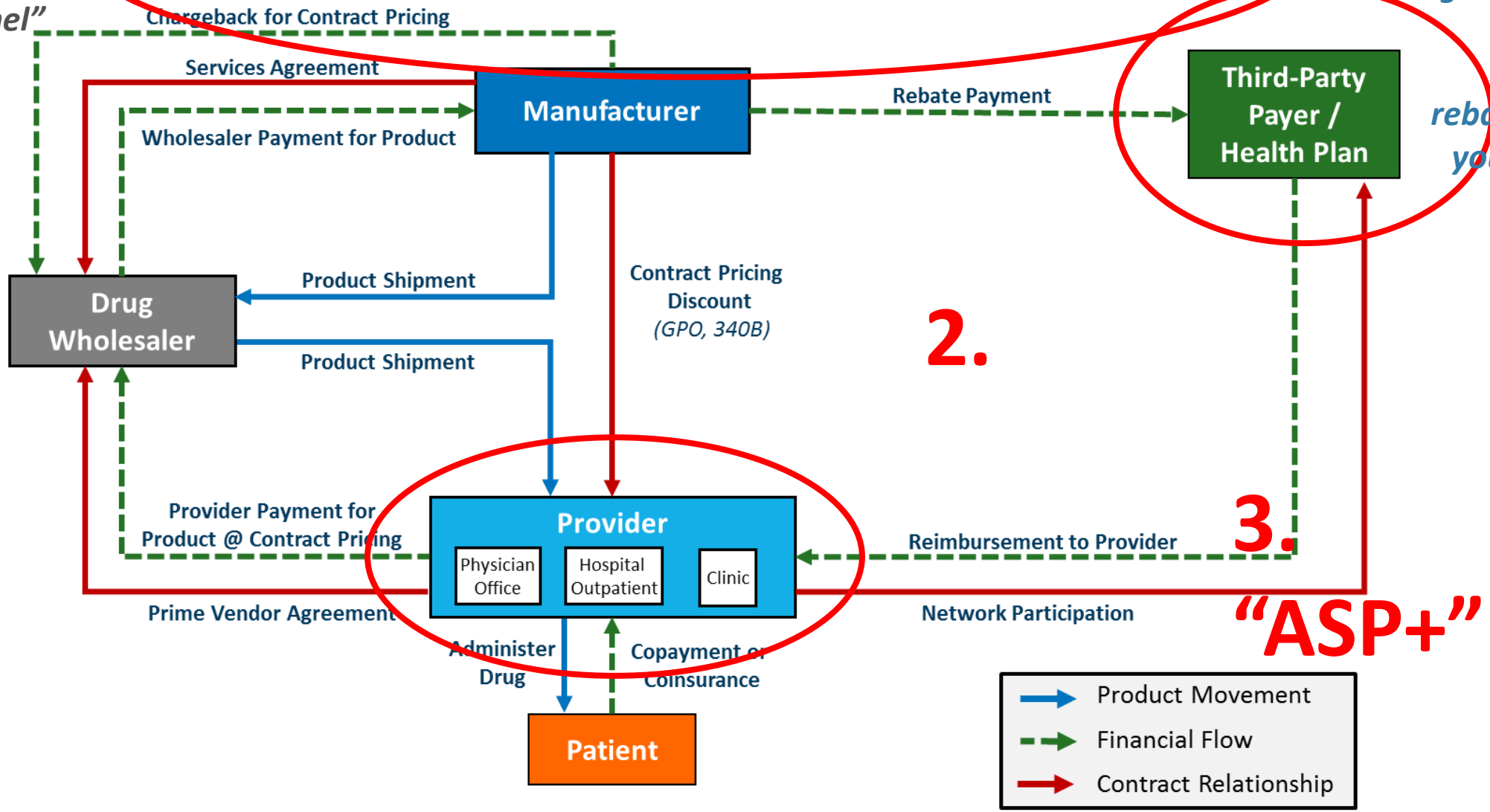
Accountable Pharmacy

Buy-and-Bill System for Distribution and Reimbursement of Provider-Administered Outpatient Drugs

1.

"Medical Channel"
"Part B"

Are you getting your "medical channel" rebates from your health plan?



GPO = Group Purchasing Organization; 340B = 340B Drug Pricing Program. Chart illustrates flows for **Provider-Administered, Outpatient Drugs**. Please note that this chart is illustrative. It is not intended to be a complete representation of every type of financial, product flow, or contractual relationship in the marketplace.
Source: Fein, Adam. J., *The 2016–17 Economic Report on Pharmaceutical Wholesalers and Specialty Distributors*, Drug Channels Institute, September 2016, Exhibit 28. Available at http://drugchannelsinstitute.com/products/industry_report/wholesale/.

“Medical Channel” Specialty Drug Strategies

- Convert them to PBM channel (white bag, brown bag)
- Concierge Clinical Management
- Site of Care
  - Might require payment reform
- Carve out specialty
  - Appropriate Usage
  - Smarter Procurement
    - ✓Pass through pricing
    - ✓Optimize coupons, etc.
    - ✓Manage site of care
- Promote Biosimilars

INTEGRITY PHARMACEUTICAL ADVISORS, L.L.C.

VIVIO

	Biosimilar Name	Manufacturer	Approval Date	Reference Product	Reference Product Manufacturer	Launched?
1	Fulphila (pegfilgrastim-jmdb)	Mylan	June 2018	Neulasta	Amgen	Yes
2	Inflectra (Infliximab-dyyb)	Pfizer	April 2016	Remicade	Johnson and Johnson	Yes
3	Nivestym (filgrastim-aafi)	Pfizer	July 2018	Neupogen	Amgen	Yes
4	Renflexis (Infliximab-abda)		May-17	Remicade	Johnson and Johnson	Yes
5	Retacrit (epoetin alfa-epbx)	Pfizer	May-18	Epogen/Procrit	Amgen	Yes
6	Udenyca (pegfilgrastim-cbqv)	Coherus	November 2018	Neulasta	Amgen	Yes
7	Zarxio (Filgrastim-sndz)	Sandoz	Mar-15	Neupogen	Amgen	Yes
8	Kanjinti (trastuzumab-anns)	Amgen	June 2019	HERCEPTIN	Genentech	Yes
9	Mvasi (Bevacizumab-awwb)	Amgen	Sep-17	Avastin	Genentech	Yes
10	Amjevita (Adalimumab -atto)	Amgen	Sep-16	Humira	AbbVie	No
11	Cyltezo (Adalimumab-adbm)	Boehringer Ingelheim	Aug-17	Humira	AbbVie	No
12	Erelzi (Etanercept-szzs)	Sandoz	August 2016	Embrel	Amgen	No
13	Eticovo (etanercept-ykro)	Samsung Bioepis	Apr-19	Enbrel	Amgen	No
14	Hadlima (adalimumab-bwwd)	Merck	Jul-19	Humira	AbbVie	No
15	Herzuma (trastuzumab-pkrb)	Celltrion and Teva	December 2018	HERCEPTIN	Genentech	No
16	Hyrimoz (adalimumab-adaz)	Sandoz	October 2018	Humira	AbbVie	No
17	Ixifi (infliximab-qbtx)	Pfizer	December 2017	Remicade	Johnson and Johnson	No
18	Ogivri (trastuzumab-dkst)	Mylan	December 2017	Herceptin	Genentech	No
19	Ontruzant (trastuzumab-dttb)	Samsung Bioepsis (Merck)	Jan-19	HERCEPTIN	Genentech	No
20	Ruxience (rituximab-pvvr)	Pfizer	Jul-19	RITUXAN	Genentech	No
21	Trazimera (trastuzumab-qyyp)	Pfizer	Mar-19	HERCEPTIN	Genentech	No
22	Zirabev (bevacizumab-bvzr)	Pfizer	June 2019	AVASTIN	Genentech	No
23	Truxima (rituximab-abbs))	Celltrion	November 2018	Rituxan	Genentech	No

Biosimilars

Biologic drugs with NO clinical difference. NOT identical, not interchangeable.

U.S. uptake MUCH slower than Europe, where biosimilars have successfully been used for years

- 23 biosimilars approved in U.S.
- Only 9 launched, slow uptake
- Except Kaiser and VA!

U.S. market dynamics

- Rebates warp incentives
- Physician compensation
- Hospital 340b discounts

PBGH Biosimilars: What can YOU do

1

Work with integrated care systems (in value-based arrangements, incentives are aligned)

2

Work with health plans to promote biosimilar use among network providers

UnitedHealthcare
Anthem
aetna
Cigna
blue of california

Today's Agenda

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Keep your eye on the end game

At the time of prescribing, the doctor has the **information**, and **incentive**, and **authority** to prescribe the **"right"** drug. No "fixes" at the drug store counter or during a pre-authorization process. The doctor's selection of the right drug would include consideration of **price** and **clinical efficacy**. The drug would be administered in the most patient-friendly and cost-effective manner.

Doctors access their performance data about Total Cost of Care (TCOC), quality metrics, and utilization practices. They learn from each other. They are paid based on their TCOC and outcome metrics. They are supported by a multidisciplinary team to meet varied patient needs.

Rx is integrated with medical care. The ACO determines the formulary, step therapy protocol, and PA standards for their population. Physician point of service prescribing is simplified & streamlined. Patients don't have issues at the drug store counters.

EMRs and digital technology work together to provide information and decision support at the time of care and can be exchanged appropriately among providers. Data is captured and shared systematically to support outcome measurement.

Financial incentives are shared among doctors, hospitals, ambulatory centers, diagnostic centers, etc. in a way that promotes high efficiency and high value care. Underlying payment structures incent care redesign and efficiency.

Patients are treated as whole persons with consideration of their psychosocial profile, personal goals and their risk preferences. Mental health is integrated and addressed as a medical condition.

The Hope of the ACO: Integrated Care

Other things we should talk about

- Benefit Design
- Manufacturers' Coupons and Patient Assistance Programs
  - Copay Accumulator Programs
- Point-of-Sale Rebates
- The power of employers in policy discussions

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