Welcome to the 2018 COLORADO PBM SYMPOSIUM
Metro Denver Chamber of Commerce
Today’s Agenda

• Welcome and Trends
  Bob Smith, MBA, Executive Director, CBGH and Michael Ell, MBA, Macct, FACHE, Director, Business Development, Employers Health

• PBM 101
  Michael Stull, MBA, Chief Marketing Officer, Employers Health

• Evaluating PBM Contracts
  Rebecca Lich, PharmD, MBA, Sr. VP & Pharmacy Practice Leader Lockton Companies, LLC

• Specialty Pharmacy under PBM & Medical
  Mary Elizabeth (Libby) Meske, B.Sci.Pharm,RPh, Regional Account Executive, OptumRx

• Panel, Questions, and Discussion
  Speakers and additional panel members Melissa Johnson, Benefits Manager, Poudre School District & Josh Pedrozo, Director, Account Management, Employers Health
Key Points

1. Spending for retail prescription drugs will be the fastest-growing health care category and will consistently outpace that of other health care spending.

2. Drivers of high prescription drug spending are increasing utilization, increasing average cost, and changes in drug mix.

3. Many strategies are being developed and tested.
A central dilemma in drug pricing policy:

Should we trade off some innovation for some access?

The true story of America’s sky-high prescription drug prices

By Sarah Kliff

sarah@vox.com

Updated May 10, 2018, 9:19am EDT
Colorado PBM Symposium
Pharmacy Landscape

Libby Meske, B.Sci.Pharm.,RPh
OptumRx Clinical Account Executive
Today’s Agenda:

- Benefits
- Specialty Drugs
- Biosimilars
- Disease States of Interest
- Pipeline
- Specialty Management Strategies
Benefits
Employers Taking Action on Pharmacy

68% of employers say pharmacy management techniques are the most effective tactics to control cost

Nearly all use common utilization management programs

- Prior authorization: 95%
- Quantity limits: 91%
- Step therapy: 90%

Member pays difference between generic and brand: 62%

- Closed formulary: 50%
- Integrate medical and pharmacy data: 48%
- Mandatory mail order for maintenance medications: 45%
- Approval only for a limited initial supply: 35%
- Four-tier or higher plan design: 34%
- No copay for select generic medications: 25%

Employer Action

Consumer-driven health plan enrollment grows

Main reasons consumers enroll in CDHP\(^1\):

- 84% Employers that will offer a CDHP in 2017
- 35% Employers that will offer only CDHPs to employees in 2017

Large Employer Adoption of Consumer Driven Health Plans Nears Universal Use\(^1,2,3\)

<table>
<thead>
<tr>
<th>Year</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>61%</td>
<td>73%</td>
<td>72%</td>
<td>81%</td>
<td>83%</td>
<td>84%</td>
<td>92%</td>
<td></td>
</tr>
</tbody>
</table>

1. Based on annual survey by the National Business Group on Health, a non-profit association of 425 large employers Source:
2. Large employers’ 2016 health plan design survey, NBGH, August 2015;
3. 1st Large Employer Health Benefit Survey Assesses 2017 Outlook, UBS Evidence Lab, Sep 2016;
Narrow pharmacy networks encourage or require members to use designated pharmacies or channels by offering cost savings or restrictions.

Restricting pharmacy networks while still maintaining adequate access to care and positive relationships with providers is a cost saving strategy gaining traction in the marketplace.

There are two main types of narrow networks:
Preferred or limited models. A limited network is more restrictive than a preferred network and allows payers greater control over prescription fulfillment (ex. mandatory mail).

In 2014, 46% of employers offered a preferred retail pharmacy network and 14% have a limited network.¹

OptumRx has a wide range of network options available that can save clients between 2% - 5% pharmacy plan spend.

Rising Health Care Costs

Employers’ Top Drivers of Rising Health Care Costs

% indicating driver as one of their top three

- Specialty pharmacy: 80%
- High cost claimants: 73%
- Specific disease or conditions: 61%
- Overall medical inflation: 29%
- Hospitalization: 18%
- Outpatient procedures: 12%
- Traditional pharmacy: 10%
- ACA compliance: 5%
- Geographic variation in cost/utilization: 5%
- Outpatient care/physician visits: 4%
- Other: 3%

Large National Employers’ Three Most Important Drivers of Medical Cost Increase for 2017

- ACA mandates: 15%
- Increase in unit costs of medical services: 21%
- Inpatient hospital costs: 23%
- Proliferation of high cost claimants: 32%
- Drug costs generally: 51%
- Specialty drug costs: 55%

1. Large Employers’ 2017 Health Plan Survey, NBGH, Aug 2016;
2. 1st Large Employer Health Benefit Survey Assesses 2017 Outlook, UBS Evidence Lab, Sep 2016;
Traditional vs. Biologics

**Traditional drugs** are produced as chemicals. Precise duplication is possible once the active ingredients have been identified.¹

**Biologic drugs** are derived from living organisms. Tiny variations in the manufacturing process can affect the finished medication.

Conventional drugs can be simply mass-produced.¹

Biologics and Biosimilars are much more difficult to manufacture. Biologics require extremely sophisticated production processes.¹

- **Development time**
  - Conventional drugs: 2-3 years
  - Biologics: more than 5 years

- **Development costs**
  - Conventional drugs: $2-5 million
  - Biologics: $100 million

- **Average savings for generics:** 75%
- **Lower up-front investment means greater savings.**

- **Average savings for biosimilars:** 15% (est.)
- **Higher up-front investment means lesser savings.**

¹ Amgen Corp. Science Overview: Biosimilars.
Traditional vs. Biologics

<table>
<thead>
<tr>
<th>Biologic</th>
<th>Traditional Drug</th>
</tr>
</thead>
<tbody>
<tr>
<td>Herceptin (breast cancer)</td>
<td>Lipitor (hypercholesterolemia)</td>
</tr>
<tr>
<td>molecular weight = 185,000 daltons</td>
<td>molecular weight = 559 daltons</td>
</tr>
</tbody>
</table>
Tackling specialty medications

THE **BASIC** DIFFERENCES

<table>
<thead>
<tr>
<th>Traditional</th>
<th>Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>is used for general health and chronic conditions.</td>
<td>is used for complex, rare diseases.</td>
</tr>
</tbody>
</table>

Only 1-2% of members have medical conditions that require the use of high-cost specialty medications.

These members often need intensive, ongoing care coordination, support and intervention.

- **Oral** Pharmacy Benefit
- **Self-Injectable** Pharmacy Benefit
- **Infused** Medical & Pharmacy Benefit

OptumRx commercial client data total cost per prescription, calendar year 2017.
Biosimilars will provide less expensive versions of branded biologic drugs in the same way generic drugs do for branded traditional drugs.

**Biosimilars Overview**

- **27** biosimilar clinical trials underway in the U.S.³
- **737** medications moving through various pipelines⁴

### TRADITIONAL MEDICATIONS
- Easily replicated and mass-produced
- FDA approval process ~50 simple tests²
- Chemicals can be copied quickly and inexpensively

#### Development time
- **2-3 years**

#### Development costs
- **$2-5 million**

### BIOLOGIC MEDICATIONS
- Made in living cells = identical copies impossible
- FDA approval requires ~250 complex tests²
- Complex: Take longer and cost more to duplicate

#### Development time
- **>5 years**

#### Development costs
- **$100 million**

**15%** expected average savings¹ with biosimilars vs. **80%** with typical generics.

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3. Thomson Reuters: Cortellis online database. 2016;
Biosimilar Barriers and Actions

**Barriers:**

- Estimated $175M cost to bring to market
- Bitter patent disputes
- Perverse reimbursement policies
- Lack of interchangeability
- Part D Doughnut Hole issues for patients
- Lack of provider confidence
- Lack of patient experience
- Manufacturers are launching biosimilars with incomplete market strategies
- Branded products will be willing to fight on price to keep market share
- Exclusivity for a biosimilar requires a long term commitment by a PBM/Payer (transparency, trust, communication)

**Actions:**

- OptumRx is making a substantial commitment to know and understand the abilities and competence of companies bringing biosimilars (Sandoz, Amgen, Pfizer) across what we call the biosimilar pillars for success:
  - Patients Support, Providers Support, Payer Strategy, Channel Strategy, Supply Strategy
Upcoming Biosimilars

BIGGEST POTENTIAL BIOLOGIC CURRENTLY IN DEVELOPMENT:

Humira® is among the top drugs by total spend.†
- A biosimilar version was approved in September 2016.
- Launch delayed due to patent litigation.

Top spend medications anticipated to launch as a biosimilar.

<table>
<thead>
<tr>
<th>Brand Name</th>
<th>Therapeutic Use</th>
<th>2015 U.S. Sales*</th>
<th>Estimated Launch Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remicade®†</td>
<td>Inflammatory Conditions</td>
<td>$4.5 B</td>
<td>Late 11/2016</td>
</tr>
<tr>
<td>Neulasta®</td>
<td>Neutropenia</td>
<td>$3.9 B</td>
<td>H1 2017+</td>
</tr>
<tr>
<td>Epogen/Procrit®</td>
<td>Anemia</td>
<td>$2.6 B</td>
<td>H2 2017+</td>
</tr>
<tr>
<td>Enbrel®‡</td>
<td>Inflammatory Conditions</td>
<td>$5.1 B</td>
<td>H2 2017 or Q4 2018+</td>
</tr>
<tr>
<td>Humira®</td>
<td>Inflammatory Conditions</td>
<td>$8.4 B</td>
<td>Q2 2017+</td>
</tr>
<tr>
<td>Rituxan®</td>
<td>Cancer</td>
<td>$3.9 B</td>
<td>2018+</td>
</tr>
<tr>
<td>Herceptin®</td>
<td>Cancer</td>
<td>$2.5 B</td>
<td>2019+</td>
</tr>
<tr>
<td>Avastin®</td>
<td>Cancer</td>
<td>$3.2 B</td>
<td>2019+</td>
</tr>
</tbody>
</table>

† Biosimilar Remicade (Inflectra™) was approved on 4/5/2016.
‡ Biosimilar Enbrel (Erelzi™) was approved on 8/30/2016.

# Biosimilars

## Current State

### Currently in the Marketplace

- **Zarxio**
  - Biosimilar for Neupogen
  - Manufacturer: Sandoz
  - Buy and Bill

### Approved by FDA, but not in Marketplace

- **Erelzi**
  - Biosimilar for Enbrel
  - Manufacturer: Sandoz
  - Specialty Channel

- **Inflectra**
  - Biosimilar for Remicade
  - Manufacturer: Pfizer
  - Buy and Bill

- **Amjevita**
  - Biosimilar for Humira
  - Manufacturer: Amgen
  - Specialty Channel
Dynamics impacting specialty trends

- Biotech Innovations
- Drug Pipeline
- Cost Implications
Disease States of Interest
Orphan drugs (those that affect less than 200,000 people in the U.S.) treat unique and rare conditions and are often more costly than non-orphan drugs.

- 12.6% Americans have condition where orphan drug would be used.
- 60% of orphan drugs are specialty medications.

<table>
<thead>
<tr>
<th>Average Annual Cost per Rx²</th>
<th>Generics</th>
<th>$18</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Brands</td>
<td>$182</td>
</tr>
<tr>
<td></td>
<td>Specialty³</td>
<td>$2,000</td>
</tr>
</tbody>
</table>

6% of total drug spend¹

Orphan Drugs

The focus on large disease populations as the biggest potential revenue streams is shifting to rare conditions where are orphan drugs are used.

1983 Orphan Drug Act

- Manufacturer incentives to develop orphan drugs
- Faster approval process
- Longer market exclusivity

260 drug applications in 2013¹

1/3 of all drugs approved in 2013¹

161 in 2012¹

- Less competition
- +5% growth rate over non-orphan drugs²
- 42% of specialty pipeline¹

Orphan drug market expected to hit $127B by 2018 accounting for 16% of total prescription drug sales.³

Inflammatory conditions occur when the body attacks healthy tissue and cells, causing excessive and painful inflammation. Conditions include Rheumatoid Arthritis, Crohn’s Disease and Psoriasis.

46 million Americans affected

46.13 prevalence per 10K lives

$41,700 average annual cost of drug therapy

Long-term length of treatment

37% Marketing Growth expected in the next 10 years

13% Savings on drug costs due to our management strategies

Top Category for Spend in both the pharmacy (#1 overall) and medical (#2 overall) benefit

Optimal Drug Tiering

Prior Auth./Drug Policy

Step Therapy

Coupon Management

Pipeline Monitoring

This list is subject to change.

2. Approximate average AWP drug cost per patient per year for Legacy Fully Insured business – calendar year 2013.
# HIV Overview

HIV or human immunodeficiency virus (HIV) attacks the cells of the immune system so that it can’t fight off infections and disease. Advanced stages of HIV can lead to acquired immunodeficiency syndrome (AIDS).

<table>
<thead>
<tr>
<th>1.1 million</th>
<th>21.31</th>
<th>$17,100</th>
<th>Long-term</th>
</tr>
</thead>
<tbody>
<tr>
<td>Americans affected(^1)</td>
<td>prevalence per 10K lives</td>
<td>average annual cost of drug therapy(^2)</td>
<td>length of treatment</td>
</tr>
</tbody>
</table>

**HIV Total drug cost by benefit**

- Pharmacy Only
- Medical + Pharmacy
- Medical Only

**Atripla**

although it’s the #1 HIV drug by spend, use is declining due to newer, more tolerable treatments

**Top 4 Category**

for spend under the pharmacy benefit

**Additional Single Tablet**

treatments are currently in the pipeline

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2. Approximate average AWP drug cost per patient per year for Legacy Fully Insured business – calendar year 2013.
Multiple Sclerosis is when the immune system attacks the protective sheath (myelin) of the nerves. This disrupts the flow of information within the brain, and between the brain and body.

- **2.3 million** affected worldwide\(^1\)
- **14.45** prevalence per 10K lives
- **$60,300** average annual cost of drug therapy\(^2\)
- **Long-term** length of treatment

**MULTIPLE SCLEROSIS**

Total drug cost by benefit

- Pharmacy Only
- Medical + Pharmacy
- Medical Only

**12% Savings** on drug costs due to our management strategies

**Top Category for Spend** in both the medical (#2 overall) and pharmacy (#5 overall) benefit

**AWP – 17%** market-leading reimbursement rates through doctor office sourcing – “buy and bill”

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2. Approximate average AWP drug cost per patient per year for Legacy Fully Insured business – calendar year 2013.
Aligned management strategies

- Pipeline Management
- Specialty Management Strategies
- Specialty Care Management
Managing the specialty pipeline

- Pharmacy and Medical Clinical Trial Data
- Pipeline Forecast
- Modeling
- Clinical Assessment / PDL Management Strategies
- Drug Approval
- Launch Strategy
Specialty Market Projected Growth

- Cardiovascular diseases: 101 Biologics, 180 Non-Biologics
- Transplant: 17 Biologics, 4 Non-Biologics
- Skin diseases: 104 Biologics, 146 Non-Biologics
- Respiratory disorders: 52 Biologics, 94 Non-Biologics
- Neurological disorders: 103 Biologics, 166 Non-Biologics
- Musculoskeletal disorders: 100 Biologics, 146 Non-Biologics
- Infectious diseases: 58 Biologics, 277 Non-Biologics
- Genetic disorders: 85 Biologics, 277 Non-Biologics
- Eye conditions: 73 Biologics, 127 Non-Biologics
- Digestive disorders: 131 Biologics, 235 Non-Biologics
- Cancer-related conditions: 93 Biologics, 735 Non-Biologics
- Blood disorders: 81 Biologics, 144 Non-Biologics
- Autoimmune: 126 Biologics, 144 Non-Biologics

45% of drugs in the pipeline are specialty drugs. Of these, over one-third are indicated for treating cancer.

Thomson Reuters Cortellis database [https://cortellis.thomsonreuterslifesciences.com/](https://cortellis.thomsonreuterslifesciences.com/)
**CGRP Antagonists**

**CGRP**
- calcitonin gene-related peptide = amino acid that transmits pain

**CGRP Antagonists**
- Preventive treatment to block the CGRP transmitters. Will not replace acute treatment medications.

- Subcutaneous injection
- Monthly/quarterly dosing regimen
- Clinical trials show a significant reduction in migraine days
- ~ $8K - $20K per patient per year

Future Pipeline Management

**Cellular Therapy**
- Cancer cells detected; immune system doesn’t view them as bad
  
  **Step 1**
  - Healthy T-cells taken from cancer patient and reprogrammed
  
  **Step 2**
  - Altered cells can now recognize and destroy cancer cells
  
  **Step 3**
  - Altered cells infused into patient

**Gene Therapy**
- Healthy gene prepared within a lab
  
  **Step 1**
  - Gene commonly inserted into an inactive virus, which carries the gene into a cell
  
  **Step 2**
  - Healthy gene injected into patient
  
  **Step 4**
  - Virus releases gene into dysfunctional cell
Specialty Management Strategies
Total Specialty Spend

**Pharmacy Benefit**
- Administered by self at home and typically oral or injected
- Distributed by retail, mail or specialty pharmacy

**Examples**
- Tecfidera (MS - oral)
- Humira (Inflammatory - self injected)
- Nutropin (GH Deficiency – self injected)
- Tarceva (Oncology - oral)

**Medical Benefit**
- Administered by a health care professional
- Administered in physician office, ambulatory infusion or home infusion or outpatient facility

**Examples**
- Lemtrada (MS - infused)
- Remicade (Inflammatory - infused)
- Gammagard (Immune globulin - infused)
- Herceptin (Oncology - infused)
Top 5 Specialty Classes with highest medical spend

81% medical spend within 5 classes

1. Oncology
   - Avastin
   - Herceptin
   - Opdivo
   - Perjeta
   - Rituxan

2. Inflammatory Conditions
   - Actemra
   - Entyvio
   - Orencia
   - Remicade

3. Immune Globulin
   - Gammagard
   - Gammaked
   - Gamunex-C
   - Hizentra
   - Octagam
   - Privigen

4. Oncology Support
   - Aloxi
   - Neulasta
   - Xgeva

5. Multiple Sclerosis
   - Lemtrada
   - Ocrevus
   - Tysabri
### Top-10 Specialty Conditions: Combined

Top-10 Specialties Represent $70.58 (92.2%) of Total Specialty Spend

<table>
<thead>
<tr>
<th>Specialty Conditions</th>
<th>Medical (000)</th>
<th>Pharmacy (000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ONCOLOGY</td>
<td>$26.58</td>
<td>51.6</td>
</tr>
<tr>
<td>INFLAMMATORY CONDITIONS</td>
<td>$21.77</td>
<td>37.9</td>
</tr>
<tr>
<td>MULTIPLE SCLEROSIS</td>
<td>$5.99</td>
<td>6.2</td>
</tr>
<tr>
<td>IMMUNE GLOBULIN</td>
<td>$3.60</td>
<td>7.6</td>
</tr>
<tr>
<td>HIV</td>
<td>$3.01</td>
<td>8.5</td>
</tr>
<tr>
<td>PULMONARY HYPERTENSION</td>
<td>$2.24</td>
<td>1.4</td>
</tr>
<tr>
<td>ANTI-INFECTIVE</td>
<td>$2.17</td>
<td>0.5</td>
</tr>
<tr>
<td>NEUTROPENIA</td>
<td>$2.16</td>
<td>8.0</td>
</tr>
<tr>
<td>HEPATITIS C</td>
<td>$1.74</td>
<td>0.9</td>
</tr>
<tr>
<td>GROWTH HORMONE DEFICIENCY</td>
<td>$1.31</td>
<td>1.9</td>
</tr>
</tbody>
</table>

Dollars are PMPM and based on pharmacy membership
# Top-20 Specialty Medications: Program Availability

<table>
<thead>
<tr>
<th>Drug</th>
<th>Specialty</th>
<th>2017</th>
<th>Trend</th>
<th>2017</th>
<th>Norm</th>
<th>Utilizers per 5,000</th>
<th>Medical</th>
<th>Pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Supply Limits</td>
<td>Diagnosis</td>
<td>PA or Med Nec</td>
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<tr>
<td>HUMIRA</td>
<td>INFLAMMATORY CONDITIONS</td>
<td>$1.29</td>
<td>33.8%</td>
<td>2.4</td>
<td>1.5</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td>ENBREL</td>
<td>INFLAMMATORY CONDITIONS</td>
<td>$1.47</td>
<td>-5.4%</td>
<td>2.8</td>
<td>1.2</td>
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<td>Y</td>
<td>Y</td>
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<tr>
<td>SIMPONI</td>
<td>INFLAMMATORY CONDITIONS</td>
<td>$1.68</td>
<td>-11.1%</td>
<td>2.8</td>
<td>0.9</td>
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<td>Y</td>
<td>Y</td>
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<tr>
<td>REMICADE</td>
<td>INFLAMMATORY CONDITIONS</td>
<td>$2.09</td>
<td>9.0%</td>
<td>4.7</td>
<td>6.2</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td>ENBREL SURECLICK</td>
<td>INFLAMMATORY CONDITIONS</td>
<td>$2.97</td>
<td>114.6%</td>
<td>5.7</td>
<td>2.9</td>
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<td>Y</td>
<td>Y</td>
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<tr>
<td>HUMIRA PEN</td>
<td>INFLAMMATORY CONDITIONS</td>
<td>$5.94</td>
<td>36.9%</td>
<td>10.9</td>
<td>9.4</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td>TAGRISSO</td>
<td>ONCOLOGY</td>
<td>$1.23</td>
<td>0.5</td>
<td>0.1</td>
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<td>Y</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td>HERCEPTIN</td>
<td>ONCOLOGY</td>
<td>$1.27</td>
<td>17.2%</td>
<td>0.9</td>
<td>1.8</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td>GLEEVEC</td>
<td>ONCOLOGY</td>
<td>$1.56</td>
<td>-52.6%</td>
<td>1.4</td>
<td>0.3</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td>OPDIVO</td>
<td>ONCOLOGY</td>
<td>$2.42</td>
<td>75.4%</td>
<td>1.4</td>
<td>1.0</td>
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<td>Y</td>
<td>Y</td>
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<tr>
<td>OPDIVO</td>
<td>ONCOLOGY</td>
<td>$2.42</td>
<td>75.4%</td>
<td>1.4</td>
<td>1.0</td>
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<td>Y</td>
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<td>KEYTRUDA</td>
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<td>0.6</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td>KEYTRUDA</td>
<td>ONCOLOGY</td>
<td>$2.94</td>
<td>25.3%</td>
<td>0.5</td>
<td>0.6</td>
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<td>Y</td>
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<tr>
<td>IBRANCE</td>
<td>ONCOLOGY</td>
<td>$3.46</td>
<td>377.4%</td>
<td>1.9</td>
<td>0.5</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
</tbody>
</table>

Dollars are PMPM and based on pharmacy membership.
Specialty Drug Management:
Inflammatory strategies in place

<table>
<thead>
<tr>
<th>Network</th>
<th>Pharmacy Benefit</th>
<th>Medical Benefit</th>
</tr>
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<tbody>
<tr>
<td>Specialty Designated Network/ National Infusion Network</td>
<td>✓</td>
<td>✓</td>
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</table>

<table>
<thead>
<tr>
<th>Clinical &amp; Utilization Management</th>
<th>Pharmacy Benefit</th>
<th>Medical Benefit</th>
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<tbody>
<tr>
<td>Review at Launch</td>
<td>✓</td>
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<td>Dosing Management</td>
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<tr>
<td>Prior Authorization</td>
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<td>✓</td>
</tr>
<tr>
<td>Site of Care – Clinical Review</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>
Specialty Care Management

- Establish care and partnership
- Ongoing support and interventions
- Optimize connections
Q & A
Colorado PBM Symposium

Setting the stage

Michael Ell, MBA, MAcct, FACHE
Employers Health
Context

• Employer-founded purchasing coalition started in Ohio in 1983
• Collective Rx Purchasing since 1995
  – CVS Health
  – OptumRx
• 200+ plan sponsors
  – Domiciled in 34 states
  – 800,000+ covered lives
  – $1 billion + drug spend
  – Work with most national / regional consulting houses
  – Evaluated 100+ times per year by various organizations
• ~40 team members
  – Attorneys, pharmacists, analysts, account management
Overall healthcare costs continue to rise.

![Chart showing average annual premiums for single and family coverage, 1999-2018](chart.png)

* Estimate is statistically different from estimate for the previous year shown (p < .05).

Workers’ share of premiums is relatively flat, but higher premiums draw more money out of families’ budgets.

* Estimate is statistically different from estimate for the previous year shown (p < .05).

Patients out-of-pocket costs are increasingly tied to the list price of medications.
The list price of branded medications continues to rise
The net price of brand drugs actually moderates due to rebates and other discounts.
Colorado PBM Symposium
October 25, 2018
Today’s Topics

• Industry Landscape
• PBM Functions
• Where do we go from here?
Context

- Employer-founded purchasing coalition started in Ohio in 1983
- Collective Rx Purchasing since 1995
  - CVS Health
  - OptumRx
- 220+ plan sponsors
  - Domiciled in 35 states
  - 800,000+ covered lives
  - $1.1 billion + drug spend
  - Work with most national / regional consulting houses
  - Evaluated 100+ times per year by various organizations
- ~40 team members
  - Attorneys, pharmacists, analysts, account management
State of the Industry

Lawmakers ask FTC for retrospective review of PBM mergers
by Evan Sweeney | Jul 30, 2018 12:00am

With Standalone PBMs Under Fire, Cigna To Buy Express Scripts For $54B
by Bruce Japsen Contributor | Pharma & Healthcare

On the Side, Express Scripts Eyes Distributing High-Priced Specialty Drugs
By Caroline Humer and Deena Beasley | August 15, 2018

Auditor’s Report: Pharmacy benefit managers take fees of 31 percent on generic drugs worth $208M in one-year period

3 REASONS WHY HEALTH INSURERS AND PBMS ARE MERGING

Amazon’s PillPack deal puts PBMs, advisers on notice
Contributors

- Manufacturers
  - High list prices
  - DTC advertising and couponing
  - Lobbying
  - Portfolio treats smaller number of patients
- Regulators / legislators
  - FDA process
  - Patent law
  - Campaign contributions
- Wholesaler
  - Misaligned incentives / reimbursement
- Retail Pharmacy
  - Misaligned incentives / reimbursement
  - Limited leverage for procurement and reimbursement
Contributors (cont...)

- **Purchasers / Payors**
  - Poor purchasing habits
  - Lack of adequate resources / misaligned resource allocation
  - Bad advice
- **Prescribers**
  - Lack of cost sensitivity
  - Reliant on drug manufacturer reps or other physicians paid by drug manufacturers
  - Give-in to patient demands
- **Patients**
  - Don’t always pay the full price of the drug
  - Poor stewards of health & finance
  - Lack of health(care) literacy
Contributors (Cont...)

• PBMs
  - Misaligned incentives
  - Spread
  - Conflicts of interest
  - Contracting gimmicks
  - One-sided contracting
  - Meaningless price benchmarks
  - Rebate spread
  - High price drugs on the formulary
  - Lack of regulation
  - Complex business practices
  - Poor customer service
  - Poor account management
  - Variable MAC lists
  - Multiple network arrangements
  - Exclusions
  - Loose contract language
  - Exploiting complexity
  - Weak clinical criteria
  - Outdated claims processing systems
  - Hard to get data
  - Doesn't communicate with prescriber
  - Not integrated with the health plan
  - Worried only about corporate shareholders
  - No transparency
  - Black box
  - Patient disruption

“Every system is perfectly designed to get the results it gets.”
—Demming or Batalden or Jones or Berwick or...
U.S. Distribution and Reimbursement System: Patient-Administered, Outpatient Drugs


GPO = Group Purchasing Organization; PSAO = Pharmacy Services Administrative Organization.
Health Plan – PBM Relationships

- Aetna
  - CVS

- Anthem
  - ESI (2019) IngenioRx (CVS)

- UnitedHealth
  - OptumRx (both UHG)

- HCSC (Blues)
  - Prime Therapeutics

- Humana
  - Humana

- Cigna
  - OptumRx → ESI
Disruptors

- CVS Health
- Aetna
- Cigna
- Express Scripts
- Anthem
- IngenioRx
- NCPA

National Community Pharmacists Association
PBM Landscape: Our View

• Dominated by Big 3 PBMs
  – Most scale / Play to the spreadsheet
    • Discounts, rebates, fees
    • Push to integrated assets
  – Service / flexibility / size limits
• Small to Mid-PBMs
  – Fighting scale by limiting spread or non-traditional pricing
  – Clinical management, service, formulary, flexibility
  – Outsource certain functions (rebates, mail, specialty, etc...)
  – Connectivity (accumulators) can be a challenge
Overall Pharmacy Cost Factors

**PRICE**
- Drug price inflation
- Contracted discounts and fees
- Contracted rebates
- Channel strategies
- Member Cost Share

**UTILIZATION**
- Disease incidence
- Prescribing guidelines
- New drug launches
- Aging population
- Turnover
- Clinical management
  - ST, PA, QL
- Formulary
Source: Health Care Cost Institute
Note: Prescription Drug Prices do not include discounts and rebates.
Note: Prescription Drug Prices includes HepC and Compounds, which peaked during time period.
Today’s Topics

- Industry Landscape
- PBM Functions
- Where do we go from here?
PBM Functions

- Claims submission and reimbursement
- Invoicing
- Plan design build
- Eligibility
- Accumulators
- Reporting
- Formulary development & maintenance
- Rebate contracting ($$)
- Clinical criteria development
- PA, Step therapy, appeals
- Adherence programs

Network Management

- Retail pharmacy contracting ($$$)
- Mail order contracting / operation ($$$)
- Specialty pharmacy contracting / operation ($$$)
- Pharmacy Help Desk

Client / Patient Management

- Account management
- Customer Call Center
- Website
- Mobile
- Sales / Growth / Scale
- Underwriting

Formulary / Clinical Management

- Claims submission and reimbursement
- Invoicing
- Plan design build
- Eligibility
- Accumulators
- Reporting

Claims Processing

- Retail pharmacy contracting ($$$)
- Mail order contracting / operation ($$$)
- Specialty pharmacy contracting / operation ($$$)
- Pharmacy Help Desk

Network Management

Client / Patient Management

Formulary / Clinical Management

Claims Processing
PBM Services - Network

• Pharmacy Networks
  – Broad national networks (~60,000 + pharmacies)
  – Limited national network (~40,000 – 50,000 pharmacies)
  – Restrictive national network (~20,000 – 30,000 pharmacies)
  – Regional network
  – On-site pharmacies
  – Retail 90 networks
  – Exclusive 90 networks
  – Mail order
  – Specialty pharmacy
Contract Definitions

Retail 30
- Brand
- Generic

Retail 90
- Brand
- Generic

Mail 90
- Brand
- Generic

Specialty
- Brand
- Generic

Contract Pricing

$  $  $  $  $  $  $  $  $
Network Contracting

- **Brands:** Discount off of Average Wholesale Price (AWP)
- **Generics:** Discounted AWP, Maximum Allowable Cost (MAC) or Usual & Customary (U&C)
- **Dispensing Fees:** Paid to the retail pharmacy per prescription dispensed
- **What defines a Brand? Generic?**
- **Does the PBM contract directly with network pharmacies (or aggregators of network pharmacies) or “lease” its network through a third-party or even a PBM subsidiary?**
- **Traditional vs. Pass-through pricing**
# Brand Drug Pricing

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>$300</td>
<td>Wholesale Acquisition Price (WAC)</td>
<td>Set by manufacturers</td>
</tr>
<tr>
<td>$360</td>
<td>Average Wholesale Price (AWP)</td>
<td>Price benchmark published by Medispan – typically not more than 120% of WAC</td>
</tr>
<tr>
<td>$61</td>
<td>Discount off AWP</td>
<td>Negotiated by plan sponsor and PBM – may or may not be reflective of what the PBM reimburses the pharmacy</td>
</tr>
<tr>
<td>$1</td>
<td>Dispensing Fee</td>
<td>Negotiated by plan sponsor and PBM – may or may not be reflective of what the PBM reimburses the pharmacy</td>
</tr>
<tr>
<td>$300</td>
<td>Gross Cost</td>
<td>AWP – Discount + Dispensing Fee</td>
</tr>
</tbody>
</table>
Network Decision Points

**Traditional vs. Pass-Through**
- What’s being passed through?
- Does the PBM utilize multiple networks?
- Are reimbursements hard-coded or aggregated towards an overall effective rate?
- Are there multiple MAC pricing variations used for reimbursement?
- What are the reimbursement rates for the pharmacies my population utilizes most?
- What are the invoice guaranteed discounts and fees?
- What’s the net cost under each model?

**Exclusive vs. Open Specialty**
- What are the financial differences?
- How many limited distribution drugs are my participants taking and are they available through an open specialty network?
- Do I care about copay coupons applying to deductibles and MOOPs?
- What additional clinical management am I losing/gaining? Can I measure the results?

**Direct Contracting**
- Do I direct contract for all or part of my network?
- Do I need a wrap national network?
- Who will negotiate the contract initially and ongoing?
- How will I validate any cost-plus arrangements?
- How will my PBM administer?
- How will this impact the rest of my PBM financials?
- Are the rates I negotiate direct not only better than what I had with the PBM, but what other models might have with the PBMs?
PBM Services - Formulary

- Pharmacy & Therapeutics Committee (P&T)
  - Independent committee of medical & pharmacy professionals
  - Typically not employees of the PBM
  - Typically not disclosed
  - Represents various medical specialties
- Reviews clinical safety and efficacy data
- Recommends formulary placement
  - Must Add
  - May Add
  - Don’t Add
- Process ensures PBMs can say formulary is “clinically based”
- Historically has not assumed comparative effectiveness nor cost
PBM Services - Formulary

- Trade Relations negotiates rebates and other discounts with pharmaceutical manufacturers
- Following P&T safety review, most formulary decisions become a matter of economics
- Few PBMs disclose actual drug-level rebates
  - Impossible to determine “lowest net cost”
  - PBM: Protects competitive advantage / intel
- Rebate audits allow auditor to evaluate a sample of rebate contracts
- Formulary typically updated quarterly
- Clinical criteria goes hand-in-hand with formulary
- Aggressive clinical criteria may impact rebate eligibility
Rebates – What to Know

- Rebates are retrospective payments made by pharmaceutical manufacturers to PBMs
- Rebates allow PBMs to bypass the supply chain and negotiate directly with a manufacturer
- Varying types of rebates
  - Access
  - Market Share
  - Price Protection
- Manufacturer Revenue is not the same as rebates
  - Includes other data fees; clinical/admin fees
  - In some agreements, includes specialty copay assistance
- 100% Pass-through (of what?)
- Minimum Guarantees
Formulary Management

• When are new drugs added to the formulary?
  – New to Market Blocks
  – Clinical criteria development
  – Additional FDA approved indications

• Non-essential drug lists

• Evaluating formulary differences

• How do I know what lowest net cost drugs are if I don’t know drug-level rebates?

• Disruption from patients, providers?

• Does my medical plan have preferred products?
Rebate Trends

• Many smaller PBMs utilize rebate aggregators to access better contracts
  – Pass-through becomes what is negotiated with the aggregator vs. what the aggregator negotiates with pharma
• “Transparent” contracts disclose the actual manufacturer rebates at the claim level
• Large PBMs shifting negotiations to MAF or product discounts and away from typical “rebates”
• Price protection rebates help offset drug price inflation above an agreed upon amount
• Outcomes-based contracts are becoming more common in specialty
• HDHP claims may or may not get full rebates
• Watch for limits on “rebateable” claims due to decline of Hep C and desire to show higher rebate values on spreadsheet
• Point-of-sale rebates getting a lot of attention with HDHP
Outcomes-Based Contracts

• For medications that don’t do what they’re supposed to, the manufacturer pays additional rebate dollars
  – Who defines expected outcomes?
  – Who measures? How is it measured?
  – What’s the timeline for measurement?
  – What scenarios void the contract?
  – Am I giving up price-protection or other forms of rebates?
  – Opposite shared savings arrangements on medical side

• Indication-based formularies
  – How to effectively communicate this to participants
Point-of-Sale Rebates

- Lower patient costs at the pharmacy counter for brand drugs
  - What’s actually being applied at the point-of-sale?
  - How are rebates used today by the plan sponsor?
  - What % of population use the plan?
  - What’s the current cost share split for utilizers?
  - Adjustments to premium contributions?
  - Adjustments to deductible and MOOP levels?
  - Apply for all brands or just maintenance and specialty?
  - Would a maintenance drug list accomplish similar results?
  - What’s the cost for rebate “float?”
  - How will reconciliation work? When?
Shifting “Rebates”

PBM 1:
- 100% Pass-Through of “Rebates”
- Price Protection not considered a “Rebate”
- Minimum Guarantee: $85 per retail brand script
- 100 Brand Rx = $8500 guaranteed

PBM 1 Collections:
- Formulary & Market Share Rebates: $4,000
- Price Protection Rebates and Other Fees: $6,000
- What does the client get?

PBM 2:
- 100% Pass-Through of “Rebates”
- Price Protection is considered a “Rebate”
- Minimum Guarantee: $80 per retail brand script
- 100 Brand Rx = $8,000 guaranteed

PBM 2 Collections:
- Formulary & Market Share Rebates: $6,000
- Price Protection Rebates and Other Fees: $4,000
- What does the client get?
## Rebate Exclusions

<table>
<thead>
<tr>
<th>Specialty Rxs</th>
<th>1312</th>
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</thead>
<tbody>
<tr>
<td>Removed by Limited Distribution</td>
<td>165</td>
</tr>
<tr>
<td>Percentage Removed</td>
<td>12.58%</td>
</tr>
<tr>
<td>ASCF Specialty Rate Offered</td>
<td></td>
</tr>
<tr>
<td>ACSF Specialty Rate w/ Limited Dist. Removed</td>
<td></td>
</tr>
<tr>
<td>Difference ($)</td>
<td></td>
</tr>
<tr>
<td>Difference (%)</td>
<td>14.3%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Specialty Retail</th>
<th>&lt;84 DS Mail</th>
<th>&lt;84 DS Specialty</th>
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<tr>
<td>Reported Claims</td>
<td>1312</td>
<td>30765</td>
<td>1312</td>
</tr>
<tr>
<td>Removed Claims</td>
<td>113</td>
<td>1873</td>
<td>52</td>
</tr>
<tr>
<td>% of Claims</td>
<td>8.61%</td>
<td>6.09%</td>
<td>4.0%</td>
</tr>
<tr>
<td>Offered Rebate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adjusted Rebate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difference ($)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difference (%)</td>
<td>9.4%</td>
<td>6.5%</td>
<td>5.8%</td>
</tr>
</tbody>
</table>
Clinical Management

• Prior Authorization
  – What are the clinical criteria?
  – How do they compare to other PBMs or Health Plans?
  – How does the criteria play into rebate guarantees?
  – What is the drug-level approval rate?

• Step Therapy
  – Must try and fail lower cost option first
  – May require two or more steps

• Quantity Limits
  – Sets a limit over a time period
FIGURE 26. Specialty Clinical Management Strategies Used in the Pharmacy Benefit

- = Significantly higher than comparison year.

<table>
<thead>
<tr>
<th>Strategy</th>
<th>2016 (n=290)</th>
<th>2017 (n=299)</th>
</tr>
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<tbody>
<tr>
<td>Prior authorization</td>
<td>93%</td>
<td>95%</td>
</tr>
<tr>
<td>Step therapy</td>
<td>85%</td>
<td>85%</td>
</tr>
<tr>
<td>Clinical care management programs</td>
<td>88%</td>
<td>83%</td>
</tr>
<tr>
<td>Limit specialty products to 30-day supply</td>
<td>72%</td>
<td>83%</td>
</tr>
</tbody>
</table>

Source: 2018 PBMI Trends in Specialty Drug Benefits
# PA Reporting

### SPECIALTY DRUGS PA SUMMARY

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<tr>
<th>STATUS_CD</th>
<th>COUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>NULL</td>
<td>4363</td>
</tr>
<tr>
<td>01 - OPEN</td>
<td>184</td>
</tr>
<tr>
<td>02 - ASSIGNED</td>
<td>119</td>
</tr>
<tr>
<td>03 - CANCELLED</td>
<td>44494</td>
</tr>
<tr>
<td>04 - PENDED</td>
<td>87</td>
</tr>
<tr>
<td>05 - DENIED</td>
<td>44269</td>
</tr>
<tr>
<td>06 - APPROVED</td>
<td>77118</td>
</tr>
<tr>
<td>09 - INACTIVATED</td>
<td>542</td>
</tr>
<tr>
<td>99 - RESERVED</td>
<td>6</td>
</tr>
</tbody>
</table>

| Total PA | 171182 |
| Approved PA | 77118 |
| Approved PA % | 45%   |
Clinical Management

• Medication Adherence
  – Face-to-face, video chats, telephonic, technology, apps
  – Medication Possession Ratio (MPR)
    • \[(\text{Actual On-Hand} / \text{Expected On-Hand}) \times 100\]
    • “Optimally Adherent” typically means the patient is above a certain MPR (e.g. 80%)
    • 90-day dispensing automatically increases adherence as measured by MPR
    • Auto-refill programs automatically increases adherence as measured by MPR
Today’s Topics

- Industry Landscape
- PBM Functions
- Where do we go from here?
Plan Sponsor Considerations

- Does my PBM strategy maximize value based on the realities of the current marketplace?
- How am I positioning my organization to maintain leverage in a consolidating marketplace?
- Who is best positioned/unbiased to help me identify the right strategy and the right PBM partner?
- Should I require a pass-through or traditional pricing arrangement?
- Should I carve-out certain PBM functions to third parties?
- Are there other options my current PBM offers that I’m not utilizing?
- Which PBM best aligns with my current needs and future strategy?
- How will we define success? Who will evaluate it?
Employer To-Dos

• Focus on the Fundamentals
  – Solid contract terms and pricing
  – Understand what you have – define what you need
  – Review pricing regularly
  – Audits
  – Clinical & Formulary Management
    • Understand disruption vs. savings
  – Plan Design

• Analyze Often
  – Focus on total net cost (PMPM) along with discounts and rebate guarantees
  – Account for acute outliers; changes in population
  – Understand disruption & administrative burden of change

• Find some help
  – Conflicts of interest abound
  – Find someone who understands PBM contracting
  – Get more than one set of eyes on the data/results
Evaluation Pitfalls

- Implementing a PA or Step Therapy is a plan decision – not necessarily unique to a PBM
  - Prove that the criteria are better and show disruption / risk
  - Assumptions on starting number of claims subject to PA
- Historical data includes drugs that have gone generic
  - The savings associated with market changes are not unique
- Repricing historical claims with today’s pricing doesn’t always translate to savings
  - Don’t compare your 2018 price to my 2016 price
- Align networks, formularies, definitions and claims groupings
  - If you cut out CVS from your network, I’d expect you to provide a more aggressive price. Others can do that too.
- Other fees / charges get calculated incorrectly
  - Medical Admin fees, Coalition fees, etc...
- Big guarantees without dollar-for-dollar true-ups are misleading
- PBMs can make any number look larger on paper
- Saving 20% in one RFP is great going forward, but...
- Staying with my incumbent allows me to avoid disruption
- Misaligned consulting relationships

Others?
Thank You!

Mike Stull
mstull@employershealthco.com

@MikeStullEHPC
A Tale of Pharmacy Purchasing

Rebecca Lich, PharmD, MBA
SVP, Lockton Pharmacy Practice Leader
A Tale of Pharmacy Purchasing

Landscape & Stakeholders

Contract & Business Partner Selection

Purchasing & Plan Design
Increased scrutiny in private & public sectors

• Opioid Epidemic
• Demand for transparency & price control
• Patient advocacy & choice

Vertical integration and consolidation

• >60 Pharmacy Benefit Managers (PBMs) in the industry
• Big three have >75% of the market share

Specialty drug segment continues to grow

• Launch of Biosimilars
• Breakthrough therapies & Orphan drugs
• Expanded Indications
Pharmacy is a Dynamic Marketplace
<table>
<thead>
<tr>
<th>Carve-in</th>
<th>VS</th>
<th>Carve-out</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Bundled pharmacy &amp; medical contract, through one vendor</td>
<td></td>
<td>- Unbundled pharmacy agreement</td>
</tr>
<tr>
<td>- Value of integration</td>
<td></td>
<td>- Direct with PBM or collective</td>
</tr>
<tr>
<td>- Patient experience, coordination of care, &amp; data integration</td>
<td></td>
<td>- Pharmacy accountability &amp; expertise</td>
</tr>
<tr>
<td>- Decreased transparency</td>
<td></td>
<td>- Increased transparency</td>
</tr>
<tr>
<td>- Less choice &amp; control</td>
<td></td>
<td>- Choice &amp; control</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Customize, tailor, &amp; innovate your plan</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Implementation credits</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Financial guarantees</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Performance guarantees</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- File integration is required between medical carrier &amp; PBM</td>
</tr>
</tbody>
</table>
Questions to Consider

- Are you concerned with pharmacy drug spend?
- Does your pharmacy benefit align with your corporate culture & goals?
- What rebates are you receiving today?
  - Administrative credit? Quarterly rebate checks?
- Results of annual check-up?
  - Was your pharmacy contract reviewed this year?
  - Are contractual guarantees being met?
  - Are you receiving annual pricing improvements?
  - Do you even have access to your contract & data?
- What will your medical carrier charge for a pharmacy carve-out?
- Pharmacy expertise & oversight?
<table>
<thead>
<tr>
<th>Admin Fees</th>
<th>Exclusions</th>
<th>Retail 90</th>
</tr>
</thead>
<tbody>
<tr>
<td>AWP Discounts</td>
<td>Clinical Programs</td>
<td>Spread Pricing</td>
</tr>
<tr>
<td>Single-Source Generics</td>
<td>Biosimilars &amp; Limited Distribution Drugs</td>
<td>Off-sets</td>
</tr>
<tr>
<td>Compounds</td>
<td>Data Integration</td>
<td>Specialty Rebates</td>
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<tr>
<td>Dispensing Fees</td>
<td>Repackaging</td>
<td>Pass-through</td>
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<tr>
<td>Generic Drugs</td>
<td>Market Checks</td>
<td>Admin Credit</td>
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<tr>
<td>MAC Pricing</td>
<td>Lessor-of Logic</td>
<td>Performance Guarantees</td>
</tr>
<tr>
<td>Usual &amp; Customary</td>
<td>Audit</td>
<td>Member Communications</td>
</tr>
<tr>
<td>Zero Balance Claims</td>
<td>Mail Order</td>
<td>Utilization Management</td>
</tr>
</tbody>
</table>
Pharmacy Contract Evaluation

Bulletproof your Contract
✓ Pharmacy Expertise
✓ Leverage
✓ Resources
Pharmacy Contract Evaluation & Optics

- Best-in-class definitions of brand, generic, and Specialty medications
- All guarantees are measured and reconciled independently and reimbursed to the plan on a dollar-for-dollar basis, at the individual client level

- Definitions that give PBM control
  - "The term generic drug shall mean a multisource drug based on indicators from a single nationally recognized source such as MediSpan and as reasonably determined by PBM and available in sufficient supply from multiple FDA approved generic manufacturers of such drugs."
- Lacking guarantees (e.g. Specialty rebate, estimates)
- Offsets are allowed. A surplus in one category may offset a shortfall in another category
Example of Optics: Which Would You Choose?

Generics with <3 manufacturers are excluded from generic guarantee and included in the brand guarantee.

Single Source Generics are reconciled with generics.
How is your PBM defining brands, generics, & specialty drugs?

PBMs may artificially inflate guarantees by reclassifying drugs.
Deal 1 artificially inflates the brand discount performance by including SSGs (~AWP-30%) in the brand guarantee (~AWP-18%).

Generics with <3 manufacturers are excluded from generic guarantee and included in the brand guarantee.

Single Source Generics are reconciled with generics.
Pharmacy Contract Evaluation: Rebate Arrangements

Employers (<5,000 lives)

- 74% (n=128) Yes, we receive rebates

Employers (>5,000 lives)

- 91% (n=162) Yes, we receive rebates

- Most employers receive rebates
  - At least for non-specialty drugs
- Most frequent arrangement is 100% rebate passthrough
  - May not include rebate admin fees or other concessions

Lockton was asked to review a pharmacy contract that another broker negotiated, supposedly a ‘solid contract’ with 100% rebates.

- ‘Estimated values’ is written all over the agreement
  - No guarantees = no guaranteed financial performance

### Financial Metrics should be Guaranteed & Client Specific

<table>
<thead>
<tr>
<th>Retail</th>
<th>Based on the geographic distribution of membership - estimated values:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AWP -</td>
</tr>
<tr>
<td></td>
<td>19.10%</td>
</tr>
<tr>
<td></td>
<td>75.50%</td>
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<tr>
<td></td>
<td>$1.40</td>
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<tr>
<td></td>
<td>AWP -</td>
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<tr>
<td></td>
<td>19.10%</td>
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<tr>
<td></td>
<td>79.00%</td>
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<tr>
<td></td>
<td>$1.40</td>
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<tr>
<td></td>
<td>$1.40</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mail Order</th>
<th>Home Delivery - estimated values:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AWP -</td>
</tr>
<tr>
<td></td>
<td>23.00%</td>
</tr>
<tr>
<td></td>
<td>77.50%</td>
</tr>
<tr>
<td></td>
<td>$0.00</td>
</tr>
<tr>
<td></td>
<td>AWP -</td>
</tr>
<tr>
<td></td>
<td>23.00%</td>
</tr>
<tr>
<td></td>
<td>81.00%</td>
</tr>
<tr>
<td></td>
<td>$0.00</td>
</tr>
</tbody>
</table>

### Rebate Sharing

For 2018 Rebate share is 100%.

<table>
<thead>
<tr>
<th>Retail</th>
<th>Estimated Minimum</th>
<th>Retail 90</th>
<th>Estimated Minimum</th>
<th>Home Delivery</th>
<th>Estimated Minimum</th>
<th>Per Brand</th>
<th>Per Brand</th>
<th>Per Brand</th>
<th>Per Brand</th>
</tr>
</thead>
<tbody>
<tr>
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<td>$0.00</td>
<td>$0.00</td>
<td>$438.43</td>
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</tbody>
</table>
PBM Marketing Process

**Data Analysis**
- Full year of your detailed claims data
- Do not assume shifts in drug utilization, or exercise caution with this approach

**Financial Comparison**
- Request financial bids based on your goals, data, & current benefit
- Perform the reprice using an unbiased third party
- Perform disruption (formulary & pharmacy) analyses using an unbiased third party
- Recommend comparing minimum guarantees

**Contract Negotiations**
- A contract is only as good as the sum of its parts!!!!
- If contract terms are negotiated after winner is selected, employer is at a disadvantage

**Other Considerations**
- Comparison of communications, clinical programs, mail order, and specialty
- Member & client support
- Plan performance may over or under perform against a contract

Utilize an unbiased, third party
- Pharmacy Expertise · Leverage · Resources ·
Lockton calculates discounts, dispensing fees, and rebates achieved for each specific channel based on contractual inclusions and exclusions
- Each pharmacy claim is run through our proprietary pricing reconciliation tool
- E.g. Retail Brand, Retail Generic, Retail Specialty

Results are reviewed by Lockton pharmacy analysts and consultants
- Ensure that each claim is categorized appropriately (e.g. a mail generic NDC is grouped for a mail generic discount, not a Brand or Retail generic discount)

Lockton also requests that the PBM provide their own audit analysis
- Allows us to determine whether both parties agree on whether a shortfall or surplus exists
- Lockton completes our analysis first, compares findings, and handles the correspondence with PBM

Lockton Success Story

$146,191
Pharmacy dollars recouped
- 6% of client’s total 2017 Pharmacy Spend ($2.4M) was recouped
- Carrier fell short of all discount guarantees
THIS ANTI-DEPRESSANT WORKS BEST IF YOU TAKE IT WITH WATER LAPPING NEAR YOUR HAMMOCK ON A CARIBBEAN BEACH.
1. Is your consultant biased? Do they own or operate a coalition?

2. Does your consultant have pharmacy expertise, leverage, & resources (analytical tools)?
   • Who completes RPF repricing & disruption analyses?
Coalitions, Collectives, vs Direct Deals

21% purchased PBM services through a coalition or group purchasing organization

1. No one size fits all

2. Group purchasing options can be great – or not
   - Coalition vs Collective vs Direct Deal

3. Employers need purchasing power, but they also need the right contract & pharmacy benefit for their organization

What to Look for in a PBM Partner?

Designing the right strategy requires understanding each client’s goals and culture, which involves a balance of savings and access.

Number of members on plan?
Drug mix?
Mix of Pharmacies?
Medical Vendor?
On-site Clinic? 340B?
Spanish or other language needs?
Geography?
Your culture & strategy?

Desired Outcomes

- Ensure Pharmaceutical Care
- Provide Cost Savings & Value
- Understand Member Experience
What to Consider in your Plan Design?

**Implement Exclusions**
- Exclusions should be thoughtful and strategic
- Specialty & non-Specialty drugs

**Narrow your network**
- Tailor based on your membership & geography
- Exclusive Specialty
Cost Containment Tactic: Strategic Exclusions

- 72% use formulary exclusions to manage drug costs and support clinical decisions\(^1\)
- 58% have at least 1 specialty exclusion\(^2\)
  - #1 employer challenge is member dissatisfaction\(^1,2\)

Cost Containment Tactic: Strategic Exclusions

$2,979 (Vimovo®)
or$36 (naproxen + esomeprazole)

I would take the two medications from the drugstore in a heartbeat — therapeutically it makes sense....What you’re paying for with [Vimovo] is the convenience. But it does seem awful pricey for that.”

- Michael Fossler, pharmacist and clinical pharmacologist, chair ACCP’s public-policy committee
Cost Containment Tactic: Narrow your Network

Deeper discounts/dispensing fees are provided in exchange for increased volume

65% use a designated specialty pharmacy

1-2% of Americans take a Specialty medication

Specialty drugs will account for 50% of total U.S. drug spend by 2020

Spend your Pharmacy Dollars Wisely

Meet Creed...

Image available at: https://sofiasees.org/life-after-luxturna-now-he-can-see/
The U.S. has a Health Literacy Problem

1/3 U.S. adults would find following directions on a prescription drug label or adhering to an immunization schedule challenging

Reference: Office of Disease Prevention and Health Promotion Health Communication Activities. Available at https://health.gov/communication/literacy/issuebrief/#tab1
Be Thoughtful & Strategic

- Patient experience & outcomes are critical
  - Does the Specialty pharmacy have specialists? (e.g. BCPS certified pharmacists, registered nurses)

- Request Pharmacy Network Mapping

- Request Formulary Impacts

- Get the details
  - Tools for prescribers?
  - Member letters? With specific drug alternatives?
  - Point-of-Sale reject messaging? With specific drug alternatives?
  - Timeline?
  - Phone calls or text messages? Automated or Live?

- Tailor your communication plan
  - Utilize internal resources & tools (e.g. newsletters, website)
  - Implementation credits
  - PBM templates or messaging
  - Option to utilize 3rd party vendors
Key Messages

- Pharmacy is complex – some prefer to keep it that way
  - Choose your business partners wisely

- Employers need three things to purchase well
  - Pharmacy Expertise
  - Leverage
  - Resources

- Business partners & execution will make or break the benefit
  - Your goals and objectives
  - Balance savings and access
  - Be thoughtful & strategic

- Stakes are rising
  - Employers spend >20% of every health dollar on the pharmacy benefit
  - Employers must manage Specialty drug spend
Our Mission | To be the worldwide value and service leader in insurance brokerage, risk management, employee benefits and retirement services

Our Goal | To be the best place to do business and to work

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