COLORADO
BUSINESS GROUP ON
HEALTH

12640 W. Cedar Drive, Suite A
Lakewood, CO 80228
PHONE: 303-922-0939
FAX: 303-922-0938

MONTHLY STRATEGY SESSION

CBGH Members and Affiliates and Guests
Thursday, July 13th, 2017
Kaiser Permanente Medical Offices, Bluffs Room 5th FL
10240 Park Meadows Drive, Lone Tree, CO 80124

Lunch Served at 11:30 a.m. Join us for food and networking. Meeting begins at 12:00 p.m.

AGENDA			
Topic	**Action**	**Person**	**Time**
Welcome/ Introductions/ Executive Committee Report	Welcome and Review of Agenda	Jessica Linart, President Bob Smith, Executive Director	12:00 p.m.
"Lifting the Hood on PBMs"	Presentation and Discussion	Michael Stull, Employer's Health	12:15 p.m.
Description: *To provide CBGH purchaser members, Affiliates, and guests with what is happening and what to expect in the Market and PBM's in the future.*			
Break: 10 minute break			1:10 pm
"Benefit Design Evolution & the Impacts of Specialty Drugs and Pharmacy Benefits "Middlemen" on the Bottom-line."	Presentation/Discussion	Cheryl Larson, Midwest Business Group on Health	1:20 p.m.
Description: *A look at how benefits are evolving in light of pharmacy trends as well as how specialty drugs and PBMs are impacting the financial performance of employers.*			
Panel Discussion – What's Working for Employers	Discussion, Questions and Answers	Michael Stull Cheryl Larson Mark Simpson, (Abbvie) Hans Wilk, (Moderator)	2:15 p.m.
Description: The opportunity to ask the questions and get answers to what is happening in the drug market, PBM's and with Specialty drugs.			
Adjourn			3:00 p.m.

Next Meeting: August 10th, 2017

"Responding to an Evolving Health Market"

RSVP to liz.olson@cbghealth.org

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

Cheryl Larson
Vice President
Midwest Business Group on Health
125 S. Wacker Drive, Suite 1350
Chicago, IL 60606
Phone: 312-372-9090 x 104
Email: clarson@mbgh.org
Web: www.mbgh.org

Cheryl Larson is Vice President of the Midwest Business Group on Health, a non-profit employer coalition comprised of over 130 self-funded, large, public and private multi-state organizations who provide health benefits to over 4 million covered lives. She joined MBGH in 1983 as the Director of Membership Development. In 1996 she left to serve as the Director of Employer Services for a population health management consulting firm, returning to MBGH in 2006.

Today, Cheryl leads MBGH's educational and networking activities focused on health benefits management, health improvement and health care reform. Additionally, she oversees several major employer-based research projects, including the National Employer Initiative on Specialty Drugs, Value-based Benefit Design Research Series and Promoting Preventive Health Benefits.

She represents the purchaser perspective at national conferences on various topics with a focus on MBGH research and employer benchmarking specific to best practices in value-based benefits, use of incentives, engagement, wellness/wellbeing, benefit communications and managing specialty drugs.

She serves on the Advisory Council of the Center for Employee Health Studies at the University of Illinois/Chicago School of Public Health, the Oncology Medical Home Steering Committee for the Community Oncology Alliance and on multiple industry committees representing the employer/purchaser perspective.

Mark Simpson

National Account Executive- Employer Channel
AbbVie

Brief Bio and Introduction:

Mark Simpson has over 22 years' experience in the biopharmaceutical space with Abbott Laboratories/AbbVie. He has held a variety of management roles in the company covering a host of disease-states, including Anti-Infective, Immunology, Neurology, Oncology, Multiple Sclerosis, Cystic Fibrosis, and Hepatitis C. Mark has a passion for collaborating with multiple stakeholders for the benefit of patients suffering from serious chronic illness. AbbVie is a patient-centric company with the goal of making a remarkable impact on patients' lives. Mark resides in Santa Rosa, California.

Mike Stull

Chief Marketing Officer, Employers Health

Mike Stull has been on the Employers Health team for more than 12 years, working with member organizations to maximize the value of their pharmacy benefits programs. To that end, Mike is actively involved in PBM contract negotiations, pricing evaluations, plan performance reviews and overall PBM strategy. As Chief Marketing Officer, Mike's primary focus is on strengthening the Employers Health brand and growing membership.

Outside of Employers Health, Mike represents employer and plan sponsor interests in local community and regional efforts aimed at improving the health care delivery system. To that end, he serves as Board Chair for the Healthcare Collaborative of Greater Columbus and was recently elected to the Board of Directors of Delta Dental of Ohio.

Mike earned his undergraduate degree from the University of Mount Union in Alliance, Ohio where he studied business, economics and chemistry, and his master's in business administration from Walsh University in North Canton, OH. He previously served as an adjunct instructor at Walsh University, teaching health care policy.

Social Media Presence:

Linkedin: Mike Stull
Twitter: @MikeStullEHPC
Podcast/HR Benecast

Hans G. Wiik, FACHE, MPH, MHA, RPh

President & CEO
Hans Wiik Health Group, LLC

Brief Bio and Introduction:

Hans is a healthcare executive with over 40 years experience as a hospital CEO and long standing consulting experience nationally, working with hospitals, health care systems, large physician groups and employers for leading and implementing value driven health care reform. Most recently, he was the President and CEO of the Centura Health sponsored iPN – one of the largest clinically integrated physician networks in the Colorado – Front Range market. Currently President and CEO of the Hans Wiik Health Group, LLC – a Colorado based consulting group that works with both providers and employers as to ACO development, positioning, contracting and overall performance. Han's holds a Colorado and Oregon Pharmacy License and works with large employers and PBM's on value based drug formulary design, and serves on the Board of Directors of Mental Health Partners of Boulder and Broomfield Counties, including the successful development and implementation of the integration of behavioral health staff/providers into local PCMH Primary Care practices.

Managing Pharmacy Trend Rates

Although determining the driving forces behind double-digit price inflation trends for pharmaceutical costs has proven increasingly difficult, one thing is clear: Drug trend rates are unsustainable for plan sponsors and will continue to be a top challenge in the coming years. This article discusses emerging strategies for dealing with prescription drug cost trends, best-in-class contracting, changing and affecting drug mix, the changing reimbursement model and what's next in mitigating evolving pharmaceutical costs.

by **Nathan Cassin** | *Aon,* **Lisa Zeitel** | *Aon* and **Hitesh Patel** | *Aon*

Recently, several pharmaceutical manufacturers have been at the center of a national debate on prescription drug prices. Some of these companies have pointed the finger at pharmacy benefit managers (PBMs) as the reason for recent price inflation. Given the complexities around contracts and reimbursements, it has become increasingly difficult to determine the driving forces behind double-digit price inflation trends. However, one thing is clear: Drug trend rates are unsustainable for plan sponsors and will continue to be a top challenge in the coming years.

It's no secret that the current pharmacy benefit landscape is opaque. To understand "the why," it is important to reduce the problem to its fundamentals and understand "the how." In the simplest of terms, imagine an activity as normal to daily life as grocery shopping. The consumer enters the supermarket with a grocery list, compares each individual product for price and quality and, ultimately, picks the one best suited to his or her needs. In the health care insurance industry, imagine the same task, only as the consumer enters the market, a salesman at the door provides a grocery list that specifies each item to be purchased. Upon checkout, the cashier rings everything up, makes a few switches from branded products to private label or sale items and requires payment of a fraction of the actual cost. Surprisingly, the relationship between PBMs and plan sponsors in today's health care insurance industry often is similar to this scenario, spurring issues around transparency regarding costs.

The reality is that, in today's health care market, the point-of-sale transaction frequently represents a fraction of the total cost of the drug. Members are able to pay less out of pocket in exchange for premiums paid throughout the year because plan sponsors pick up the remainder of the bill at rates negotiated with PBMs. PBMs leverage scale to negotiate drug prices with pharmacies, wholesalers and drug manufacturers in the form of discounts and rebates. Rebates are paid by pharmaceutical manufacturers to PBMs retroactively for reasons such as preferred placement on the formulary and may include, but are not limited to, volume purchasing, formulary access, market share incentives and exclusivity. In many cases, 80-100% of all rebates are passed back to the plan sponsor, with the PBM keeping 0-20%, while members typically get the benefit of rebates in the form of lower premiums.

Rebates typically are paid out on brand-name products. However, with generic dispensing rates (GDRs) in the high 80% range and sufficient competition to keep the cost of most generics to less than $30 per fill, most plan sponsors' pain is caused by approximately 10-15% of prescriptions. One percent to 2% of prescription drugs are high-cost specialty products that treat chronic and complex disease states such as hepatitis C, rheumatoid arthritis and multiple sclerosis, while the rest are traditional brand-name medications. The focus of PBM cost-control efforts has shifted to the 10-15% of prescriptions driving costs through market share movement and rebates, but there are other strategies plan sponsors can use to mitigate trend.

Emerging Strategies for Controlling Prescription Drug Cost Trend

Plan sponsors should continue to encourage generics and use prior authorization, quantity limits, dose optimization and step therapies to promote clinical appropriateness at the lowest net cost. However, in the future, these traditional strategies will offer little additional value to curb trend. Instead, strategies have evolved to include new approaches to contracting, maintaining economic incentives, and increasing transparency and payment terms in rebate agreements.

Best-in-Class Contracting

The most important method of managing prescription drug costs is to ensure PBM agreements have best-in-class contract language. Competitive pricing starts with strong definitions and financial obligations. A small word change in a definition or the methodology for how financial performance is measured and reconciled can have material financial impact.

The type of financial arrangement is just as important. So-called transparent models, when investigated further, are not transparent. The transparency is limited to network contracts at retail, which mostly affects branded products. The adoption of mail-at-retail networks or mandatory mail programs pushes many maintenance medications out of the retail 30 network, which in turn erodes transparency (though pricing tends to be better). Traditional or spread pricing options tend to have deeper discounts and provide lower net cost than transparent deals, but the PBM still keeps spread at retail, as network improvements are not necessarily passed through to the plan sponsor.

To ensure that prescription drug costs are aligned with PBM cost-reduction initiatives, plan sponsors may want to consider an acquisition-cost-based pricing model. The model passes through the PBM's acquisition cost for a drug regardless of where the drug is filled. PBMs will charge higher dispensing fees and administration fees than typical pricing arrangements, since this becomes their only source of profit. While on the surface this model may not appear to maximize plan savings, it does protect plan sponsors against spreads obtained through network price improvements or marketplace price inflation. Due diligence through market checks and benchmarking is key to maintaining a competitive deal.

Second, pricing should be evaluated across the board (discounts, dispensing fees, administration fees, rebates, clinical program fees, etc.) and not focused on any individual factor, since financial performance can be measured differently across components and channels. For example, while an "all-in" traditional generic guarantee is best in class, a strong all-in specialty discount may look competitive at the headline rate, but contractual nuances may undermine the value. Maximum allowable cost (MAC) pricing for generic specialty drugs should be reviewed and factored into the evaluation of an overall effective specialty drug discount. Some drugs may be classified as specialty drugs but command discounts like traditional generics, which can artificially inflate the overall effective specialty drug discount. Accurately evaluating the treatment of these "generic" specialty medications for guarantees will help ensure competitive specialty pricing for the duration of the PBM contract.

As another example of how pricing can change across channels, when using a mail-at-retail network or an incentivized or mandatory mail-order program, it's important to keep MAC lists stable across channels to ensure a consistent member experience. Mail-order pricing tends to be better than retail pricing because PBMs own the mail-order pharmacy, allowing them to purchase products at acquisition cost pricing. As a result, MAC pricing should be equal to or better than retail.

Regardless of the pricing model chosen, because the mar-

ket is evolving year to year, plan sponsors should ensure their overall pricing and terms are competitive through a bidding process, renewal, market check or coalition purchasing.

Changing and Affecting Drug Mix

Plan sponsors can also manage costs by changing and affecting the drug mix of their populations through clinical programs. In some drug classes, there are many generic products, and there is value in promoting certain generics over others. There has been increased interest in bifurcating the generics into high-cost and low-cost generics with differential copays. In some cases, there is such a large difference in cost that plan sponsors could pay for the full cost of the low-cost generics and still see significant savings. Another example is dispense as written (DAW) programs. They positively impact drug mix by driving current brand utilization to the much cheaper generic. Though members can still get the brand product, they'll have to pay the cost difference on top of their copay as a penalty for choosing the brand over the generic equivalent. Savings can vary depending on current multisource brand utilization.

On the flip side, drug mix can be negatively impacted by copay waiver cards currently being funded by pharmaceutical manufacturers, especially when a generic is available. For example, Pfizer currently covers up to $126 in copays for its brand Lipitor®, with the patient paying $4 for a 30-day supply. PBMs frequently exclude certain brands that have generics available where there is an aggressive copay waiver card. Plan sponsors can improve their rebate yield without eroding their generic utilization by (1) having an "all-in" rebate definition, (2) increasing the percentage pass-through of rebates from the PBM and (3) adopting the PBM's formulary exclusions that target high-cost disease states or products that add cost with little to no clinical value.

The Changing Reimbursement Model

Over time, PBMs have increased rebate yields by creating competition among manufacturers by pitting therapeutically similar drugs against each other to drive the lowest net cost in exchange for formulary exclusivity. The result has been a large increase in the amount of available rebates from drug manufacturers and, due to the proprietary nature of these contracts, it has opened a new revenue source for PBMs.

For background, PBMs used to make most of their money at mail order, especially from generics. But now that most mail-at-retail networks have stagnated mail-order growth, the PBM revenue model has shifted toward specialty drugs and rebates. Generics continue to play a significant role, but the growth of specialty drugs in the pipeline and the success of exclusive specialty networks and exclusion-based formularies have created an incentive for PBMs to demand additional funds and other new revenue streams from pharmaceutical manufacturers. While the pay-to-play tactic is touted as being successful in bending drug trend, there is increasing interest in moving away from the current rebate-driven model to a net price model that captures all revenue received from pharmaceutical manufacturers. This shift has been driven by the lack of adequate transparency in certifying that all incentives are aligned among PBMs, manufacturers, payers and members/consumers. Plan sponsors should demand PBMs provide greater transparency around rebate agreements, other revenue streams from pharmaceutical manufacturers and acquisition costs to determine if narrowing access to pharmacies and products is curbing trend while maintaining clinically appropriate access to products for patients and physicians.

What's Next?

The health care landscape is evolving rapidly, and the pharmaceutical industry is no different.

In the future, expect manufacturers to price their drugs based on individual outcomes. If a drug works for a patient for a particular condition within a certain time frame, the plan sponsor will pay for the drug. If the drug does not work, the cost will be significantly lower or free. This will require a significant change in data collection, negotiation strategy and payment structures.

In addition, expect plan sponsors to have preferred generics, where the cost is covered at 100%, because other products (including other generics) in the same class are much more expensive.

The need for measurable actual outcomes for high-cost

specialty claimants has sparked interest in separating specialty drugs from the PBM to ensure patients are getting the best service and clinical support while plan sponsors are getting the best price.

Mail-at-retail programs will continue to proliferate, and mail-order pharmacies will have to compete to maintain their share by improving the member experience and speed of delivery.

Conclusion

As reimbursement for traditional brands and specialty drugs shifts more to a rebate-driven model, the need for transparency in rebate contracts has never been greater to ensure that narrowing access to pharmacies and products is producing better clinical outcomes at the lowest net price. Plan sponsors should consider adopting acquisition cost pricing models that pass through the full purchase price PBMs pay for products to plan sponsors and consumers. In addition, plan sponsors should consider further adoption of consumer-driven health plans to promote consumerism, in order to increase price transparency to members. Consumers can and will make rational choices that best suit their health care needs, but only when they and their health care providers have adequate information on price and choice. BQ

AUTHORS

Nathan Cassin is a pharmacy consultant/financial lead at Aon in the Minneapolis, Minnesota area. He previously was a pharmacy analyst at Aon and a health care economics analyst at OptumRX. Cassin holds a B.S. degree in economics from Minnesota State University in Mankato.

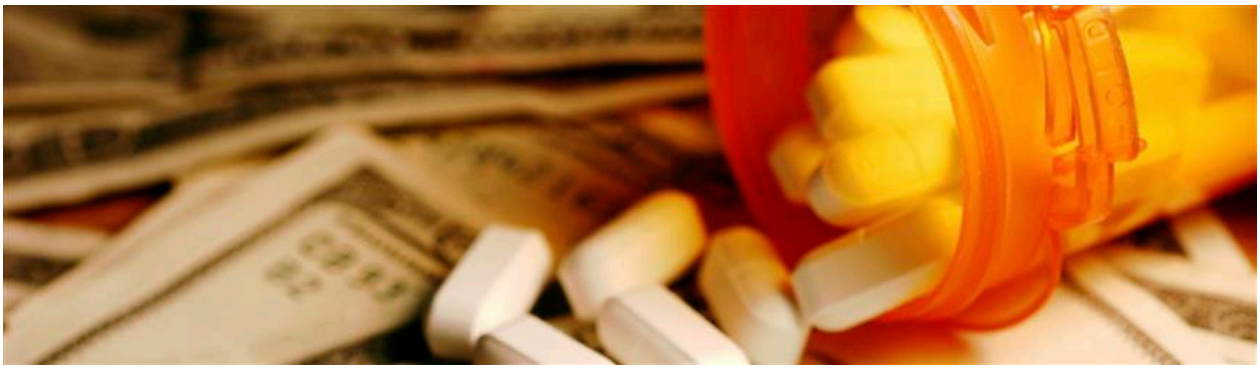
Lisa Zeitel, M.P.H., is a senior vice president on the pharmacy team for Aon in Norwalk, Connecticut and also is the strategic lead for Aon's pharmacy coalitions. She has vast experience in the pharmacy and health care fields and has focused on health care for her entire career. She has a master's degree in public health from Columbia University.

Hitesh Patel is a vice president in Aon's pharmacy benefits practice. A licensed pharmacist, Patel helps employers with any pharmacy-related issues, with a focus on improving the health of their employees and members. Patel is a member of the Academy of Managed Care Pharmacists, the International Society of Pharmacoeconomics and Outcomes Research and the American Society of Healthcare Pharmacists. He has bachelor's degrees in pharmacy from the University of London and from Long Island University. He also has a master's degree in management from Northwestern University.

International Society of Certified Employee Benefit Specialists

Reprinted from the Second Quarter 2017 issue of *BENEFITS QUARTERLY*, published by the International Society of Certified Employee Benefit Specialists. With the exception of official Society announcements, the opinions given in articles are those of the authors. The International Society of Certified Employee Benefit Specialists disclaims responsibility for views expressed and statements made in articles published. No further transmission or electronic distribution of this material is permitted without permission. Subscription information can be found at iscebs.org.

pdf/417



Drivers of Expenditure on Primary Care Prescription Drugs in 10 High-Income Countries with Universal Health Coverage

Variation in prescription drug spending in nations with universal health coverage is driven by prices & drug choices

Countries with single-payer health systems spend less on prescription drugs than those with multipayer systems

Synopsis

In comparing spending on prescription drugs across 10 high-income countries with universal health care coverage, researchers found that differences in prices and drug choices—not the volume of drugs purchased—account for the wide spending variations found. Countries with single-payer systems have greater purchasing power in price negotiations with manufacturers, which may allow them to promote lower prices and encourage use of lower-cost treatments. This, in turn, results in lower pharmaceutical spending than in countries with multipayer systems.

The Issue

The rising cost of prescription drugs presents a challenge for health care systems around the world. As their per capita spending on pharmaceuticals increases, high-income countries with universal coverage are striving to manage costs to maintain affordable drug prices for the people who need them. The drivers of spending growth can include the volume of drugs prescribed, the choice of drugs within a category or class of pharmaceuticals, or factors related to price, including use and availability of generics. Former Commonwealth Fund Harkness Fellow Steven Morgan and coauthors compared 10 high-income countries' spending on prescription drugs used in primary care by focusing on six common drug categories: hypertension treatments, pain medications, lipid-lowering medications, noninsulin diabetes treatments, medication for depression, and drugs to treat gastrointestinal disorders such as ulcer and heartburn.

Among the 20 OECD countries with gross domestic product per capita of more than $45,000 (Canadian), average per capita expenditures on pharmaceuticals increased by approximately one-third in the past 10 years and more than doubled in the past 20 years.

Key Findings

- Average spending per capita on the six medication categories varies by more than 600 percent across the 10 countries. Volume of drug use varies by only 41 percent, suggesting that drug choices and prices drive differences in expenditures.
- Total volume of pharmaceutical use is highest in Germany and Norway. Hypertension medicines account for the largest share of use in all countries.
- The mix of therapies prescribed (within the drug classes included in the study) led to higher costs in Canada, Australia, France, and Switzerland. In contrast, in New Zealand, Norway, Sweden, the United Kingdom, and Germany, patients were prescribed lower-cost treatments within the drug classes studied.

- The average daily cost of drug treatment in New Zealand and the United Kingdom is approximately one-third that of other countries. This difference is attributed to lower-cost drug choices. Alternatively, in Canada, patients were prescribed higher-price drug treatments, resulting in significantly higher spending than in other countries. This is especially true for depression and lipid-lowering medications.
- Switzerland and Canada have the highest list prices for drugs and the highest average per capita expenditures in all six drug categories. List prices are 61 percent higher in Canada and 57 percent higher in Switzerland than the average list prices in the other nine countries.
- Canada's high list prices are offset somewhat by a greater use of cost-saving generic drugs. In contrast, a preference for brand-name pharmaceuticals results in 12 percent higher expenditures per capita in Switzerland.

The Big Picture

The wide variation in prescription drug spending seen across the 10 countries stems more from disparities in pricing and mix of drugs rather than from the volume of drugs consumed. The nations with single-payer systems appear to be more successful at maintaining lower costs. The authors suggest that these countries have greater purchasing power in negotiating drug prices with manufacturers and can therefore promote lower prices. In addition, single-payer systems are better able to encourage the use of lower-cost treatments. Results also point to the value of generic alternatives in keeping down drug spending. Public health systems aiming to reduce expenditures could achieve savings by reexamining the drug choices they offer and availing themselves of less-costly options.

About the Study

The authors used market research data from the IMS MIDAS or QuintilesIMS sales database for 2015. This database tracks more than 95 percent of the international pharmaceutical market. They compared data from 10 developed countries that participated in The Commonwealth Fund's International Health Policy Survey: Australia, New Zealand, Norway, Sweden, the United Kingdom, France, Germany, the Netherlands, and Switzerland. The countries included in the study all offer some form of universal health coverage.

The Bottom Line

Wide differences in spending on primary care prescription drugs in high-income countries can be attributed to prices and prescribing patterns within drug classes, rather than volume of drugs purchased. These drivers are amenable to policy intervention; for instance, price negotiations with pharmaceutical manufacturers or encouraging providers to choose lower-cost drug options.