Colorado Business Group on Health
Working Together to Improve Health Care Value

DENVER METRO CHAMBER OF COMMERCE

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

American Academy of Actuaries

Issue Brief

Prescription Drug Spending in the U.S. Health Care System

An Actuarial Perspective

MARCH 2018

KEY POINTS

- Over the next decade, the Centers for Medicare and Medicaid Services projects that spending for retail prescription drugs will be the fastest-growing health care category and will consistently outpace that of other health care spending.
- Many strategies are being developed and tested, aiming at reducing prescription drug spend while maintaining or improving health outcomes.
- The important cost drivers of high prescription drug spending are increasing utilization, increasing average cost, and changes in drug mix.

The focus of this issue brief is on prescription drug spending in the United States. The American Academy of Actuaries' Health Practice Council has undertaken a multiyear study of various components of the U.S. health financing system to help policymakers and the U.S. public better understand the challenges that are driving health spending growth and potential ways to address them.[1] Actuaries are uniquely qualified through rigorous education and experience to be experts in assessing the historical and future impact of factors and characteristics that impact levels of health care spending. The Academy's mission is to serve the American public and the U.S. actuarial profession.

Health care spending in the United States is high and continues to increase, as does the spending for prescription drugs in particular. In 2016, the U.S. spent $3,337 billion, or 17.9 percent of the gross domestic product (GDP), on national health expenditures, of which $329 billion was spent on prescription drugs.[2] In some years, prescription drug spending growth has far exceeded the growth in other medical spending, while in others it has fallen below other medical spending growth. Over the next decade, however, the Centers for Medicare and Medicaid Services (CMS) projects that spending for retail prescription drugs will be the fastest growth health category and will consistently outpace that of other health spending.[3] As a result, policymakers, providers, pharmacy benefit managers, and insurers are considering options to slow prescription drug spending increases that affect health plans, consumers, and businesses. This issue brief will focus on retail prescription drugs, and not on drugs administered by physicians or in an outpatient hospital setting due to the unique characteristics associated with drugs administered in those settings.

1 American Academy of Actuaries; "Controlling Health Care Spending Growth." Accessed at actuary.org/controlling-health-care-spending-growth/.

2 Micah Hartman et al.; "National Health Care Spending in 2016: Spending and Enrollment Growth Slow After Initial Coverage Expansions"; *Health Affairs* 37 (1): 150-160; January 2018. Note that the "retail prescription drugs" category excludes drugs purchased directly from physicians or hospitals (e.g., infusion drugs).

3 Gigi Cuckler et al., "National Health Expenditure Projections, 2017-2026"; *Health Affairs* 37(3); March 2018.

American Academy of Actuaries
Objective. Independent. Effective.™

1850 M Street NW, Suite 300
Washington, DC 20036
202-223-8196 | www.actuary.org

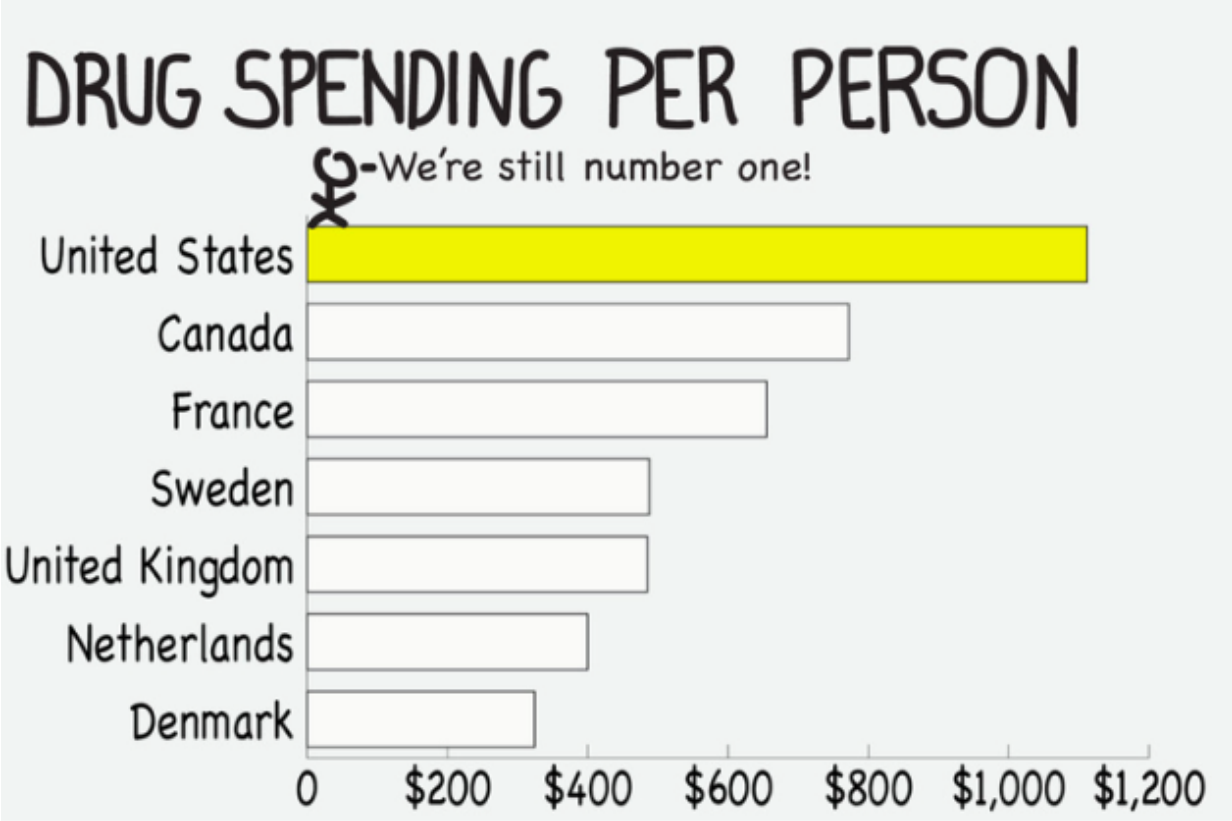
Craig Hanna, Director of Public Policy
Cori Uccello, Senior Health Fellow

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?



Vox

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

By Sarah Kliffsarah@vox.com Updated May 10, 2018, 9:19am EDT

Colorado PBM Symposium

Pharmacy Landscape

Libby Meske, B.Sci.Pharm.,RPh
OptumRx Clinical Account Executive

UnitedHealthcare

Today's Agenda:

- Benefits
- Specialty Drugs
- Biosimilars
- Disease States of Interest
- Pipeline
- Specialty Management Strategies

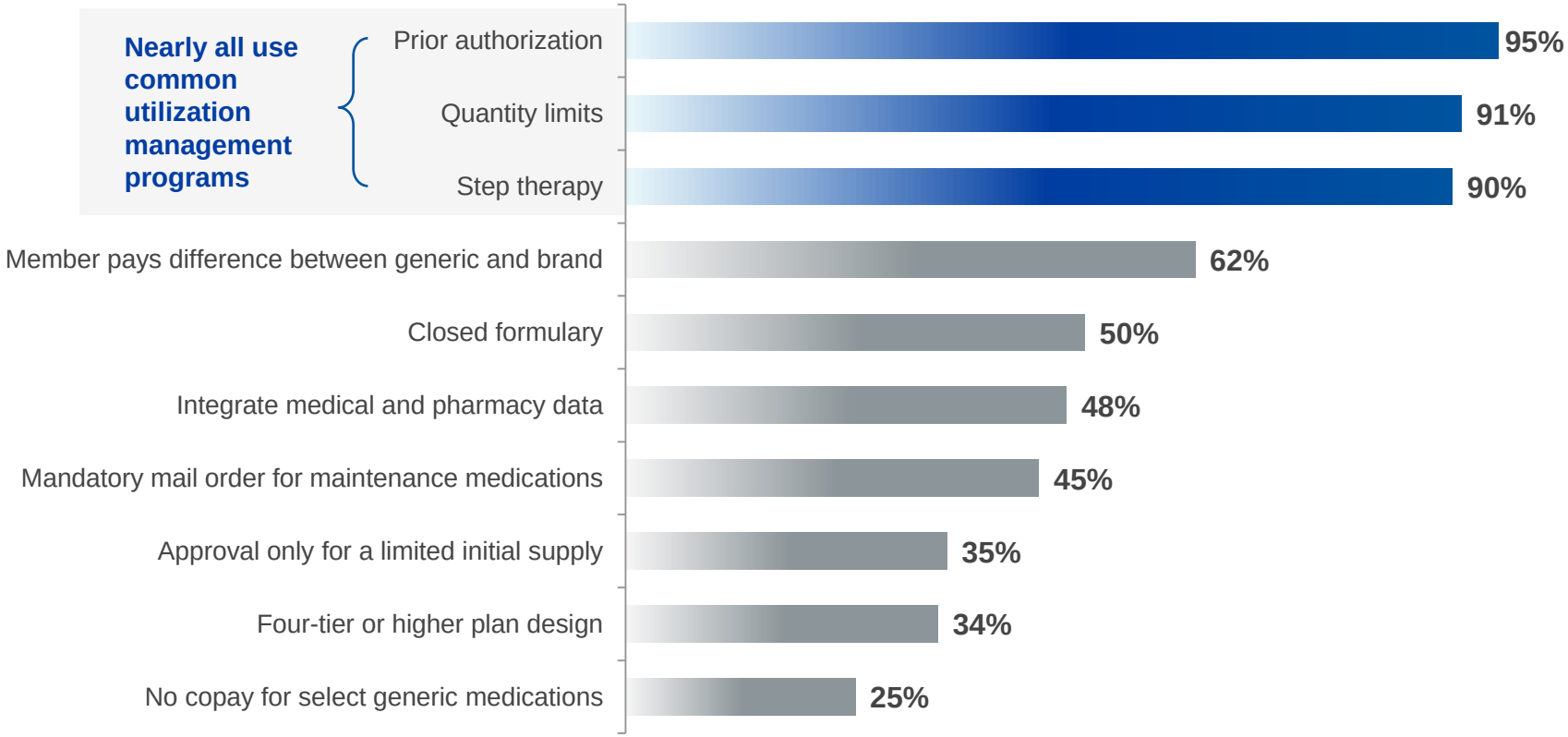
Benefits

UnitedHealthcare®

UnitedHealthcare®

Employers Taking Action on Pharmacy

68% of employers say pharmacy management techniques are the most effective tactics to control cost[1]

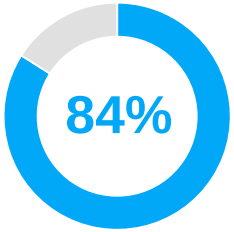


1. Large Employers' 2017 Health Plan Survey, NBGH, Aug 2016

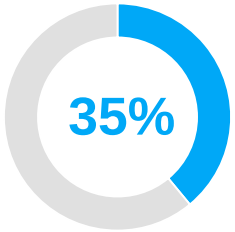
Employer Action

Consumer-driven health plan enrollment grows

Main reasons consumers enroll in CDHP[1]:

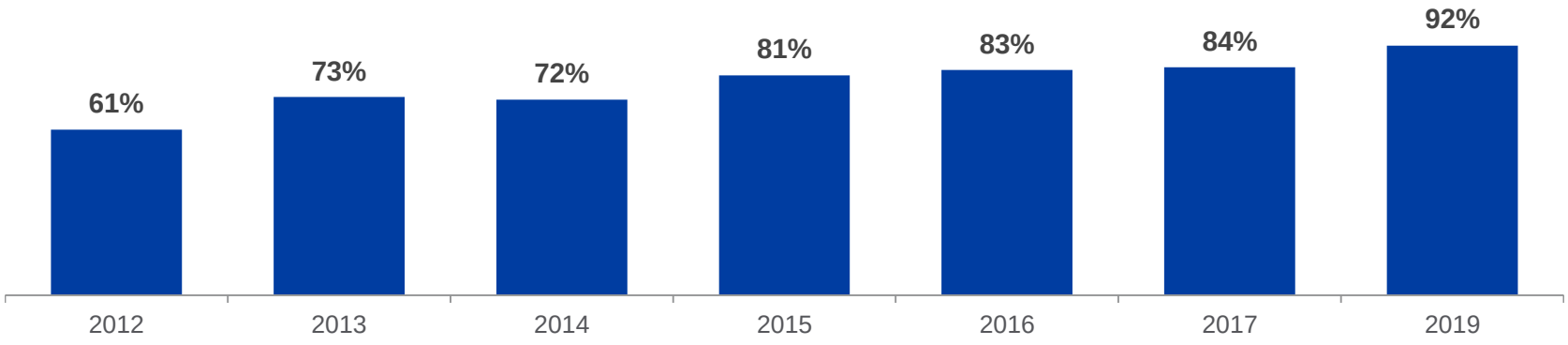


Employers that will offer a CDHP in 2017



Employers that will offer only CDHPs to employees in 2017

Large Employer Adoption of Consumer Driven Health Plans Nears Universal Use[1, 2, 3]



National Business Group on Health Orgs.

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;

UnitedHealthcare

Narrow Pharmacy Networks Getting Attention

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.

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.**

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).

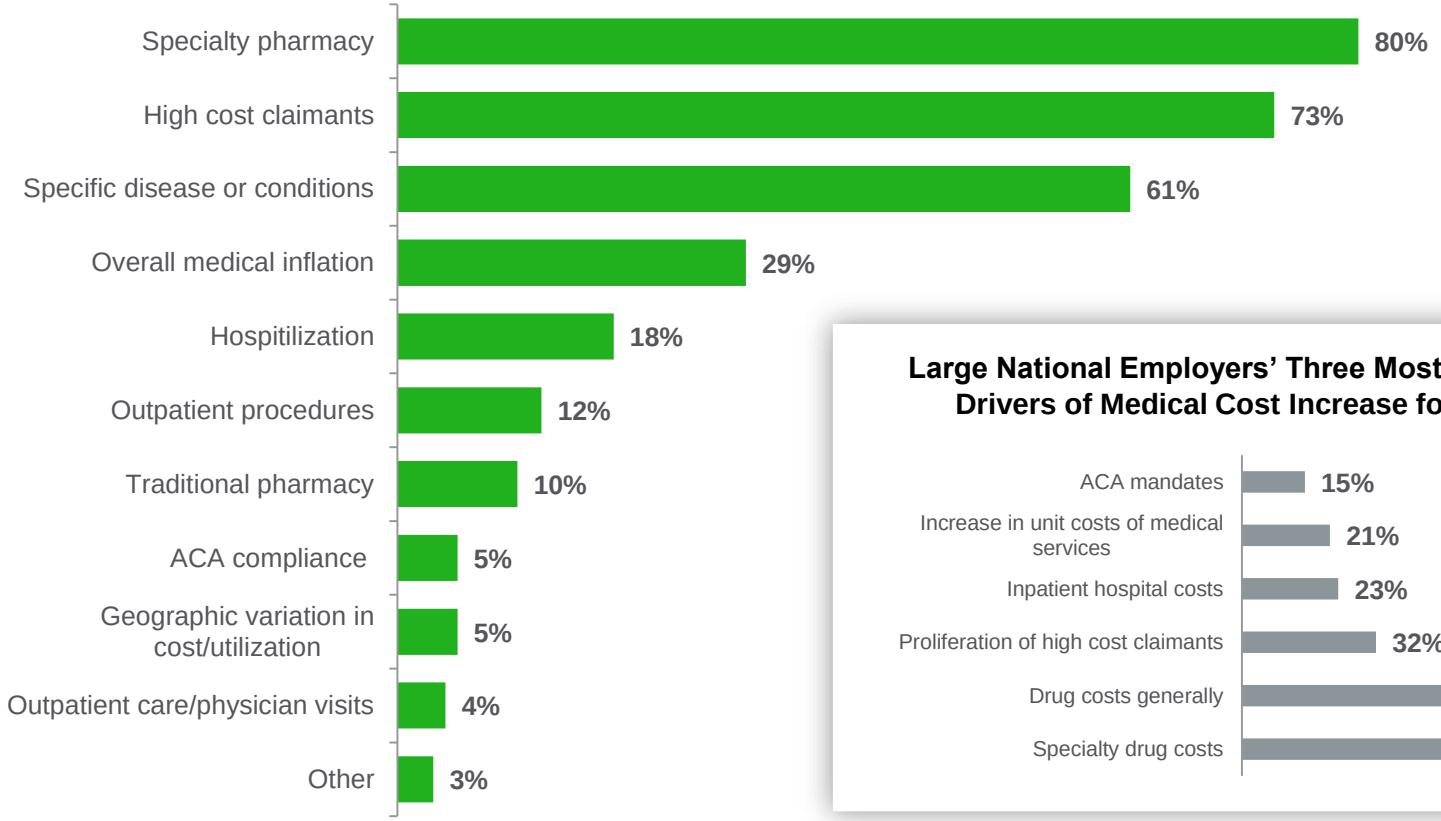
1. The Big Squeeze, PharmExec.com. Pharmaceutical Executive Editors, 2013.

UnitedHealthcare®

Rising Health Care Costs

Employers' Top Drivers of Rising Health Care Costs[1]

% indicating driver as one of their top three



Large National Employers' Three Most Important Drivers of Medical Cost Increase for 2017[2]

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;

Specialty Pharmacy

UnitedHealthcare®

UnitedHealthcare®

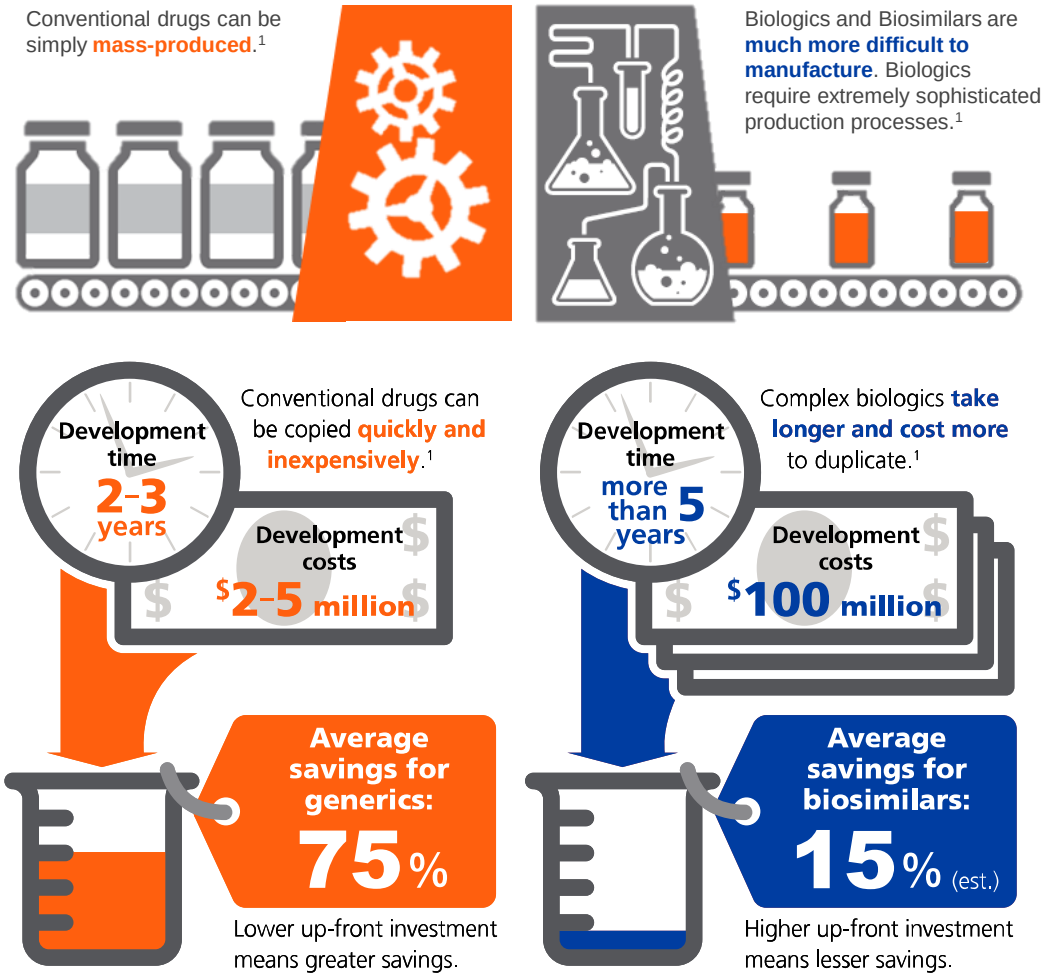
Traditional vs. Biologics

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.

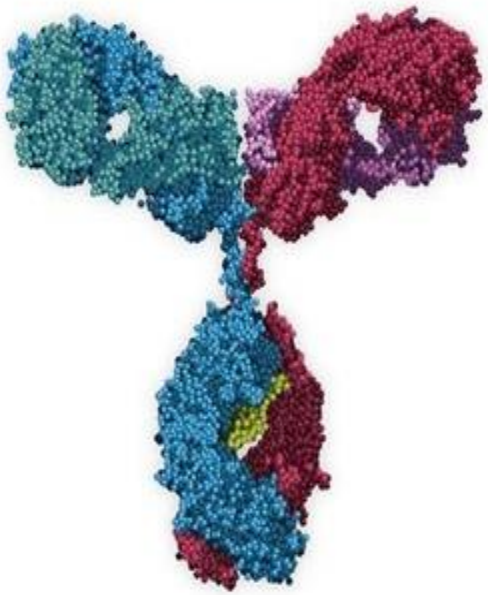
Tiny variations in the manufacturing process can affect the finished medication.



1. Amgen Corp. Science Overview: Biosimilars.

UnitedHealthcare®

Traditional vs. Biologics

Biologic	Traditional Drug
	
Herceptin (breast cancer) molecular weight = 185,000 daltons	Lipitor (hypercholesterolemia) molecular weight = 559 daltons

1.

UnitedHealthcare®

Tackling specialty medications

THE BASIC DIFFERENCES

Traditional

is used for general health and chronic conditions.

Specialty

is used for complex, rare diseases.

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

UnitedHealthcare®

UnitedHealthcare®

Biosimilars Overview

Biosimilars will provide less expensive versions of branded biologic drugs in the same way generic drugs do for branded traditional drugs.

27 biosimilar clinical trials underway in the U.S.[3]

737 medications moving through various pipelines[4]

TRADITIONAL MEDICATIONS	BIOLOGIC MEDICATIONS
• Easily replicated and mass-produced • FDA approval process ~50 simple tests[2] • Chemicals can be copied quickly and inexpensively	• Made in living cells = identical copies impossible • FDA approval requires ~250 complex tests[2] • Complex: Take longer and cost more to duplicate
2-3 years Development time	**>5 years** Development time
$2-5 million Development costs	**$100 million** Development costs

15% expected average savings[1] with biosimilars vs. 80% with typical generics.

1.Ventola CL. Evaluation of Biosimilars for Formulary Inclusion: Factors for Consideration by P&T Committees. P T. 2015 Oct;
2. Buildingciologics.com. Manufacturing Matters with Biological Medicines: How Are Biological Medicines Different from Other Medications? 2013
3. Thomson Reuters: Cortellis online database. 2016;
4. Biosimilarspipeline.com. Biosimilars/Biobetters Pipeline Database – Top Level Data (3/8/2016).

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

UnitedHealthcare®

Upcoming Biosimilars

BIGGEST POTENTIAL BIOLOGIC CURRENTLY IN DEVELOPMENT:

Humira® is among the top drugs by total spend.[1]

- A biosimilar version was approved in September 2016.
- Launch delayed due to patent litigation.

Top spend medications anticipated to launch as a biosimilar.

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

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

* BioMedTracker (internet database). Updated periodically. Sagient Research Systems, Inc. Available by subscription at: http://www.biomedtracker.com/.

UnitedHealthcare®

Biosimilars

Current State

Currently in the Marketplace

Zarxio

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

Inflectra

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

Approved by FDA, but not in Marketplace

Erelzi

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

Amjevita

- **Biosimilar for Humira**
- Manufacturer: Amgen
- Specialty Channel

Dynamics impacting specialty trends

Biotech Innovations

Drug Pipeline

Cost Implications

Disease States of Interest

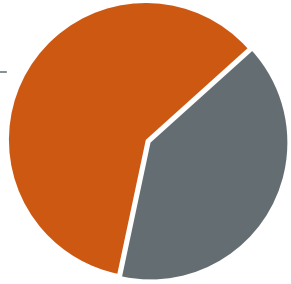
UnitedHealthcare®

Orphan Drugs

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[1]
have condition where orphan drug would be used.

60% of orphan drugs **are specialty medications**[4]



6% of total drug spend[1]

Average Annual Cost per Rx[2]

Generics
$18

Brands
$182

Specialty[3]
$2,000

Orphan Drugs[1]
$18K

1. Projected Future Trends in Specialty Pharmacy. First Report Now. Nov. 2013. Non-cancer drugs only. 2. Average cost per scrip based on average retail cost. 3. UnitedHealthcare average total cost per prescription based on legacy Fully Insured membership, 2012 4. U.S. Food and Drug Administration (FDA)

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

1/3 of all drugs approved in 2013[1]

- **Less competition**
- **+5% growth rate over non-orphan drugs**[2]
- **42% of specialty pipeline**[1]

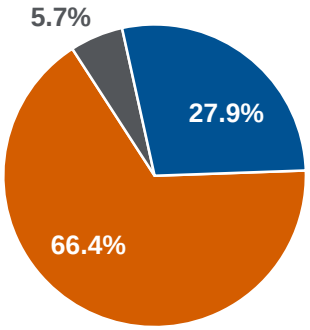
Orphan drug market expected to hit **$127B by 2018** accounting for 16% of total prescription drug sales.[3]

Source: Regulators adopt more orphan drugs. NATURE. April 2014. 2. "The Economic Power of Orphan Drugs". Thomson Reuter. 2012. 3.2013 Orphan Drug Report. EvaluatePharma.

Inflammatory Conditions Overview

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	**46.13**	**$41,700**	**Long-term**
Americans affected[1]	prevalence per 10K lives	average annual cost of drug therapy[2]	length of treatment



INFLAMMATORY CONDITIONS

Total drug cost by benefit

- Pharmacy Only
- Medical + Pharmacy
- Medical Only

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

This list is subject to change.

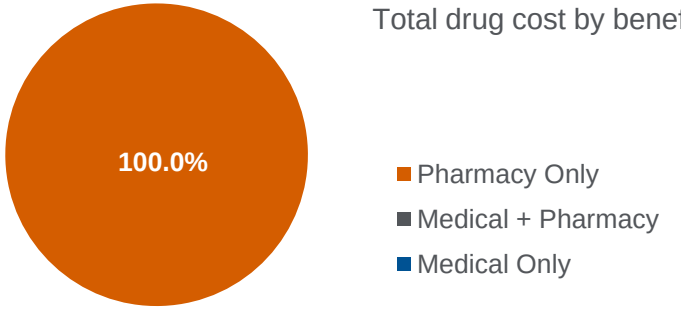
- **Optimal Drug Tiering**
- **Prior Auth./ Drug Policy**
- **Step Therapy**
- **Coupon Management**
- **Pipeline Monitoring**

1. Questions and Answers About and Rheumatic Diseases. National Institute of Arthritis and Musculoskeletal and Skin Diseases, Apr 2012. Web. 23 Jul 2014.
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).

1.1 million	**21.31**	**$17,100**	**Long-term**
Americans affected[1]	prevalence per 10K lives	average annual cost of drug therapy[2]	length of treatment



HIV
Total drug cost by benefit

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

This list is subject to change.

Optimal Drug Tiering | **Educational Support** | **Clinical Mgmt Program** | **Adherence Program**

1. http://www.cdc.gov/hiv/basics/statistics.html 2. Approximate average AWP drug cost per patient per year for Legacy Fully Insured business – calendar year 2013.

Multiple Sclerosis (MS) Overview

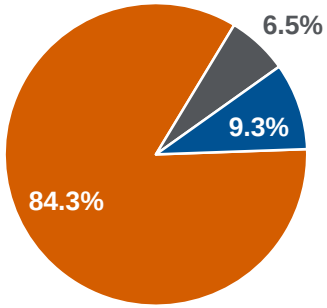
Multiple Sclerosis is when the immune system attacks the protective sheath (myelin) of the nerves. This disrupts the flow of information within the brain, and between the brain and body.

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”

This list is subject to change.

Step Therapy | **Prior Authorization** | **Drug Policy** | **Adherence Program** | **Pipeline Monitoring**

1. "FAQs about MS." National MS Society. National Multiple Sclerosis Society, n.d. Web. 22 Jan. 2014.
2. Approximate average AWP drug cost per patient per year for Legacy Fully Insured business – calendar year 2013.

UnitedHealthcare®

Aligned management strategies

Pipeline Management

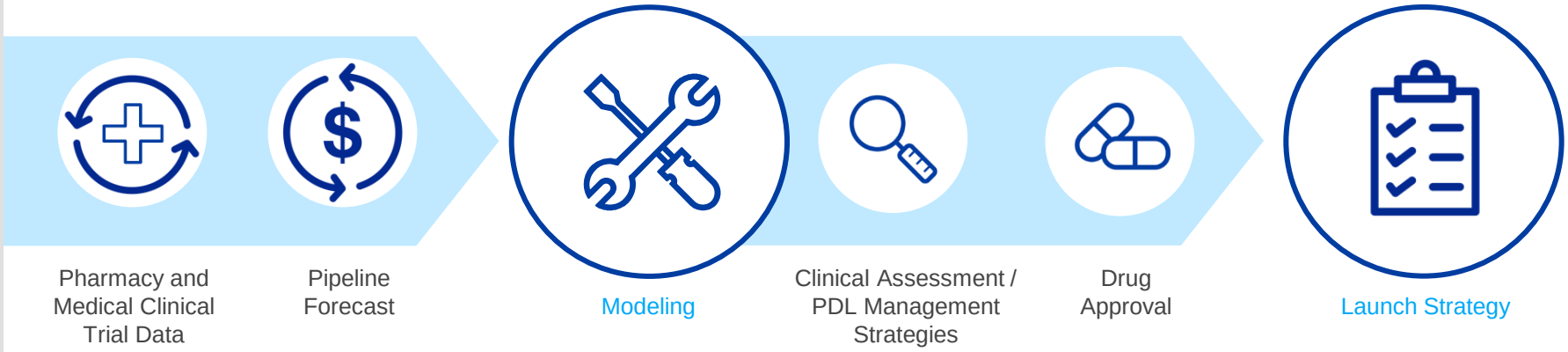
Specialty Management Strategies

Specialty Care Management

Pipeline

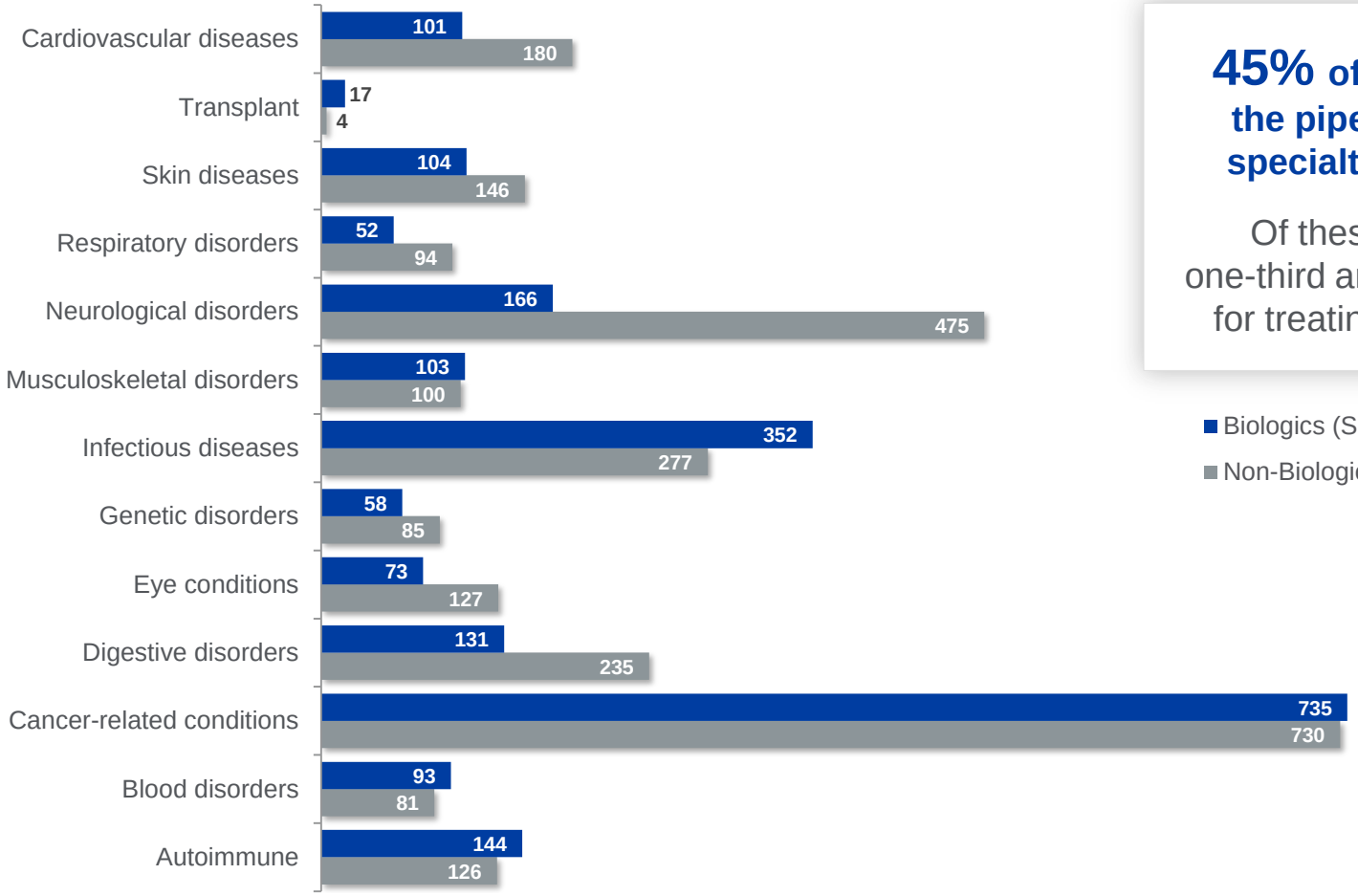
UnitedHealthcare®

Managing the specialty pipeline



UnitedHealthcare®

Specialty Market Projected Growth



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/

CGRP Antagonists

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

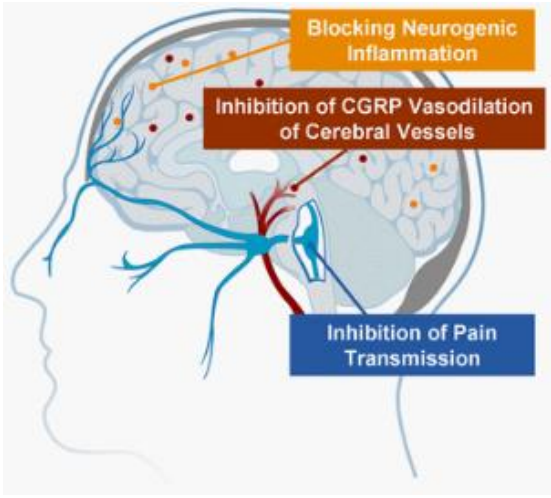
CGRP Antagonists ▶ **Preventive treatment** to block the CGRP transmitters. Will not replace acute treatment medications.

Subcutaneous injection

Monthly/quarterly dosing regimen

Clinical trials show a significant reduction in migraine days

~ $8K - $20K per patient per year



www.theverge.com/2016/5/24/11712554/migraine-drug-treatment-headache-cost-pharmaceutical-health-insurance

UnitedHealthcare

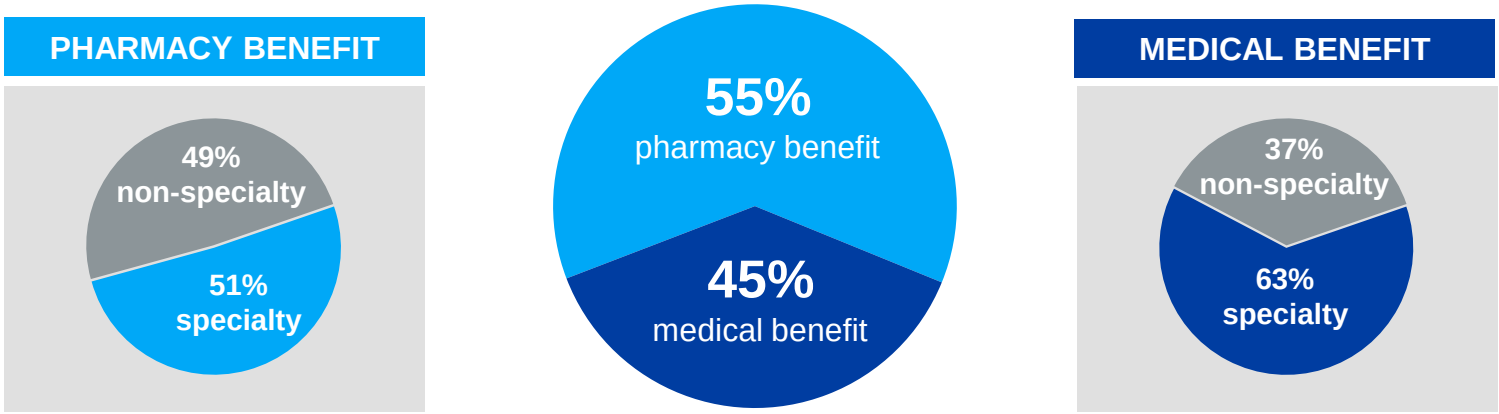
Future Pipeline Management

Cellular Therapy		Gene Therapy
Cancer cells detected; immune system doesn't view them as bad	Step 1	**Healthy gene** prepared within a lab
Healthy T-cells taken from cancer patient and reprogrammed	Step 2	Gene commonly **inserted into an inactive virus**, which carries the gene into a cell
Altered cells can now recognize and **destroy cancer cells**	Step 3	Healthy gene **injected into patient**
Altered cells **infused into patient**	Step 4	**Virus releases gene** into dysfunctional cell

Specialty Management Strategies

UnitedHealthcare®

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)

Fully Insured FY 2016 Allowed Amount

Top 5 Specialty Classes with highest medical spend

81%

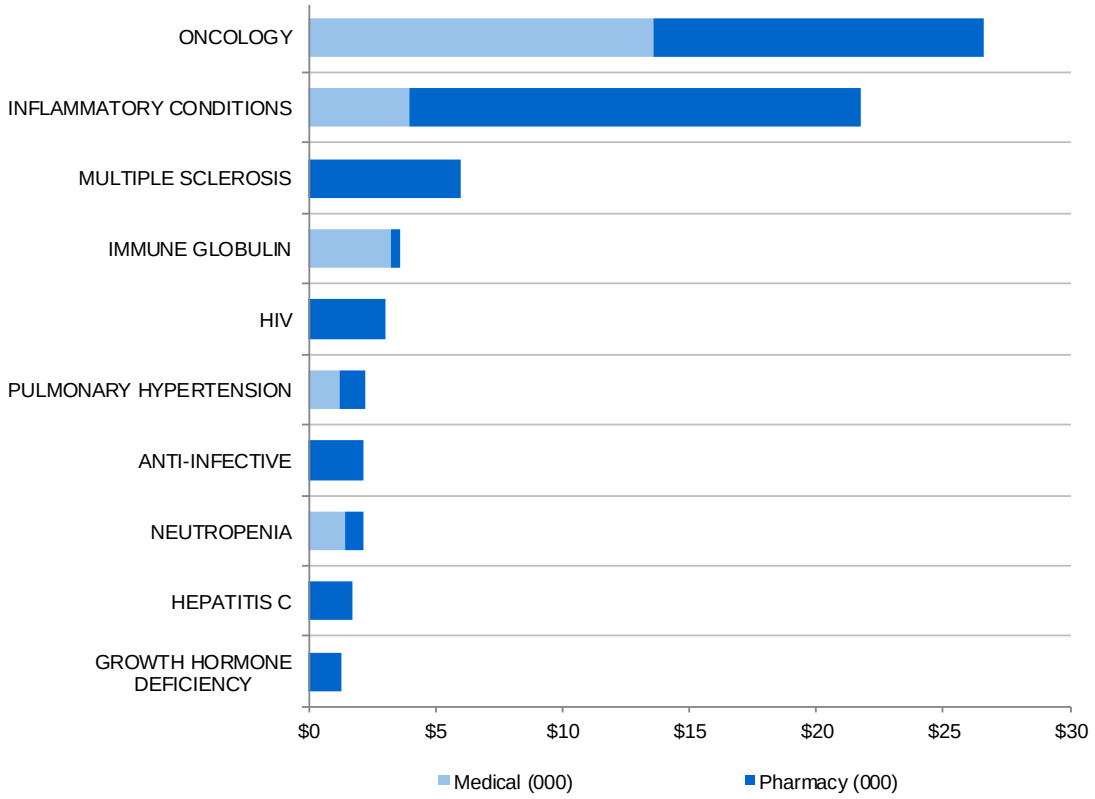
medical spend within 5 classes

1	2	3	4	5
Oncology	Inflammatory Conditions	Immune Globulin	Oncology Support	Multiple Sclerosis
Avastin Herceptin Opdivo Perjeta Rituxan	Actemra Entyvio Orencia Remicade	Gammagard Gammaked Gamunex-C Hizentra Octagam Privigen	Aloxi Neulasta Xgeva	Lemtrada Ocrevus Tysabri

2016 Fully Insured - Net Paid Amount

Top-10 Specialty Conditions: Combined

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



ONCOLOGY	$26.58	51.6	45.4
INFLAMMATORY CONDITIONS	$21.77	37.9	32.2
MULTIPLE SCLEROSIS	$5.99	6.2	7.0
IMMUNE GLOBULIN	$3.60	7.6	12.9
HIV	$3.01	8.5	19.7
PULMONARY HYPERTENSION	$2.24	1.4	1.4
ANTI-INFECTIVE	$2.17	0.5	0.0
NEUTROPENIA	$2.16	8.0	7.4
HEPATITIS C	$1.74	0.9	1.4
GROWTH HORMONE DEFICIENCY	$1.31	1.9	1.8

Dollars are PMPM and based on pharmacy membership

UnitedHealthcare®

Top-20 Specialty Medications:
Program Availability

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

Dollars are PMPM and based on pharmacy membership

Specialty Drug Management:

Inflammatory strategies in place

	Pharmacy Benefit	Medical Benefit
Network		
Specialty Designated Network/ National Infusion Network	✓	✓
Clinical & Utilization Management		
Review at Launch	✓	✓
Dosing Management	✓	✓
Prior Authorization	✓	✓
Step Therapy	✓	✓
Site of Care – Clinical Review		✓

UnitedHealthcare®

Specialty Care Management

Establish care and partnership

Ongoing support and interventions

Optimize connections

UnitedHealthcare®

Q & A

Colorado PBM Symposium

Setting the stage

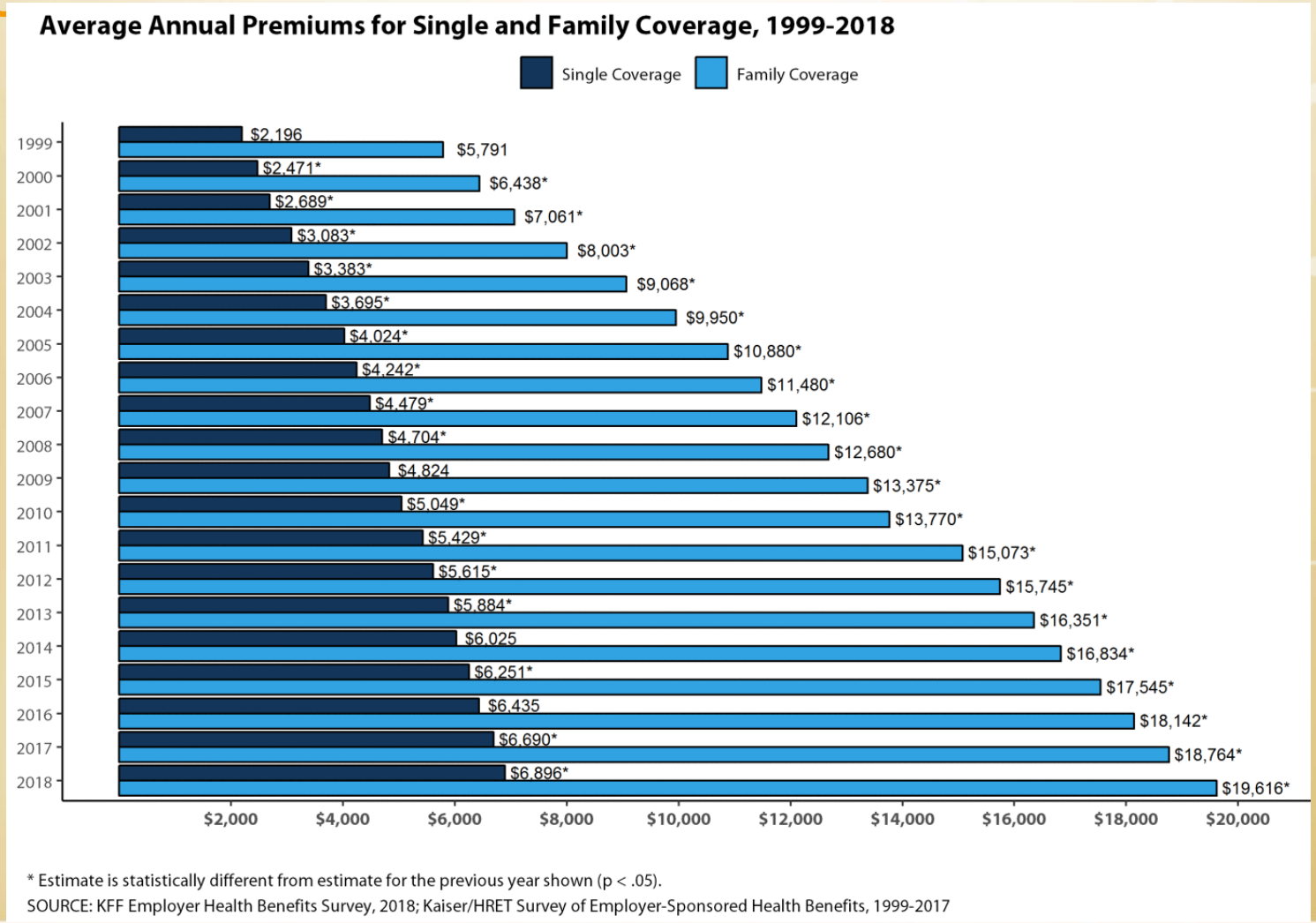
Michael Ell, MBA, MAcct, FACHE
Employers Health

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

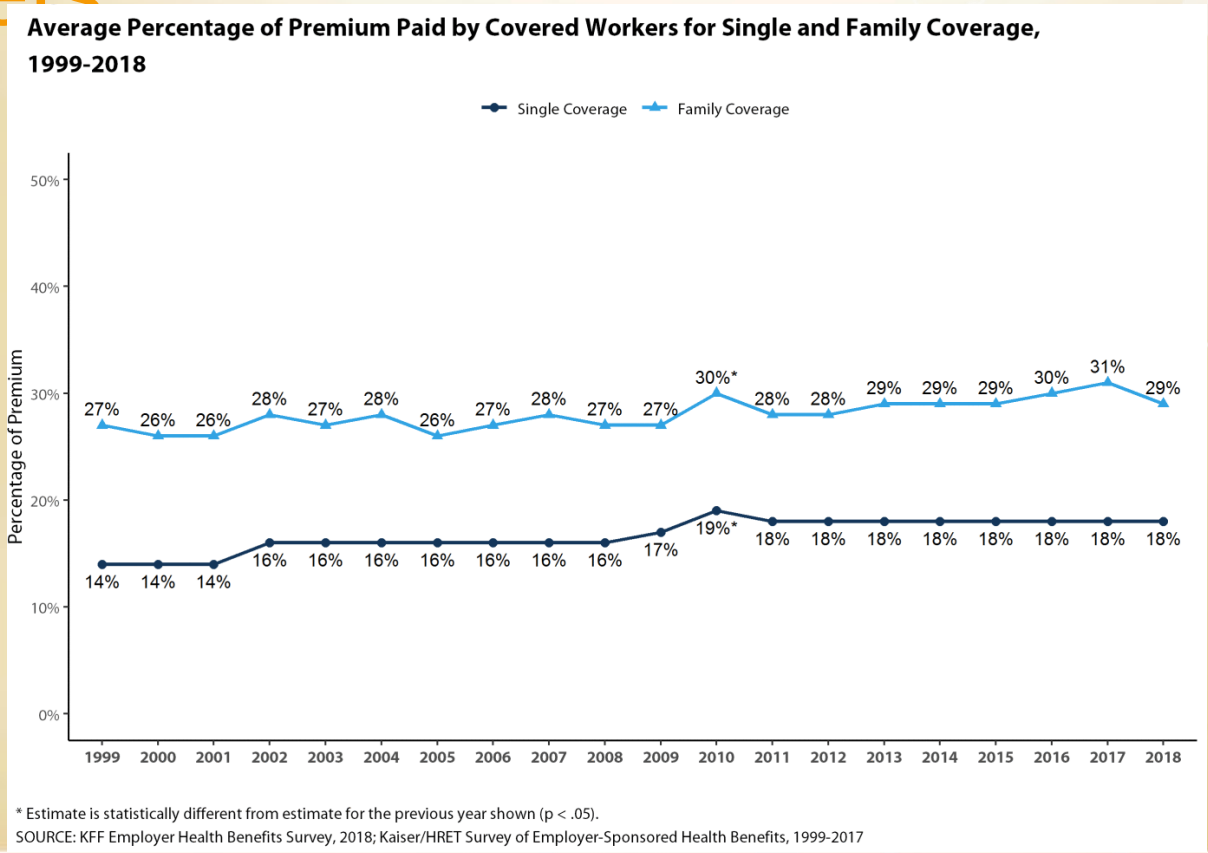


* Estimate is statistically different from estimate for the previous year shown ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2018; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

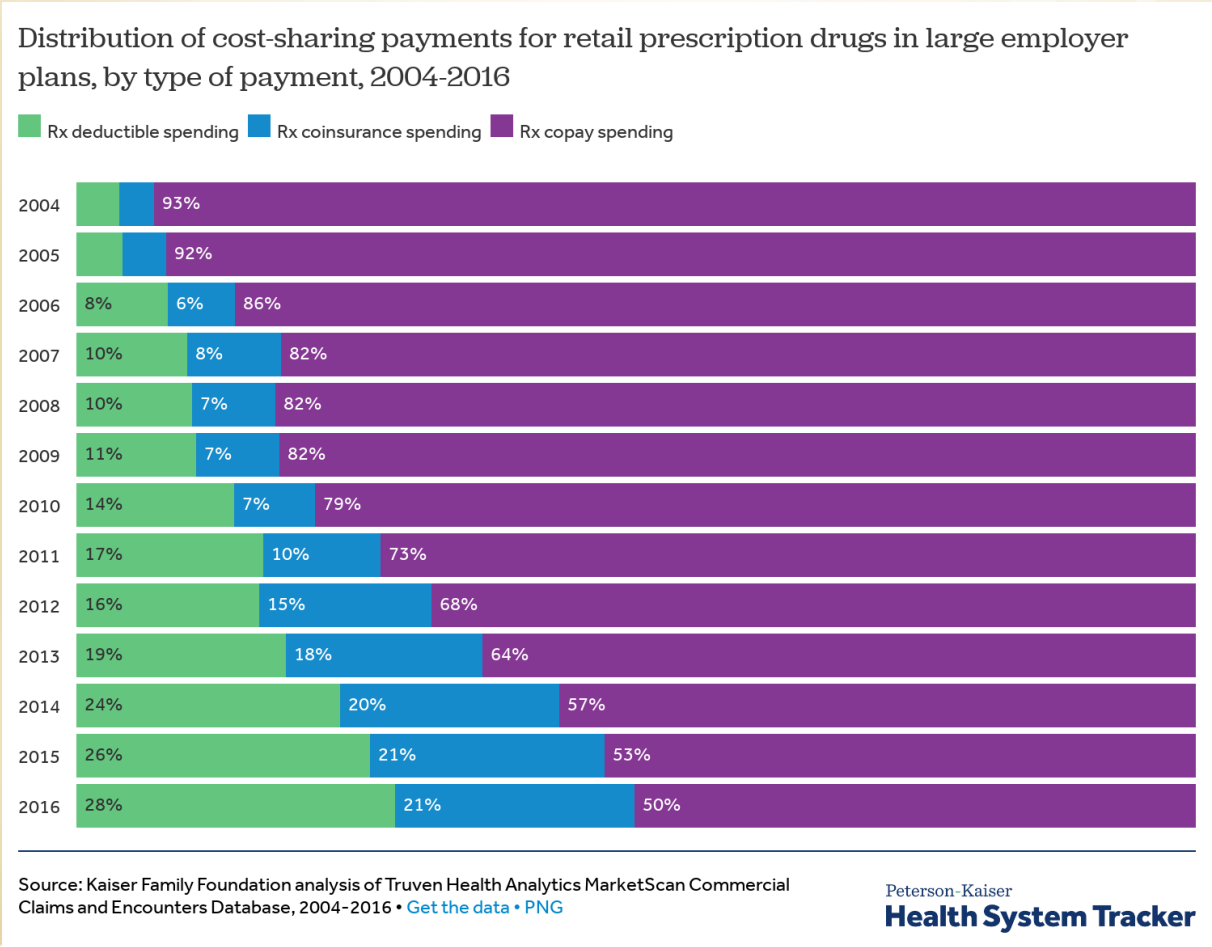
EMPLOYERS HEALTH

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



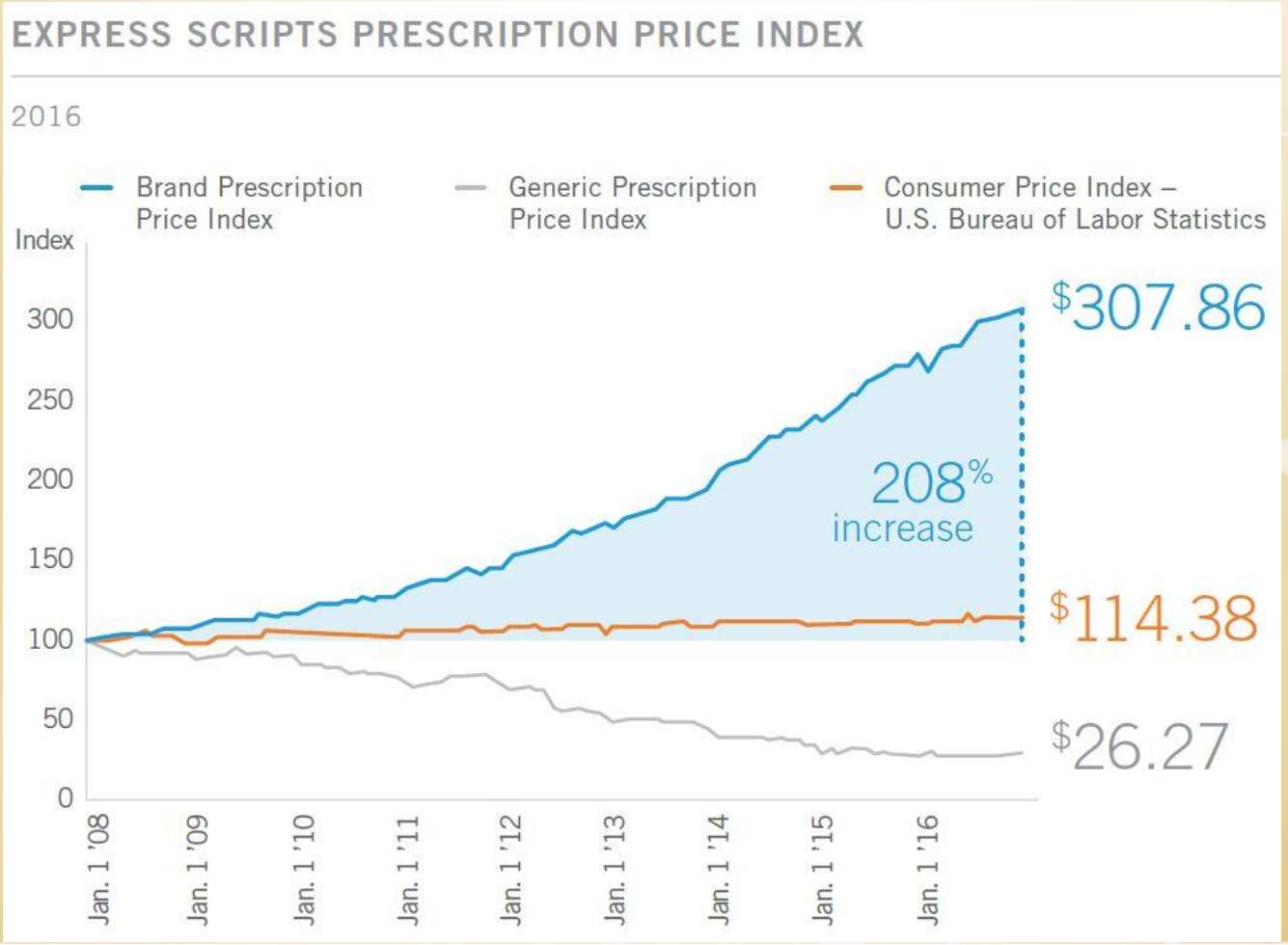
EMPLOYERS HEALTH

Patients out-of-pocket costs are increasingly tied to the list price of medications



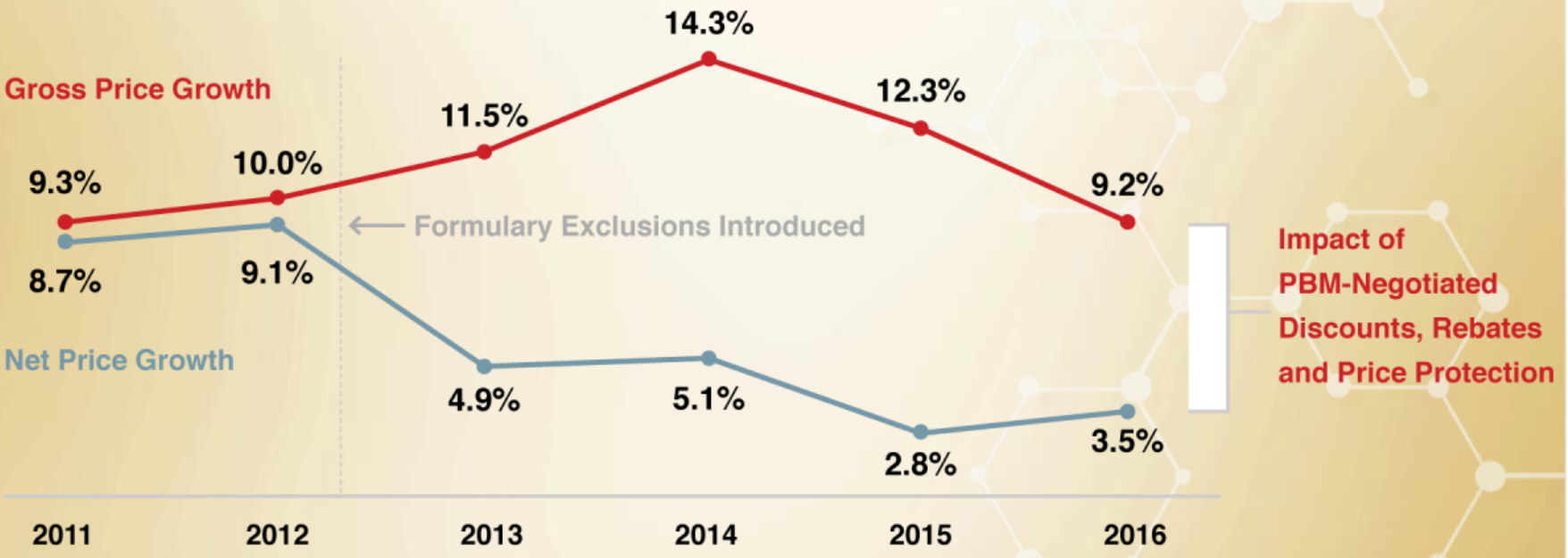
EMPLOYERS HEALTH

The list price of branded medications continues to rise



EMPLOYERS HEALTH

The net price of brand drugs actually moderates due to rebates and other discounts



EMPLOYERS HEALTH

Colorado PBM Symposium

October 25, 2018

Colorado Business Group on Health
Working Together to Improve Health Care Value

DENVER METRO CHAMBER OF COMMERCE

EMPLOYERS HEALTH

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

EMPLOYERS HEALTH

State of the Industry

4

EMPLOYERS HEALTH

Today's PBM Environment

5

EMPLOYERS HEALTH

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…)

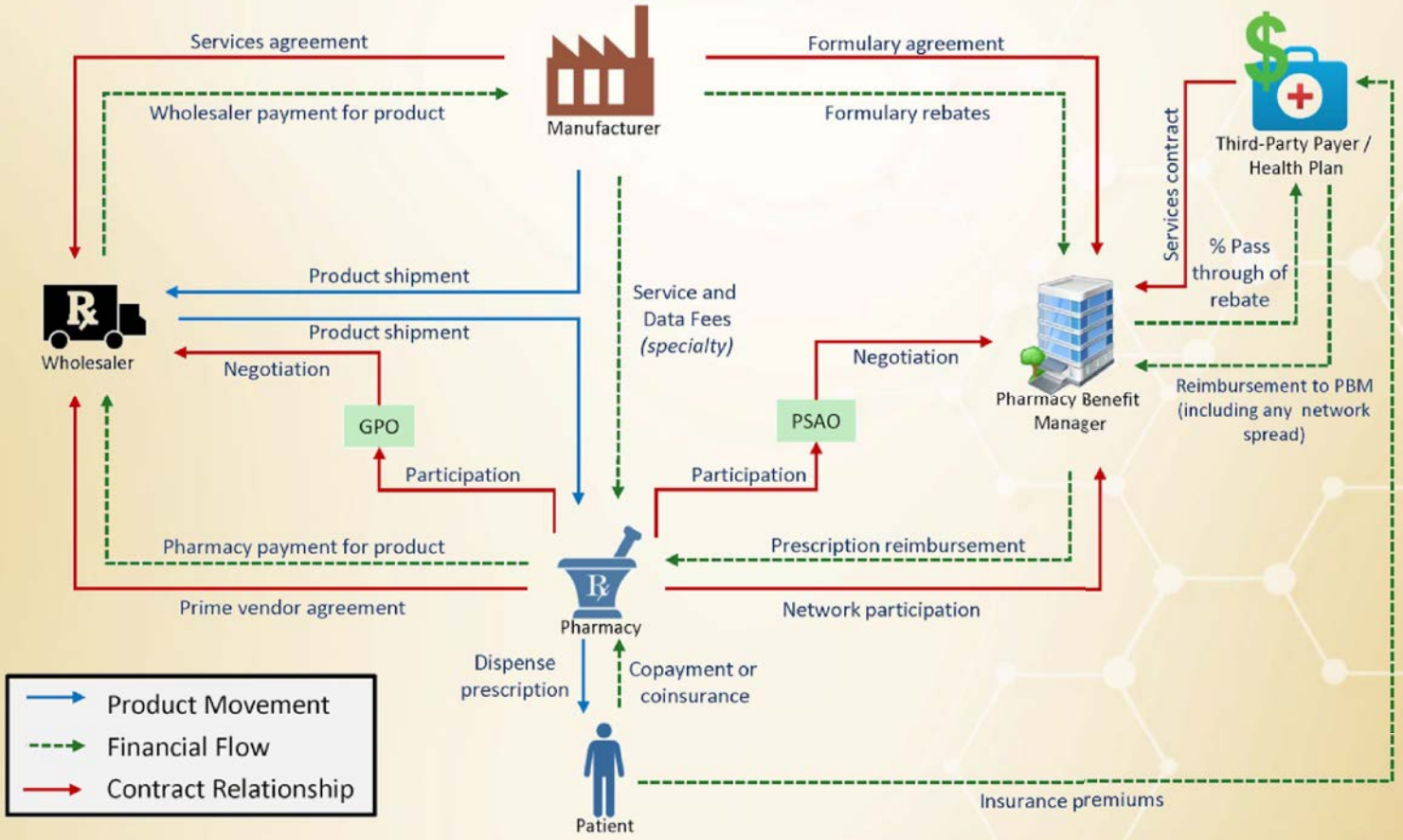
- Purchasers / Payors
  - Poor purchasing habits
  - Lack of adequate resources / misaligned resource allocation
  - Bad advice
- Prescribers
  - Lack of cost sensitivity
  - Reliant on drug manufacturer reps or other physicians paid by drug manufacturers
  - Give-in to patient demands
- Patients
  - 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



Source: Fein, Adam J., *The 2017 Economic Report on U.S. Pharmacies and Pharmacy Benefit Managers*, Drug Channels Institute, 2017. Chart illustrates flows for **Patient-Administered, Outpatient Drugs**. Please note that this chart is illustrative. It not intended to be a complete representation of every type of financial, product flow, or contractual relationship in the marketplace.
GPO = Group Purchasing Organization; PSAO = Pharmacy Services Administrative Organization

DRUG CHANNELS INSTITUTE

EMPLOYERS HEALTH

Pharmacy Distribution

PBMs

- CVS caremark
- Express Scripts
- OptumRx
- Prime Therapeutics
- MedImpact
- Humana Pharmacy

Manufacturing & Marketing

- Johnson & Johnson
- Pfizer
- Merck
- Gilead
- AbbVie
- Amgen
- Lilly
- Sanofi

Wholesale Distribution

- AmerisourceBergen
- Cardinal Health
- McKesson

Retail & Mail Pharmacies

- CVS pharmacy
- CVS caremark
- Walgreens
- Express Scripts
- OptumRx
- Rite Aid
- Walmart
- Kroger

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

amazon

CVS Health

aetna

Cigna

EXPRESS SCRIPTS

Anthem

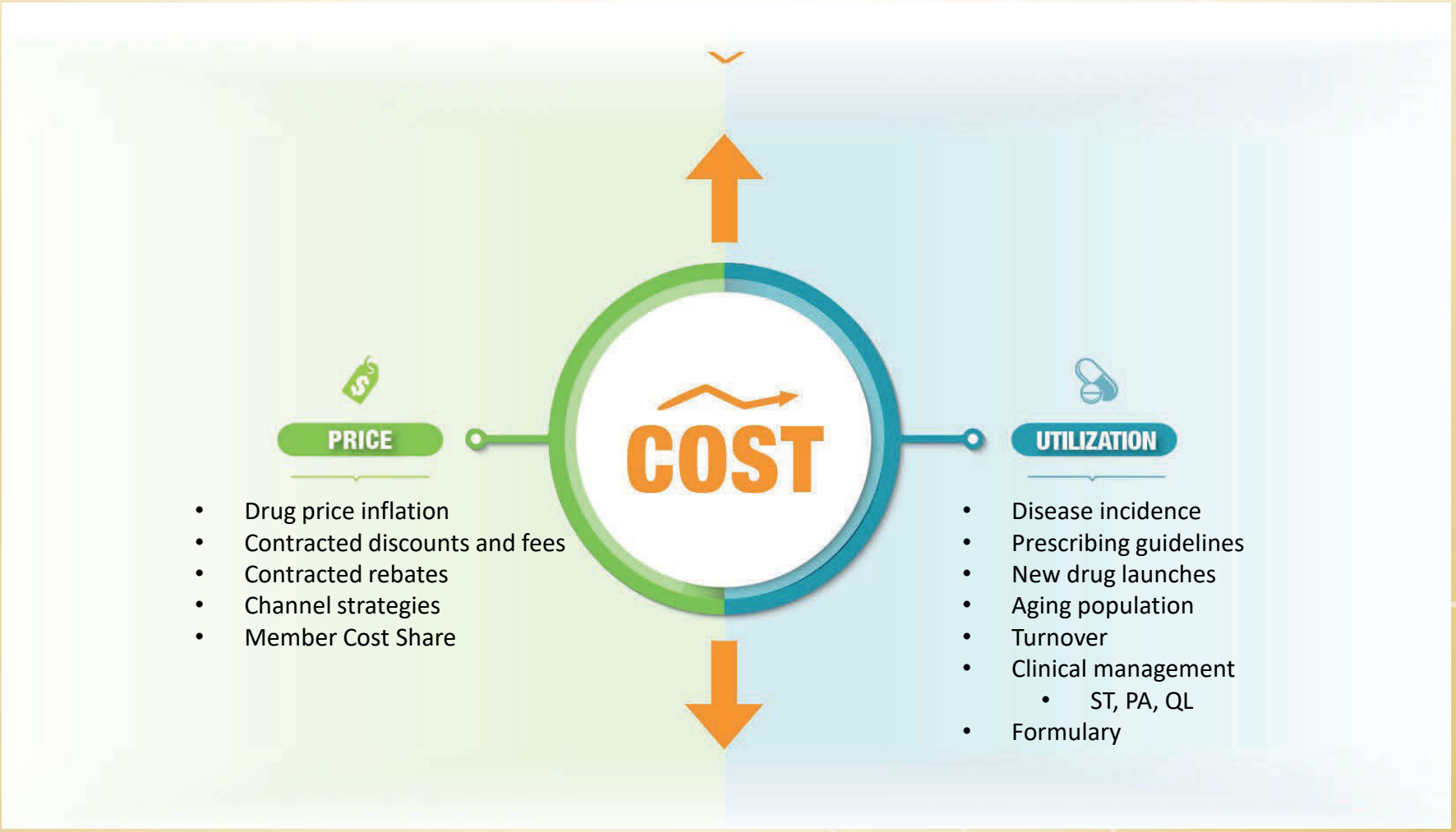
IngenioRx

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

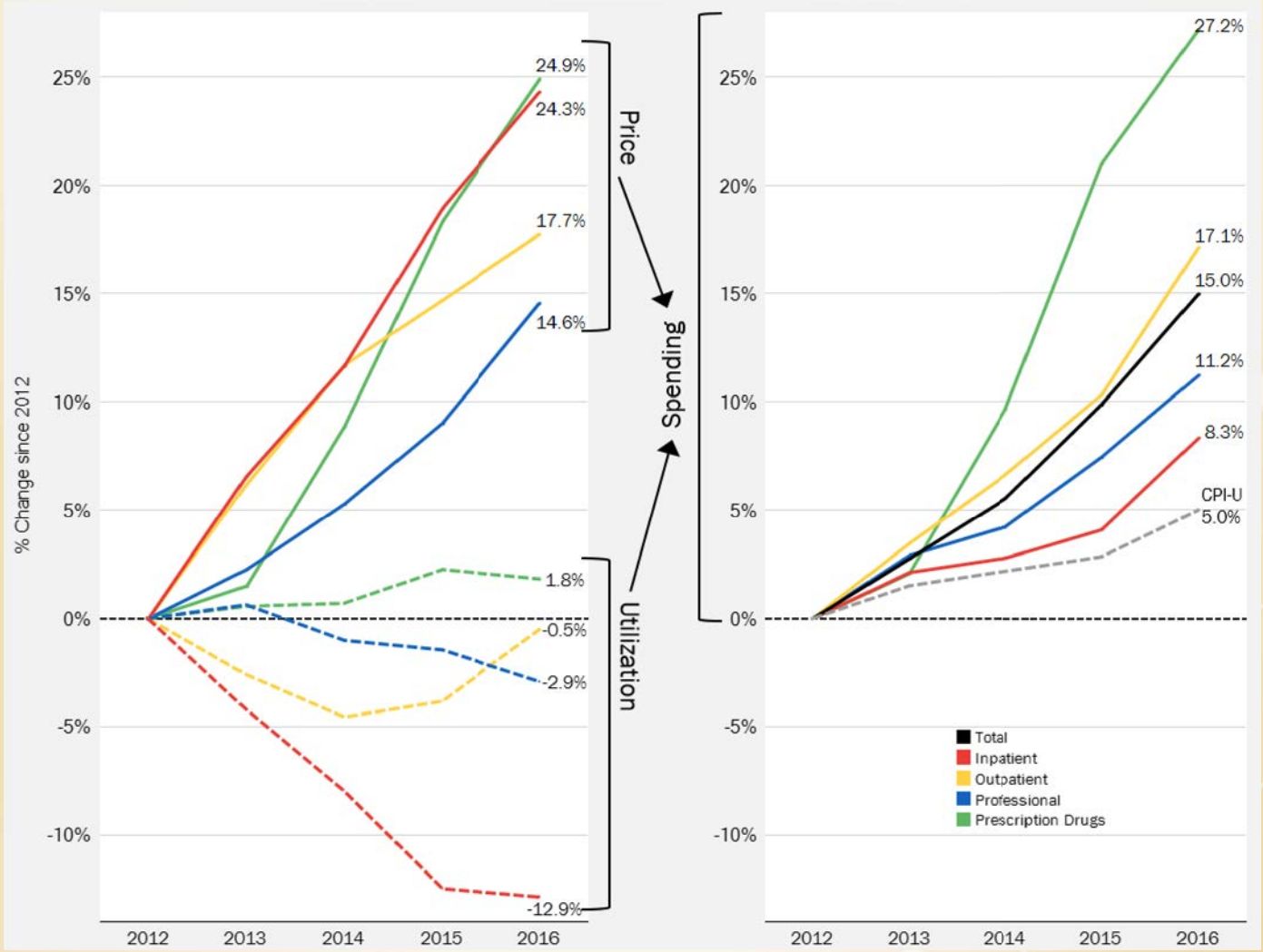
Overall Pharmacy Cost Factors



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

- Disease incidence
- Prescribing guidelines
- New drug launches
- Aging population
- Turnover
- Clinical management
  - ST, PA, QL
- Formulary

EMPLOYERS HEALTH

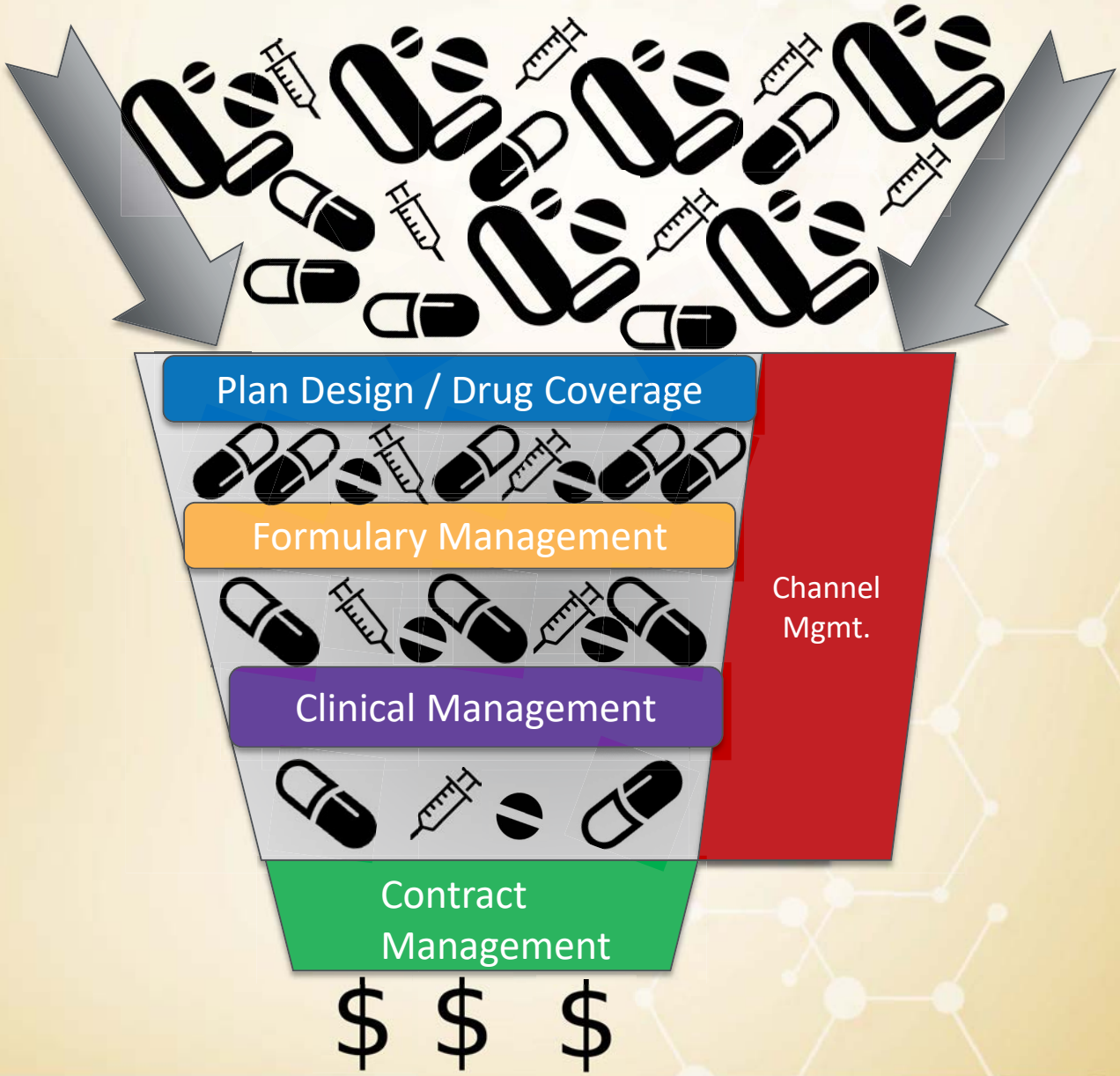


Source: Health Care Cost Institute

Note: Prescription Drug Prices do not include discounts and rebates.

Note: Prescription Drug Prices includes HepC and Compounds, which peaked during time period.

EMPLOYERS HEALTH

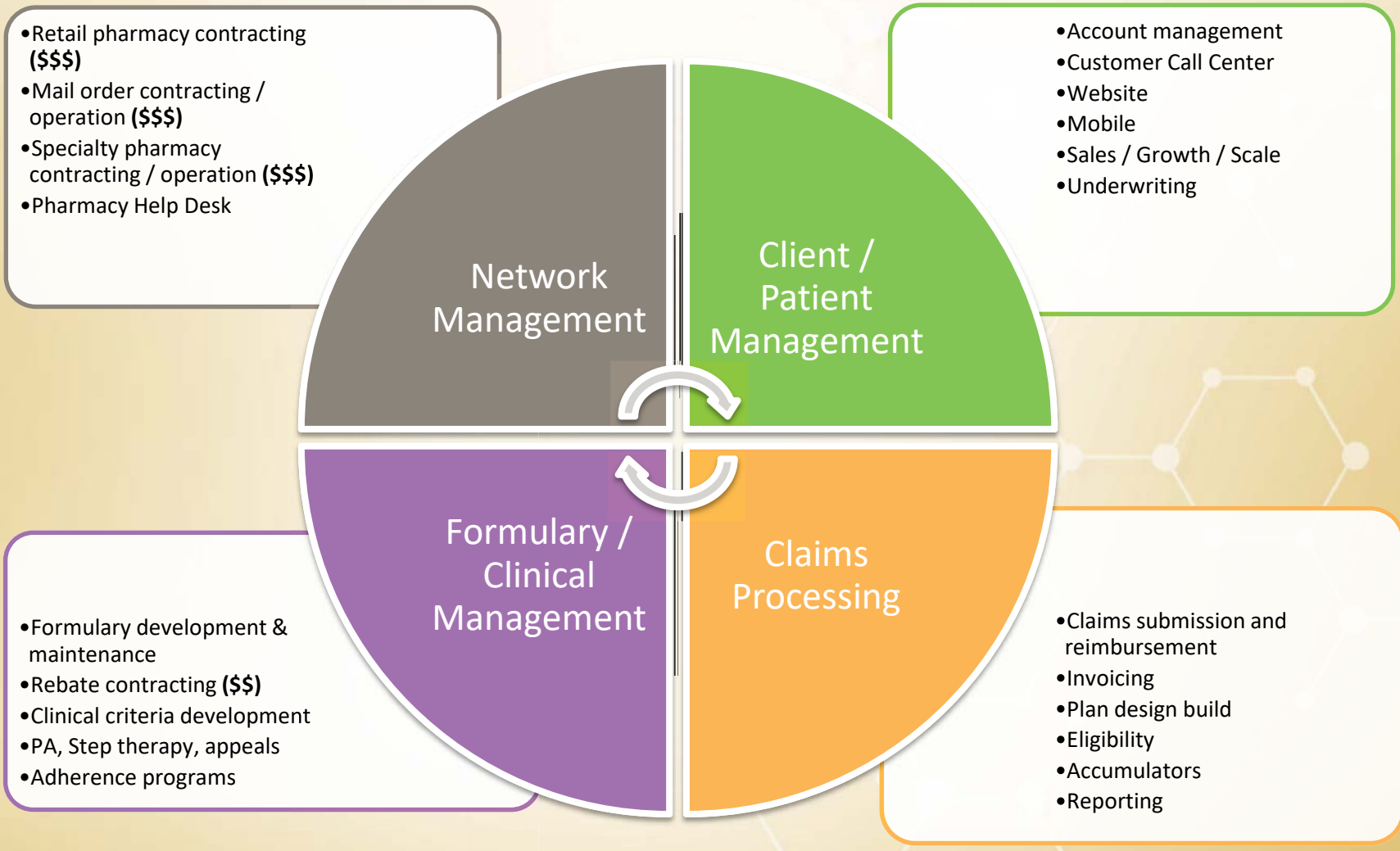


EMPLOYERS HEALTH

Today's Topics

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

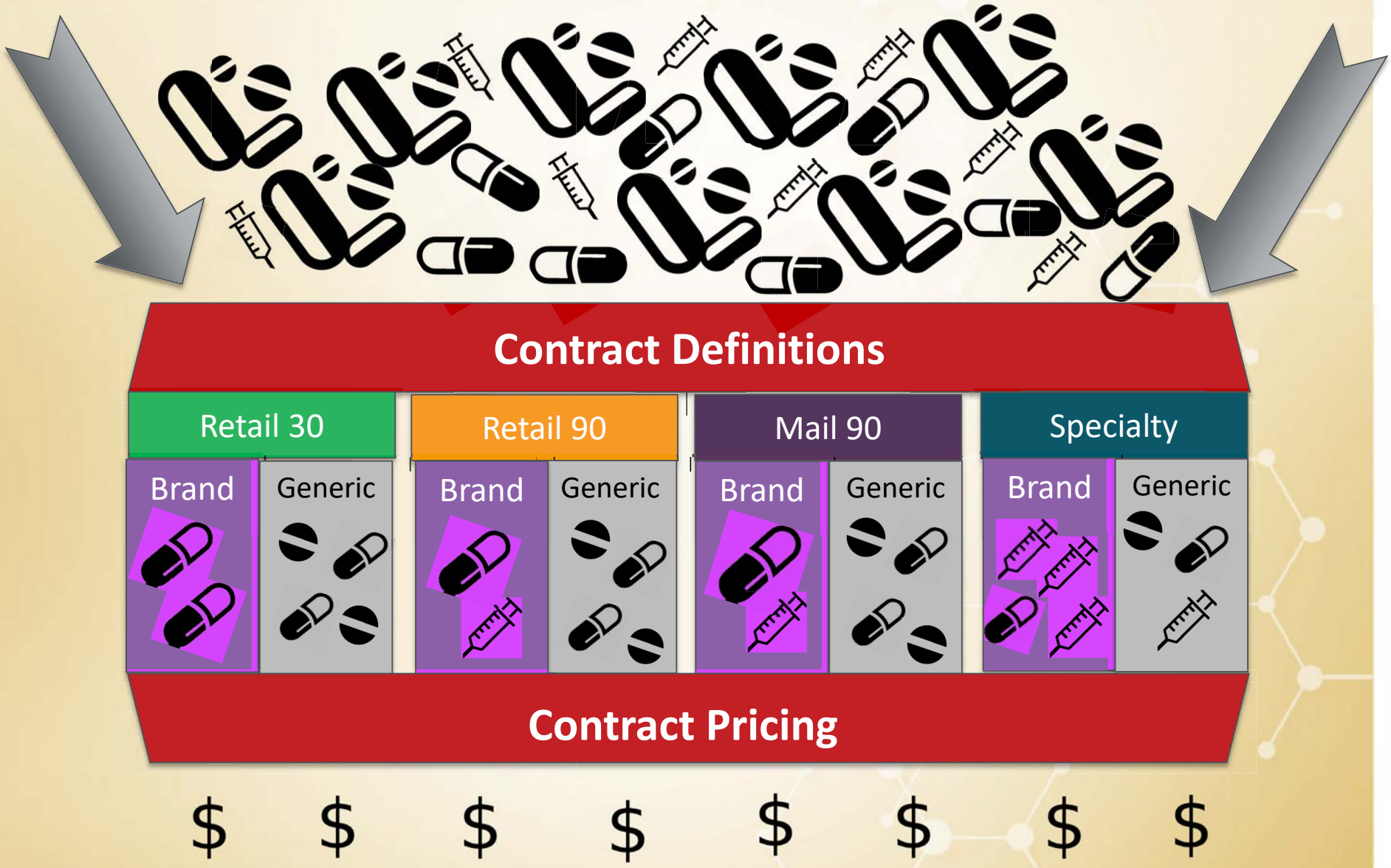
PBM Functions



EMPLOYERS HEALTH

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



EMPLOYERS HEALTH

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

$300	Wholesale Acquisition Price (WAC)	Set by manufacturers
$360	Average Wholesale Price (AWP)	Price benchmark published by Medispan – typically not more than 120% of WAC
$61	Discount off AWP	Negotiated by plan sponsor and PBM – may or may not be reflective of what the PBM reimburses the pharmacy
$1	Dispensing Fee	Negotiated by plan sponsor and PBM – may or may not be reflective of what the PBM reimburses the pharmacy
$300	Gross Cost	AWP – Discount + Dispnesing Fee

Network Decision Points

Traditional vs. Pass-Through	Exclusive vs. Open Specialty	Direct Contracting
• 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?	• 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?	• 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?

EMPLOYERS HEALTH

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 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 1 Collections:

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

PBM 2 Collections:

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

Rebate Exclusions

Specialty Rxs	1312
Removed by Limited Distribution	165
Percentage Removed	12.58%
ASCF Specialty Rate Offered	
ACSF Specialty Rate w/ Limited Dist. Removed	
Difference ($)	
Difference (%)	14.3%

	Specialty Retail	<84 DS Mail	<84 DS Specialty
Reported Claims	1312	30765	1312
Removed Claims	113	1873	52
% of Claims	8.61%	6.09%	4.0%
Offered Rebate			
Adjusted Rebate			
Difference ($)			
Difference (%)	9.4%	6.5%	5.8%

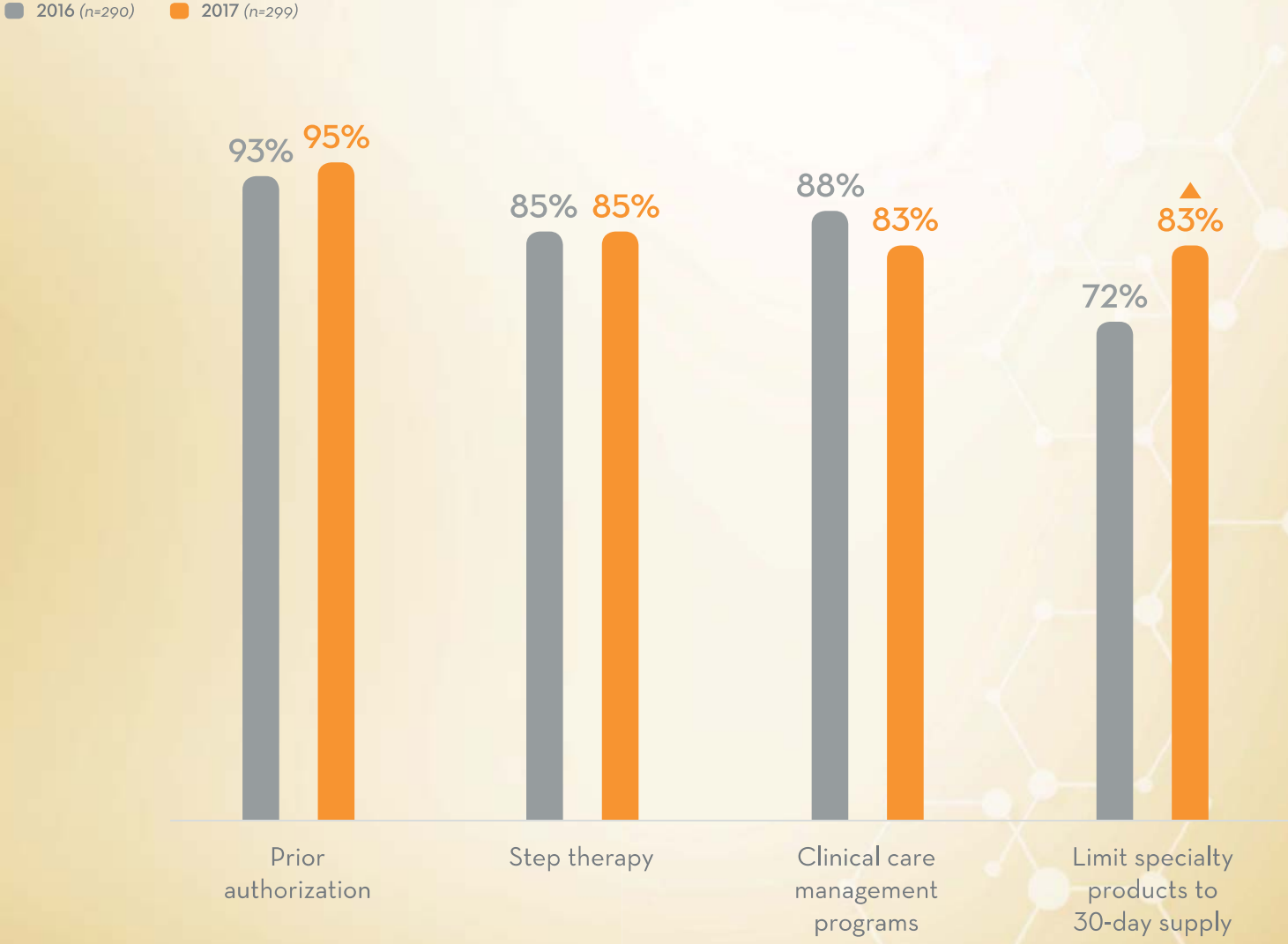
EMPLOYERS HEALTH

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.*



EMPLOYERS HEALTH

Source: 2018 PBMI Trends in Specialty Drug Benefits

PA Reporting

Total Members	Total Episodes Initiated	Episodes Resulting in: PA Approval	PA Denial	PA Admin Denial	No PA Requested	Gross Savings	Net Savings
1	1	0	0	0	1	$32,103	$31,423
2	3	1	0	1	1	$4,936	$4,589
1	1	1	0	0	0	$0	$0
5	5	5	0	0	0	$0	$0
1	2	2	0	0	0	$0	$0
9	10	8	1	0	1	$3,880	$3,437
1	1	1	0	0	0	$0	$0
5	5	5	0	0	0	$0	$0
2	2	2	0	0	0	$0	$0
2	2	0	0	0	2	$8,614	$8,327
4	4	4	0	0	0	$0	$0
1	1	1	0	0	0	$0	$0
1	1	1	0	0	0	$0	$0
4	4	4	0	0	0	$0	$0
1	1	1	0	0	0	$0	$0
2	2	2	0	0	0	$0	$0
1	1	1	0	0	0	$0	$0
2	2	1	1	0	0	$37,364	$36,692
2	9	9	0	0	0	$0	$0
2	2	2	0	0	0	$0	$0
1	1	0	0	0	1	$328	$242
2	3	2	0	1	0	$0	$0
2	2	0	0	0	2	$7,262	$6,968
6	8	5	1	2	0	$11,547	$10,455
2	2	1	0	0	1	$18,336	$17,346
1	1	0	0	1	0	$52,913	$0
2	2	1	0	1	0	$11,625	$11,054
1	1	1	0	0	0	$0	$0
1	1	0	1	0	0	$0	$0
2	2	2	0	0	0	$0	$0
1	1	1	0	0	0	$0	$0

SPECIALTY DRUGS PA SUMMARY	
2017 (20170101-20171214)-Specialty	
STATUS_CD	COUNT
NULL	4363
01 - OPEN	184
02 - ASSIGNED	119
03 - CANCELLED	44494
04 - PENDED	87
05 - DENIED	44269
06 - APPROVED	77118
09 - INACTIVATED	542
99 - RESERVED	6
Total PA	171182
Approved PA	77118
Approved PA %	45%

EMPLOYERS HEALTH

Clinical Management

- Medication Adherence
  - Face-to-face, video chats, telephonic, technology, apps
  - Medication Possession Ratio (MPR)
    - (Actual On-Hand / Expected On-Hand) * 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

LOCKTON

A Tale of Pharmacy Purchasing

Pharmacy Landscape & Market Update

Increased scrutiny in private & public sectors

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

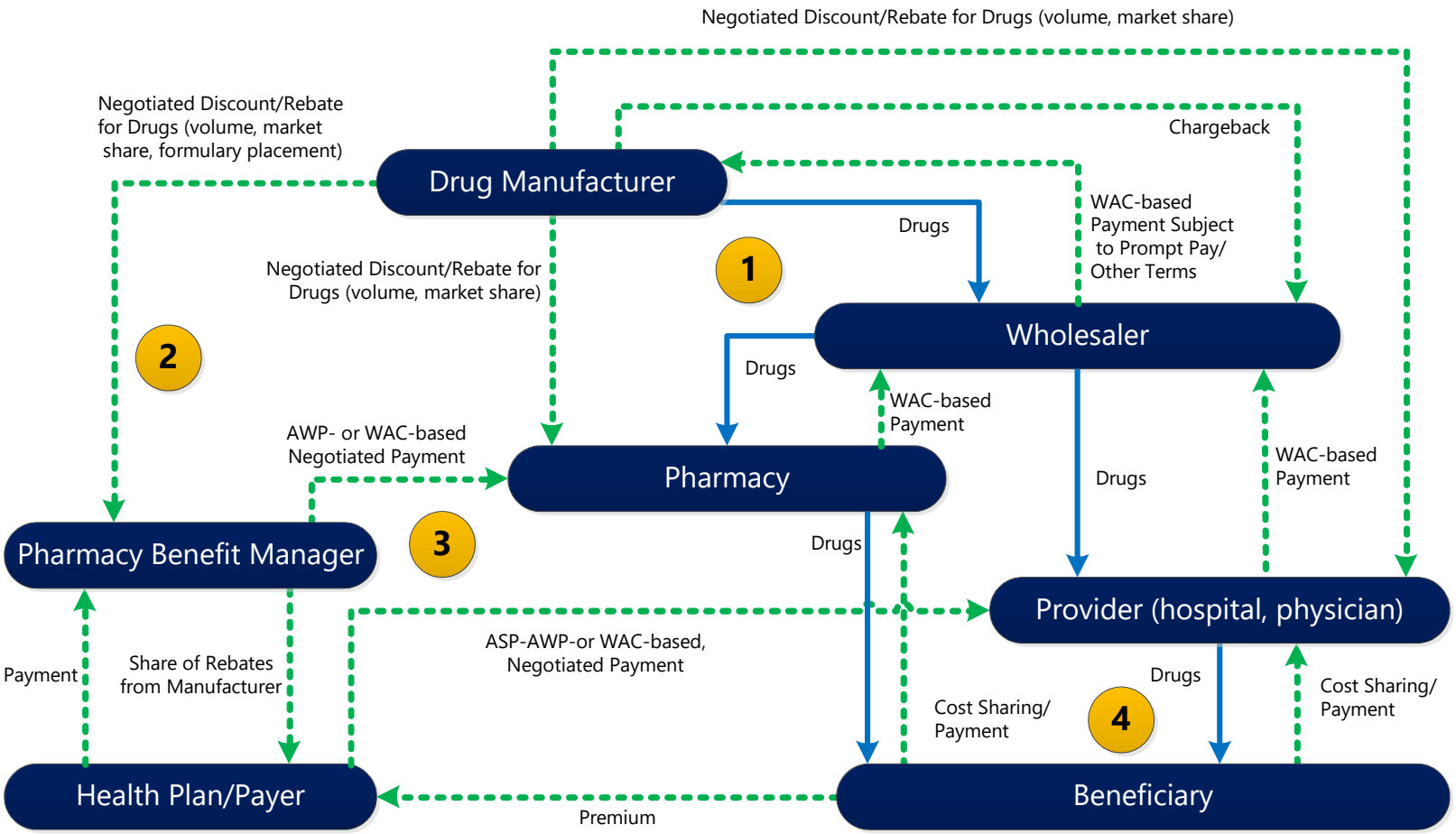
Vertical integration and consolidation

- >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

Stakeholders & Pharmacy Dollars



Pharmacy is a Dynamic Marketplace

Carve-in

- Bundled pharmacy & medical contract, through one vendor
- Value of integration
  - Patient experience, coordination of care, & data integration
- Decreased transparency
- Less choice & control

VS

Carve-out

- Unbundled pharmacy agreement
  - Direct with PBM or collective
- Pharmacy accountability & expertise
- Increased transparency
- Choice & control
  - Customize, tailor, & innovate your plan
  - Implementation credits
  - Financial guarantees
  - Performance guarantees
- File integration is required between medical carrier & PBM

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?

Pharmacy Contract Evaluation

Admin Fees	Exclusions	Retail 90
AWP Discounts	Clinical Programs	Spread Pricing
Single-Source Generics	Biosimilars & Limited Distribution Drugs	Off-sets
Compounds	Data Integration	Specialty Rebates
Dispensing Fees	Repackaging	Pass-through
Generic Drugs	Market Checks	Admin Credit
MAC Pricing	Lessor-of Logic	Performance Guarantees
Usual & Customary	Audit	Member Communications
Zero Balance Claims	Mail Order	Utilization Management

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

Pharmacy Contract Evaluation: Example of Optics

Single Source Generics
AWP-30%

Brand Discount	Generic Discount
AWP-18%	AWP-80%
SSGs Added	SSGs Excluded
Inflated brand discounts	Inflated generic discounts

How is your PBM defining brands, generics, & specialty drugs?

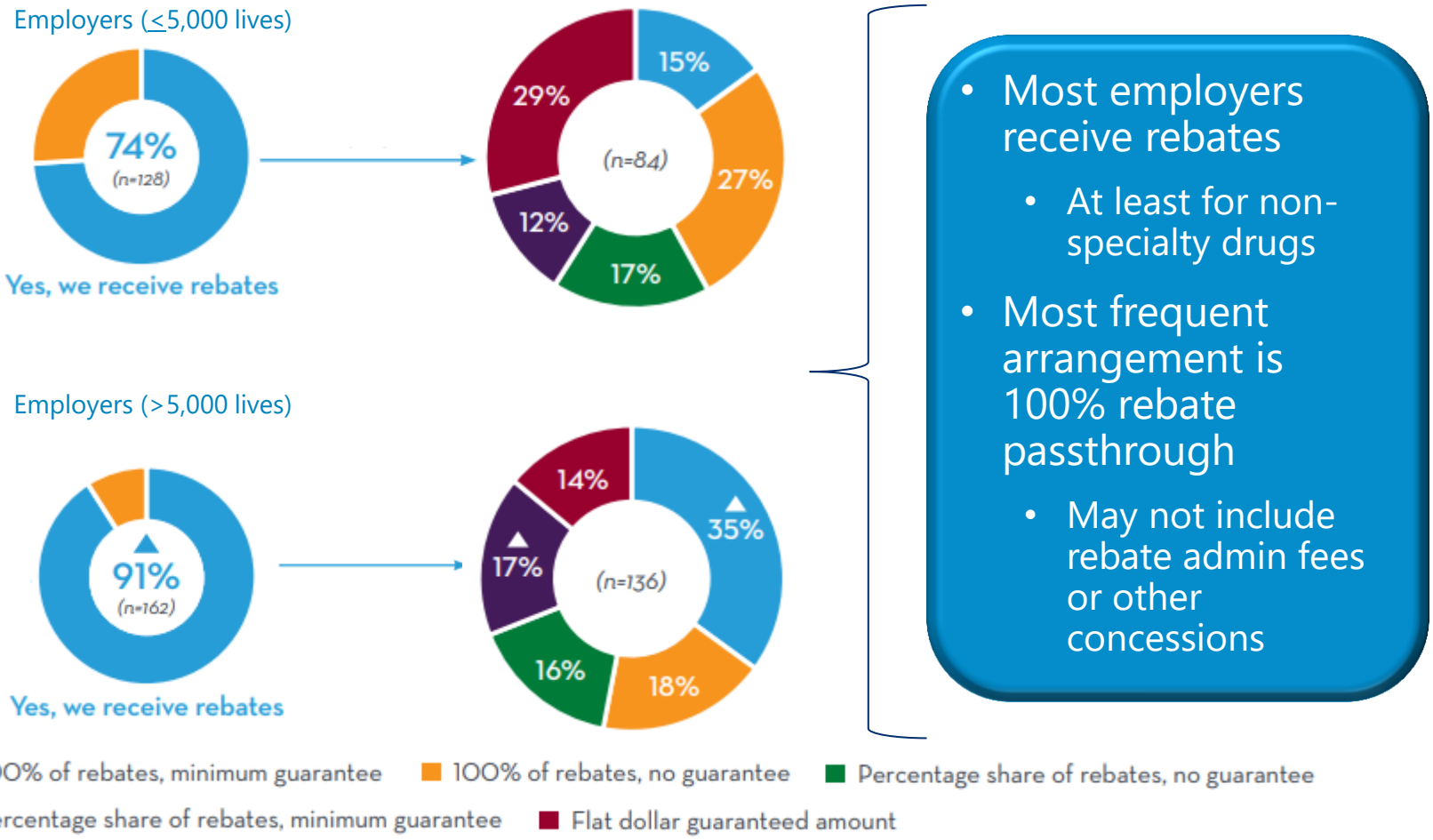
PBMs may artificially inflate guarantees by reclassifying drugs

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



- 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

Reference: Pharmacy Benefit Management Institute (PBMI). 2017 Trends in Drug Benefit Design

Financial Metrics should be Guaranteed & Client Specific

- 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

Retail	**Based on the geographic distribution of membership - estimated values:**			
	Retail 30 Brand	AWP -	19.10%	19.10%
	Retail 30 Generic (MSG)	AWP -	75.50%	79.00%
	Retail 30 Dispensing Fee Brand		$1.40	$1.40
	Retail 30 Dispensing Fee Generic		$1.40	$1.40
Mail Order	**Home Delivery - estimated values:**			
	Home Delivery Brand Discount	AWP -	23.00%	23.00%
	Home Delivery Generic Discount (MSG)	AWP -	77.50%	81.00%
	Home Delivery Dispensing Fee		$0.00	$0.00
Rebate Sharing	For 2018 Rebate share is 100%.	Retail	Per Brand	Per Brand
		Estimated Minimum	$0.00	$68.78
		Retail 90	Per Brand	Per Brand
		Estimated Minimum	$0.00	$0.00
		Home Delivery	Per Brand	Per Brand
		Estimated Minimum	$0.00	$438.43

PBM Marketing Process

Data Analysis

- Full year of <u>your</u> 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 ·

Pricing Reconciliation Audit
Ensure Your Contractual Guarantees are Met

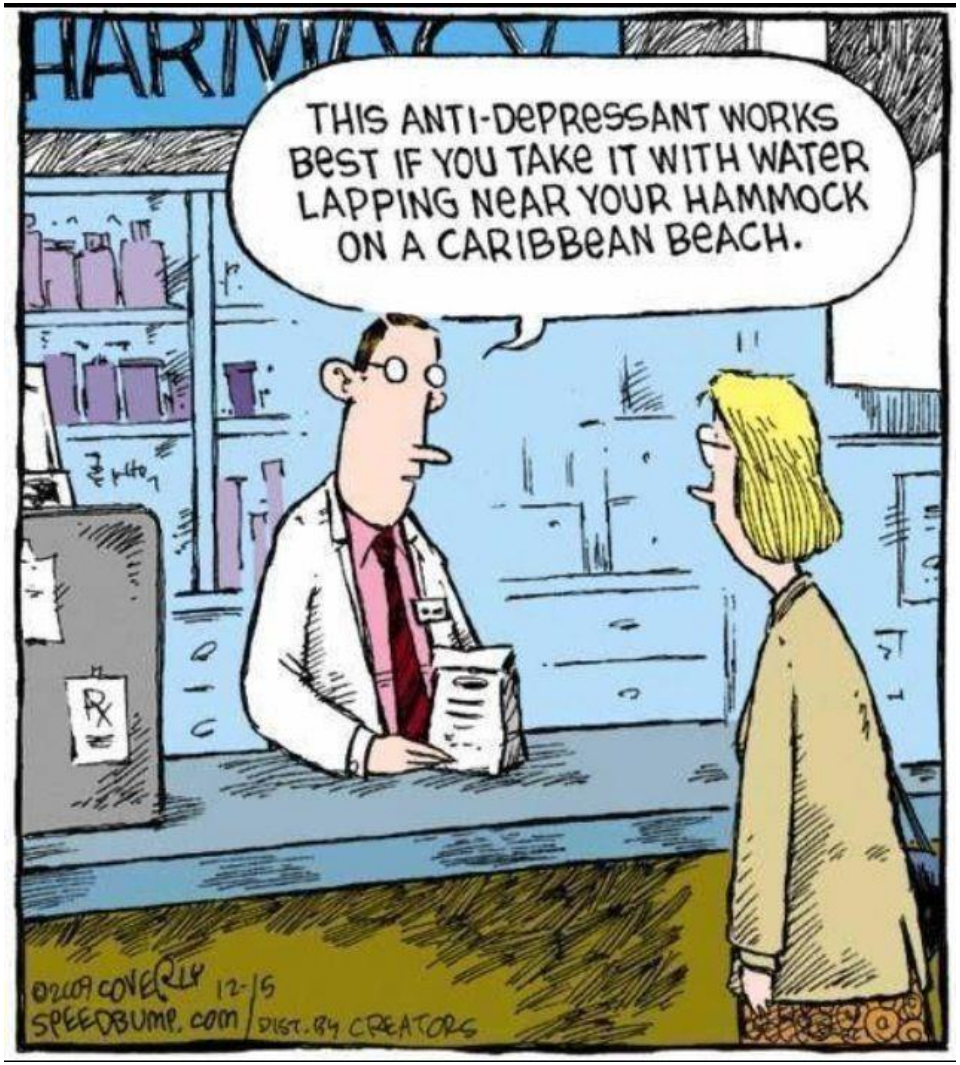
Lockton Success Story

$146,191

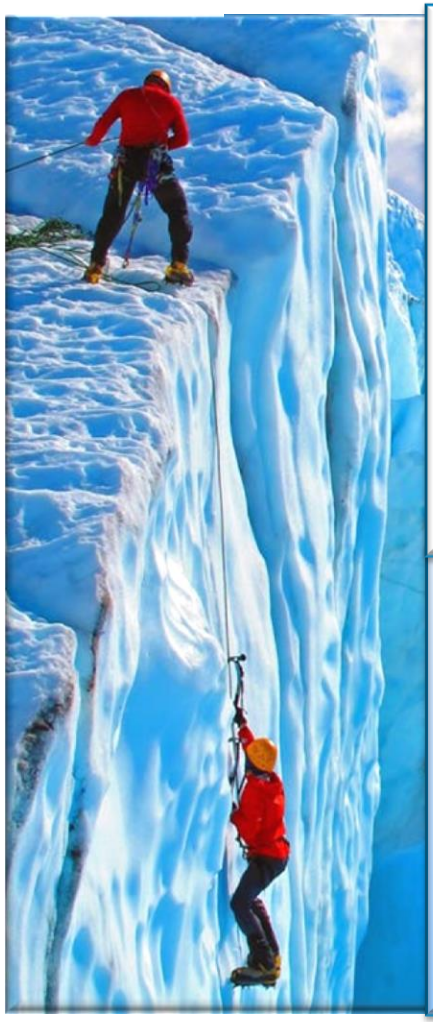
Pharmacy dollars recouped

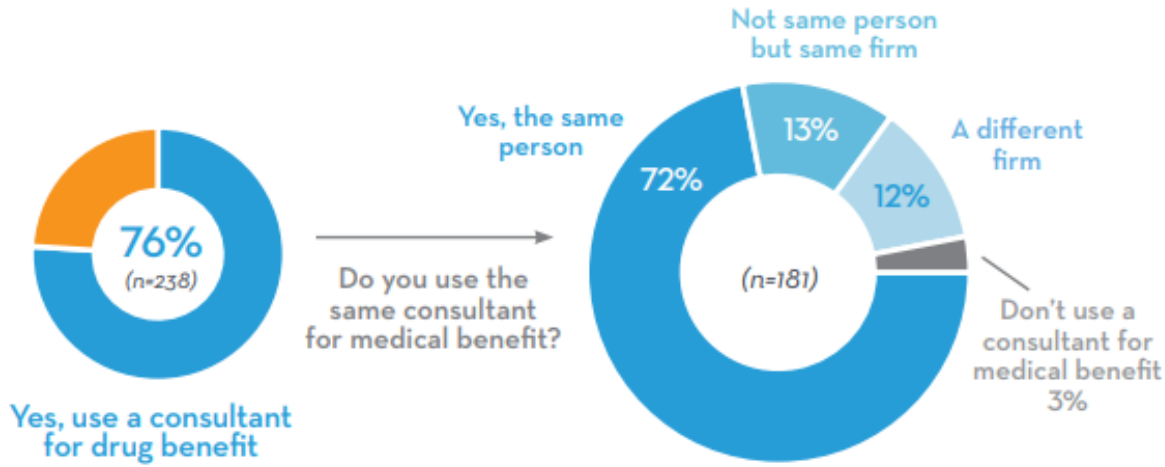
- *6% of client's total 2017 Pharmacy Spend ($2.4M) was recouped*
- *Carrier fell short of all discount guarantees*

- 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


HARMA
THIS ANTI-DEPRESSANT WORKS BEST IF YOU TAKE IT WITH WATER LAPPING NEAR YOUR HAMMOCK ON A CARIBBEAN BEACH.
Rx
©2009 COVERLY
SPEEDBUMP.COM
12-15
DIST. BY CREATORS

Consulting Landscape



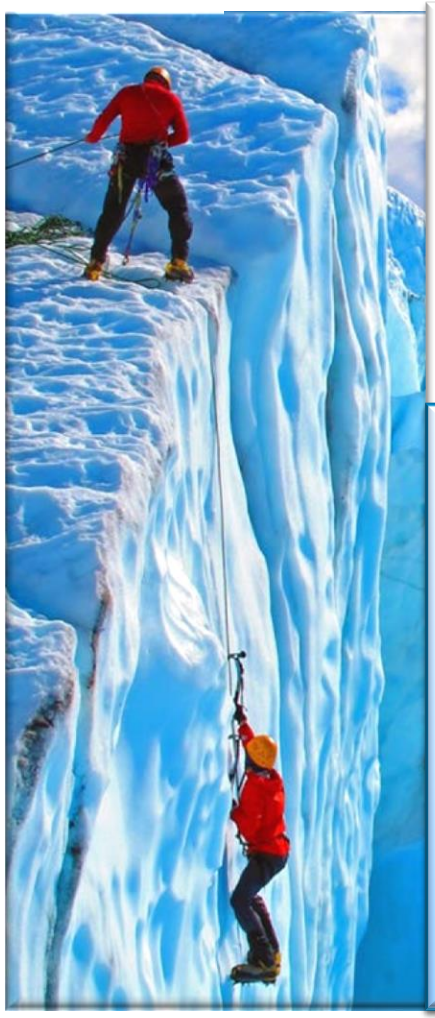


1. Is your consultant biased? Do they own or operate a coalition?

2. Does your consultant have pharmacy expertise, leverage, & resources (analytical tools)?
   - Who completes RPF repricing & disruption analyses?

Reference: Pharmacy Benefit Management Institute (PBMI). 2017 Trends in Drug Benefit Design

Coalitions, Collectives, vs Direct Deals



21% purchased PBM services through a coalition or group purchasing organization[1]

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

Reference: [1]Pharmacy Benefit Management Institute (PBMI). 2017 Trends in Drug Benefit Design

What to Look for in a PBM Partner?

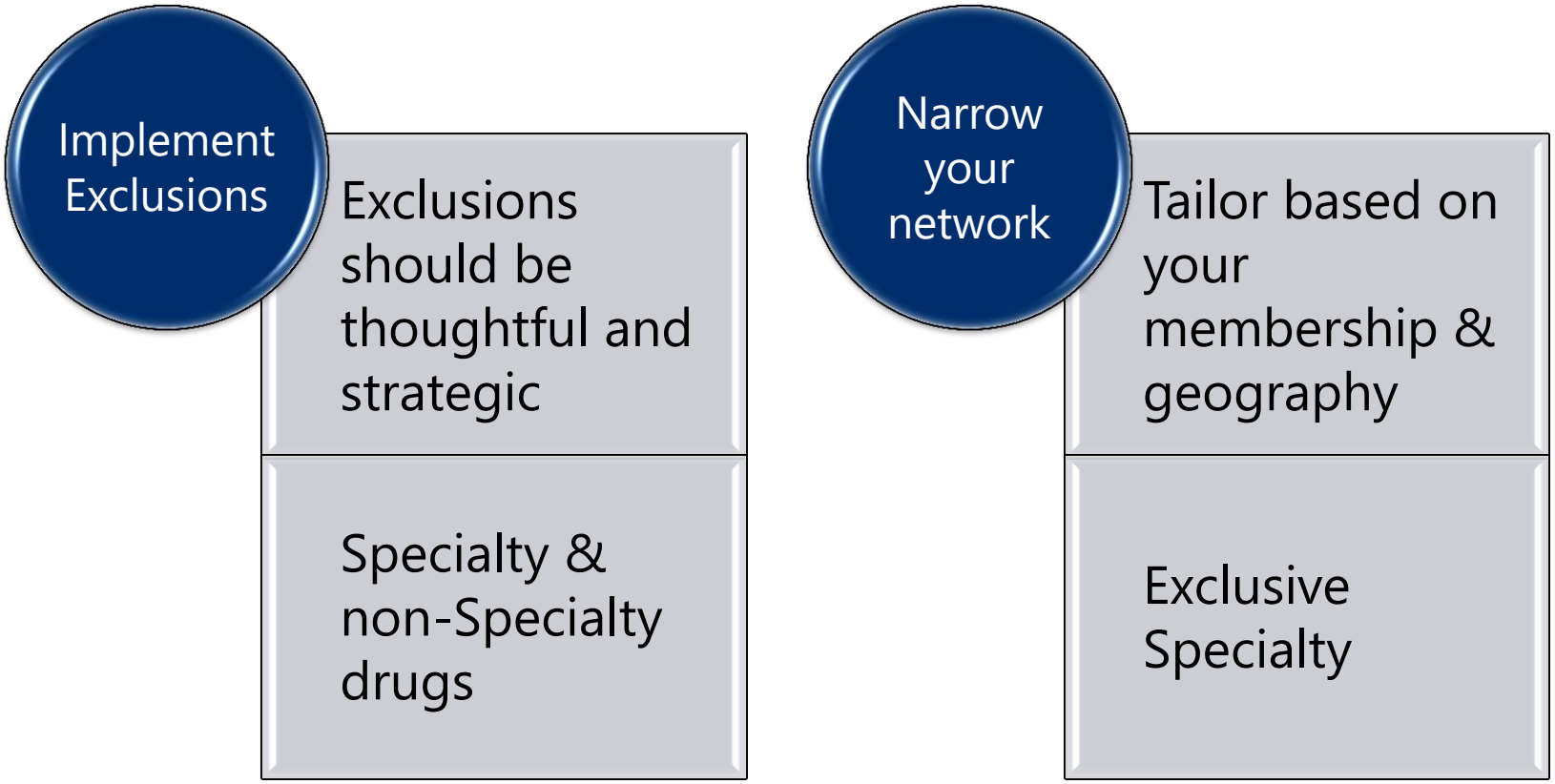
Designing the right strategy requires understanding each client's goals and culture, which involves a balance of savings and access

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?

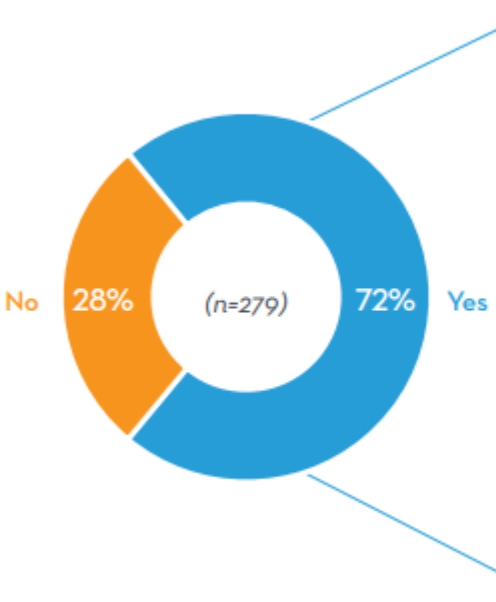
Desired Outcomes

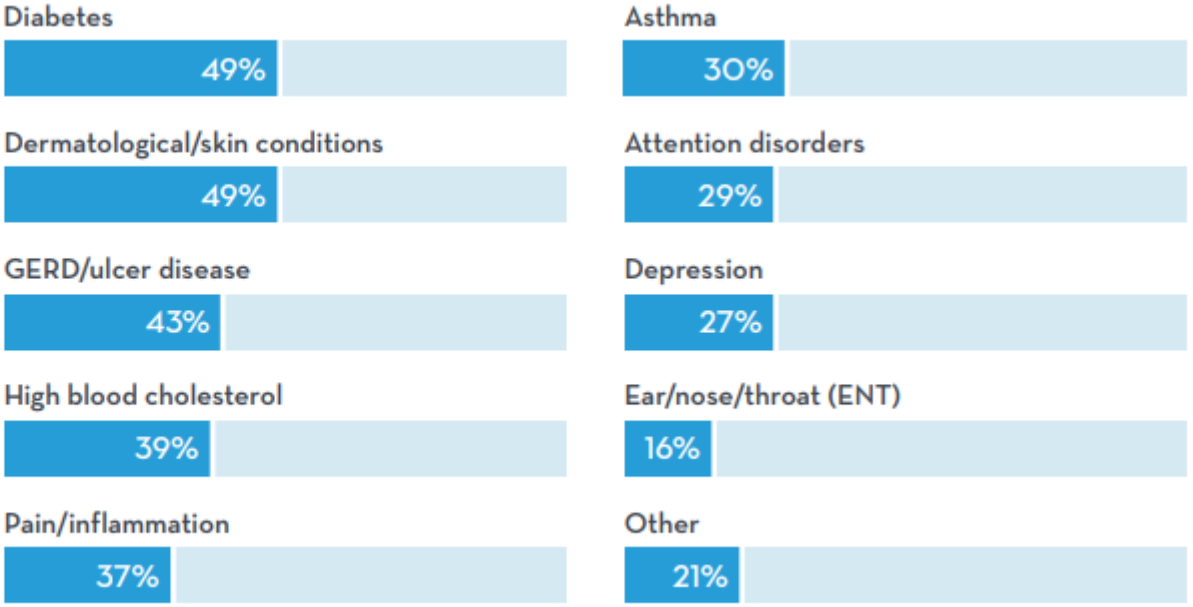
- *Ensure Pharmaceutical Care*
- *Provide Cost Savings & Value*
- *Understand Member Experience*

What to Consider in your Plan Design?



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]

Reference: [1]Pharmacy Benefit Management Institute (PBMI). 2017 Trends in Drug Benefit Design
[2.] Reference: Pharmacy Benefit Management Institute (PBMI). 2018 Specialty Drug Benefit Report

Cost Containment Tactic: Strategic Exclusions

$2,979 (Vimovo®)

or

$36 (naproxen + esomeprazole)

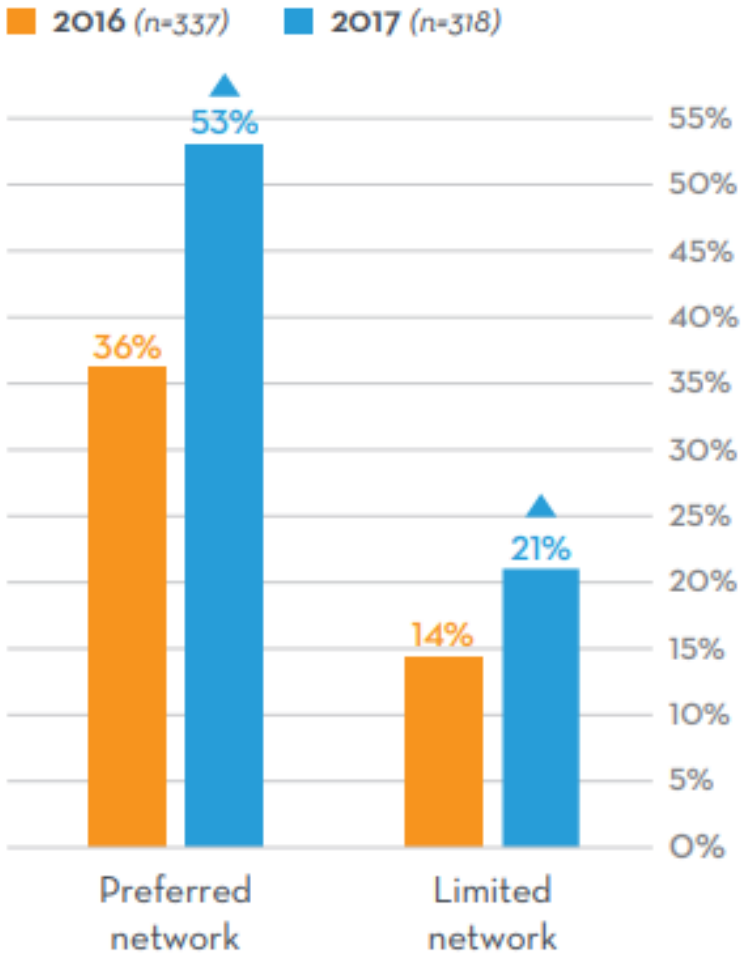
I would take the two medications from the drugstore in a heartbeat — therapeutically it makes sense….What you're paying for with [Vimovo] is the convenience. But it does seem awful pricey for that."

- 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



Reference: Pharmacy Benefit Management Institute (PBMI). 2018 Specialty Drug Benefit Report

1-2% of Americans
take a Specialty medication

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

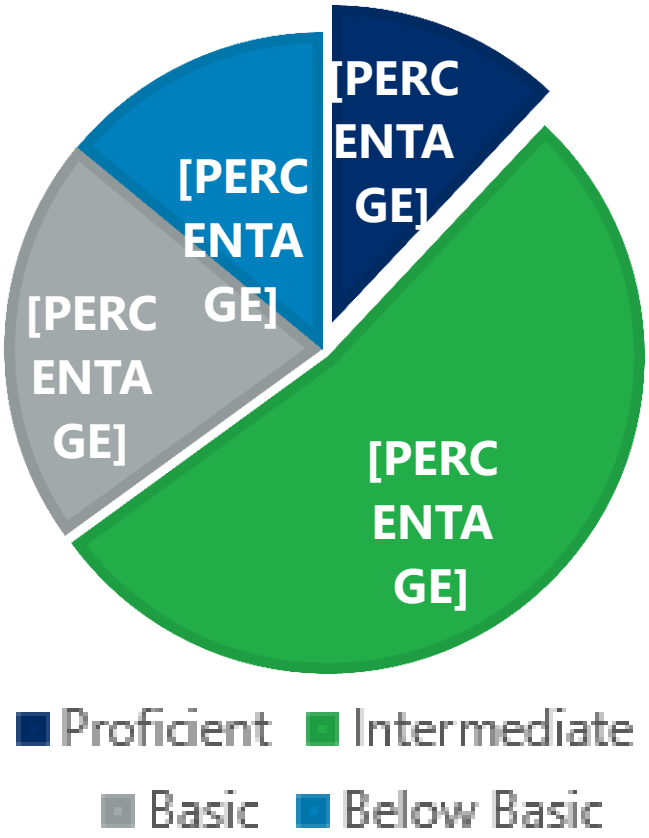
Spend your

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

RISK MANAGEMENT • EMPLOYEE BENEFITS • RETIREMENT SERVICES

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

LOCKTON®

LOCKTON.COM