

Findings on the State of the PBM Industry

**FEATURING
INFORMATION ON:**

Drug Therapy Management

CoPay Assistance Programs

Maximizing the Value
of Audits

Promoting Biosimilars

Eliminating Low Value Drugs



FEATURING THE FOLLOWING LEADING PBMS:





“As a large self-insured employer, the information we received in the **National Alliance of Healthcare Purchaser Coalitions’ PBM Quality Assessment was invaluable**, particularly as we work regularly to manage our pharmacy spend using all of the tools available to plan sponsors. We will also be able to take this information into consideration as we draft our future PBM requests for proposals.”

Keith A. Athow, CGBA, Director of Pharmacy, FSA & HSA, State of Tennessee Employee Benefits Administration

“Year over year, I would sit in a room with our PBM and listen to how great our generic drug participation was, get an inside glance at our top 25 drugs, updates on the drugs that were slated to have their patents expire, and more. These meetings were focused on the quantitative measures, not qualitative. A few years ago, I sat in on a presentation at PBGH and was presented with the National Alliance of Healthcare Purchaser Coalitions’ PBM Quality Assessment report. As a large, self-insured employer that was preparing to launch an RFP for PBMs, **the quality information in this report was beyond important**. I reviewed all of the side-by-side PBM results, studied the questions and responses from those that participated in the assessment and felt completely equipped to prepare and ask meaningful qualitative questions that would impact overall cost, satisfaction, adherence, end-user experience, and much more. This enabled our company to set a new bar of expectations and accountability for our PBM.”

Tammy Fennessey, Director of Benefits, American Eagle Outfitters, Inc.

“As a national consulting firm, we are barraged by new product innovations and vendors in the pharmacy space. Add that dynamic to the constantly evolving pharmacy market that we live in, and we do not go one week without breaking drug, legislative or benefit news. Our industry needs the invaluable, unbiased and objective expertise the National Alliance provides. **Their PBM quality report is an excellent resource for consultants and plan sponsors** to reference as they make vendor and benefit selections throughout the year.”

Michael Zucarelli, PharmD, National Pharmacy Practice Leader, CBIZ Benefits & Insurance Services, Inc.

“Most of the information available to employers about the best practices in pharmacy benefit management come from the PBM’s themselves. **This PBM assessment is a source of information we can trust**. I also appreciate that the participating pbms are willing to open their books to the survey. I use the assessment to educate myself about the factors to consider in selecting a PBM partner; and I use it to develop the questions I will ask when we put our plan out to bid. It’s the most valuable tool I’ve found.”

Janet McNichol, Human Resources Director, American Speech-Language-Hearing Association

“Effectively managing the waste out of the pharmacy benefit cost required a multi-faceted approach that constantly educates and informs purchasers in an ever evolving environment. We see constant information overload, so finding **a reference source that lays out important knowledge in a clear, concise manner that translates into actionable risk management** is critical to success for benefit managers in both choosing competent advisors and evaluating the potential solutions brought by them. The National Alliance educational articles and surveys are a terrific starting point for this.”

John R. Adler, President, ELMC Rx Solutions, LLC



Dear Reader:

We're delighted to share with you our 2020 Purchasers Guide to PBM Quality. This 2020 Report includes a cross-section of PBMs, with large and small, "carve-out" and "carve-in" organizations demonstrating their commitment to transparency by answering questions on their policies and programs.

For the first time, our report publicly identifies the Participating PBMs' comparisons in graph form for each section. We also include more educational articles than ever before, ranging from Opioid treatment to maximizing PBM Audits, and understanding CoPay Assistance programs. PBM transparency is cornering the headlines, but we'll take this opportunity to point out that there are other aspects of transparency, and that by sharing their policies, programs, and results, our participating PBMs are already demonstrating a degree of transparency with our coalitions and their members.

An important note: you, as the purchaser, bear considerable responsibility in the quality of services your PBMs deliver to you and your members.

1. Examine your benefit design to be sure it aligns with your company's goals and your members' best interest, such as supporting genetic testing when appropriate for precision medicine.
2. Require your vendors to share relevant information with the PBM, and for the PBM to reciprocate. Pharmacy data intersects with Medical, Behavioral Health, Wellness, and other vendors serving you and your members. It's important that everyone have all the available information.
3. Use this Guide to help you manage performance in your current vendors, and in future vendor selection. Invite our partner PBMs to participate in your RFPs. **Encourage/insist that your PBMs participate in the next Assessment!**

PBMs are under considerable scrutiny today, but the organizations in the 2020 Purchasers Guide to PBM Quality have demonstrated a willingness to open their actions to your scrutiny. Use it to guide discussions with your current or prospective PBM and you'll emerge better informed than ever before!

John Miller
Mike Thompson
Foong-Khwan Siew

NOTE: We would especially like to thank Elan Rubenstein, PharmD for his invaluable assistance and advice in creating the 2020 PBM Report.
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NOTE: We would especially like to thank Elan Rubenstein, PharmD for his invaluable assistance and advice in creating the 2020 PBM Report.

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Summary of Steps Purchasers Can Take

Examine the PBM Business Practices with regard to Outcomes-Based Contracts, Audit Limitations, and the PBM Drug Therapy Management program. (See page 7)

Deploy steps to promote Biosimilars. (See page 15)

Get familiar with the National Alliance Path Forward for Mental Health and Substance Use. (See page 16)

Take steps to eliminate Low Value Drugs. (See page 19)

Learn about the impact of PBM Copay Assistance policies on you and your members. (See page 23)

Participating PBMs



Cigna Pharmacy Management® is a Pharmacy Benefits Manager within a health services company. Our goal is to leverage holistic customer insights and integrated analytics to deliver a more personalized and connected customer experience and, ultimately, better outcomes and lower total medical costs.

Cigna Pharmacy Management is a business division of Cigna Health and Life Insurance Company that provides pharmacy benefit management services.

FOR MORE INFORMATION, please contact Kevin Buron at kevin.buron@cigna.com or 651-295-2078.



CVS Caremark provides a full range of pharmacy benefit management (“PBM”) solutions to clients including employers, insurance companies, unions, government employee groups, health plans, Medicare Part D plans, Managed Medicaid plans, plans offered on the public and private exchanges, throughout the United States. Our innovative tools and strategies, as well as quality client service, can help improve clinical outcomes for members, while assisting clients with managing pharmacy and overall health care costs. Our goal is to produce results for our clients and their plan members, leveraging our expertise in PBM services, including: plan design and administration, formulary management, Medicare Part D services, mail order, specialty pharmacy and infusion services, retail pharmacy network management, prescription management systems, clinical services, disease management, and medical spend management.

FOR MORE INFORMATION, please contact Christopher Wilson at [christopher.wilson4@cvshealth.com](mailto:wilson4@cvshealth.com) or 201-602-8895.



Express Scripts is a healthcare opportunity company. Our services are designed to unlock new value in pharmacy, medical, and beyond—and create better health for all. We provide a full range of integrated pharmacy and medical benefit management services that guide patients and plans toward better health by prioritizing care and increasing savings. Services include home delivery pharmacy care, specialty pharmacy care and benefit management, benefit design consultation, drug utilization review, formulary management, and medical and drug data analysis. We drive down the cost of care for employer-funded, Medicare, Medicaid, and Public Exchange plans, and create the headroom needed to keep your members’ cost-share low, access broad, and do more for those who are challenged by high out-of-pocket costs.

FOR MORE INFORMATION, please contact Vince Zwilling at vjzwilling@express-scripts.com or 314-684-6033.

Participating PBMs



MaxorPlus is a market-leading Pharmacy Benefit Manager that is pioneering the use of analytics and technology to identify intervention opportunities to engage members in new ways. The company's engagement platform, combined with a suite of clinical solutions, guides members through targeted journeys designed to address wasteful spending and sub-optimal clinical results. Performance of these programs is backed with a financial guarantee, creating a PBM solution that is member-focused, aligned with the interests of clients, and grounded in a foundation of service excellence. Maxor's PBM platform is complemented by Maxor Pharmacy Management & Consulting Services, a provider of outpatient pharmacy management solutions, and Maxor Specialty, a clinically-driven specialty pharmacy focused on rare and orphan diseases.

FOR MORE INFORMATION, please contact Eric Wan, Chief Commercial Officer by e-mail at ewan@maxor.com and/or by phone at (651) 235-4699.



Navitus Health Solutions, LLC, a division of SSM Health, is a full-service, URAC-accredited pharmacy benefit management (PBM) company. As a zerospread, full pass through PBM, Navitus aligns performance with plan sponsors' benefit goals to deliver comprehensive clinical programs and cost-saving strategies that lower drug trend and improve member health. Navitus provides its flexible services to government entities, self-funded employers, coalitions, labor organizations, third-party administrators, and health plans, including managed Medicaid, Exchanges, and Medicare Part D.

FOR MORE INFORMATION about Navitus' tangible solutions to the rising cost of health care, visit www.navitus.com or call 877-571-7500. Or, email us atsales@navitus.com.

Using the Guide

This guide is best used as a conversation guide.

Remember your last meeting with a PBM? Typically, the PBM comes prepared with reports and advice, while the client acts as a passive audience. Using this guide, you can take an active role in the meeting, and find out more about the PBM's philosophy and practices. In using the guide to steer the conversation, think of the graphs not as "scores," but as context.

Ask your PBM:



Why is your score so low? There may be good reason, and you may be able to help improve the score!



How did you score so high?



How does this performance impact your customers?



This year, we supply specific discussion suggestions in **five emerging areas**. Make sure you ask your PBM what they're doing in these areas!

Think about your goals:



Are you looking for a PBM to **manage utilization** to keep pharmaceutical spend low, or do you want to **increase medication utilization** to drive down medical expenses for the long term?



Are you looking for a **flexible PBM**? For example: Can they help with on-site pharmacy? Will they allow you to customize



your formulary, prior authorizations, or other categories? Or maybe your needs are simple, and you're just looking for an **"off-the-shelf"** solution.

Do you want to be more involved in **PBM Management**? This guide includes information on outcomes-based contracting, audits, biosimilars, and low-value drugs, and more. If you want to actively manage your PBM, be sure to ask them about their position in these areas.

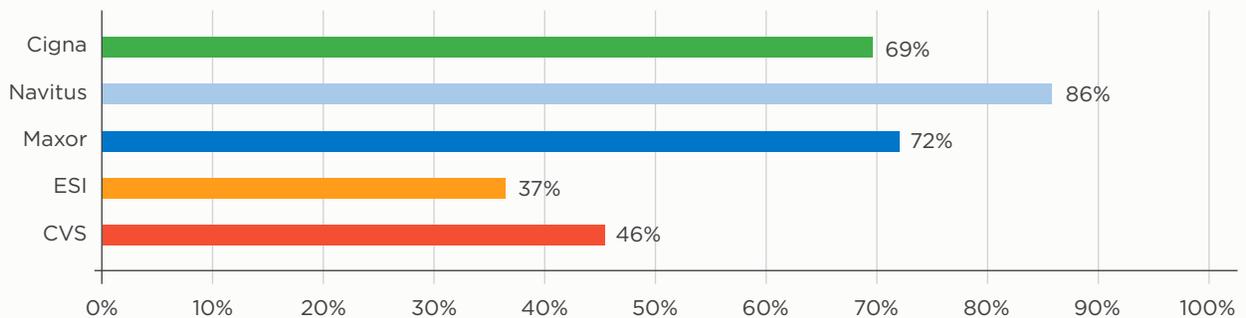
Finally, ask yourself whether you are willing to implement benefit designs, such as linking co-pay to medication adherence, participation in disease management programs, or using higher value providers, to better manage both Pharmacy and Medical spend.

Business Practices Including Transparency

The PBMs in this survey represent about 70 Million Commercial Lives. This Section Compares the PBMs' on a variety of business practice information, such as level of data analysis and reporting, ability to coordinate data with other vendors, contracting practices, copay assistance policies, and more. Of particular note in 2020:

1. PBMs have established Outcomes-based contracts around Diabetes, Cancer, Hepatitis C, Asthma, Arthritis, Oncology, Multiple Sclerosis, and more.
2. PBMs generally allow one audit per year. Navitus showed the greatest transparency into Pharmacy Network, Pharmaceutical Industry, and Site of Care contracts.
3. Based on roundtables conducted by the National Alliance, purchasers are exploring direct contracts with specialty pharmacies. Only two PBMs met all expectations in this respect.
4. Only one PBM (CVS) was URAC Accredited for Drug Therapy Management.

BUSINESS PRACTICES INCLUDING LEVEL OF TRANSPARENCY



What Can Purchasers Do?

- ▶ Purchasers should ask their PBM to disclose outcomes based contracts with manufacturers, and whether any performance guarantee funds flow to the client.
- ▶ Purchasers should examine their contracts to understand audit limitations. (See special report "Maximize the Use of Audits")
- ▶ Purchasers should explore their PBM's drug therapy management program, and urge the PBMs to obtain URAC accreditation (See Special Reports on URAC and Drug Therapy Management)

Maximize the Use of Audits

Among the many types of audits, an annual audit of PBM contract pricing guarantees is (and should be) a standard part of a plan sponsor's pharmacy benefit program. As such, what are the key variables that determine the success or failure of this audit?

There are many, including the auditor's competency in understanding and taking into account which PBM contract terms, conditions and definitions impact the audit results. This means that the work necessary for an audit's success starts with negotiating these terms, conditions, and definitions to maximize potential recoveries while staying out of disputes with the PBM.

On the other hand, there is no other area that is as rife with ambiguity as Specialty Drugs, the greatest financial pain point in pharmacy benefit costs.

There is no clearly defined classification reference for Specialty Drugs, including what is or isn't classified as such. Three example classes of drugs that may be classified as either specialty or non-specialty are HIV, transplant, and PCSK-9 medications. To complicate matters either further, there are three classes of Specialty Brand Drugs—Brands, Limited Distribution Brands, and Exclusive Distribution Brands. Each of these will

have different discount guarantee levels, typically ranging from AWP -3% to AWP -22%.

Since there is no industry standard like MediSpan for Specialty Drugs, PBMs may define them with as much as a 40% variance. Imagine the impact on a pricing guarantee if 40 out of 100 Specialty Drug claims are allowed to process at an 11% discount instead of a 22% discount. At an average cost of \$60,000 per year, a plan sponsor is paying an additional \$6,600 per year for every drug that is classified as Limited Distribution instead of non-limited distribution. It doesn't take long for this to become significant wasted dollars. This is just one example of many involving "leakage" in the reconciliation of PBM contract pricing guarantees.

The bottom line? The starting point for an effective audit is your PBM contract, so ask your pharmacy benefit consultant to review it and highlight the terms, conditions, and definitions that impact the pricing guarantees, and why they are effective in preventing an ineffective audit.

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Cigna's Integrated Specialty Management & Reporting Capabilities

Pharmaceutical spend typically accounts for one-third of an employer's overall healthcare spend (medical and pharmacy), and Specialty pharmacy is the fastest growing segment of pharmaceutical spend in the industry. According to our 2019 book of business, 50% of specialty drug spend occurs on the medical benefit. And as new therapies are

approved, treatment for an increasing number of conditions involves a combination of drugs, some of which are paid under the pharmacy benefit and some of which are paid under the medical benefit, further complicating management and potentially fragmenting patients' care.

At Cigna, we know that pharmacy benefits integrated with medical and behavioral creates a single, comprehensive view of our customers—and a single view of all the main costs for an employer’s population, particularly those with the most complex and costly conditions. Understanding comprehensive pharmacy utilization patterns, member cost share, and top therapeutic drug classes are critical to managing overall costs.

Our inclusive pharmacy reporting across benefits provides our clients with a full understanding of key trend drivers, allowing for more informed consideration of programs that would likely assist in improving their employees’ health and better managing their drug spend. Variables like demographics, illness burden, generic and specialty drug utilization, and benefit plan design greatly impact pharmacy metrics.

- ▶ Our performance based reporting with savings highlights the value of the strategies being used by our clients.
- ▶ Going beyond just prescription volumes on the pharmacy benefit, and understanding the top-therapeutic classes by total cost burden, allows us to derive important insights into the most expensive conditions in the employer population.
- ▶ Approval and denial reporting for Utilization Management shows clients important opportunities for intermediations.
- ▶ Reviewing details around the prescriptions dispensed on both benefits could open up opportunities to talk about the use of generic drugs for those that have a generic alternative, including biosimilars.

A complete view of our customers via integrated client reporting and connected internal dashboards allows for better strategy development and ability to focus intervention on where it’s needed. Without the complete picture, reporting could only show one side of the story, neglecting the direct effects one benefit can have on the other. With more than 20 years of managing care for those with complex conditions, we have the right programs and strategies that impact Specialty drug utilization and spend on both the pharmacy and medical benefits. Our Medical Specialty approach includes many strategies including a **National Injectable and Immunization Fee Schedule (NIIFS)** which controls drug costs through physician fee schedules and value-based relationships with physician partners, **Clinical and Site of Care Review** which helps ensure customers receive the most cost effective clinically appropriate therapy and in the right location, **Buy and Bill Restriction** which limits the procurement and reimbursement of specified high-cost and limited distribution drugs to Cigna-contracted specialty pharmacies when being delivered in an outpatient facility, and our innovative **Biosimilar Strategy**, which we manage across benefits to determine the lower-cost option. As of 7/1/2020, we have moved all biosimilars to biosimilar preferred, or in two instances to biosimilar co-preferred. Only one drug today is an innovator preferred product.

With integration of our pharmacy and medical data, Cigna has a complete view of an employer’s population’s total health. And this total health view lets us see where savings are possible.

Michael Sullivan, PharmD, MBA, Producer Relations, Cigna Pharmacy Management
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CVS Caremark and URAC Accreditation

CVS Caremark believes in the provision of high-quality care and access to our members. Aiming for this level of excellence, our commitment to quality is evident through the achievement of multiple third-party accreditations. The accreditation process entails a rigorous survey of documentation, processes, and performance to ensure business is conducted in line with the strictest quality standards. Survey findings are then assessed by an independent review committee who designates an accreditation status based on the organization's performance against these standards. CVS Caremark holds accreditations from The Accreditation Commission for Health Care, The Joint Commission, The National Association of Boards of Pharmacy, The National Committee for Quality Assurance, and URAC.

Specific to URAC, to achieve and maintain any one of their accreditations, organizations must comply with core standards and program-specific standards. Core standards address foundational business practices such as compliance, marketing, information systems, staff training, and quality. Program-specific standards encompass more detailed requirements for the programs or services under the scope of a given accreditation program. One such program is URAC's Drug Therapy Management (DTM) accreditation, which is comprised of multiple standards including program criteria development and review, patient identification and assessment, patient counseling and education, and outcomes reporting. The CVS Caremark DTM offering identifies and helps members with medication-related concerns such as those taking multiple medications for the same condition, those receiving medications from multiple prescribers, or those whose medication may be ineffective or causing side effects.

Clinicians evaluate the member's medications for appropriate indication, effectiveness, safety, and/or adherence. Lifestyle interventions may also be reviewed to improve health outcomes. Coordination of care and ongoing communication with other health care professionals is another key component that enables a streamlined, multi-disciplinary, patient-centric approach. DTM program components are based on current,

► Why Does Drug Therapy Management Accreditation Matter?

Organizations who achieve URAC's DTM Accreditation have demonstrated to a respected 3rd party that their program meets the highest standards, and eliminates the need for purchasers to conduct their own exhaustive evaluation. URAC is a non-profit organization that uses evidence-based measures and develops standards through inclusive engagement with a range of stakeholders. URAC's DTM Accreditation requires that organizations meet objective standards for:

- Monitoring efficacy and safety of medication therapy
- Formulating medication treatment plans
- Enhancing medication adherence through patient empowerment and education
- Tracking outcomes of medication interventions

Heather Bonome, PharmD
Director, Pharmacy, URAC

clinical, evidence-based guidelines, are reviewed and approved by the clinical oversight body, and can be combined with other CVS Caremark offerings. Achieving and maintaining URAC DTM accreditation affirms CVS Caremark as an industry leader who provides high quality care and services that aim to help control costs, improve

adherence, enhance access to care, and contribute toward positive health outcomes.

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► Drug Therapy Management: WHAT and WHY?

Drug Therapy Management (DTM) is a spectrum of patient-centered, pharmacist-provided, collaborative services that focus on medication appropriateness, effectiveness, safety, and adherence with the goal of improving health outcomes. <https://jcopp.net/wp-content/uploads/2018/05/Medication-Management-Services-Definition-and-Key-Points-Version-1.pdf>

Key features of DTM include:

- Having a trusted relationship with patients as this is critical to gain patients' input and buy-in to their medication care plan so as to facilitate patient behavior changes needed to improve health.
- Having knowledge of the local community to coordinate care with the patient's physicians and other providers. This requires gathering needed information, accessing social services, and gaining prescriber approval when medication changes are warranted. Pharmacists can participate in prescriptive authority independently or via collaborative practice agreements in most states. Pharmacists' scope of practice is determined at the state level.
- Assuring individualized patient care needs are met to include patient follow-up visits based on individual patient status.

- Assuring patients can be identified for DTM by a pharmacist, referral by a physician or other provider, and by the health plan.
- Understanding that DTM can be a component of pharmacist-provided chronic disease management services.

DTM, alone or with chronic disease management, is aimed at improving patient health outcomes by making sure medications work, control/slow the progression of chronic diseases, prevent ED visits/hospitalizations, and reduce costs. For example, a Memphis Tennessee study showed that **Pharmacist led interventions are successful in resolving 41.8% of drug therapy problems relating to indication, 31.9% related to efficacy, 35.9% related to safety, and 77.9% related to compliance. An Ohio study showed blood pressure control increased from 0% to 68.6%.**

Anne Burns, Pharmacist
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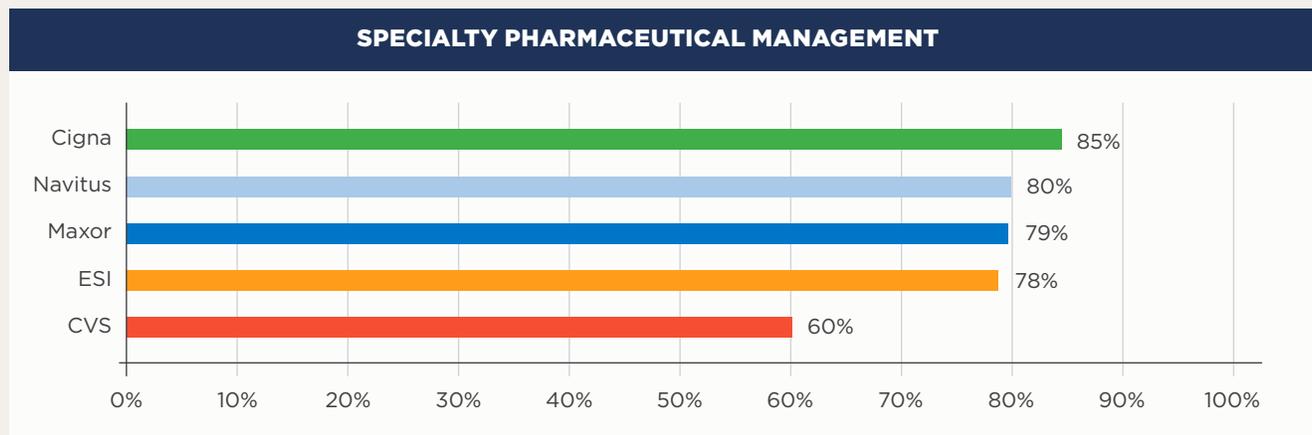
and

Gloria Sachdev, BS Pharm, PharmD, FASHP
President and CEO of the Employers' Forum
of Indiana

Specialty Pharmaceuticals Management

This section looks at access criteria, utilization strategies, and patient safety and adherence for

these very expensive drugs. Here is how our PBMs compared to National Alliance criteria:



This year, we focus on Biosimilars and Third Party Value Assessments. As with previous years, we report and track the PBM's progress in promoting Biosimilars. Also, the industry's ongoing transition from fee-for-service to value-based healthcare has created more value analysis in healthcare than ever before. Four of our five responding

PBMs reported using analyses from the Institute for Clinical and Economic Review (ICER) as an important part of their formulary decision-making. Because third-party assessments such as ICER's are so prominent, purchasers should understand the role they play in drug formularies.

See article on the next page.

► Why Are Third-Party Value Assessments Important?

With so many financial conflicts of interest throughout the pharmaceutical supply chain, purchasers often lack visibility into where they are getting good value from their drug spend, and where they are overpaying. However, independent value assessments can help. The Institute for Clinical and Economic Review (ICER) is a nonprofit research organization that 1) analyzes the safety and efficacy evidence of treatments approaching FDA approval; 2) calculates how much a new drug is likely to improve patients' lives and/or avoid other health care costs, when compared to the previous standard of care; and 3) recommends a price benchmark that aligns fairly with the treatment's clinical and economic benefits. While ICER has found approximately 30% of

the drugs it has reviewed to be cost-effective, it has also uncovered many others that would require significant discounts—sometimes as much as 90%—for their pricing to match their benefits for patients. Due to the organization's independent funding model, transparent process, and academic rigor, ICER's value assessments are now used by more than 75% of US insurers and PBMs to inform formulary decisions, coverage criteria, and price negotiations.

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Oncology Care Value Program®

Over the last decade, the number of oncology medications approved by the Food and Drug Administration (FDA) has increased significantly. These new medications offer oncologists and patients many more treatment options. However, the cost of these medications represents an ever-greater challenge to the healthcare system.

Express Scripts' Oncology Care Value Program® (OCV) is an innovative approach that represents a significant step forward for clients' management of oncology spend. The program aligns a drug's cost with its health outcomes for specific types of cancer, helping ensure members get the medications they need at the right price. The OCV program also minimizes clients' financial exposure for select oncology drugs when patients must discontinue treatment early, and plans that participate in the program are eligible to receive additional discounts on select oncology products dispensed through Accredo®, Express Scripts' specialty pharmacy.

The OCV program includes a rigorous clinical review process by a dedicated clinical team at Express Scripts and specialized care through the Oncology Therapeutic Resource CenterSM, helping patients stay on course with sometimes difficult drug regimens. Accredo oncology patients are 5% more adherent than those who fill their prescriptions at retail.

Benefits of OCV

The OCV program:

- ▶ Provides exclusive oncology management by Accredo, with specialized care from our Oncology Therapeutic Resource Center

- ▶ Dispenses prescriptions for non-participating medications only after a dedicated clinician team approves clinical documentation for each patient
- ▶ Offers all patients assistance and education from specialized clinicians and advocates
- ▶ Aligns a drug's cost with its health outcomes
- ▶ Minimizes clients' exposure when patients discontinue therapy early on select medications filled at Accredo
- ▶ Includes additional discounts when claims for select oncology medications are filled at Accredo
- ▶ Lays the foundation for future oncology savings, while adding no extra cost to clients
- ▶ Early identification of overall effectiveness of treatment through optional Pharmacogenomics testing for CML patients on Tyrosine Kinase inhibitor drugs
- ▶ Patients filling Oncology medications through Accredo have an average adherence rate of 81%
- ▶ No extra fees and the program lays the foundation for future oncology savings

When we launched the OCV program in 2016, we started with a small number of treatments and communicated we would add more over time. In 2019, the program includes discounts on drugs that represent 60% of oncology spend—up from 23% of spend in 2017.

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Biosimilars: An Opportunity for Savings

The opportunity for biosimilars adoption and savings is far greater than employers have experienced to date. The table below shows that only two PBMs responding to this survey achieved biosimilar market share of equal to or over 50% for any originator biologic.

A Johns Hopkins study for the ERISA Industry committee reports that if all employers who self-insure health coverage achieved full biosimilar substitution for just the first two biologics to have biosimilars in the US, savings could have been between \$407 million to \$1.4 billion in 2018, not including the impact of undisclosed confidential rebates.¹ Yet for most marketed biosimilars, market share is lagging expectations. In part, this reflects health plan and PBM drug formulary decisions, although it also reflects the extent of prescriber and patient confidence in the evidence of biosimilar equivalence to the reference biologic.

A recent study showed that in 2019, US health plans selected biosimilars as the preferred drug just 14% of the time, concluding that this may have been the result of pharmaceutical rebates.² Testimony during an FDA/FTC workshop in March 2020 suggested that rebates may block biosimilar formulary preference by erecting a ‘rebate wall or trap’ in which the rebate is bundled across multiple products, indications, and/or therapeutic specialties, which the new rival can’t match. The rebate wall can prevent entry of a newly approved biosimilar even if the biosimilar is offered at a lower net price. The witness said, “Biosimilars lose because they can’t get on a formulary. Patients lose because they do not have access to lower cost drugs.”³ Biosimilar manufacturers express concern that “the practice

of withholding significant rebates for both current and future patients, unless insurers agree to biosimilar exclusion contracts, effectively block coverage of biosimilars. Without such coverage, providers are reluctant to stock biosimilars.”⁴

What Can Employers Do? Deploy the five steps recommended by a recent action brief on biosimilars from the national alliance.

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https://higherlogicdownload.s3.amazonaws.com/NAHPC/3d988744-80e1-414b-8881-aa2c98621788/UploadedImages/National_Alliance_of_Healthcare_Purchaser_Coalitions_BioSimilars_FINAL.pdf

PBM PERFORMANCE FROM THE 2000 PBM ASSESSMENT

| | Biosimilar Share of Prescriptions | |
|--------------------------------------|-----------------------------------|---|
| | At or Above 50% | Below 50% |
| Zarxio : % Patients on Biosimilar | CVS, Navitus | Cigna, Express Scripts, Maxor |
| Inflectra : % Patients on Biosimilar | | CVS, Cigna, Express Scripts, Maxor, Navitus |
| Renflexis: % Patients on Biosimilar | | CVS, Cigna, Express Scripts, Maxor, Navitus |
| Retacrit: % Patients on Biosimilar | Navitus | CVS, Cigna, Express Scripts, Maxor |

1 <https://www.eric.org/wp-content/uploads/2020/03/JHU-Savings-Opportunities-for-Large-Employers.pdf>.

2 <https://www.ajmc.com/view/survey-of-commercial-health-plans-finds-few-give-biosimilars-preferred-status>.

3 Testimony of A Barlow, public interest attorney with Coalition to Protect Patient Choice, presented at FDA/FTC Workshop on a Competitive Marketplace for Biosimilars. March 9, 2020. Source: <https://www.fda.gov/media/136791/download>.

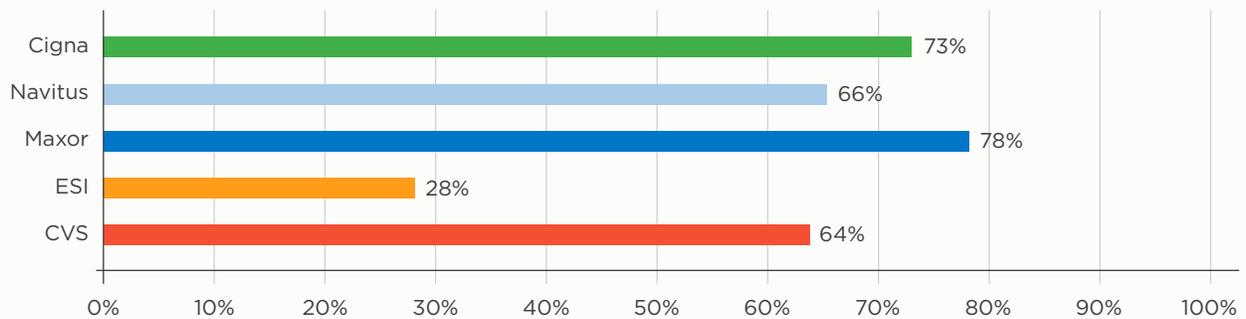
4 Testimony of L McKinley, Director of Regulatory Policy, Pfizer. Same FDA/FTC Workshop as cited earlier.

Rx Management in Chronic Condition Management

This section examines the PBMs ability to support patients with chronic disease or behavioral health (BH) issues, including adherence monitoring and coverage of BH/substance use medications and

monitoring for appropriate prescribing among clinicians. It also measures for adherence rates measured as Proportion of Days Covered for statins, hypertension and diabetes.

RX MANAGEMENT IN CHRONIC CONDITION MANAGEMENT



Managing Substance Use Medications

Within the category of Chronic Disease Management, we include Mental Health and Substance Use Disorder. In 2020, the nation's opioid epidemic has grown into a much more complicated and deadly drug overdose epidemic, in part due to ongoing challenges presented by the COVID-19 pandemic. According to the American Medical Association, more than 40 states have reported increases in opioid-related mortality as well as ongoing concerns for those with a mental illness or substance use disorder. (source: <https://www.ama-assn.org/system/files/2020-10/issue-brief-increases-in-opioid-related-overdose.pdf>) The COVID-19 pandemic—

along with its impact on the opioid epidemic—will take time to resolve. For this reason, we highlight PBM programs disclosed in the survey, which monitor for and manage substance abuse and opioid abuse—and encourage all PBMs to develop and advertise such programs.

We commend Cigna Rx for its Narcotics Therapy Management Program, which uses comprehensive medical information to form a complete view of members' medical conditions and prescription drug use, and includes a predictive model to identify members at high risk for an opioid overdose.

We also commend Navitus for its Opioid Safety Solutions program, which promotes safe, effective opioid use among members, including those with substance abuse disorder. For more information, see Navitus' article in this report.

It is important that members taking Anti-Substance Use Disorder medications are monitored to ensure adherence to treatment. We asked the PBMs if they track such patients for Adherence

WHICH PBMS MONITOR MEMBERS FOR ADHERENCE TO SUBSTANCE USE DISORDER MEDICATIONS?

| Members are Monitored | Adherence is not systematically assessed |
|-----------------------|--|
| CVS, Cigna, Maxor | Express Scripts, Navitus |

What Can Purchasers Do?

The National Alliance has launched an important initiative addressing Mental Health and Substance Use Disorder, called the Path Forward for Mental Health and Substance Use. <https://www.nationalalliancehealth.org/>

[initiatives/initiatives-national/workplace-mental-health](#)

We urge you to join us as we work to repair the dysfunctional Mental Health system.

Navitus Health Solutions

Morphine Milligram Equivalent (MME) Program

Opioid overutilization is a challenging epidemic with significant public health concerns and financial impacts. In addition to the risk of death from overdose, opioids carry a number of other health risks, including respiratory depression, confusion, drug tolerance, and physical dependence, with associated effects on quality of life and mental health.

Safe opioid use remains a top concern for Navitus. As such, we offer many proactive, concurrent, and retrospective tools. One of the most recent additions to our Opioid Safety Solutions is the Retrospective Drug Utilization Review (RDUR) Morphine Milligram Equivalent (MME) Program, which was selected as an eValue8 Innovations Award Finalist by the National Alliance of Healthcare Purchaser Coalitions. This program is based on CDC guidelines and CMS guidance.

The goal of this program is to promote safe, effective and appropriate opioid use for members by increasing prescriber awareness of overutilization and supporting care coordination. The program identifies members who have been prescribed an average of 90 MME or greater per day, excluding members with cancer or those in hospice or long-term care.

A key differentiator of this program is that we engage all opioid prescribers of identified

members and provide them with key information including the member's average daily MME and medication profile. This encourages care coordination among the PBM, the different providers, and the member. Other care coordination components are the inclusion of all prescribers, pharmacies, and potentiator medications (non-opioid drugs that enhance the effect of the opioid), along with a naloxone medication reminder.

We piloted this intervention for one client in July 2019, and expanded to all clients in November 2019. Outcomes observed have included a decrease in MME, and declines in number of opioid fills, total opioid quantity filled, and opioid day supply. We anticipate that the percentage of members prescribed greater than the recommended average daily MME will also decrease over time with continued use of the intervention.

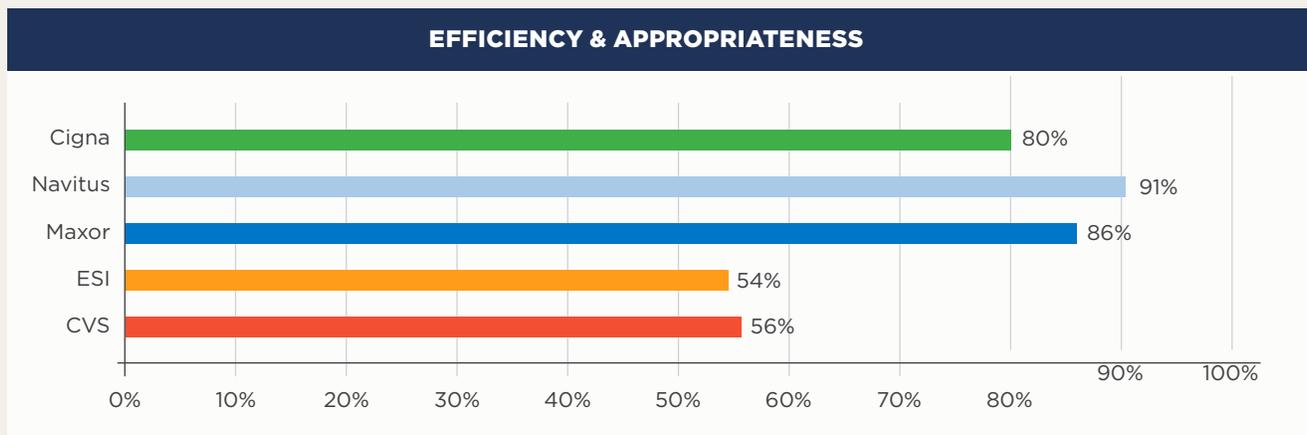
The RDUR MME Program, including reporting and outcomes tracking, is part of Navitus' RDUR Safety Suite and is included in the base administrative fee.

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Efficiency (Generic) & Appropriateness Drug Use

This section assesses the breadth and types of strategies PBMs use to assure appropriate, cost-effective utilization, including removal of low-value medications from formulary, addressing

overuse of antibiotics of concern, and programs in place to assure stabilization of medication regimens prior to filling drugs via mail service or extended retail.



Low Value Drugs

The Pacific Business Group on Health, in a Commonwealth Fund sponsored study published August 2019, found nine specific drugs to be of low clinical value compared to alternatives. Responding PBMs showed wide variation regarding coverage and tier placement of these drugs, as PBM responses ranged from one that in all cases made both coverage and tier placement a client decision, to a PBM that in all cases designated these drugs to be

non-formulary. Between these extremes, PBM respondents designated some of these preferred generic, generic or non-preferred brand. While a designation of non-preferred brand remains a disincentive to use due to a higher cost-share that typically applies, the designation of either preferred generic or generic is an incentive to use for the opposite reason.

For a table of how the PBMs treat low-value drugs, see the following page.

PBM POSITION ON LOW VALUE DRUGS

| DRUG | On Formulary | Off Formulary | No Formulary Designation (I.e., Client Decision) |
|---|-----------------------------------|---------------------------|--|
| Metformin HCl ER MOD: Formulary status on formulary with most commercial lives | Express Scripts | Cigna Maxor Navitus | CVS |
| Metformin HCl ER OSM: Formulary status on formulary with most commercial lives | Express Scripts | Cigna Maxor Navitus | CVS |
| DEXILANT: Formulary status on formulary with most commercial lives | Cigna Express Scripts | Maxor Navitus | CVS |
| DUEXIS: Formulary status on formulary with most commercial lives | Express Scripts | Cigna Maxor Navitus | CVS |
| Mometasone Furoate nasal spray: Formulary status on formulary with most commercial lives | Cigna Express Scripts Maxor | Navitus | CVS |
| ABSORICA: Formulary status on formulary with most commercial lives | Express Scripts | Cigna Maxor Navitus | CVS |
| SOLODYN: Formulary status on formulary with most commercial lives | Express Scripts | Cigna Maxor Navitus | CVS |
| Esomeprazole Magnesium: Formulary status on formulary with most commercial lives | Cigna, Express Scripts | Maxor Navitus | CVS |
| JUBLIA: Formulary status on formulary with most commercial lives | Express Scripts | Cigna Maxor Navitus | CVS |

What Can Purchasers Do?

As with biosimilars, low value drugs may be tied in rebate bundles, or otherwise financed to purchasers' disadvantage. Ask your PBM

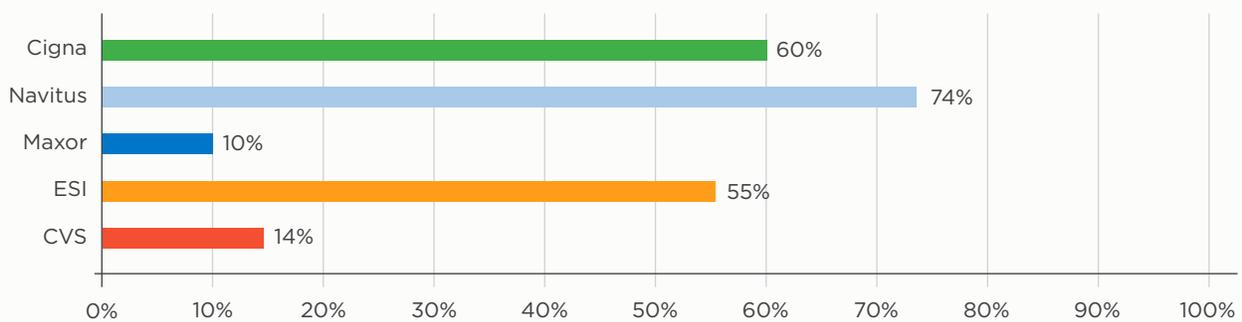
where these drugs are positioned, and seek to have them removed from your formulary.

Outpatient Quality, Safety and Adherence

This section examines the PBMs programs for monitoring and managing patients on respiratory medications. It also looks at how the PBM tracks

and manages drug conflicts, and potential opioid misuse and management of retail pharmacies.

OUTPATIENT QUALITY, SAFETY AND ADHERENCE



Recent research has shown that as many as 24% of e-prescriptions for new medications are not filled at the pharmacy. This “Primary Medication Nonadherence” (PMN or PNA), is not reflected in prescription claims data, so cannot be measured from that database, but the increasing rate of e-prescribing allows us to measure PMN, which provides opportunities for PBMs and pharmacists to intervene. The Pharmacy Quality Alliance (PQA) measure of PMN reflects a credible and consistent measure of the extent to which the first fills of prescribed medications are not dispensed. This year’s PBM survey results show that some PBMs rely on the PQA’s measure of

PMN while others measure PMN using a different metric, and still others do not measure PMN at all. A consistently applied and reliable measure of PMN is important to enable intervention, comparison and tracking of PMN over time. **Last year’s PBM report advised “Require your PBM to use the PQA measure to track primary non-fulfillment, and implement strategies to reduce it.” This year’s survey result underscores both the importance of measuring PMN and of implementing interventions to reduce it.**

For a look at how PBMs address Primary Nonfulfillment see the next page

NETWORK PHARMACIES PRIMARY NON-FULFILLMENT REQUIREMENTS

| Required to track using PQA Metrics | Required to track using other metrics | No tracking requirement |
|-------------------------------------|---------------------------------------|-------------------------|
| None | Cigna Express Scripts | CVS Maxor Navitus |

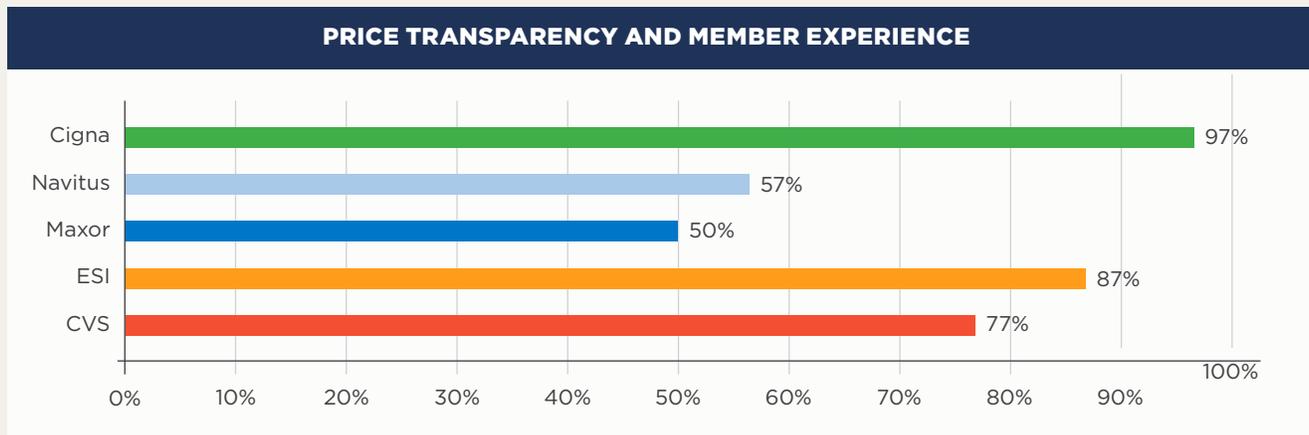
For more information: Reasons for Primary Medication Nonadherence: A Systematic Review and Metric Analysis. SQ Lee. J Manag Care Spec

Pharm. 2018;24(8):778-94. <https://www.jmcp.org/doi/pdf/10.18553/jmcp.2018.24.8.778>

Price Transparency and Member Experience

In this section, we examine the PBM’s ability to empower consumers to make decisions about drugs. This section measures the scope of the cost calculator and if members use the calculator. We look at the calculator’s content, functionality,

specificity and account management capabilities, as well as whether there was an evaluation of the calculator (unique users, completed sessions and assessment of user satisfaction)



Co-pay assistance Programs

Co-pay Assistance programs are an important policy decision for plan sponsors in the member experience with their PBM. Accordingly, we

focus on Co-pay Assistance Programs in this year’s Report.

What Can Purchasers Do?

Purchasers should ask their PBM about their copay assistance approach, and the impact to both the plan sponsor, and the member.

(See special report “Get the Most Out of CoPay Assistance Programs” on the next page)

Get the Most Out of CoPay Assistance Programs

Over the past decade, particularly with the boom in availability of specialty drug products—manufacturer copay assistance programs have become “the new norm”, for high-cost, specialty medications. Historically, manufacturer copay assistance programs were developed to allow access to potentially life-saving, or life-altering medications to those patients who had financial hardships associated with their prescription drug out of pocket expenses. In recent years, these programs have evolved in that health plans, and plan sponsors may also tap into these potential funds available.

Many health plans, PBMs, and stand-alone vendor programs have developed their own nuances and copay assistance programs. Although programs may vary in design around elements such as the number of specialty medications included, variable vs. fixed dollar amounts, drug categories included, and whether or not programs are voluntary or mandatory—there are a few fundamental tenants. Most programs include a wide range of specialty medications, and require alteration of the benefit design in some way to increase the member out-of-pocket liability, which is then charged to the manufacturer copay assistance programs.

Additionally, there are several proposed state and federal regulations that may dictate requirements for funding programs in the future; however, at this point, the majority of program designs are subject to the manufacturer’s discretion. It is

uncertain whether or not manufacturer programs will remain in effect over the next decade—but they are certainly a standard in the current PBM and prescription drug landscape.

What Can Purchasers Do?

There are several key components for plan sponsors to consider when evaluating implementation of a copay assistance program.

Some of the key considerations include, alteration of a plan design and plan documents to outline the specifics of the program (i.e. what happens in the event of a member who does not qualify for copay assistance?), inclusion criteria for the program (i.e. does the program require financial attestation from the patient?), accumulator validation (i.e. does the manufacturer assistance attribute towards the members true out-of-pocket accumulation?), and administrative fees (i.e. are there any shared savings charges?).

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Caveats of the PBM Assessment

As with any performance assessment there are possible limitations/considerations in using the results:

1. The advantage of experience

Over years, PBMs gain familiarity with the tool, and have the opportunity to refine their responses. Therefore, you could expect PBMs that have been with us for a few years to have slightly better scores.

2. Data barriers

To achieve “apples to apples” comparisons, we require use of third-party specifications, which some PBMs are not prepared to incorporate. As they use these standardized measures, their scores could improve. More on this below.

3. Business strategy decisions

The PBM may simply not include some elements in their business plan. PBMs can't work on all elements of the Assessment at one time, and some areas may not be high on their current priority list. And it could be that their customers haven't asked for some features. PBMs are not likely to expand their functions, and improve performance, until you ask them to!

4. Satisfaction

This tool does not assess satisfaction. Only experience can tell whether your representatives will be amenable, responsive, and competent.



The National Alliance of Healthcare Purchaser Coalitions is the only nonprofit, purchaser-led organization with a national and regional structure dedicated to driving health and healthcare value across the country. Our members represent more than 12,000 employers/purchasers and 45 million Americans, spending over \$300 billion annually on healthcare. Purchasers range from small and mid-sized to very large organizations, representing private and public sector, nonprofit, and union/Taft-Hartley groups.

nationalalliancehealth.org/home



THE INFORMATION IN THIS REPORT IS DRAWN FROM A SUBSET OF EVALUE8, an evidence-based tool of the National Alliance of Healthcare Purchaser Coalitions. eValue8 was created by business coalitions and employers like US Bank, Ford Motor Company, General Motors and Marriott International to define, measure and evaluate health plan performance. eValue8 asks health plans probing questions about how they manage critical processes that control costs, reduce and eliminate waste, ensure patient safety, close gaps in care and improve health and health care. Plans and purchasers receive objective scores enabling comparison of plans against regional and national benchmarks and a roadmap for improvement. As a result of face-to-face discussion of findings and roadmap, plans learn what they need to do to align their strategies with purchaser expectations to maximize the value of the health care investment and, ultimately, improve health and quality of care. eValue8 is a transformational resource to help National Alliance member coalitions lead in improving health and value of health care services in their communities by advancing value-based purchasing.

nationalalliancehealth.org/www/initiatives/initiatives-market-assessments/evalue8

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