DFWBGH Specialty Pharmacy Discussion Group

Summary Report

September 21, 2017

Managing specialty pharmacy benefits and supporting employee health needs can be a difficult balancing act for employers. DFWBGH employers are growing increasingly concerned about the year over year growth of specialty pharmacy costs, which for second year in a row, are trending more than 18% higher than the year before.

To help our employers better understand the challenges of managing specialty pharmacy benefits, DFWBGH convened a Specialty Pharmacy Discussion Group on September 21, 2017 at Las Colinas Country Club in Irving, Texas. The meeting focused on the challenges employers face of managing specialty pharmacy utilization and spend while ensuring access to quality care for employees with high cost chronic conditions.

Participants included nine DFW employers, representing large global and U.S. companies and midsize local employers. Representatives from four specialty pharmacy benefits managers (PBMs) served as Panelists. (See attached list of participants.)

The interactive discussion was facilitated by Sandra Morris, Principal, About Quality Design, LLC, and former Senior Manager of US Benefits Design at Procter & Gamble. The luncheon program was supported by AbbVie.

Prior to the meeting, DFWBGH surveyed its employer members about their specialty pharmacy benefits designs, PBM relationships and service expectations. Although there was little consistency in the responses, the research suggests a need for greater understanding of both specialty pharmacy and PBM services, which in turn could lead to more effective vendor management practices and less reliance on health plans and PBMs to manage costs and access to specialty drugs. Survey responses are available on DFWBGH's website at www.dfwbgh.org.

The following section summarizes the facilitator and the employers' comments expressed during the meeting.

Setting the Stage

Sandra Morris set the stage for a productive interactive discussion by providing background information and insights about specialty pharmacy costs, utilization, PBM marketing strategies and tactics:

- Specialty drugs are forecast to reach 50% of employers' total pharmacy spend in the next couple of years. In some cases, specialty spend is already at or above this threshold.

- Specialty drugs are used by only 2% of the population, yet account for up 40% or more of the employer's total pharmacy budget
- Many benefits managers think their PBMs effectively manage their specialty drug claims through use of their company-based specialty pharmacies, but this is not always the case. Employers sometimes find, through a RFP process, that carve-out specialty pharmacy options are able to manage claims in a more effective and cost-efficient manner, while providing their members with highly valued and individualized support and education.
- PBMs tend to be "financial driven": They started out in the 1960s as drug claim payment processors and have evolved into a complex financial entity that touches virtually every stakeholder in the supply chain. PBMs now negotiate discounts, rebates, and develop formularies, as well as serve as a dispensing entity in some cases.
- Complex Rx pathway in terms of the supply chain: Rx Manufacturer (profit)→Wholesaler/ Distributor (profit)→Pharmacy (profit) →PBM (typically greatest profit)→Employer (cost) →Patient (cost).
- Today, drug manufacturer rebates paid to PBMs and partially passed on to employers are the primary driver for selection of drugs included on a PBM's drug formulary.
- The drug manufacturer typically sells to the drug wholesaler/distributor at a 2-5% discount off Wholesale Acquisition Cost (WAC). The wholesaler/distributor uses WAC as a basis to sale to the pharmacy. The pharmacy then places a % mark-up on WAC and calls it Average Wholesale Price (AWP).
- Three major PBMs now own 80% of the market, thus reducing competition.
- PBMs are getting heat because their contracts are very complex and lack transparency concerning the costs of drugs and services.
- Here's how PBMs make their money:
    - Roughly 1/3 of the net price of a brand drug is rebate money. Only a portion of the rebate is typically passed to the employer.
    - Even when an employer has what they believe is 100% pass-through of rebates, some of the rebate money may be renamed something else and retained. Contracts should define rebates as any form of income received by the PBM from the manufacturer.
    - PBMs may reprice drugs, and charge additional fees to improve their profit margins.
    - PBMs push use of mail-order services with a focus on 90-day supply and use of brand drugs to collect rebates. When generics are used, they are typically priced higher than they are with retail use.
    - PBMs may charge pharmacies direct or indirect remuneration fees.
    - Use of "Clawbacks"
        - Example: A drug costs the pharmacy $85 and the minimum patient co-pay is $100. Pharmacy pockets the extra $15, but doesn't tell the patient about this. PBM requires the pharmacy to share up to 50% of the over-payment.
        - Pharmacy cannot tell the patient/employer that it will cost less to pay cash, as this would violate the terms of the pharmacy's contract with the PBM
        - To avoid clawbacks, your contract with the PBM should say the minimum co-pay is $XX or the pharmacy's actual cost for the drug, whichever is lower.

Advice to Employers:

Use one of the agencies specializing in Employer-PBM contracting to very carefully analyze how the PBM is administering your plan and eliminate terms that benefit the PBM at a greater level than your plan. You have a fiduciary responsibility to protect your plan's finances and eliminate waste of funds. The investment in one of these agencies is well worth it and some firms are willing to accept a percentage of first-year savings as payment.

Complete a market check of PBM services and costs (including specialty drug) at least every couple of years. This is a dynamic market and staying on top of changes will save you in the long run.

Specialty Pharmacy Panel Discussion

Panelists were asked to consider 3 questions:

- What is your role as a "middleman" in the pharmacy benefits management process?
- How do you serve the patient?
- What could be changed to include the needs of the patient and employer in the mix?

Penny Surrat, RN, MBA (ReCept Healthcare Services):

Patients frequently cannot afford the cost of specialty drugs, so they often do not adhere to their prescribed medications.

Penny and her employer built their own specialty pharmacy management company with a focus on the physician-patient relationship to improve continuity of care via provider groups and IDNs. Providers are increasingly at risk for hospitalization rates but they are often too far removed from data and high-touch resources to help them manage specialty patients.

- Specialty pharmacy managers also are data analytics companies, because they must show good outcomes through data.
- Most nurses in specialty pharmacy are the ones that hand-hold the patient through their journey and educate them on why they are taking their specialty medication.
- Specialty pharmacies should partner with both physicians and employers.
- Employers should investigate direct contracting options with specialty pharmacies to ensure better patient care and outcomes.

Sandra Morris: The costs of drugs for specialty pharmacy care that are not self-administered depend on the site of care: a hospital setting is typically much more expensive than physician offices and infusion clinics and therefore, the specialty pharmacy can and should negotiate the site of care that is best for both the patient and the employer. The specialty pharmacy can also help patients manage their co-pays and guide them to cost support programs.

Bob Wilburn (SenderraRx):

Employers have a lot of negotiating power when it comes to PBM cost management. Yet they feel like the PBM is holding them hostage, mainly because of the complexity and obscurity of the drug distribution process and money flow. (See Bullet 5 in Setting the Stage section.)

Because specialty pharmacies treat serious, high cost, low prevalence conditions, they operate on thin margins, which increases the pressure on reimbursements. Manufacturers also operate under similar pressures given that it takes between $1-2 billion to bring a new specialty drug to market and less than 20% of drugs studied actually make it to market.

The specialty pharmacy's role is to make sure that the prescribed drug ends up with the patient, but often, it never gets to the patient due to formulary obstacles or out of pocket costs. Additionally, many independent specialty pharmacies are not considered in-network, so prescriptions must be transferred to the mandated specialty pharmacy which may lead to patient confusion or Rx abandonment.

The Employer's challenge is figuring out how to manage both the cost and the choice of specialty drugs appropriate for the patient. But the PBM and/or the health plan often won't permit choice (known as "Lockout"). The solution is to let the physician choose where to send the prescription, whether to an in-network pharmacy, contracted PBM, or an independent specialty pharmacy.

Joe Carlosi (Alliance Specialty)

A Specialty Pharmacy might be owned by a PBM which is owned by a health plan (ex: Prime Therapeutics, Walgreens & BCBS Alliance), which provides greater flexibility and choice for patients and enables personal interactions with patients onsite at Walgreens stores.

Specialty pharmacy "limited drug distribution" contracts are growing. This may create a barrier to growth for some of the smaller independent specialty pharmacies and may fragment members as employers may have members using a variety of specialty pharmacies.

Employers may help by increasing communication to their employees to better understand the specialty pharmacy "flow" process such as expected time to process a specialty prescription, as well as the expected out of pocket costs of specialty medications.

Sandra Morris:

Employers are not in the business of drug procurement and thus rely on other service providers to help them manage this process.

Some manufacturers are launching new drugs with a lower WAC-based list price strategy compared to existing therapies, without significant rebates; this is in response to the growing employer interest in alternative pricing models vs. the existing focus on rebates.

According to the laws governing HSAs, all non-preventive pharmacy and medical service costs must be applied to the deductible. Drug manufacturers often offer limited-term co-pay cards as financial assistance so that members can afford their drugs. Some employers have mandated that PBMs not apply copay card amounts to member's deductibles because the members did not pay the amount of the assistance. This often leads to price sticker shock and lack of treatment compliance once the manufacturer support has run out.

There is also some concern about manufacturer co-pay assistance cards presenting discriminatory health plan practices when employers allow application of the copay assistance to the member's deductible. If all members using a specialty drug are not aware of or do not have access to the co-pay assistance cards, the employer is knowingly treating like individuals differently by allowing application of the co-pay assistance to the deductible for some but not for others. While some may argue that other providers waive co-pays, co-insurance, or deductibles, the medical carrier and the employer typically are not aware when this happens.

Co-pay assistance cards are very common and are adjudicated at the point of sale in the pharmacies and reflected in pharmacy records with the information typically being passed on to the PBMs.

Paul Godley

Regarding the ACO model and specialty pharmacy, not as much progress has been made in this area as in other areas of healthcare. BaylorScott&White has partnered with Aetna for this type of model, with 65,000 members. Aetna now has 77 contracts like this nationally with other ACOs.

ACOs are just now starting to go "at risk" for pharmacy and are seeking physicians that can be more transparent regarding costs and patient outcomes. In this model, the ACO develops its own specialty pharmacy, but doesn't mandate the use of its own specialty pharmacy. Instead, the ACO serves as an agent for the physician's office for prior authorization and patient adherence.

Most pharmacies do not have direct access to physicians, but in an ACO this is possible, and thus provides better monitoring of the patient and better service for both provider and patient.

An advantage with the ACO model is the common EHR (which most pharmacies do not have); this allows for better safety monitoring and the ability to streamline the PA process.

Interactive Discussion with Employers, Panelists and Facilitator

Following comments by the specialty pharmacy representatives, Sandra Morris engaged the employers in an interactive discussion of their concerns, challenges, and strategies related to the information shared by the panelists.

Employer #1: Our PBM has a 6-month "Lockout" for new drugs, which is typical with many other PBMs.

Sandra Morris: Lockouts are not good for patients in need of more effective and cost efficient new drugs. Employers should advocate to manufacturers and PBMs for a model less driven by negotiation of rebates, a process that is often too complex and may result in long delays in formulary placement upon a drug's approval. If a new drug lockout is in place, ask your PBM to put in an access appeal process in the interim.

Specialty drugs may be life-saving, so a value-based benefit design approach would eliminate formulary use and instead base the member's cost on the shared value of a drug between the member and the company. For example, a drug used to treat Diabetes has great value to the member and the employer

(Diabetes is typically a key driver of lost productivity and plan costs), so it would have a minimum employee co-pay or none at all. Other drugs with shared medical value such as antibiotics would have the second lowest employee co-pay. "Nice -to- have" drugs with more value to the member than the employer (i.e. drugs to treat acne, toenail fungus, etc.) would cost the member 50% of the total drug cost. Lifestyle enhancing drugs (Viagra, cosmetics, etc.) would have a 100% employee pay.

Some companies (e.g., Caterpillar) are developing their own specialty pharmacy formularies, and making case management available to all specialty pharmacy patients.

Employers also should ask their PBM to provide medication possession ratio (MPR) reporting on all classes of chronic drugs (diabetes, cholesterol, specialty medications, etc.) to determine treatment adherence and identify opportunities for interventions to improve outcomes.

Employer #2: What is the value of genetic testing? And what should an employer do if the employee tests positive for a medical risk?

Sandra Morris: Some genetic tests, such as BRACA Test for breast cancer, are valuable for assessing the risk for this high cost medical condition. Employers should have discussions with their PBMs and medical carriers to determine their current plan design concerning genetic testing for disease risk vs. efficacy of drug treatment (known as pharmacogenomic testing). These are 2 very different purposes for genetic testing. Health plans often exclude coverage for disease risk. There is proactive value to both members and employers for coverage of disease risk testing. Employers can examine aggregate data to determine if specific types of preventive screenings should be given priority in member communications.

Even if the employer chooses not to cover genetic testing for medical risk, they may want to consider making the tests available to members for a discounted group self-pay rate and also paying for the services of companies, such as MyPeople Health, to make sure the members with positive results receive on-going help to maintain appropriate screenings and decision support. This is not a common service in the market today but will be as genetic testing for disease risk becomes increasingly popular, and physicians and carriers ponder what to do about patients that are not currently ill but have high risks of becoming ill from diseases such as cancers.

It's very important to make sure your medical plan is covering pharmacogenomic testing. PBM prior authorization protocols should require this testing prior to beginning treatment. Physicians sometimes skip the testing because they think it will not be covered by the member's insurance plan

Employer #3: Our company has implemented a "split-fill" program for the first month of a prescribed specialty drug as a way to "test" the efficacy of a prescribed drug treatment.

Employer #1: "Clawback" doesn't apply to "percent co-insurance" plan designs with no minimum co-pay. They do apply to plans with just a prescription co-pay or a co-insurance and a minimum employee out-of-pocket cost.

Sandra Morris: Employers should talk to their lobbyists about supporting removal of HSA requirements to apply prescription drug costs to the deductible. With HRA plans, there is no such

requirement which helps to remove cost as a driver of patient prescription abandonment. Employers may want to consider putting in an HAS and a HRA to provide support to chronically ill members.

Sandra Morris closed the discussion by reminding the employers to be aware of the differences in site of care costs for specialty drugs that cannot be self-administered. Hospital outpatient services are typically high cost while free standing infusion centers and physician offices tend to be lower in cost. The PBM/Specialty Pharmacy should be steering members to the lower cost sites of care as part of the prior authorization protocol.

Sandra also suggested that HR Managers [or Coalitions] consider convening a panel of employees on specialty medications to get feedback on pain points and discuss ways to improve service and utilization of medications and support programs.

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DFWBGH would like to thank all participants--employers, specialty pharmacy representatives and Facilitator--for their valuable contributions to this productive group learning experience. A special thanks to AbbVie for its generous support of this important educational program.

DFWBGH Specialty Pharmacy Discussion Group Participants

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