EMPLOYERS HEALTH®

SUMMER 2021
A publication of Employers Health Coalition, Inc.

EHCONNECT

CLIENT SPOTLIGHT

TQL
TOTAL QUALITY LOGISTICS

IN THIS ISSUE

elixir
CRAFTED Rx SOLUTIONS

The Cure to Your Pharmacy Benefits Challenges

Crafted pharmacy benefits solutions for Employers Health members

Elixir, formerly EnvisionRxOptions, offers an alternative to traditional pharmacy benefit management. Owning all of the functions to optimize the full pharmacy care experience and maintaining both NCQA and URAC accreditations, we are able to provide you with the flexibility and control you want, including:

- Pricing options, from traditional to our innovative pass-through pricing model that passes all negotiated discounts and rebates to you
- Condition-focused approach to specialty medications with individualized care to optimize outcomes
- A digital-first, health-centric member experience to help members improve their whole-being health
- A consultative partnership, with the ability to offer you the solutions you want and need

To learn more about our solutions, call Employers Health at 330-305-6565 or visit elixirsolutions.com.

CONTENTS

UPCOMING EVENTS

2021

AUGUST

10 Sponsor Spotlight: Delta Dental

SEPTEMBER

23 Sponsor Spotlight: Novo Nordisk

30 Sponsor Spotlight: ComPsych

NOVEMBER

18 Employers Health Annual Meeting

2022

MARCH

16 Pharmacy Benefits Conference

MAY

18 Innovations in Benefits

Did you miss Summer Benefits Camp?
Go to employershealthco.com/webinar-recordings
to view the recordings.

MESSAGE FROM CHRIS

Christopher V. Goff
CEO & General Counsel

WELCOME TO OUR NEWEST CLIENTS

ITS Conglobal

Encompass Health

Pinal County, AZ

I hope this issue of EH Connect finds you enjoying your summer and reconnecting with family and friends as COVID-19 restrictions are eased in most states. The team at Employers Health moved from a remote work environment back into our offices at the beginning of May and have enjoyed the ability to once again work and collaborate with one another. We look forward to meeting in person with each of you as your state, local and organizational rules allow.

While we don't set a single theme for our authors, each article in this issue can be tied back to price, and particularly how employers are impacted by increasing health care costs. The article by Clinical Advisor, Hannah Whitesel, on page three discusses employers' coverage of infertility treatments. In a recent Employers Health benchmarking survey, respondents ranked price as the no. 1 barrier to providing infertility benefit coverage. The article on page seven provides an overview of the various specialty copay assistance programs and how they can be utilized to reduce overall specialty spend for both plans and plan participants. Finally, "Generic Drug Pricing: Why all the Fuss?" on page 11 provides a primer on the various ways generic drugs can be priced and state efforts to regulate these prices and the ultimate impact on self-funded plan sponsors.

Employers Health was founded by business leaders looking to maximize the value of each health care dollar spent. Today, our team of clinical pharmacists, data analysts, lawyers and employee benefits experts keep a watchful eye on the latest developments in the industry. The team uses its knowledge and experience to shape strategies, develop trend-lowering solutions and share best practices with benefits professionals and their consultants through articles in this magazine, educational webinars, podcasts, one-on-one discussions and more. As it has always been, our purpose is to provide resources, tools and advice to help plan sponsors deliver high-quality health care benefits at a sustainable cost.

Today's employers find themselves in a difficult position to effectively manage their health care costs. The rising prices of medical procedures and specialty pharmaceuticals are compounded by increased utilization from an ever-aging population with more conditions and, to the credit of medical innovation, more treatment options for those conditions. Consolidation among the players in the supply chain, from hospitals to pharmaceutical companies to PBMs and insurers, limits employer choice and drives even higher prices. Regulatory efforts, particularly at the state level, seem more interested in ways to reallocate profit among the supply chain versus bringing down the prices that hamper so many employers and the individuals on their plans.

More employers are figuring out that the most effective way to combat these market forces is to work collaboratively through Employers Health. After several years of record-setting growth, the 2021 selling season is shaping up to be one of our best. To date, we've secured 15 new clients accounting for more than $100 million in pharmacy spend. We're also adding new resources to support this growth. Courtney Keefe and Tu Doan joined our clinical pharmacy team on July 1 and we're also adding new positions on our account management, sales and marketing teams as well.

BEST EMPLOYERS IN OHIO | 2021

CRAIN'S CLEVELAND BUSINESS

Employers Health was recently recognized as one of the Best Employers in Ohio by Crain's Cleveland Business and Best Companies Group. We are proud to have been ranked number three of 22 small to medium employers in Ohio.

The program is open to all publicly and privately held organizations, either for-profit or not-for-profit. To be eligible for consideration, organizations must have at least 15 employees working in the state. Winning organizations participate in a two-part evaluation process. First, the employer completes an in-depth questionnaire to collect information about its benefits. The second portion solicits employee feedback via a company-wide survey which accounts for 75% of the organization's overall score. The results are then analyzed by Best Companies Group to determine the winners and their rank.

> *"The main goal of Best Employers in Ohio is to create an environment where employees love to come to work,"*

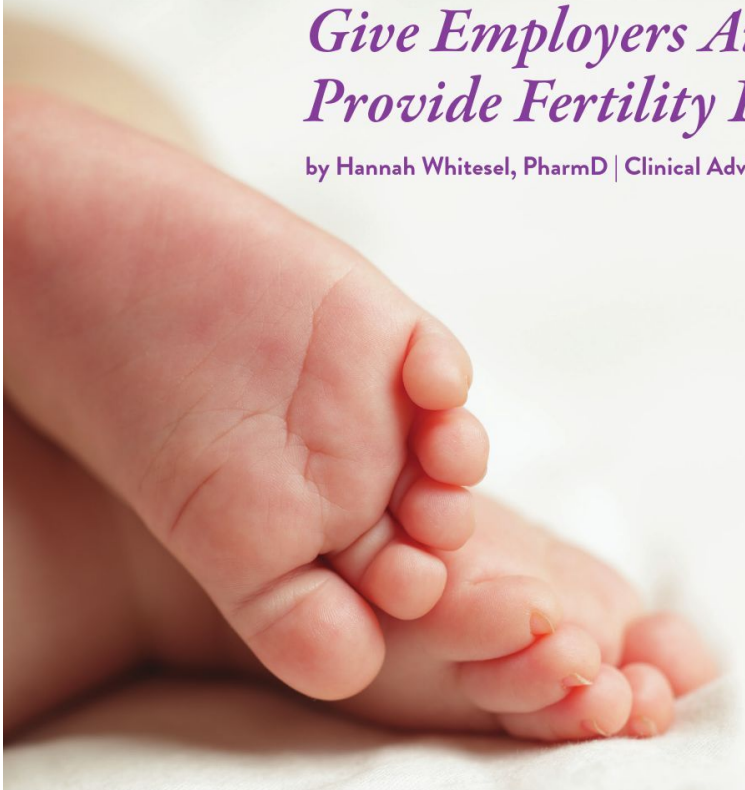
says Peter Burke, president and co-founder of Best Companies Group. The Harrisburg, PA-based employer research and survey provider managed the registration process, conducted the two-part survey, evaluated the data and ultimately chose the employers on the list.

To learn more about the Best Employers in Ohio program and this year's recipients visit www.BestEmployersOH.com.

Baby Steps to Fertility Coverage

How Advances in Treatments may Give Employers Another Reason to Provide Fertility Benefits

by Hannah Whitesel, PharmD | Clinical Advisor



As an optional coverage decision, fertility benefits are often excluded in an attempt to minimize health care spend. However, the implications of excluding fertility benefits go beyond the initial perceived cost avoidance.

The definition of infertility is the inability to achieve pregnancy after one year of unprotected intercourse, if not sooner under certain circumstances.[1] The prevalence within the U.S. may be underappreciated, as one-in-eight couples, or roughly 15% meet this diagnosis.[2] Infertility is a diagnosis many employees may face, and employer backing could drastically improve their journey towards successful treatment. While many factors go into a decision to design or omit a fertility benefit, this article will detail considerations for benefits and human resources teams when designing an ideal fertility benefit plan.

Infertility is a recognized disease state with its own diagnostic ICD codes. Nonetheless, the perception and treatment of infertility as a clinical diagnosis within the self-insured market has been slow to catch on. Recent data suggest that infertility is here to stay, and it is likely growing. Trends within the past few years have shown individuals are electively waiting longer to have children; and with age being the most important factor in determining fertility rates, infertility is becoming more and more common.[3] Nationally reported statistics for fertility services, especially in vitro fertilization (IVF), appear to reflect this trend. IVF is one of the most costly and complex forms of assistive reproductive therapy; where the egg and sperm are gathered, fertilized in a laboratory setting and the resulting embryo is transferred into the mother. From 2015-2019, there has been over a 20% increase in these IVF cycles[4] with 2019 preliminary data suggesting that more infants are being born through IVF than ever before.

Fertility and the Workplace: HR Advantage?

Results from a 2015 national survey found the top reasons to postpone starting a family included being able to focus on a career and child-related expenses.[5] This is emphasized with drops in fertility rates in response to widespread financial hardship such as the great depression or the 2008 economic crisis. Proof of how impactful the workplace can be on family planning, whether an employer is aware of it or not; the ability to perform in a career is the most commonly reported reason to postpone starting a family.[5] Even indirect employee consequences occur due to managing their health and diagnosis as well as the confusing course of treatment. These concerns are frequently echoed in decision making when seeking new employment.

A robust benefits package is a known tactic to sway new hires towards a new employer. The inclusion of fertility benefits is quickly gaining traction within this practice. In fact, 68% of employees are willing to change jobs entirely to obtain this perk.[5] These trends are reflected within the 2020 Employers Health Infertility Benefits Benchmarking Survey results, as the two biggest perceived advantages to coverage by those who include it are recruiting and retaining skilled employees and recognition as a family-friendly company FIGURE 1.

FIGURE 1

EMPLOYER RANKINGS OF REASONING FOR PROVIDING FERTILITY BENEFITS:

1. Recruiting and retaining skilled employees
2. Being recognized as a family-friendly company and to generate positive public relations
3. Reducing the risk of multiple pregnancies and unnecessary neonatal ICU costs
4. Enabling access to quality infertility care that is effective and appropriate

The advantage of using infertility benefits for employee recruitment and retention is especially beneficial for those who have a history of infertility, as reported statistics show the majority feel that infertility is more stressful than traumatic events such as unemployment or divorce.[5] In addition, the inclusion of fertility benefits can reinforce company values and support employee loyalty and longevity. This is notably seen in increasingly competitive industries; with many Fortune 500 companies, such as Bank of America and Facebook, providing a fertility benefit. As infertility projections are only expected to increase in the next few years, employee standards for adequate benefits are likely to follow.

Cost versus Clinical Rationale

It is no secret that many fertility treatments can quickly rack up health care spend in the tens of thousands. These costs, however, do not occur within a vacuum. There are many downstream consequences of either the decision to include fertility benefits or not. Perhaps counterintuitively, a growing body of evidence highlights that a robust fertility benefit has the potential to offset medical costs by reducing high-risk pregnancies. Even though IVF cycles are not cheap, inpatient hospital stays, notably those in the neonatal intensive care unit (NICU), can easily exceed the entire cost of a fertility treatment.

With the average cost of IVF ranging by state from $9,000 to $16,000 per cycle, the high cost of IVF can incentivize poor clinical practices that can quickly rack up medical benefit dollars unbeknownst to the payer. If a member is paying for IVF out of pocket, they will be much more inclined to take unnecessary risks such as using more than one embryo at a time for the procedure to statistically increase their chances of conceiving. Even though this may appear to be positive on the surface, pregnancies with twins or more, are innately high risk. Pregnancies with multiples are more likely to be born prematurely or with a low birth weight. These complications can incur almost five times the healthcare costs when compared to all births, and over ten times the cost when compared to uncomplicated births. According to a 2013 study, this contributes to an additional $49,760 per premature or low birth weight newborn on average.[6] An employer-sponsored benefit could easily address this by requiring elective single embryo transfers (eSET) when medically appropriate, or by covering multiple IVF cycles, therefore reducing the fear of not conceiving on the first try.

Another IVF option, yet more controversial, can produce a dramatic impact on pharmacy benefit spend as well. The practice of preimplantation genetic testing (PGT) can be added to any IVF treatment. PGT screens embryos for genetic disorders while they are still in a lab before the procedure. Screening can detect over 500 genetic conditions including pharmacy benefit heavy hitters such as cystic fibrosis, spinal muscular atrophy and hemophilia. Though the potential benefit can be substantial, PGT is not required within an IVF regimen. So if costs are directing the course of treatment, PGT may never be considered. Even with these factors playing a role, only one-third of fertility-covering respondents in our survey reported including PGT services. For employers, providing PGT coverage may be beneficial in the long term for the plan as well as their members.

Employers Health Infertility Study Results

A fertility coverage survey was distributed at the end of 2020 providing insight into fertility practices currently utilized within our coalition. Questions explored fertility trends, services provided and different opinions and management strategies endorsed by clients. A subsequent data pull was conducted comparing utilization trends based upon survey responses. Within the survey responses received, roughly half included fertility benefits within their plan. Of those covering fertility, the most common management strategy was through lifetime monetary caps limiting employer contributions. The amounts of these caps varied significantly between plan sponsors, starting at $750 and going up to $60,000, with the average falling around $25,000 per member. Interestingly, around 30% of respondents reported no restrictions managing coverage. This is a perfect example of how there is no one-size-fits-all fertility benefit.

FIGURE 2

% MALE UTLIZATION OF PHARMACY CLAIMS WHEN IVF IS COVERED VS. NOT COVERED

Utilization metrics were compared between two groups, those who cover IVF and those who do not. A poignant finding was plans that cover IVF had much more male utilization of products than those who did not (34% versus 25%). Since approximately 40% of infertile couples have a male factor as the sole or contributing cause of infertility, this difference can be meaningful. The suggestion that IVF coverage may encourage more male treatment is substantial, as assessing and treating both partners is imperative for success **FIGURE 2**.

In addition, IVF covering clients had 26% less utilization of the oral infertility medication clomiphene. This is notable as the manufacturer labeling reports 8% of all clomiphene-induced births are multiples, with no way to mitigate that risk. Providing coverage of more advanced treatments, such as IVF, appears to reduce the utilization of clomiphene and its subsequent multiple-birth rate **FIGURE 3**.

Overall, the quality of fertility treatments have drastically improved in the past 20 years. It is time that insurers take advantage of the industry's progression and encourage the use of these increasingly safe and effective treatments.

In conclusion, even providing a minimal fertility benefit can make a major difference among employee satisfaction, recruitment and retention. This impact is likely to grow in the future as infertility rates continue to rise. Before deciding on fertility benefits, consider requesting medical benefit data for the health plan. Inconspicuous medical spend for childbirth and neonatal care may come to light and drastically influence the financial appraisal of the benefit. Ultimately, ensure that elections are well-informed and reflect on population parameters such as average member age, employee turnover rate and total lives covered. An effectively designed plan can direct members towards high-quality care while tailoring cost management strategies to the appetite of the plan sponsor.

FIGURE 3

	IVF Non-Covering Utlilization	IVF Covering Utlilization
Clomiphene	69%	43%
Gonadotropins	22%	36%
Gonadotropin Releasing Hormone Antagonist	9%	21%

REFERENCES

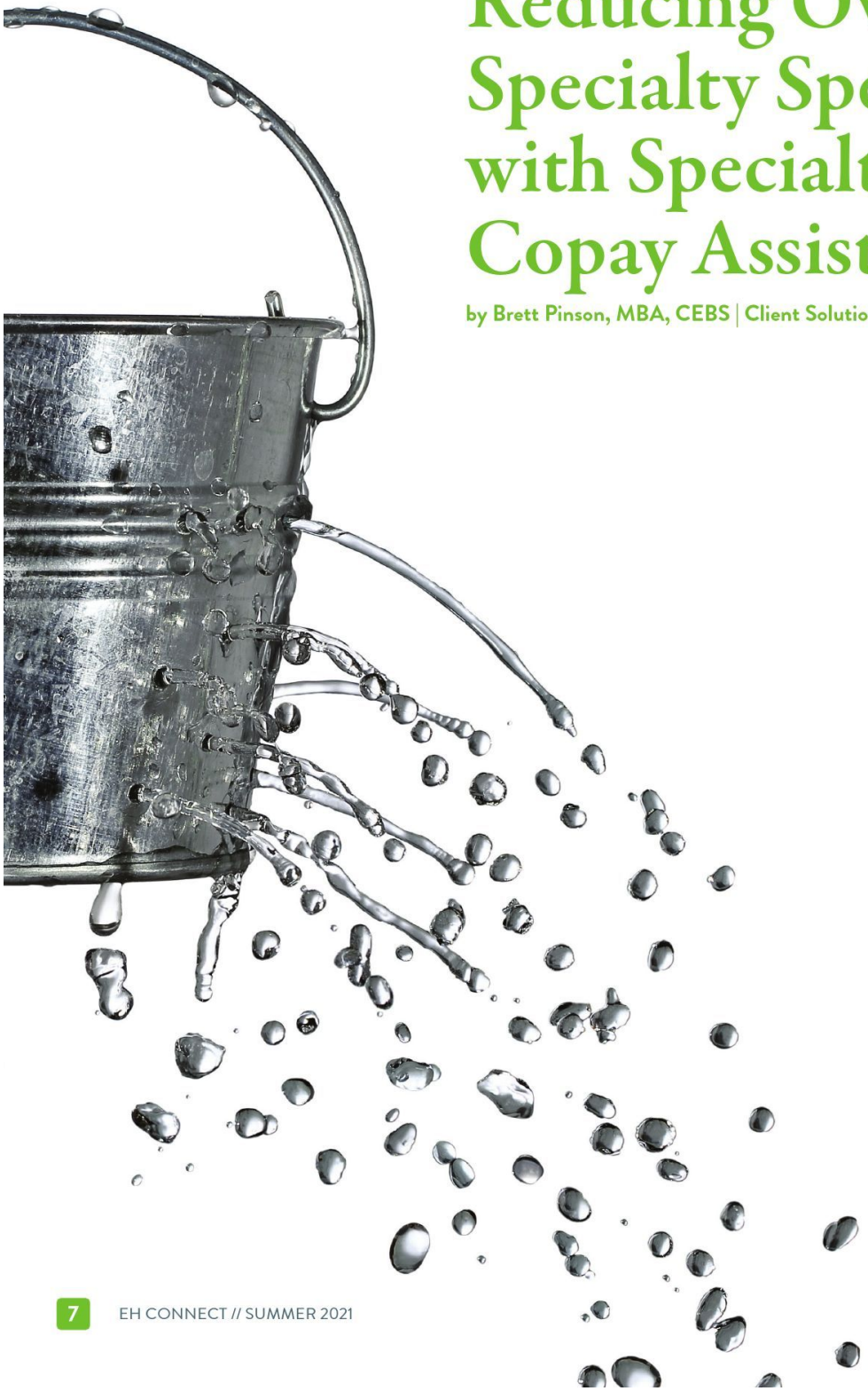
1. World Health Organization. Infertility definitions and terminology. http://www.who.int/reproductivehealth/topics/infertility/definitions/en/. Accessed March 4, 2021
2. Jarow, Jonathan, et al. "Optimal Evaluation of the Infertile Male." Optimal Evaluation of the Infertile Male – American Urological Association, American Urological Association, 2011, www.auanet.org/guidelines/male-infertility-optimal-evaluation-best-practice-statement. Accessed March 8, 2021
3. Ely DM, Hamilton BE. Trends in fertility and mother's age at first birth among rural and metropolitan counties: United States, 2007–2017. NCHS Data Brief, no 323. Hyattsville, MD: National Center for Health Statistics. 2018. Accessed March 8, 2021
4. Centers for Disease Control and Prevention: Assisted Reproductive Technology (ART). Assisted Reproductive Technology (ART) | Reproductive Health | CDC. Accessed May 7, 2021
5. RMANJ: Infertility In America Report, http://www.rmanj.com/wp-content/uploads/2015/04/RMANJ_Infertility-In-America-SurveyReport-_04152015.pdf. Accessed March 8, 2021
6. March of Dimes. Premature birth: The financial impact on business. 2013. https://www.marchofdimes.org/materials/premature-birth-the-financial-impact-on-business.pdf. Accessed April 9, 2021

TO LEARN MORE CONTACT:

Hannah Whitesel, PharmD
hwhitesel@employershealthco.com

Reducing Overall Specialty Spend with Specialty Copay Assistance

by Brett Pinson, MBA, CEBS | Client Solutions Specialist



How can plan sponsors reduce overall specialty spend within their plans? This is a common question directed to Employers Health and its PBM providers. Rightly so, specialty continues to be a focal point throughout Employers Health's book of business. Specialty increased by roughly $54 billion from 2011-2016 and is now projected to represent close to 50% of total prescription drug spend.[1] As a result, PBMs have developed new initiatives to provide strategies that reduce both plan sponsor and plan participant specialty spend.

One strategy involves the evolution of specialty copay assistance or manufacturer copay cards. Outlined below are the different copay assistance opportunities available to plan sponsors and how both employers and their participants can benefit from these opportunities to save on their pharmacy spend.

What is Specialty Copay Assistance?

Manufacturer copay assistance helps patients afford higher cost specialty brand name prescription drugs by reducing their out-of-pocket spend. When using copay assistance, the drug manufacturer covers part or all of the cost a member is responsible for through either a copay, coinsurance or a deductible. Consider a scenario where a specialty brand drug is approximately $5,000 per 30 days' supply. The member's benefits plan has a $250 copay on all specialty brands. A copay assistance program is available through the drug manufacturer that has a $4,500 annual value maximum and a required $50 per script payment by the member. In this instance, the coupon card would cover $200 of the $250 member copay, thus the member would only pay $50 out-of-pocket (OOP) for the member's $5,000 specialty brand drug per month. Through this specialty copay assistance, or copay coupon, the member is saving $2,400 annually.

What are Specialty Copay Accumulators?

Because of the significantly lower payments incurred by members due to copay coupons, plans have shifted their focus to an approach called "accumulator adjustment." The PBM's approach ensures members are not falsely, or prematurely, hitting their deductibles early in the plan year. Going back to the specialty brand example, if a copay coupon lowers a member's out-of-pocket payment to just $50, then only that $50 amount would reflect toward the member's maximum out-of-pocket (MOOP) and deductible; not the total member cost share amount of $250 which would take place without the accumulation approach. By doing so, the spend is balanced between the member and plan sponsor by giving credit for only what the participant has actually paid.

Copay accumulation has been a popular program amongst Employers Health clients, with just under 60% of our CVS book of business utilizing this strategy. To help plan sponsors and their participants battle rising health care costs, many PBMs have launched new copay optimization strategies, offering the potential for greater savings for plan sponsors who choose to participate.

What is Copay Optimization?

Based on a recent PBM study, it was determined that more than 90% of specialty brand prescription fills have a copay card program available. To ensure these coupons are being fully utilized, many PBMs have offered new copay optimization initiatives to maximize savings from manufacturer copay cards and reduce both plan and participant costs. There are different ways PBMs approach these copay optimization strategies. Whether it is an approach, such as PrudentRx, that eliminates a patient's out-of-pocket obligations altogether, or a variable copay arrangement, where copays are adjusted to maximize the value of the copay coupon cards, the overall goal of copay optimization programs is to reduce employer spend while simultaneously utilizing copay coupons to reduce the plan participant's cost. Using the scenario covered in the section, "What is Specialty Copay Assistance?," the optimization strategy would seek to maximize the full $4,500 annual coupon value available. To ensure this takes place, the member's copay would be adjusted from $250 to $425 per month for this specific drug. This allows the copay assistance coupon to cover $375 of the $425 copay after the required $50 member share. While the copay amount does change, there is no impact on the member's actual out-of-pocket responsibility. The member paid $50 with the coupon card prior to the adjustment and they will continue to pay $50 after the adjustment. By increasing the copay to $425 and maximizing the annual $4,500 coupon value, the plan saves the additional $2,100 available annually when compared to the

standard copay assistance approach that only utilized $2,400 of the total coupon value.

Thus far, Employers Health's book of business has shown an average savings of 25% in gross specialty spend for clients who have implemented copay optimization programs. Due to the significant cost savings, client adoption has increased as well. More than 50 clients currently participate in these strategies, and we anticipate adoption of these offerings by Employers Health clients will continue to increase.

Next Steps

Specialty is indeed growing and changing rapidly. Of the $1.5 billion in overall drug spend in Employers Health's book of business in 2020, roughly 47% of total spend was specialty. Employers Health works proactively with its pharmacy benefit managers to be innovative in promoting different strategies to help plan sponsors anticipate trends and control spend. It should be noted, there are various legislative and regulatory initiatives that may impact the effectiveness and longevity of these programs.

So, how can plan sponsors help reduce specialty spend? Specialty copay assistance programs, whether a copay accumulation or optimization approach, are options to consider. There are real savings available and plan sponsors should take advantage of the ability to incorporate these opportunities to save on their pharmacy spend. Reach out to your Employers Health client solutions or business development executive for more information on these specialty offerings.

REFERENCES

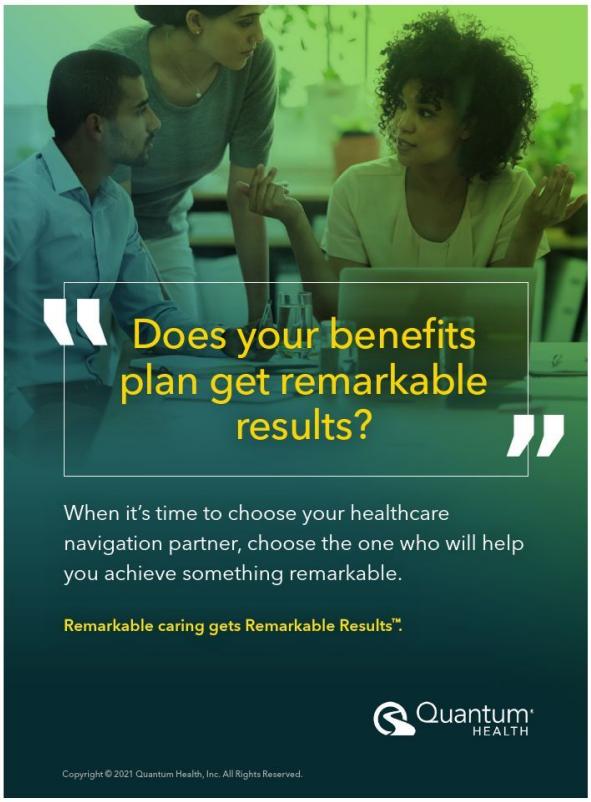
1. https://www.admere.com/amr-blog/the-rising-costs-of-specialty-drugs#:~:text=Spending%20on%20specialty%20medicines%20increased,U.S.%20household%20income%20that%20year

TO LEARN MORE CONTACT:

Brett Pinson, MBA, CEBS
bpinson@employershealthco.com


HOW CAN WE DRIVE BETTER HEALTH CARE CHOICES?
HOW
WE KNOW HOW. WE ARE THE HOW.
At OptumRx, we arm you with insights and options
that give you more control over pharmacy costs and care.
OPTUM.COM/OPTUMRX
OPTUMRx
© 2021 OPTUM, INC. ALL RIGHTS RESERVED.


When it comes to obesity, support employees with The Weigh Forward
Losing weight and keeping it off is hard because of how my body reacts to weight loss. Making a weight-management plan with my healthcare provider is important to my success— as is having coverage for an anti-obesity medicine because they can help me lose weight and maintain it!
Employers play an important role in providing access to treatment for employees with obesity
Novo Nordisk is a registered trademark of Novo Nordisk A/S.
© 2021 Novo Nordisk All rights reserved. US21OB00101 March 2021


Does your benefits plan get remarkable results?
When it's time to choose your healthcare navigation partner, choose the one who will help you achieve something remarkable.
Remarkable caring gets Remarkable Results™.
Quantum HEALTH
Copyright © 2021 Quantum Health, Inc. All Rights Reserved.

Generic Drug Pricing

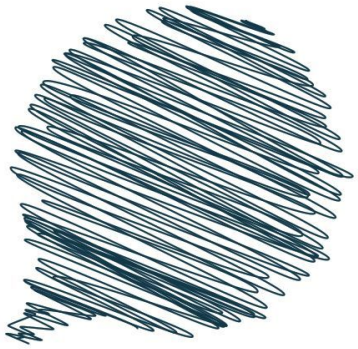
Why all the Fuss?

by Garrett Brown, J.D., CEBS | Assistant General Counsel

As covered in past communications, a myriad of market forces impact generic drug pricing and there are many "best practices," depending on who you ask. Some entities have identified alternative approaches or cost limits and others have worked to maintain the status quo. This tension has led to many states taking steps to address the pricing of these medications and the success thereof may ultimately drive changes at the federal level. This article will provide context on the role of generic medications, a refresher on current pricing methodology and present some of the policy proposals that are already impacting some self-funded plans.

How Generic Pricing Works

Generic pricing is certainly important to many stakeholders, although it typically does not beat out headlines related to expensive brand drugs, rebates and the delta between the list price of a brand drug and the net price after any associated rebate. Passionate stakeholders typically approach generic drug pricing from frustrations



around variability in pricing and pricing dynamics related to volume and market share.

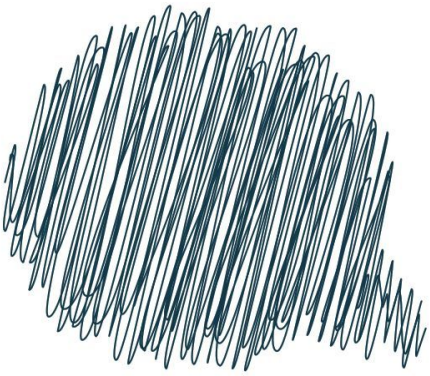
For many plan sponsors, generic drugs can represent upwards of 90% of the total prescriptions and about 25% of the total discounted drug spend. These proportions can vary significantly based on client size and specialty utilization within a given plan. For example, smaller plans may have a few specialty medications that drive a disproportionate amount of spend and thereby make the generic cost a smaller percentage of overall drug cost.

With so much of a plan's prescription volume being dispensed as generics, it is more likely that price volatility can result in participant disruption. Generic drug prices can vary between pharmacies if one pharmacy has a low-cost generic program, similar to the $4 generic offer Walmart introduced in 2006. Price differences occur when the plan changes PBMs, as the MAC lists utilized by the different PBMs will generate margin for the PBM on different generic products. Pricing differences can also be exposed through third-party tools like GoodRx, which can deliver lower prices at specific pharmacies for specific medications when used outside of the sponsored benefit plan.

These areas of price variability and volatility are exasperated when participants are in the deductible phase of their plan and paying the full price of the medication.

Generic medications are prevalent and typically have lower prices than the reference brand drug. Upon patent expiration, a barrier to entry is removed and additional sellers enter the market. As such, the price of a generic product decreases as additional competitors come to market. An FDA study reported that the first generic version of a drug has a price very similar to the reference brand, but the entry of the second and third generic competitors led to more substantial price decreases in excess of 50% of the brand retail price.

Manufacturers sell the majority of their products to wholesale distributors, which market drugs to pharmacies. Most of these products pass through one of three distributors which control roughly 85% to 90% of the market. These entities have greater leverage in negotiations with manufacturers of multiple-source drugs because the drug manufacturers compete to gain a distributor's business. Thus, distributors often secure lower prices from manufacturers when purchasing generics, increasing the margin between the price at which distributors purchase and sell a product.



Chain retail pharmacies are the predominant purchasers of drugs destined for retail pharmacies. It has been reported that sales to chain customers (including chain drug stores, mass merchandisers, food stores and chain warehouses) accounted for nearly half of distributors' sales volume. The market power of a pharmacy plays a key role in these financial relationships. Chain pharmacies that serve a greater number of patients and hold a higher market share can negotiate more favorable financial arrangements with manufacturers.

Pharmacies also exert greater leverage when negotiating for generic rather than brand-name drugs. This is mainly because plan sponsors and PBMs do not control or select the specific generic product ultimately dispensed to the participant. Pharmacies can select which product to stock from all available generic versions of a drug. As a result, pharmacies may negotiate discounts and rebates for generic products. Thus, while a drug's list price may be a good indicator of the price pharmacies pay for brand-name products, pharmacies frequently pay below the listed value for generic products due to this leverage. The size of the retail chain or an independent pharmacy's affiliation drives its ability to leverage price concessions.

Distributors have created group purchasing organizations to gain greater access to pharmacies and consolidate additional negotiating power with manufacturers. Distributors also partner with or administer Pharmacy Services Administrative Organizations (PSAOs), which provide administrative services on behalf of independent pharmacies or represent pharmacies in negotiations with PBMs and third-party payers. The three largest distributors, all of which are listed in the top 16 of Fortune's 2020 list of largest companies, own three of the five largest PSAOs. In these cases, the distributors are both determining the prices at which independent pharmacies procure the drugs they dispense and also the amount they are reimbursed for those dispensed medications by the PBMs. When independent pharmacies cannot get their reimbursement to cover the cost of a particular medication, their first call should be to the distributors who negotiate both the buy and sell price on their behalf.

Significant gross margin is available within the supply chain, and it must be noted that proposals to reform the market seek to redistribute this margin rather than diminish it for the payor.

While exact figures are difficult to ascertain, the table below contains an estimate based on information released by the University of Southern California's Center for Health Policy and Economics. Gross profits vary greatly between brand name and generic drugs driven in part by where each entity can gain leverage and negotiate, and also by the overall large proportion of generics as a percentage of total scripts dispensed. See FIGURE 1

Relative to generic medication pricing, the only points of leverage for plan sponsors are the composition of their retail network, plan designs impacting channel and the contract with a PBM. As such, the ability for a plan sponsor to unilaterally revamp the market paradigm is limited. Proposals seeking to regulate these limited abilities or the nature of the plan's contract with a PBM are likely more beneficial to another member of the supply chain than the plan or its participants.

Current Pricing

Currently, a manufacturer generally sells a drug to a wholesale distributor at a list price set by the drug maker called the Wholesale Acquisition Cost (WAC), minus discounts negotiated between the parties. The distributor then sells the product to a pharmacy at a price roughly based on the WAC. Next, PBMs reimburse retail pharmacies based on lists identifying a "Maximum Allowable Cost" (MAC) for each product. This list identifies maximum payment the PBM will pay for a particular drug. This approach theoretically provides an incentive for retail pharmacies to procure the least expensive generic version. A retail pharmacy directly or indirectly through an entity such as a PSAO has agreed to accept such pricing methodology as a condition of participating in the PBM's network.

A PBM's MAC lists impact how a plan sponsor, and participant, pay for drugs. Regardless of the pricing arrangement, it is important to understand there is more than one MAC list available. Under a more traditional pricing model, a PBM would reimburse pharmacies using a MAC list with lower prices and bill a plan sponsor using a MAC list with higher prices, thereby creating spread. For a pass-through arrangement, the PBM may use one set of price points for reimbursing the pharmacy and billing the client, but it does not mean that the PBM does not still utilize multiple MAC lists to optimize its book of business. There are also a host of post-transaction fees and adjustments that occur between retail pharmacies and PBMs which may not be subject to the pass-through requirements.

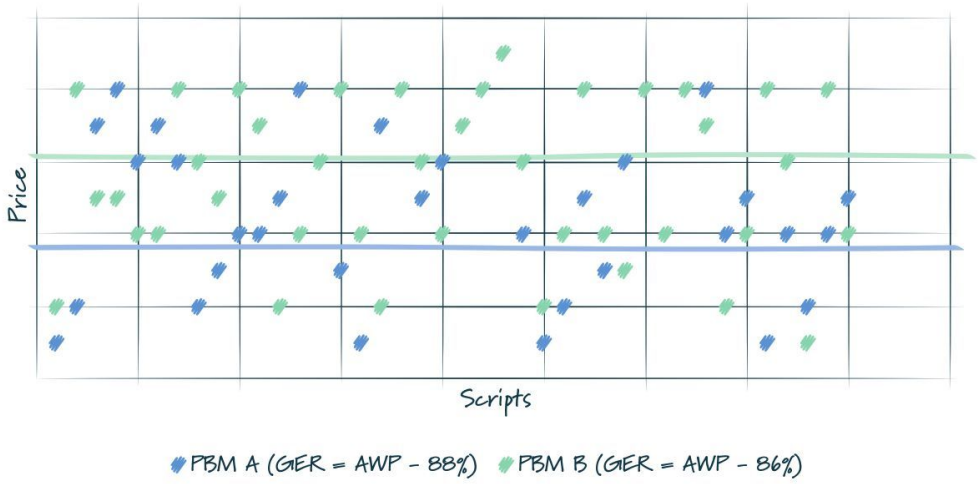
Commonly, in traditional or hybrid models, the PBM puts forth an overall average discount that must be met for all generic medications dispensed under the plan. As such, MAC lists may be manipulated throughout the year to ensure that the plan performs as it is contractually guaranteed. Given the many factors that impact utilization and drug mix, there is typically some variation between the actual performance and the guarantee. Depending on the services agreement, a plan sponsor is likely made whole for a shortfall or would have already benefited from overperformance of the guarantee.

Retail Distribution System Gross Profit Per $100 FIGURE 1

Entity	Brand	Generic
Wholesaler	$1	$8
Pharmacy	$3	$32
PBM	$2	$7

Not inclusive of rebates

Guarantees vs MAC FIGURE 2



Policy Proposals
(Reimbursement Controls and NADAC Pricing Methodology)

Having navigated through the above acronyms, it is clear that generic pricing is nuanced and involves many stakeholders. As such, any seeming straightforward "transparent" solution or definitive finger pointing merits a deep review.

NADAC Benchmarking

There have been several instances of state-based proposals that require retail pharmacies be reimbursed at NADAC rates plus a dispensing fee. What is NADAC? National Average Drug Acquisition Cost, or NADAC, is a file published by the Centers for Medicare & Medicaid Services (CMS) that contains the results of a retail price survey that is administered by a third party. These pricing files provide state Medicaid agencies with covered outpatient drug prices by averaging survey invoice prices from retail community pharmacies across the United States.

On its face, many sponsors could believe this approach yields a greater degree of transparency, but it is important to understand some fundamentals of NADAC and these proposals. First, NADAC is an invoice price and does not include off-invoice discounts. It yields an average benchmark price that is higher than the average net acquisition cost. Second, it is important to recognize that the survey is voluntary, and many major chains and grocers do not report, leaving the sample to be comprised primarily of prices from independent pharmacies and PSAOs. In addition to reimbursement tied to the NADAC file, proposals typically also include a mandatory $8-to-$12 per prescription dispensing fee.

An analysis of generic pricing based on a large sample of self-funded plans under a well-managed PBM program identifies that NADAC pricing is similar, albeit slightly behind, MAC pricing for the top 25 generic drugs by volume. Depending on the quality of the underlying contract a plan

sponsor utilizes, NADAC could very well provide a lower per-unit cost. General comparability is not a surprise as NADAC pricing is a factor that plays into many PBMs' MAC lists, but it does not set a floor on what a retail pharmacy must be reimbursed. For many plan sponsors, especially those with an already well-managed contract, the statutorily required addition of an $8-to-$12 dispensing fee to this unit cost likely increases costs for plan sponsors.

Reimbursement Controls

Some states have successfully implemented legislation (e.g. Ark. Code Ann § 17-92-507(a)(6)) that requires PBMs to reimburse pharmacies at or above the pharmacies' drug acquisition cost and permits a pharmacy to reverse and rebill below cost transactions if the pharmacy concludes that the MAC list rate is below the pharmacy's acquisition cost. Such approaches have been deemed permissible under the Employee Retirement Income Security Act of 1974 (ERISA) due to the view that this rule is within a state's ability to regulate provider reimbursement. These types of requirements undermine the utility of MAC pricing, eliminate the incentive for pharmacies to seek to competitively purchase drugs and contribute to a plan's greater overall pharmacy spend.

Final Thoughts

For a plan sponsor, a key question must be who is seeking to obtain a larger piece of the pie? Followed by, who will bear that cost? Regarding the latter, such cost will likely not be borne by one of the many jumbo organizations in the supply chain.

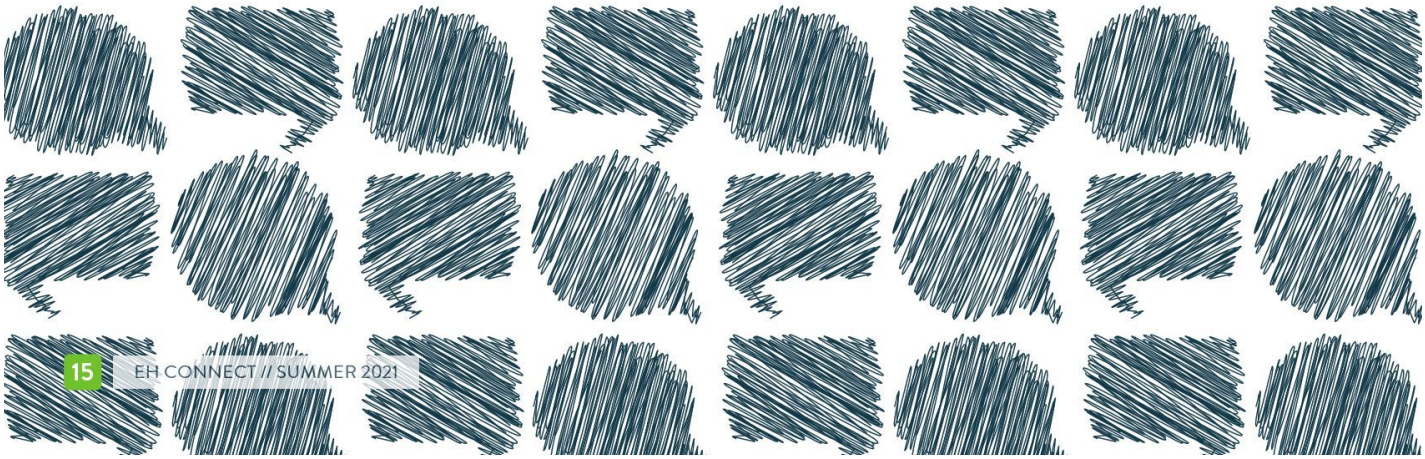
Spread is addressed by pricing model and an employer's contract with a PBM that clearly details the operation of the underlying model. However, pricing model is not the most important indicator of the financial stewardship of the plan. The key indicator for an employer is total cost for all medications from all channels. Many pundits lose sight of this dynamic and fall into the trap of evaluating the cost of a single drug at a single retail pharmacy for a single plan sponsor. While excessive spread is never appropriate, an understanding of the total costs to the plan and its participants must complement the evaluation of any model. As such, effective plan sponsors can manage their plans without purported assistance from state legislators.

REFERENCES

1. NADAC Cost Comparison Taken From EH Q1 2021 BoB Data
2. CMS, CMS Retail Price Survey National Average Drug Acquisition Cost (NADAC) Overview and Help Desk Operations (2017), https://www.medicaid.gov/medicaid/prescription-drugs/downloads/retail-price-survey/nadac-overview-operations.pdf
3. FDA, Generic Competition And Drug Prices (2017), https://www.fda.gov/AboutFDA/CentersOffices/OfficeofMedicalProductsandTobacco/CDER/ucm129385.htm
4. Neeraj Sood Et Al., Leonard D. Schaeffer Ctr. For Health Policy & Economics, Univ. Of Southern California, The Flow Of Money Through The Pharmaceutical Distribution System (2017), http://healthpolicy.usc.edu/documents/USC%20Schaeffer_Flow%20of%20Money_2017.pdf
5. HDA Research Foundation, HDA Factbook: The Facts, Figures And Trends In Healthcare (2017- 2018) 5 (88th ed. 2017)
6. Minority Staff of the U.S. Senate Committee on Finance, A Tangled Web: An Examination Of The Drug Supply And Payment Chains (2018)

TO LEARN MORE CONTACT:

Garrett Brown, J.D., CEBS
gbrown@employershealthco.com



Client Spotlight

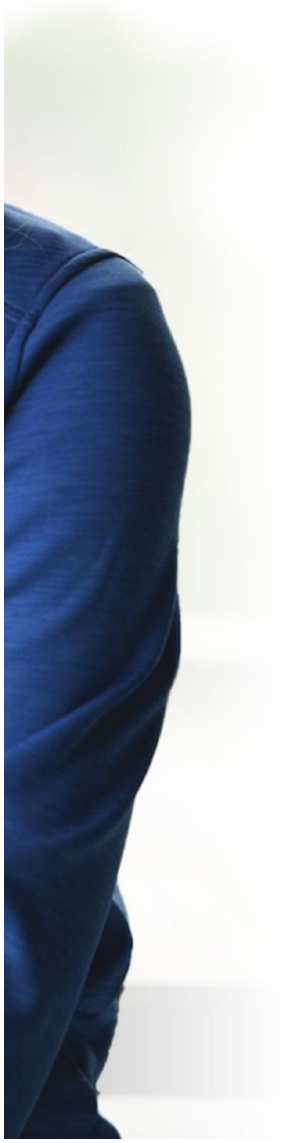
TQL

TOTAL QUALITY LOGISTICS

Founded in Cincinnati, Ohio in 1997, Total Quality Logistics is one of North America's largest freight brokerage firms. TQL connects customers with shipping needs to a network of over 90,000 transportation companies that have the available capacity and service offerings to get their goods where they need to be.

This is accomplished through a combination of world-class customer service and industry-leading technology.

From left to right: Connor Hamilton, Lisa Gruber, Kathryn Pravel, Megan Napier



How long have you been with Total Quality Logistics and have you been with the HR / Benefits Team the entire time?

I'm going on my third year with TQL and have been on the HR/benefits team the entire time.

Why/how did you choose to get involved in employee benefits?

Like most people I fell into HR, and knew it was the right career path for me. When the opportunity arose for a benefits manager at a growing company in Cincinnati, I had to take the chance and go for it. Managing benefits for 5,000 employees across the country is rewarding and challenging and I am extremely thankful that I have this opportunity to work with an amazing team.

How does your company approach health benefits and overall well-being for your employees?

At TQL we want to ensure employees have the right care at the right price. We realize not everyone falls into the same bucket, so we have a variety of medical plans and supplemental benefits that employees can choose from. We are also dedicated to ensuring employees understand the benefits available to them. Educating employees on insurance basics, including HSAs, is a priority for us. When employees understand their benefits, they take personal ownership and are a better health care consumer.

For us, overall well-being of employees spans beyond benefits. Our investment in a brand-new headquarters expansion was employee focused. We now offer an expanded complimentary 24/7 gym complete with a yoga room, over 60 pieces of equipment and locker rooms; campus-wide walking trails; a basketball court; nursing mother's room and break areas with games like ping pong and foosball. We also invest significantly in employee culture and engagement events like regular employee recognition, company-wide celebrations that family members are invited to and even a pet adoption reimbursement program.

Kathryn Pravel, Benefits Manager

How has your organization been innovative in delivering health care benefits?

Employees want benefits to be simple, but as we know the health care industry can be difficult and complex. We're always looking at new vendors and technology that can make the benefits process easier for employees. Currently we utilize Workday (HRIS) which allows employees to view plan information, select benefits and upload supporting documentation throughout the year. During open enrollment our employees can review plan offerings and select their benefit elections all within their Workday app. Outside of Workday, we constantly update our intranet with cost saving tools, informative videos and new apps our vendors offer to keep our plans at employees' fingertips. Even though we are growing at an extremely fast rate, we know customer service comes first. We openly invite employees to call us if they have questions so we can walk them through our offerings and have that one-on-one connection.

What has surprised you about working in benefits?

Honestly, how much everything costs has been shocking. I continue to educate myself on ways to handle the rising costs of specialty drugs and work with our broker, Employers Health and our pharmacy benefit provider to make sure employees are not only getting the right care but also at the right price.

What are your thoughts on the future of employee benefits?

The pandemic revealed that employees like to have the ease of talking to their doctor from the comfort of their home using telehealth. I believe most companies will adjust their plan document to allow telehealth moving forward.

Another area I see growing is the technology space. We have the mindset of instant gratification (thank you Amazon Prime and two-hour grocery delivery), so why should our health benefits be any different? Employees want to make decisions quickly and not have to think about all the what-ifs. There are a lot of benefit decision making tools on the market and that will continue to grow as millennials are estimated to make up 75% of the workforce by 2025.

How long have you been engaged with Employers Health?

We joined Employers Health in 2019.

What value do you derive/perceive by being part of an organization like Employers Health?

We conservatively save 5-7% in pricing with our pharmacy contract through Employers Health vs. a direct arrangement. Having live/on-demand webinars, podcasts and articles at our fingertips is essential to the team so we can stay on top of new regulations and trends.

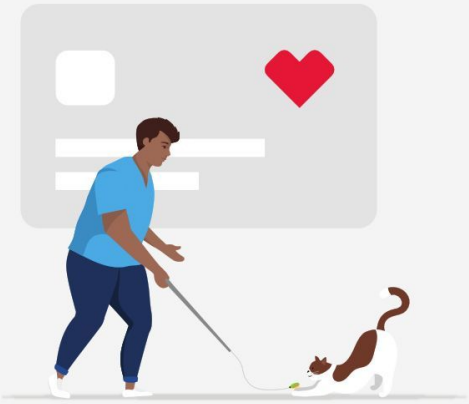
Have a story to share?
Contact us at
info@employershealthco.com

Enhance savings with PrudentRx, an innovative copay plan design

The PrudentRx Copay Optimization Program is a specialty copay plan design strategy with a best-in-class experience that enables payors to help reduce or eliminate member cost share for most specialty medications dispensed by CVS Specialty®, while saving the plan money.

- **~22% average gross savings**[1] for clients who have adopted PrudentRx Copay Optimization
- More than **326 clients adopted the program**, representing 2.5M lives[2]
- Members have $0 out-of-pocket costs and **<1% of eligible members opt-out**[3]

Want to learn more? Visit PayorSolutions.cvshealth.com.



"After speaking with my PrudentRx representative, I was delighted to find out **I will have a $0 out-of-pocket cost**."

– PrudentRx member

"I thought the savings estimate seemed too good to be true. **The actual savings were even greater than expected.** 92% of members were enrolled prior to go-live; remaining members were enrolled two weeks post go-live."

– Sr. Director of Benefits, Health Care company in NJ

1. CVS Health Analytics, 2021. Data from PrudentRx Savings Summary, March 2021. All data sharing complies with applicable law, our information firewall and any applicable contractual limitations. Savings projections are based on CVS Caremark data. Actual results may vary depending on benefit plan design, member demographics, programs implemented by the plan and other factors. P1008460321
2. CVS Specialty Internal Data, accessed March 16, 2021. P1008500321
3. CVS Specialty Internal Data, accessed March 16, 2021. P1008480321

EMPLOYERS HEALTH®
4771 Fulton Drive NW
Canton, OH 44718