March 30, 2021

PHARMACY BENEFITS
CARVE-IN VS. CARVE-OUT

Employee Benefits
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PBM: Carve-in vs. Carve-out

Agenda

- The Situation
- The Actors
- Motivation
- Solutions Continuum
- Definitions and Attributes
- Pros and Cons
- Opportunity and Challenges

PBM: Carve-in vs. Carve-out

The Situation

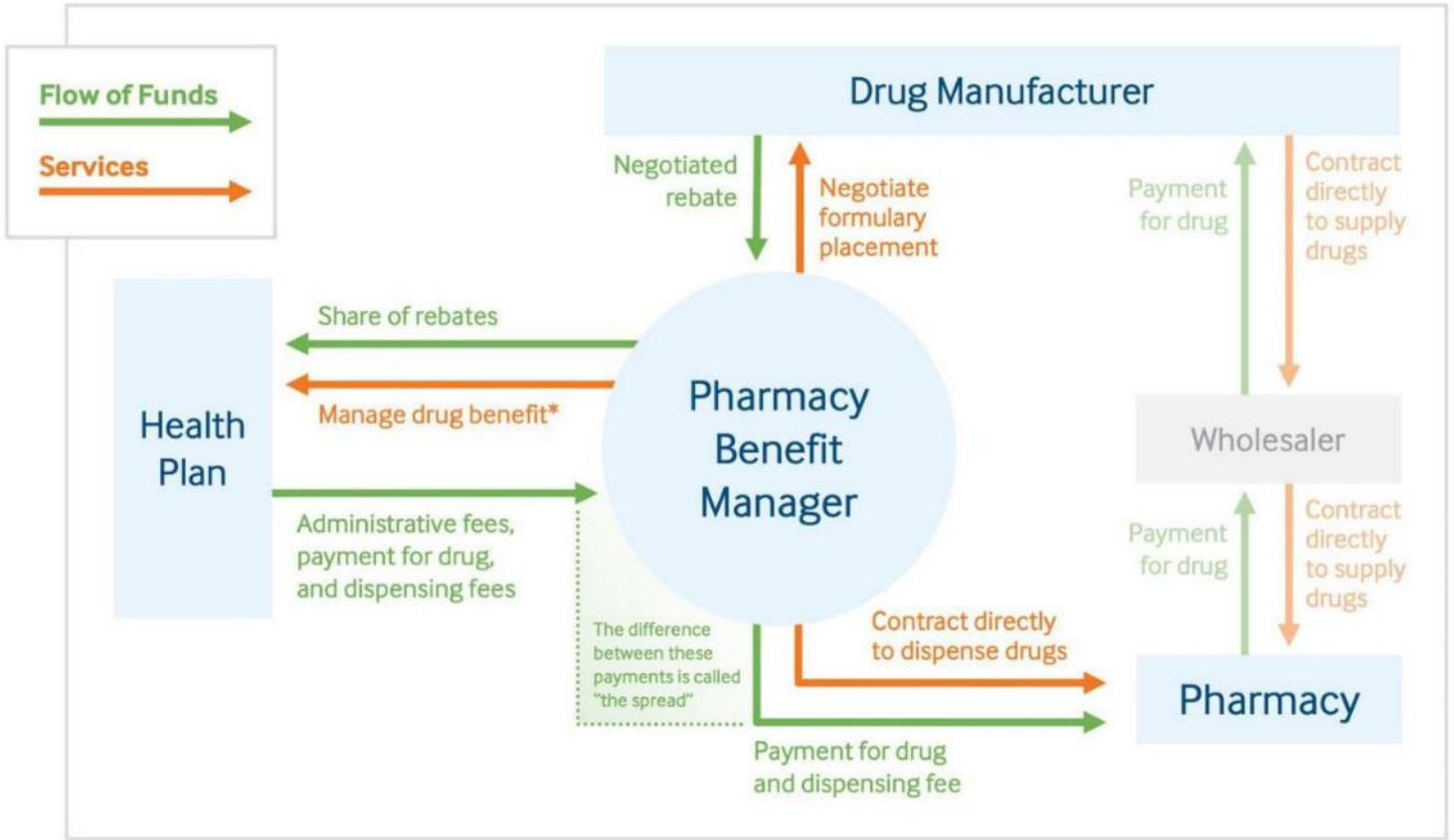
- **VISIBILITY:** Most used employee benefit – by a lot, by everyone, all the time, non-stop
- **SPEND:** 2,200 self-funded client average: ~30% of total health plan expense. Some as high as 50%... or more
- **HYPER-INFLATION:** Fastest growing expense in health plan

Current State

The Actors

Extremely (intentionally?) complex.

Transactions and interactions hide and increase drug costs.



Source: Elizabeth Seeley and Aaron S. Kesselheim, *Pharmacy Benefit Managers: Practices, Controversies, and What Lies Ahead* (Commonwealth Fund, Mar. 2019). https://doi.org/10.26099/n60j-0886

PBM: Carve-in vs. Carve-out

The Actors

	CVS Health	United Healthcare	Cigna	Anthem	McKesson	Walgreens Boots Alliance	Cardinal Health
Wholesaler	Ø	Ø	Ø	Ø	McKesson	Amerisource Bergen	Cardinal Health
PBM	CVS Caremark	OptumRx	Express Scripts	IngenioRx (CVS)	Relay Health	Ø	Ø
Health Insurance Carrier	Aetna	UHC	Cigna	Anthem	Ø	Ø	Ø
Pharmacy	CVS Pharmacy	Ø	Medco	Ø	Ø	Walgreens	Cardinal Health
Specialty Pharmacy	CVS Specialty	BriovaRx	Accredo	Ø	Ø	AllianceRx	Ø

Consolidation and vertical integration by industry actors reduces competitiveness and transparency.

PBM: Carve-in vs. Carve-out

The Actors

PBMs have consolidated into three main players - representing **76%** of the market!

CVS CAREMARK — 30%

- Largest PBM
- Largest retail pharmacy
- Retail, mail and in-house specialty
- Programs created around retail CVS stores such as maintenance choice
- Acquired **Aetna** 2018

EXPRESS SCRIPTS — 23%

- Focus on mail and in-house specialty
- Therapeutic Resource Centers
- Behavioral Science
- Acquired by **Cigna** 2018

OPTUMRx — 23%

- Focus on integrated medical and Rx offering
- Programs driven by holistic view of patient and leading Rx technology
- Owned by **United Health Group**

Plus 100 more… and growing

Source: Alia Paavola *Top PBMs by market share* (Becker's Hospital Review, May 30. 2019). https://www.beckershospitalreview.com/pharmacy/top-pbms-by-market-share.html

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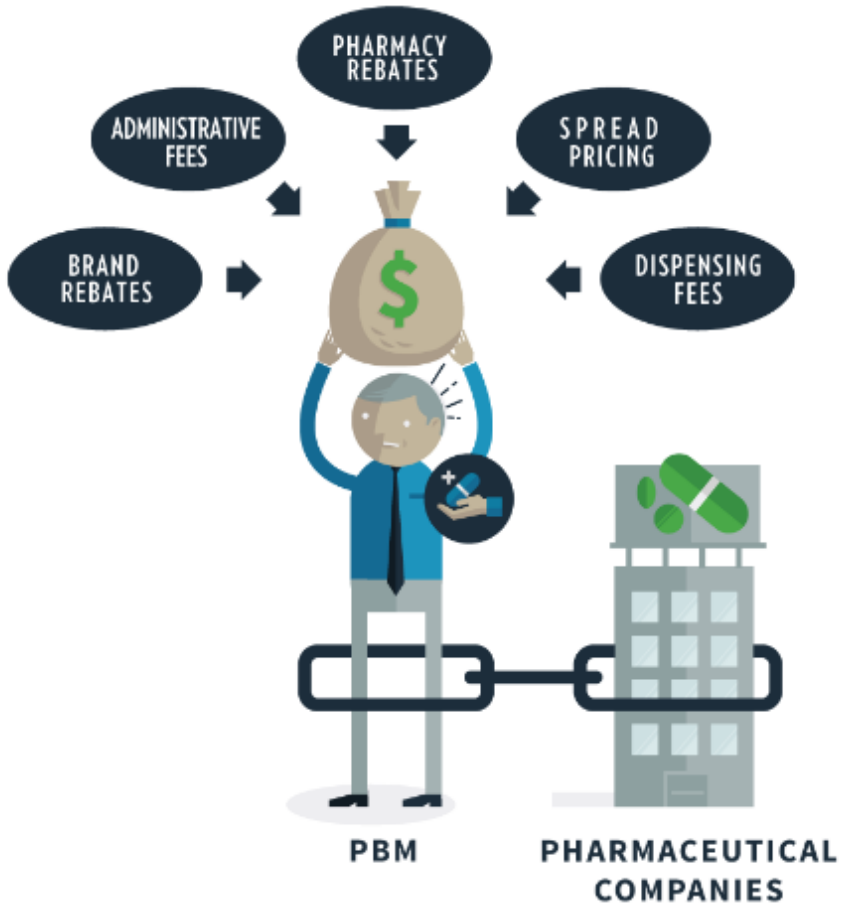
Motivation



- **Administration fees :** Fees for processing claims and clinical programs.
- **Spread pricing:** Difference between what the PBM pays the pharmacy and bills the plan—the PBM retains undisclosed profit.
- **Rebates:** Drug manufacturers pay PBMs to promote expensive brand-name drugs that do not have a generic equivalent - rebates, admin fees, clinical studies, price protection and data.
- **PBM-owned pharmacies:** Profit from PBM-owned mail order and specialty pharmacies.

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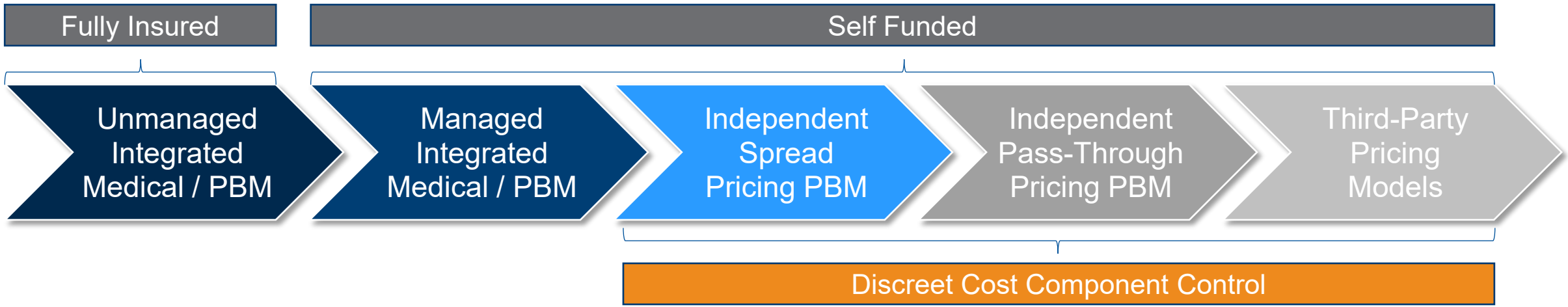
Solutions Continuum

Cost and control are inversely related; as employer control increases, costs decrease.



The Point: shine light into the darkness of opacity

PBM: Carve-in vs. Carve-out

Definitions and Attributes

Carve-In (AKA Integrated)

- Employer contracts TPA who contracts PBM
- TPA may own PBM / Pharmacy, undisclosed incentives
- Focus on medical
- "One size fits all"
  Fully Insured, Smaller Groups

Carve-Out

- Employer contracts PBM
- Employer selects PBM on its own merits
- Focus on pharmacy
- Customized vendor selection can offer tailored solutions - All self-funded

Visibility, options, control, and the power to choose are all elements of an optimized and successful pharmacy arrangement

PBM: Carve-in vs. Carve-out

Pros and Cons

- One vendor contract
- One client relationship / account team
- One ID card, 800#, system
- Smaller groups leverage scale
- Out-of-pocket aggregation seamless
- Medical and pharmacy specialty drugs managed
- Integration of data: gaps in care, improve outcomes and reduce total medical spend

- PBM missing from ASO, incomplete, opaque, cross-subsidized
- Often warm-transfer, daily batch files
- Smaller groups can subsidize large groups
- Integration varies widely by carrier/TPA/PBM
- Fairly rare: drug cost, rebates typically independent
- Value of integration white papers, yes. Client level proof, no.

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Opportunities and Challenges

- **Contract control**: words and numbers
- **Data**: no or limited access to data – actionable?
- **Economic transparency**: PBM revenue model (spread v pass-through w fee), drug pricing model (AWP v NADAC v ASP), rebate sharing model (fixed, minimum with reconciliation, pass-through, all sources)
- **Vendor access**: specialty pharmacy, specialty prior authorization, therapeutic alternatives, copay assistance, patient assistance
- **Formulary control**: Potential for greater flexibility, control and access to customized solutions in plan design, network, formulary and clinical programs

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Opportunities and Challenges

- **Reporting**: detailed, timely reporting can help the plan provider monitor changes in claims utilization, identify trend drivers and support strategic actions to manage drug spend.
- **Competition**: PBMs and aggregators compete aggressively; "best-in-class" contractual language financial guarantees. This may also result in a greater opportunity for full disclosure and transparency in the financial contract.
- **Penalties**: billed carve-out fee (pro-rated PEPM), elimination of ASO admin fee discounts, retain rebates earned but not paid (180-day lag), exorbitant fees to integrate with outside PBM
- **Data integration**: deductible and out-of-pocket accumulation between vendors

Empirical leverage

healthy process that empowers conversation with all vendors including incumbent

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Opportunity: Formulary Control

Horizon Therapeutics

- **Duexis:** ibuprofen (Advil/Motrin) 800mg / famotidine (Pepcid) 26.6mg
  - 30 tabs @ $2,500 vs. $20
- **Vimovo:** naproxen (Aleve/Midol) 500mg / esomeprazole (Nexium) 20mg
  - 30 tabs @ $1,200 vs. $30
- **Rayos:** prednisone 5mg
  - 30 tabs @ $2,700 vs. $5

Kaleo, Inc.

- **Auvi-Q:** epinephrine (EpiPen)
  - 2 auto injectors of 0.3mg @ $5,000 vs. $150
- **Evzio:** naloxone (Narcan)
  - 2 auto injectors of 2mg @ $5,000 vs. $50

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Opportunity: Specialty Prior Authorization

- Separate PBM from prior authorization functions
- Expert, independent clinical oversight
- Strict validation of medical necessity and appropriateness
- Conformance to established guidelines and best practices
- Prevention of waste and auto-shipping by dispensing pharmacies
- Utilization of cost-effective therapies and step therapy, when appropriate

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Opportunity: Therapeutic Alternatives

Target Medication	Rx Count	Target Plan Paid	Target Cost Per Rx	Alternative Medication	Alternative Plan Paid	Alternative Cost Per Rx	Dollar Savings	Percent Savings
Latuda	44	$66,121	$1,503	Risperidone	$278	$6	$65,843	99.6%
Vyvanse	330	$86,785	$263	Amphetamine Mix ER	$29,923	$91	$56,861	65.5%
Dexilant	112	$52,343	$467	Lansoprazole	$1,293	$12	$51,050	97.5%
Bystolic	163	$46,829	$287	Metoprolol ER	$487	$3	$46,342	99.0%
Oxycontin	67	$41,788	$624	Morphine ER	$2,653	$40	$39,136	93.7%
Nuvaring	118	$39,974	$339	Ethinyl Estradiol Norethindrone	$4,057	$34	$35,917	89.9%
Onfi	6	$35,853	$5,976	Clonazepam	$100	$17	$35,753	99.7%
Tradjenta	100	$59,105	$591	Alogliptin	$23,660	$237	$35,445	60.0%
Trintellix	68	$31,287	$460	Fluoxetine	$177	$3	$31,110	99.4%
Trokendi XR	42	$29,946	$713	Topiramate	$171	$4	$29,775	99.4%
Total:		**$490,031**			**$62,800**		**$427,231**	

Conclusions

- **Which One Is Right for You?**
- There is no magic bullet
- Basics still apply: disruption, timing of other benefit changes, compensation, business realities
- Multi-year strategy: akin to decision to self-fun medical
- The process is health and necessary

Questions & Answers

Open items and questions received