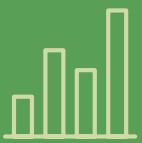


# PURCHASERS GUIDE TO PBM QUALITY 2018



Comparative  
Information on  
PBMs



Special Reports  
on Cutting Edge  
Practices



Action Steps  
You Can Take  
Now



Includes the following PBMs, evaluated by the National Alliance objective criteria:



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 & HAS,  
State of Tennessee Employee  
Benefits Administration

The Pharmacy Quality Alliance is the premier developer of meaningful, consensus-based medication use measures. We applaud the National Alliance for leading the way by using standardized, third party measures as a foundation of value-based purchasing. Value-minded healthcare purchasers should consider including the National Alliance PBM Assessment in their PBM management strategies.

**Laura Cranston, RPh**  
CEO, PQA

The cost and quality of services delivered through a drug benefit are increasingly important to employees. The performance of a purchaser's PBM is critical not only to employee satisfaction but to a purchaser's bottom line. Accreditation is an important tool to assess the relative quality of PBMs and the National Alliance makes it easy for purchasers by incorporating accreditation into their PBM Assessment Measures.

**Kylanne Green**  
CEO, URAC

Dear Reader:

We're delighted to share with you our 2018 Purchaser's Guide to PBM Quality.

This 2018 Report, including 9 PBMs that cover over 119 million lives, includes two new features that you'll find especially useful;

1. **Special Reports.** Throughout the Guide you'll find articles from experts at our participating PBMS. Use these articles to educate yourself regarding best practices that purchasers should be looking for from their current or prospective vendors.
2. **Action Steps.** We have highlighted five emerging areas that PBMs can improve. Use them in your discussions with current and prospective PBMs. If purchasers align to drive improvement in these simple areas, we can move the market toward better transparency and value.

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. (For example, 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 2018 Purchaser's Guide to PBM Value shows that PBMs can bring considerable value to purchasers, providers, and patients. Welcome to the 2018 Purchaser's guide to PBM Quality. If you use it to guide discussions with your current and prospective PBM, you'll emerge better informed than ever before!

John Miller

Mike Thompson

Foong-Khwan Siew

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## SPECIAL REPORTS

### 12 SPECIAL REPORT

#### **Biosimilars: Challenge and Opportunity**

MaxorPlus

Although there are many advantages to biosimilar medications, there are also many challenges associated with their entry into the drug market. Because there are currently dozens of biosimilars in the FDA's Development program, purchasers should understand what their PBMs are doing to facilitate entry.

### 13 SPECIAL REPORT

#### **Preventing Adverse Drug Reactions with Pharmacogenetics**

BeneCard PBF

Each year patients experience 45-50 million adverse drug reactions (ADRs). ADRs are the leading cause of hospitalization in the country, and can double the length and cost of hospital stays. How can your PBM help manage this challenge?

### 15 SPECIAL REPORT

#### **Real-Time Prescription Benefits**

CVS Health

When prescribers use real-time prescription benefits information to access drug coverage and OOP cost at the point of prescribing, then choose a lower-cost alternative, it leads to savings of \$130 per fill on average for members. PBMs should implement a comprehensive real-time benefits information strategy.

### 17 SPECIAL REPORT

#### **A Value-Based Pharmacy Network**

Express Scripts

Patients interact with pharmacists up to 12 times a year, making the pharmacist one of the most visited healthcare providers, and well positioned to make meaningful impacts for patients. Enhancing the pharmacist-provider and pharmacist-patient communication can lead to significant breakthroughs in medication adherence. PBMs should tie payments to patient outcomes and make providers more accountable for driving quality and cost efficiencies.

### 20 SPECIAL REPORT

#### **Managing Opioid Addiction**

United Healthcare

Prescription opioid overdose is the leading cause of accidental death in the United States. UnitedHealthcare members with opioid use disorder (OUD) incur medical costs \$6,000 per year greater

than members without OUD. The opioid crisis is potentially impairing the health and productivity of many Americans. PBMs should manage prevention, treatment and support.

### 23 SPECIAL REPORT

#### **Managing Low Value Drugs**

Cigna

Traditionally, PBMs contract with drug companies to place drugs on their formularies using rebates to reduce costs and determine preferred placement, which can lead to formularies containing heavily rebated drugs that have lower cost alternatives. Can a PBM use a low net drug cost formulary strategy that challenges drug makers to rethink their traditional pricing?

### 28 SPECIAL REPORT

#### **Point-of-Sale Rebates**

Optum Rx

While PBMs have negotiated with drug manufacturers to secure rebates that help lower the net cost of the prescription, historically these rebates have been passed along to the employer. PBMs can use point-of-sale discounts to simplify pharmacy benefits, expand transparency and deliver savings directly to the member whose prescription generated the rebate payment.

### 30 SPECIAL REPORT

#### **Innovative Contracting Practices**

In response to increased scrutiny of PBM business practices, this year the National Alliance PBM Assessment asked about several innovative contracting practices that have been gaining interest. These questions are groundbreaking, and should get the attention of all purchasers!

### 31 SPECIAL REPORT

#### **Using Audits to Enhance Plan Performance**

Navitus Health Solutions

Today's marketplace is demanding more transparency, greater accountability and higher performance. Through an audit, plans can get visibility into how their pharmacy benefit is working, hold their PBM accountable to the agreed services and recover funds lost through processing errors and overpayments. Ultimately, plans can use audits to identify opportunities for improvement and strengthen PBM performance.

# Participating PBMs



BeneCard PBF offers innovative solutions to control costs while providing the highest quality in prescription benefit management. BeneCard approaches the industry from a completely different perspective, one that truly understands the member and client, and always puts their needs first.

As a transparent, independent PBM, BeneCard is focused on member safety and well-being.

BeneCard PBF pharmacists are empowered to be at the center of care while considering all available medical information to support a holistic view of a member's health and eliminate waste. As a result, BeneCard's trend has consistently been half that of the industry average.

BeneCard PBF is raising the bar by providing a new standard of care. As BeneCard continues to drive the PBM evolution, always delivering accountable prescription drug management.

**FOR MORE INFORMATION**, please contact Bob Zakrajsek, Regional Vice President, [Bob.zakrajsek@benecardpbf.com](mailto:Bob.zakrajsek@benecardpbf.com); or Hugh Gallagher, Vice President, Business Development, [Hugh.gallagher@benecardpbf.com](mailto:Hugh.gallagher@benecardpbf.com).



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](mailto: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:christopher.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](mailto:vjzwilling@express-scripts.com) or 314-684-6033.



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](mailto: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 zero-spread, 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](http://www.navitus.com) or call 877-571-7500. Or, email us at [sales@navitus.com](mailto:sales@navitus.com).



OptumRx is a pharmacy care services company helping clients and more than 65 million members achieve better health outcomes and lower overall costs through innovative prescription drug benefit services. Through expertise, flexible technology and a network of over 67,000 community pharmacies and state-of-the-art home delivery pharmacies, OptumRx is putting patients at the center of the pharmacy experience and making health care more connected—ensuring patients get the right medication at the right time at the best cost.

Working together, Optum and OptumRx connect capabilities at every touchpoint in the health care continuum to create a better, whole health picture. When a prescription connects with the rest of patient care, we can improve health outcomes for everyone.

**FOR MORE INFORMATION**, visit [www.optum.com/optumrx](http://www.optum.com/optumrx) or contact Don Houchin, Senior Vice President at OptumRx, [Don.Houchin@optum.com](mailto:Don.Houchin@optum.com)



Through innovative and flexible programs, our partners improve the holistic wellbeing of their membership, medication adherence, outcomes and reduce overall pharmacy and medical trend. We accomplish this through industry accreditations, clinical focus, adaptive technology, regulatory compliance expertise, and flexible pricing options.

PerformRx is a 19 year strong Pharmacy Benefit Manager with a national presence. We currently administer PBM services in 14 States and the District of Columbia covering 5 million lives.

We are a trusted pharmacy benefit manager that provides innovative, cost-effective pharmacy benefit management services for Commercial, Exchange, Medicaid, and Medicare lines of business. Services can be offered as a full PBM solution or as an a la carte offering. We also offer flexible pricing methodologies including transparent, traditional, or hybrid pricing models.

**FOR MORE INFORMATION**, please contact Nicholas Dinsmore at 215-863-5874 or [ndinsmore@performrx.com](mailto:ndinsmore@performrx.com).



UnitedHealthcare provides an innovative pharmacy benefit that drives lower cost while improving outcomes. We simplify the experience by connecting medical and pharmacy information. This holistic approach delivers better health and lower costs.

Our approach differs from the standard by:

- **Data Exchange:** Information is captured in one system and we provide real time information.
- **Care Management:** We provide one team of skilled professionals who help members make better health care decisions.
- **Support:** Our advocates have access to member's pharmacy and medical benefits to provide personalized support. Members have 24-hour, seven days a week access to pharmacists and advocates.
- **Specialty Pharmacy:** Our approach uses intelligent data that aligns outreach to members that need it the most.

**FOR MORE INFORMATION**, please contact Bill Stewart at 314-909-0990, or [bill.stewart@optum.com](mailto:bill.stewart@optum.com).



# Using the Guide

This guide is best used as a conversation manual.

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 some 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.



Are you looking for **innovative contracting approaches**? This guide includes a focus on innovative PBM contracting practices, such as transparent contracts, open auditing, outcomes-based contracting (see page XX). If these approaches are of interest, be sure to ask your PBM which they offer. On the other hand, you may not be worried about cutting-edge arrangements.

**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.**

# Standardization and Satisfaction

## A word on standardized measures

Standardized measurement is fundamental to comparing performance, and the concept is late coming to healthcare. Understandably, over time each PBM has developed their own internal metrics. However, to compare performance, we have adopted third party, standardized measures, and strongly encouraged the PBM industry to use those metrics to supply information, thereby insuring an “apples to apples” approach. One of our main partners in this process is the Pharmacy Quality Alliance, which develops quality measures through a transparent and consensus-driven process. With over 250 members, including most major PBMs, health plans and life sciences organizations, PQA represents an important voice in optimizing patient outcomes through the safe and appropriate use of medications.

[www.pqaalliance.org](http://www.pqaalliance.org)

## About satisfaction

To gain an objective view on plan sponsor views on their PBMs performance, we recommend the Pharmacy Benefit Management Institute (PBMI). For more than 20 years the Pharmacy Benefit Management Institute (PBMI) has been researching and reporting on PBM customer satisfaction. The 2018 PBM Customer Satisfaction Report is available for purchase in electronic format. This year’s report includes detailed profiles for 12 PBMs and represents the views of 466 employers, union/Taft-Hartley groups, and health plans who cover more than 85 million lives.

[www.pbmi.com](http://www.pbmi.com)

# Pharmaceutical Management

PBMs should offer value that goes far beyond price negotiation. This section highlights the PBM role in managing pharmaceutical use, including safety, and member support.

Why do we ask?

PBMs should play an important role in not just restricting, but enabling access to medications, and improving medication adherence, to offer the best chance of achieving optimal outcomes. They should ensure medication safety and appropriate use. PBMs have a role in Specialty Rx management that goes beyond negotiating a price. In both traditional and specialty drugs, not adhering to drug protocols is a huge opportunity for wasted money, and potentially tragic health outcomes.

PBMs should actively be moving patients to the most effective/least expensive—and therefore highest value—drug. It's important that they monitor and interacting with providers as appropriate, and that includes informing providers of higher value alternatives, and working with physicians to improve medication adherence.

This section measures PBM performance in this important function.

## Overview of Pharmaceutical Management

### Specialty Pharmaceuticals Management

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- Management Strategies and results, Sites of care, and Flexibility
- Adherence Monitoring and Closing gaps
- Transparency
- Hepatitis C Completion Rate
- Use of biosimilars

### Efficiency

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- Management Strategies and Generic Dispensing rates
- Overuse of Antibiotics of Concern

### Program Organization

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- Value-Based Formulary
- Value-Based Insurance Design Implementation
- Ability to Customize

### Quality, Safety and Adherence: Outpatient

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- Adherence Monitoring and Closing gaps
- Addressing primary non-adherence
- Drug Conflicts and Opioid Misuse
- Assessment of Pharmacies in network and Quality Incentive Programs

### Pharmaceutical Support: CAD, Diabetes, BH

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- Monitoring Adherence and Closing Gaps
- Adherence Results and appropriate management of cholesterol
- Policies on access to Substance Use medications
- Monitoring appropriateness of antidepressant and pain medication prescribing practices of practitioners.

### Pharmaceutical Support: Tobacco and Obesity

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- Coverage and access to medications
- Eligibility Criteria for Obesity



# Specialty Pharmaceutical Management

This section looks at administration, utilization strategies, and patient adherence for these very expensive drugs. Accordingly, we measure:

- The PBM's Management Strategies; detailed below
- Programs to monitor that patients are taking these very expensive drugs correctly, and closing gaps
- Transparency: can they share their costs for certain drugs?
- Hepatitis C Completion Rate: As the National Alliance works to ensure use of standardized measures, we asked if the PBM used the recognized PQA completion rate for Hepatitis C, and what the PBM's rate was.
- Use of biosimilars: As these drugs become available, where are they positioned on the PBM's formulary, and what steps is the PBM taking to promote them?

## Management Strategies

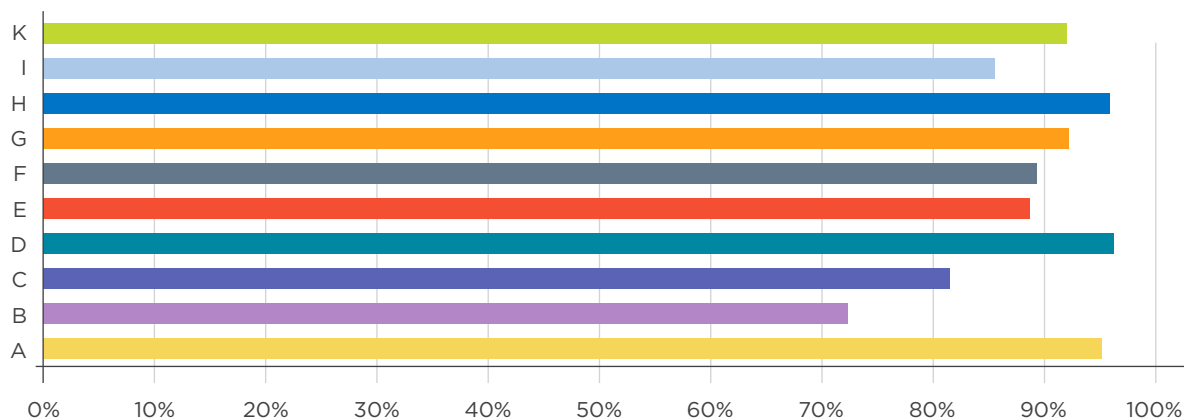
All PBMs have broad range of programs to manage specialty pharmaceuticals use. Some examples include:

- **Split Fill.** These programs control waste by dispensing a limited initial amount, to insure the drug is effective and tolerated before dispensing more of these expensive medications.
- **Genomic Testing.** These programs ensure that the patient's genetic profile will allow the drug to work.
- **Channel Management.** Channel management refers to delivering the drug through mail, specialty pharmacy, medical provider, or other arrangement.
- **Site of Care Optimization.** Where the drug is administered (Hospital, Outpatient, Self-Administered) can have a huge impact on expense. PBMs should manage this variability.
- **Reimbursement based on a Fixed Fee Schedule.** In some cases specialty drugs are purchased by a different vendor (physician, specialty pharmacy, etc.), who then bills the PBM or healthcare purchaser. Is that reimbursement capped?

Scoring Differences were based on:

- Programs and processes in place to manage members and monitor for gaps in adherence.
- The PBM's willingness to provide Per Member Per Month costs for listed conditions

## SPECIALTY PHARMACEUTICAL MANAGEMENT



### ACTION STEP

#### HEPATITIS C COMPLETION RATE

**Action Step:** As an indicator of quality, ask about your PBM's Hepatitis C completion rate using the PQA Standards. It should approach 99%. A higher Hep C completion rate indicates better adherence to treatment.

**Why is it important?** First of all, poor completion rates equal wasted money. Also, it is important to push PBMs to use external standards. Unless they do, purchasers cannot get apples-to-apples comparisons of quality and performance.



### ACTION STEP

#### BIOSIMILARS

**Action Step:** Ask your PBM where biosimilars are positioned on the formulary, and whether the PBM is making efforts to increase uptake. There are already several major biosimilars on the market at the time of this writing, but biosimilars' position on the formulary is not consistently favorable. And only four of the nine PBMs are contacting prescribers about changing to the less expensive biosimilars.

**Why is it important?** As the biosimilar market expands, biosimilars have the potential to drive competition, and lower costs significantly. Unless PBMs and purchasers promote emerging biosimilars, manufacturers will discontinue research and development of this important alternative.



## SPECIAL REPORT

### BIOSIMILARS: CHALLENGE AND OPPORTUNITY MAXORPLUS

Biosimilars are drugs that are “highly similar” to an FDA-approved biological product (referred to as the biosimilar’s reference product). A biosimilar drug has no clinically meaningful difference in terms of potency and purity from its reference product, and does not compromise quality or clinical outcomes for patients. The only difference in a biosimilar compared to its reference product is chemically inactive components. Based upon current biosimilar pricing and the biosimilar market in the EU, the average costs savings expected from biosimilars are approximately 20% lower than their associated reference product.

Although there are many advantages to biosimilar medications, there are also many challenges associated with their entry into the drug market. The time to approval for these products is larger than traditional generic medications. Additionally, interchangeability of these products is complicated; requiring special laws and guidance to clarify prescribing and substitutability for prescribers and pharmacists. Naming conventions also create an obstacle to clearly understand which biosimilars are associated with the branded reference products. In an effort to address many of these challenges, the FDA has issued biosimilar guidance for the industry, and many professional organizations have played an active role in educating the healthcare community.

Biosimilar management strategies include: formulary, utilization management and channel/access strategies. As cost is a core focus of payers, Pharmacy Benefit Managers (PBMs) should align their formularies to promote the utilization of the lowest net cost drug option in a therapeutic class. A key component of this decision includes factoring in the rebate associated with the reference product, as biosimilar medications are not typically rebated medications. Given the smaller cost decrease of

biosimilar medications compared to traditional medications generic savings, this decision to either prefer or not prefer biosimilar medications on a formulary is a complex decision.

Perhaps more important than formulary placement are the utilization management strategies. Utilization management strategies, such as step therapies, play a key role in requiring the use of biosimilar agents prior to use of branded agents. In addition, use of indication-based prior authorization is effective in ensuring clinical appropriateness based upon the patient’s diagnosis. This extra level of clinical management is essential to a biosimilar strategy and PBMs should provide custom solutions for clients in this area.

There are currently dozens of biosimilars for nearly 20 reference products in the FDA’s Biosimilar Development Program. Recently, there have been several biosimilar FDA approvals, including a Humira® biosimilar, Amjevita®. Patent litigation, however, is expected to delay a launch of Amjevita® for several years. As the biosimilar landscape continues to evolve, the industry will be paying close attention, eager for increased competition and innovation to lower costs of specialty therapies for burdensome specialty conditions.

#### About MaxorPlus

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MaxorPlus is a market-leading PBM that is pioneering the use of analytics and technology to identify intervention opportunities to engage members in new ways.

For more information, contact Eric Wan at [ewan@maxor.com](mailto:ewan@maxor.com) and/or (651) 235-4699.



## SPECIAL REPORT

### PREVENTING ADVERSE DRUG REACTIONS WITH PHARMACOGENETICS BENECARD PBF

Each year in the United States, patients experience 45-50 million adverse drug reactions (ADRs). Up to 5 million of these are serious, debilitating, or even fatal events. ADRs are the leading cause of hospitalization in the country, and can double the length and cost of hospital stays as well as the patient's risk of death.

These statistics underscore the importance of safe prescribing to protect member health and reduce overall healthcare spending. Traditionally, physicians have relied on trial and error to find the best medication for their patients. However, thanks to a growing body of genetic research, there is now a better approach for many.

#### **Precision Prescribing with Pharmacogenetics**

Pharmacogenetics, a science that studies the way drugs interact with the body, offers an opportunity to predict how well a medication will work before it's prescribed. Each individual is unique, and what may work to treat one patient could have serious consequences for another.

For example, patients who have diabetes rely on products such as Starlix® (nateglinide) to help control their blood sugar. When the medication doesn't work as expected, this can lead to serious and life-threatening consequences such as a diabetic coma. Pharmacogenetic testing identifies genetic and metabolic traits that can determine how the medication will perform. Some patients' bodies may break down the medication too quickly, leading to dangerously high concentrations in their bloodstream. Others may break a medication down so slowly that it has no therapeutic benefit whatsoever, leaving the patient vulnerable to complications from a poorly controlled medical condition.

#### **Tapping the PBM and Pharmacogenetics to Reduce Costs**

When pharmacy benefit managers (PBMs) include pharmacogenetic data as part of a member's complete health profile, they can help make that information available to all of a member's healthcare providers to facilitate safer prescribing. PBM pharmacists certified in pharmacogenetics can also assist prescribers in applying test results to enhance a patient's care regimen.

Because the pharmacogenetic data is fully integrated with the PBM claim system, it can be applied at the point of sale to protect patients from receiving potentially harmful or ineffective medication that could lead to severe side effects. This in turn helps to protect members and plan sponsors from the high cost of medical complications that could arise as a result of a serious ADR. In a study published by *Translational Psychiatry*, patients who received pharmacogenetic-guided prescribing incurred \$5,188 less in annual healthcare costs.

Pharmacogenetic test results do not change over time. This means that the results of a single test can provide a lifetime of clinical guidance for better prescribing. A PBM that offers fully integrated pharmacogenetic services can provide plan sponsors with a valuable tool to protect their members' health and keep costs down.

#### **About BeneCard PBF**

BeneCard PBF enhances patient outcomes while lowering prescription costs through innovative clinical programs. For information about pharmacogenetics and our fixed-rate and self-funded prescription benefit programs, please contact Bob Zakrajsek at 440-729-2052.



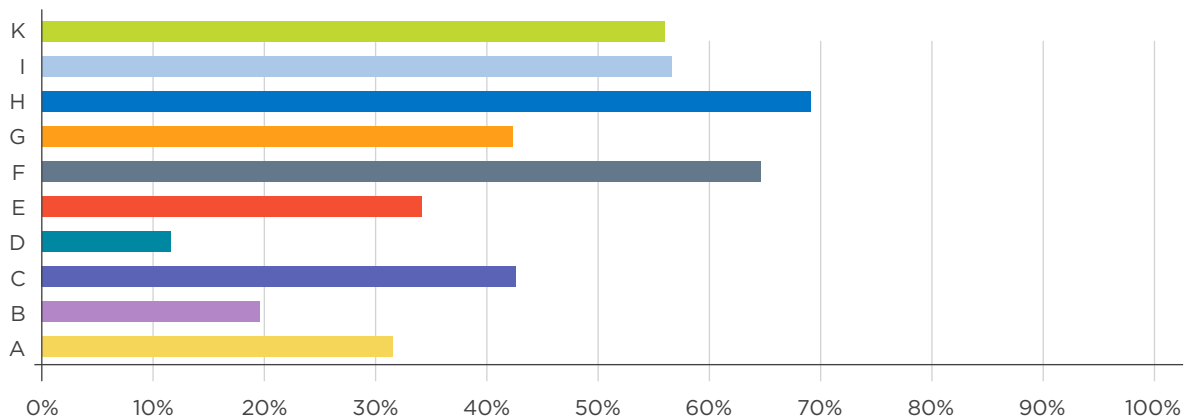
# Outpatient Quality, Safety and Adherence

This section examines the PBMs ability to support patients with Chronic Disease or Behavioral Health issues, including adherence monitoring and coverage of BH/substance use medications. It also looks at managing drug conflicts, opioid misuse, and whether the PBM assesses network pharmacy performance, and rewards high performing pharmacies.

Scoring Differences were based on:

- Appropriate treatment of cholesterol in patients with heart disease
- Adherence monitoring practices and rates
- Monitoring appropriateness of antidepressant and pain medication prescribing practices of practitioners
- Coverage of and access to medications to treat substance use

## OUTPATIENT QUALITY, SAFETY AND ADHERENCE



## ACTION STEP

### COMMUNITY PHARMACY MANAGEMENT

**Action Step:** Require your PBM to manage community pharmacies to ensure compliance to safety and quality standards. Only one PBM partners with a neutral third-party to analyze claims data of community pharmacies for quality.

**Why is it important?** Why is this important? Pharmacies can play an important role in adherence and potential safety concerns.





## SPECIAL REPORT

### SAVING PATIENTS MONEY: KEY COMPONENTS OF A REAL-TIME PRESCRIPTION BENEFITS SOLUTION THAT DELIVERS RESULTS CVS HEALTH

The portion of health care costs shouldered by consumers is rising and cost continues to be a barrier to medication adherence. In a recent survey, 84 percent of Americans said it would be helpful to know their prescription cost *before* they go to the pharmacy, and 64 percent said they would use prescription cost information to find lower-cost alternatives instead of foregoing treatment.<sup>1</sup>

With the rise of consumerism in health care, and the growth of high deductible health plans, many pharmacy benefit managers are now providing real-time prescription benefits information about what a medication will cost based on the plan member's specific coverage and where they are in their deductible, as well as visibility to lower-cost, clinically appropriate alternatives.

Key attributes of a truly comprehensive real-time prescription benefits solution include:

- Member-specific drug coverage and out-of-pocket (OOP) cost available at the point of prescribing, at the pharmacy and directly to members.
- Real and quantifiable results, as evidenced through paid claim activity, not theoretical or “possible” savings.
- Clinically appropriate lower-cost brand and generic alternatives that match the originally searched drug in terms of clinical efficacy, and dosage strength, and have equal or better formulary placement—along with OOP cost for each based on where the member is in their deductible phase.
- Integrated into an EHR and e-prescribing tool/workflow, not through a stand-alone provider portal.

CVS Health recently reported that when prescribers use real-time prescription benefits information to access drug coverage and OOP cost at the point of

prescribing, then choose a lower-cost alternative, it leads to savings of **\$130 per fill on average** for CVS Caremark members.

CVS Health's real-time prescription benefits capability is powered by the company's proprietary engine, Script Intelligence, and database of clinically mapped therapeutic alternatives. The database displays up to five clinically appropriate lower-cost brand or generic alternatives with equal or better formulary status on the member's specific plan design, and the real-time OOP cost for each based on where they are in their deductible.

Today, CVS Health is making real-time prescriptions benefit information available within the EHR at the doctor's office, at CVS Pharmacy and directly to members within the Caremark portal and mobile app. By the end of 2018, the database will include drug classes that comprise 90 percent of all prescriptions written for CVS Caremark members.

Providing actionable member-specific prescription benefits information across multiple points of care has proven to help lower consumers' OOP costs and can improve adherence. As more EHR vendors connect with Surescripts for real-time prescription benefit information and physicians begin to routinely access this information at the point of prescribing and then choose lower-cost alternatives, we can expect a broader number of patients to save money on their prescriptions.

#### About CVS Caremark

CVS Health's pharmacy benefit manager (PBM), CVS Caremark offers PBM solutions to employers, unions, government entities, health plans, and Medicare Part D and managed Medicaid plans.

For more information, contact Christopher Wilson at 201-602-8895 or [christopher.wilson4@cvshealth.com](mailto:christopher.wilson4@cvshealth.com).

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1. CVS Health Morning Consult poll, July 23-25, 2018. The Morning Consult poll was conducted from July 23-25, 2018, among a national sample of 2,201 registered voters. The interviews were conducted online and the data were weighted to approximate a target sample of registered voters based on age, race/ethnicity, gender, educational attainment, and region. Results from the full survey have a margin of error of plus or minus 2 percentage points.

Source: CVS Health Enterprise Analytics, 2018.

Savings will vary based upon a variety of factors including things such as plan design, demographics and programs implemented by the plan.

CVS Health uses and shares data as allowed by applicable law, and by our agreements and our information firewall.

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## SPECIAL REPORT

### TAKING ON THE TOUGHEST: A VALUE-BASED PHARMACY NETWORK EXPRESS SCRIPTS

Payers are in search of new alternatives for delivering and paying for care. Shifting focus from the traditional fee-for-service model to a pay-for-performance model, these models are often classified as *value-based*, *quality-based*, and *performance-based*. Regardless of the name, the themes are the same: Tie payments to patient outcomes and make providers more accountable for driving quality and cost efficiencies.

Patients interact with pharmacists up to 12 times a year,<sup>1</sup> making the pharmacist one of the most visited healthcare providers, and well positioned to make meaningful impacts for patients. Enhancing the pharmacist-provider and pharmacist-patient communication can lead to significant breakthroughs in medication adherence.

#### A new path forward

Express Scripts innovated a value-based pharmacy network solution for the Medicare plans we serve in 2014. In collaboration with one of our Medicare clients, who wanted to foster improved outcomes between pharmacists and patients, we piloted the Medicare Preferred Value Network (MPVN). In 2017, we used our learnings from this pilot to launch a standard Medicare performance network, and as of 2018, more than 95% of Express Scripts eligible health plans are enrolled in the Medicare Preferred Value Network.

Clients' feedback was very positive about the effectiveness of MPVN, including access, savings, and member outcomes. This showed us how critical offering measurable pay-for-value solutions are for clients seeking to tackle both quality and cost control in the midst of a changing industry. In fact, many of our health plan clients asked for a value-based network for other lines of business.

In response, in June 2018, we announced the expansion of our value-based network solutions to

all Commercial and Medicaid clients for 2019. The Performance network and Performance Medicaid network are quality-based approaches to partnering with retail pharmacies that link reimbursement to quantifiable outcomes.

Beyond simply dispensing, these networks address quality measures related to some of the costliest therapy classes in the U.S. Participating pharmacies are evaluated for their performance related to **diabetes, hypertension, and cholesterol** adherence, as well as **asthma** medication therapy and **opioid** safety. In addition, this network provides clients with greater visibility into the performance of the pharmacies via a web dashboard called EQuIPP, bringing them new insight into their network's performance and placing further accountability on our pharmacy partners.

#### Our vision

Performance networks aim to make both pharmacies and clients more informed about member behavior when it comes to medication usage and adherence. By leveraging data tied to performance, pharmacies can see how greater member interactions can lead to higher rates of adherence, and can flag any at-risk members. Our hope is that by taking on some of the toughest challenges in our industry and costliest disease-states, a performance-based network will reveal new opportunities to directly improve member health.

#### About Express Scripts

Express Scripts is a healthcare opportunity company. From pharmacy and medical benefits management, to specialty pharmacy, and everything in between—we make healthcare better.

For more information contact: Jen Awsumb, Sr.  
Director Express Scripts Supply Chain,  
[jaawsumb@express-scripts.com](mailto:jaawsumb@express-scripts.com).



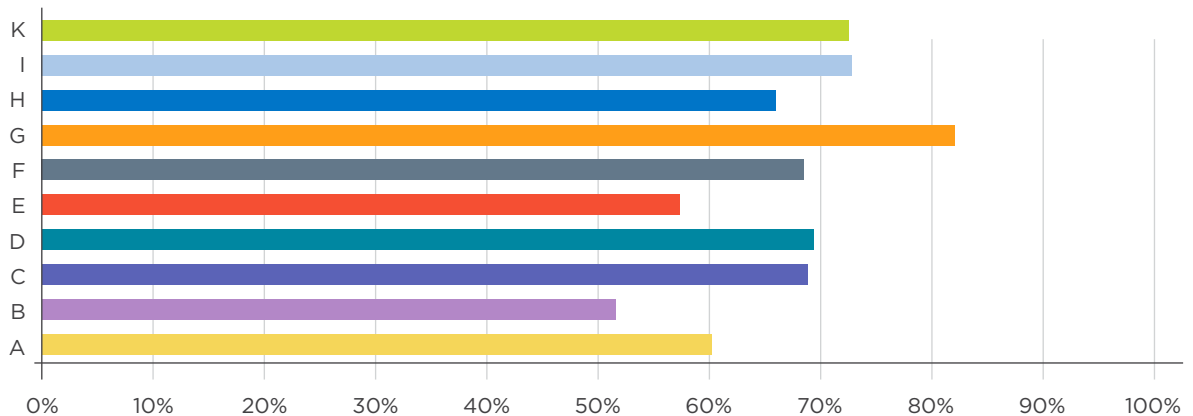
# Efficiency

This section assesses the breadth and types of management strategies PBMs use to assure appropriate, cost-effective utilization including education to physicians, requiring a trial period prior to mail order fill, avoiding duplicative refills by tracking multiple fills within a 90 day period for same therapeutic class, and managing cost by requiring filling of single agent drugs before filling a combination agent. We also evaluate the PBMs management of antibiotics of concern, a well-known public health threat.

While all respondents utilize a broad range of strategies (e.g., therapeutic interchange, step therapy, mandatory mail order refills), scoring differences were based on:

- Generic dispensing rate
- Addressing overuse of antibiotics of concern
- Programs in place to assure stabilization of medication regimens prior to filling drugs via mail service or extended retail

## EFFICIENCY & APPROPRIATENESS





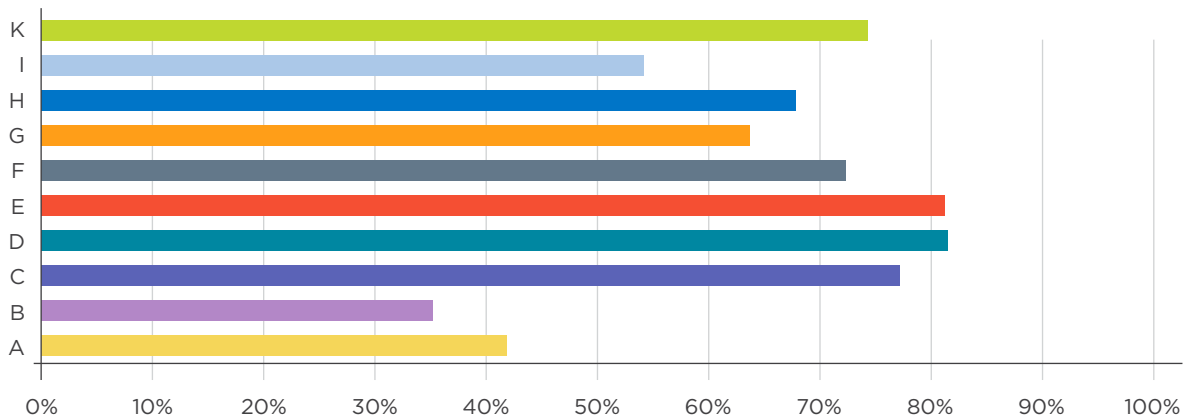
# Pharmaceutical Support: CAD, Diabetes, Mental Health

This section examines the PBMs ability to support patients with Chronic Disease or Mental Health issues, including adherence monitoring and coverage of behavioral and substance use medications

Scoring Differences were based on:

- Appropriate treatment of cholesterol in patients with heart disease
- Adherence monitoring (diabetes, CAD, depression and substance use) practices and rates (Note that adherence rates will be higher for those who send out automatic refills. Automatic refill programs may also lead to waste.
- Monitoring appropriateness of antidepressant and pain medication prescribing practices of practitioners.
- Coverage of and access to medications to treat substance use

## RX MANAGEMENT IN CHRONIC CONDITION MANAGEMENT



## ACTION STEP

### PRIMARY NON-FULFILLMENT

**Action Step:** Require your PBM to use the PQA measure to track primary non-fulfillment, and implement strategies to reduce it. Only one PBM requires Pharmacies to *track* primary non-fulfillment (First-time prescriptions not picked up at pharmacies), which can range as high as 30 percent.

**Why is it important?** Patients may be progressing to unnecessary and expensive complications because they don't pick up medications.



## SPECIAL REPORT

### MANAGING OPIOID ADDICTION WITH PREVENTION, TREATMENT, AND SUPPORT UNITED HEALTHCARE

Prescription opioid overdose is the leading cause of accidental death in the United States. UnitedHealthcare members with opioid use disorder (OUD) incur medical costs \$6,000 per year greater than members without OUD. The opioid crisis is potentially impairing the health and productivity of many Americans. It's an unprecedented epidemic that begins with illegal drug use or an opioid prescription.

The industry has been focused on prevention with the intention of decreasing opioid prescriptions to stop abuse before it begins. UnitedHealthcare's strategy combines data and analytics, medical and behavioral expertise, and research-driven solutions to:

- **Prevent** misuse and addiction by ensuring appropriate opioid treatment from the beginning.
- **Treat** those who are addicted by guiding individuals to effective treatment that is right for them.
- **Support** long-term recovery by helping individuals avoid relapse.

UnitedHealthcare's opioid management strategies promote safety and awareness with focus on preventing misuse and addiction through:

- Cumulative morphine equivalent dose (MED) limit
- New to therapy short-acting opioid MED and supply limits with recent modification to decrease the supply to 3 days or less for children/adolescents
- Refill too soon edit adjustment for controlled substances
- Concurrent Drug Utilization Review point-of-sale alerts to address dangerous combinations
- Continuous monitoring and outreach to address providers prescribing excessive opioids, members seeking opioids

from multiple providers and members using opioids when prescribed OUD medication

- Home Delivery dispensing limits

We have seen a decrease in the number of opioid prescription claims as well as approximately 95 percent compliance with CDC guidelines for initial prescriptions for those new to therapy. The 5 percent of non-compliant prescriptions are from individuals with cancer, end-of-life pain and members already established on therapy yet new to our plan. These prevention efforts have yielded a successful decrease in the volume of opioid prescription claims and the number of overdoses, but deaths continue to climb. In response, our work to confront the opioid epidemic continues with an emphasis on treatment.

Individuals must have access to the medical care they need, including Medication Assisted Treatment (MAT), in order to decrease overdoses and prevent deaths. MAT combines evidence-based behavioral therapy and medications to provide a "whole-person" approach to OUD treatment. A treatment plan that includes MAT dramatically improves recovery chances and reduces risk of fatal overdose. Adherence to MAT medications is monitored to help guide successful treatment. UnitedHealthcare will contact the provider and engage the member when non-adherence activity is identified through claims review, including failure to begin therapy, gaps in prescriptions or premature discontinuation of therapy. Target outcomes of this strategy include increased utilization of MAT and improved adherence.

#### About UnitedHealthcare

UnitedHealthcare offers a full-service pharmacy solution that drives value and lowers cost of care while improving member outcomes.

For more information contact: Jennifer Bradford, [jennifer.l.bradford@uhc.com](mailto:jennifer.l.bradford@uhc.com), (952) 202-7398.



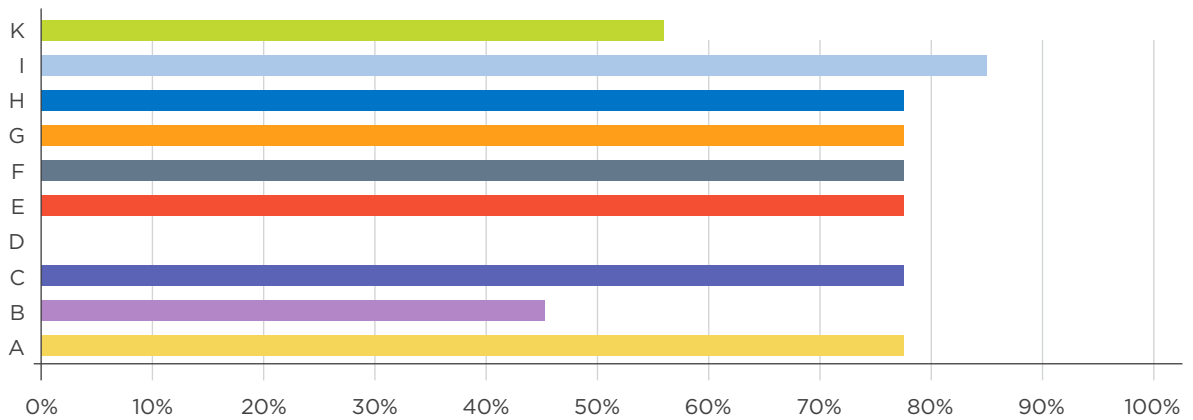
# Pharmaceutical Support: Tobacco and Obesity

This section measures how the PBM supports Rx coverage of Obesity and Tobacco medications, which can substantially affect these expensive and pervasive issues.

Scoring Differences in this section were based on:

- Options to reduce barriers for medications to treat tobacco cessation and for weight management medications.
- Whether the PBM provided guidance on eligibility criteria for covering medications for weight loss.
- Are PBMs advising clients that all tobacco cessation medications need to be covered with no out of pocket for members?

## RX MANAGEMENT IN TOBACCO AND OBESITY



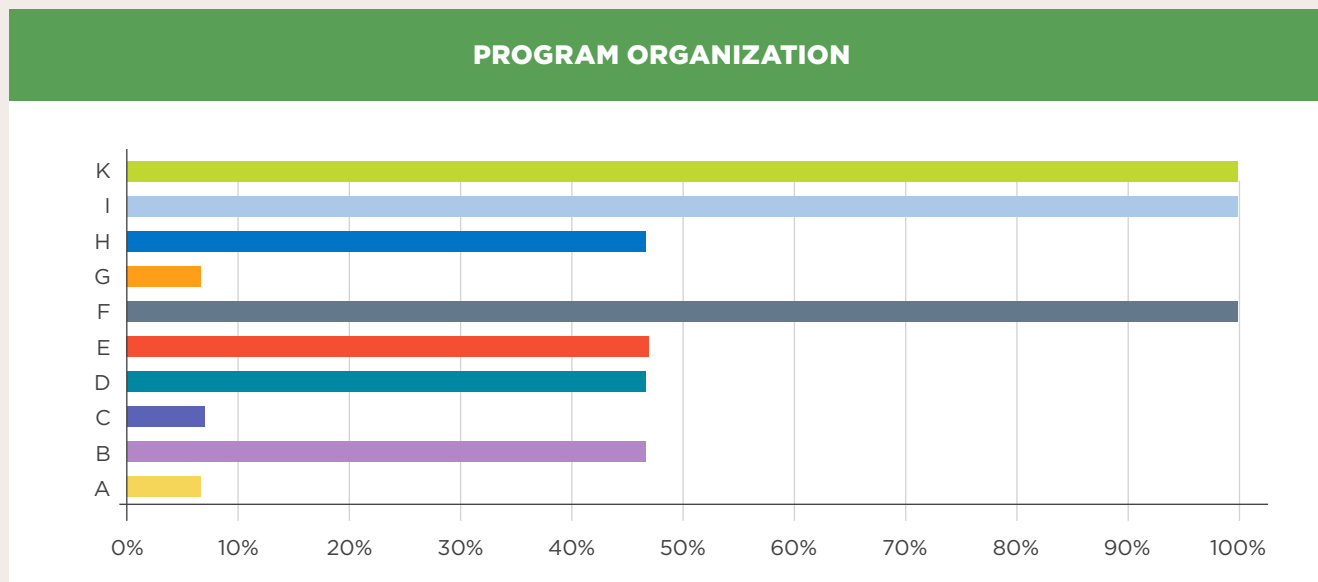


# Program Organization

This section assesses the PBM's ability to provide a Value-Based Formulary, implementation of Value-Based Insurance Design with client, and the PBM's flexibility.

Scoring differences are based on:

- The option of a value-based formulary that is based on evidence and not based on contracts with manufacturers
- The ability to provide an example of a value-based benefit design with at least one Employer
- Flexibility in allowing Employers to customize certain functions







## SPECIAL REPORT

### FORMULARY PERFORMANCE: THINK DIFFERENTLY TO MANAGE PHARMACY COSTS CIGNA

Drug costs (under pharmacy and medical benefits) are the number one driver of overall health care spend for an employer.<sup>1</sup> Contributing to drug cost growth is the fact that today, more than one in two American adults live with at least one chronic condition (e.g., diabetes, heart disease, depression) and nearly one in three have with two or more.<sup>2</sup>

Traditionally, Pharmacy Benefit Managers (PBMs) contract with drug companies to place drugs on their formularies using rebates to reduce costs and determine preferred placement. This method can lead to formularies containing heavily rebated drugs that have lower cost alternatives. And once these drugs are accessible, drug companies deploy couponing and advertising strategies to build consumer brand loyalty.

Cigna Pharmacy Management uses a low net drug cost formulary strategy that challenges drug makers to rethink their traditional pricing. This strategy removes high-priced, low-value drugs from the formulary—regardless of incentives—and instead promotes lower-cost, clinically appropriate alternatives. Encouraging the use of generics and preferred branded drugs that have the lowest net prices for similar health improvements is eliminating millions of dollars of unnecessary drug spending each year.<sup>3</sup> And it helps our clients and customers achieve immediate and sustainable lower drug costs.

While less than two percent of our customers were impacted by the drug list changes effective January 2017 for example, we decreased pharmacy costs for clients by an average of 3%–4%.<sup>3</sup> And Since 2016, this approach yielded a decreased overall pharmacy cost trend by 12%.<sup>4</sup>

To further illustrate these cost savings, the chart below highlights a price comparison of certain popular brand name drugs with their rate of inflation vs. their lower-cost alternatives.

Cigna has removed these drugs from our most utilized formularies:

DRUG	COST PER RX	COST OF ALTERNATIVE RX
Jublia (toenail fungus)	\$815	\$22
Vimovo (pain treatment)	\$2,144	\$10
Pennsaid (anti-inflammatory knee arthritis)	\$2,482	\$14
Doxepin (pain treatment)	\$1,108	\$215
EpiPen (Severe allergic reactions)	\$630	\$168

As you can see while rebates may reduce drug cost they often don't reduce them enough to compete with the savings of lower cost alternatives.

#### The bottom line

Employers should engage their PBMs to assess both the depth and breadth of their formulary strategies and the financial impact of their approach. And during this time of heightened concern about drug prices and transparency, customer savings should be a main consideration in assessing the success and performance of a formulary strategy.

Removing drugs from a formulary is a bold move. And so is foregoing rebates when appropriate since it can reduce competitiveness during client pricing exercises. But it's a necessary move—and a proven strategy—to help our clients and customers lower pharmacy claims costs now and in the future.

#### About Cigna

For over 24 years, Cigna's PBM has used holistic customer insights and integrated analytics to deliver a more personalized experience and, ultimately, better health outcomes and lower total medical costs.

For more information, please contact Kevin Buron.  
[Kevin.buron@cigna.com](mailto:Kevin.buron@cigna.com) 651.295.2078

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1. Cigna book of business national study 2016. Projection compares the following health care spend for medical service categories: drugs and biologics, inpatient facility, outpatient facility, professional services, other medical services.
2. Partnership to Fight Chronic Disease, 2016 National White Paper, [www.fghtchronicdisease.org](http://www.fghtchronicdisease.org)
3. Cigna's national book of business study of 1/1/17 formulary changes. Individual client results will vary.
4. Savings from 2016–2018 Q2 for formularies that use low net drug cost approach, uses average client pricing inclusive of both ingredient cost and rebate improvements, excludes global business.

# Consumer Engagement

This section examines the PBMs' policies and practices with regard to

- Racial, Cultural and Language Competency
- Alignment of Benefit Design/Incentives
- Price Transparency and Member Experience

## Why do we ask?

Because PBMs should know the cultural background and health literacy levels of their members so that they can connect effectively, should align their benefit designs with best value health outcomes, and should keep members aware of the cost implications of their pharmaceutical decisions.

## Overview of Consumer Engagement

### Racial, Cultural and Language Competency

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- Member Demographics & Sources of Information
- Provider Demographics
- Using the Information
- Health Literacy

### Alignment of Benefit Design/Incentives

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- Reducing Barriers for Chronic Disease
- Reducing Barriers for Acute Care

### Price Transparency and Member Experience

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- Cost Calculators
- Patient-Centered Care/Care Coordination

### Member Support & Programs- Cardiovascular Disease, Diabetes, Behavioral Health

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### Member Support & Programs, Tobacco and Obesity

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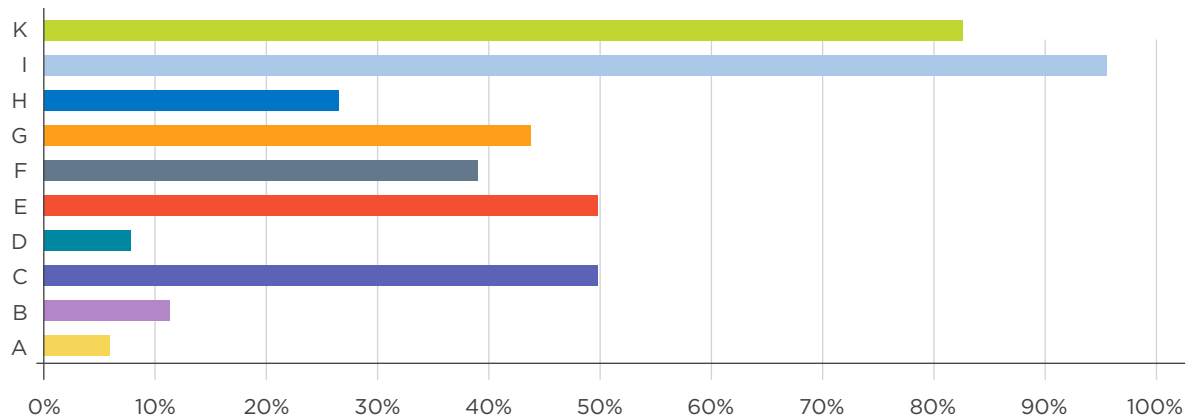
# Cultural Competency

This section measures how well the PBM supports and engages members with who are racially/ethnically/culturally diverse and may have limited language and health literacy

Scoring Differences in this section were based on:

Capturing demographic information on new and existing members and using information to support member's language and/or cultural needs as well as supporting those with health literacy limitations. We also asked if the PBMs evaluated the impact of their language and/or literacy activities.

## RACIAL, CULTURAL AND LANGUAGE COMPETENCY





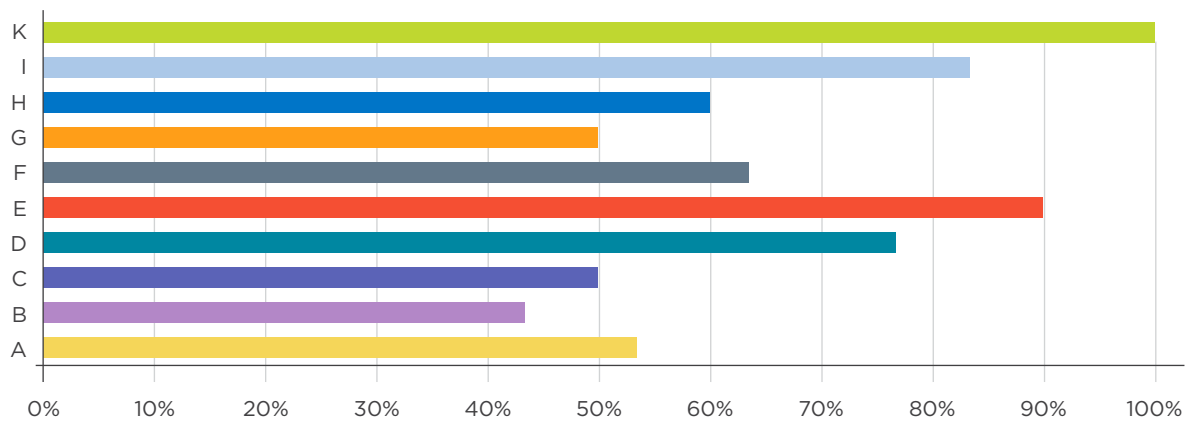
# Price Transparency

This section measures the scope of the PBM's cost calculator, whether members use the calculator, and whether impact is measured.

Scoring differences in this section were based on:

The calculator's content, functionality, specificity and account management capabilities, and whether there was an evaluation of the calculator (unique users, completed sessions and assessment of user satisfaction)

## PRICE TRANSPARENCY AND MEMBER EXPERIENCE





## SPECIAL REPORT

### POINT-OF-SALE REBATES

#### OPTUM RX

Point-of-Sale Rebate strategies have existed for a number of years with limited adoption, so what's with all the recent attention?

There are two key challenges impacting consumers and employers: first, the rising costs of prescription drugs set by drug manufacturers; and second, the increased number of consumers in high-deductible plans or plans where they pay a significant percentage of every prescription filled. These two challenges have resulted in more consumers shouldering the full financial burden of rising drug costs. While PBMs have negotiated with drug manufacturers to secure rebates that help lower the net cost of the prescription, historically these rebates have been passed along to the employer. The employer then leverages the rebate dollars to create a richer plan design (i.e. lower overall premiums) for all members, rather than using rebates to reduce the consumer's cost at the point-of-sale.

OptumRx is helping to change this dynamic. Our point-of-sale discounts are simplifying pharmacy benefits, expanding transparency and delivering savings directly to the member whose prescription generated the rebate payment.

Here is how the discounts work: when a member presents a prescription to the pharmacy or places an order for home delivery, OptumRx systems identify if that drug is eligible for a discount. If the drug is eligible, the discount is automatically applied to the member's prescription drug cost at the point-of-sale, resulting in lower out-of-pocket costs. Before presenting a prescription, members can also log in

to their benefit website or mobile app to see how the discounts will impact their cost-share amount.

By passing on rebates at the point-of-sale, employers are uniquely positioned to deliver new value and clarity to their pharmacy benefit design.

If you have an interest in a point-of-sale rebate strategy, partner with your PBM and health plans to understand:

- If rebates will be applied at the point-of-sale at an NDC basis
- The member and prescriber price-check tool experience
- How much of the future rebate yields will be passed on at the point-of-sale
- Administrative impact of point-of-sale rebates, including reconciliation and data sharing restrictions
- Implications to net client costs

#### About OptumRx

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OptumRx is a pharmacy care services company helping consumers and clients achieve better health outcomes and lower overall costs through innovative prescription drug benefit services.

For more information contact Don Houchin, Senior Vice President at OptumRx, [Don.Houchin@optum.com](mailto:Don.Houchin@optum.com), (713) 446-4045

# Business Practices

- Third Party Accreditations and Level of access for third-party audit
- Client Support: Data Analyses and Reporting; Beneficiary Communication and Outreach support; Co-ordination and Collaboration

## Why do we ask?

Because PBMs should meet professional standards and should be open to clients' audits, and exchange data effectively with other vendors. They should provide accurate, meaningful, and effective reports to their clients, and provide a level of guarantee for their services.

## Overview of Business Practices

### Third Party Accreditations (URAC)

- Level of access for third-party audit
- Outcomes-based contracting with Manufacturers
- Willingness to act as Fiduciary

### Client Support:

Data Analyses and Reporting; Beneficiary Communication and Outreach support; Co-ordination and Collaboration

- Employer Reporting: Type, Frequency
- Beneficiary Communication and Outreach
- Specialty Drug Reporting
- On-site pharmacy support
- Support direct contracting with Specialty Pharmacies and/or Manufacturer
- Program(s) to counteract Manufacturer co-pay assistance tactics



## ACTION STEP

### INNOVATIVE CONTRACTING

**Action Step:** PBM business practices have come under fire. Purchasers must let PBMs know that they are aware of new and different contractual structures, and considering them. Ask your PBM about its approach to these innovations, and discuss pros and cons to each.

**Why is it important?** Until their customers push back, PBMs will continue to engage in opaque practices that may not be in the client's or member's best interest.



## SPECIAL REPORT

### INNOVATIVE CONTRACTING PRACTICES

In response to increased scrutiny of PBM business practices, this year the National Alliance PBM Assessment asked about several innovative contracting practices that have been gaining interest. These questions are groundbreaking, and should get the attention of all purchasers!

#### Audits

We asked the nine PBMs whether they allow access to all claims over the life of the contract (four do); whether they provide a Maximum Allowable Cost (MAC) list for generics for review against paid claims (four do); whether they offer open book access to *pharmacy network* contracts and payments (three do); and whether they offer open book access to *pharmaceutical industry* contracts and payments (three do).

#### Outcomes-Based Contracting

We asked whether the PBMs have contracts that shift manufacturer rebates away from market share of medication, to outcomes in patients. Four of the PBMs said they had such contracts, if a variety of conditions, including Rheumatoid Arthritis, Obesity, Multiple Sclerosis, Cholesterol, Diabetes, Hepatitis C, Stroke, Heart Failure, and Cardiovascular conditions. However, only 3 of the 9 described the type of outcome measured, including such meaningful categories as prevention of relapse, hospital and emergency room avoidance, total cost of care, and medication adherence. *Only one PBM supplied information about the nature of the guarantee:* in this case additional rebates were paid by the drug manufacturer if goals are not met.

#### Outcomes-Based Contracting Direct Contracting

More aggressive purchasers have begun to express interest in establishing contracts directly with entities beyond PBMs. These contracts will still require PBM engagement for access and management purposes. We asked about whether the PBM could support purchasers in contracting with Specialty Pharmacies; and with Drug Manufacturers. This concept is very progressive, and the responses varied from a willingness to provide full support, to only offering consultative support for an additional fee. Some PBMs did not engage in this practice at all.

#### Programs to Counterbalance Manufacturer Copay Assistance Programs

Co-pay programs are designed to reduce the patient's share of drug costs which of course is a good thing. However, co-payments may be used to steer patients to higher value drugs, so co-payments are subsidized, patients are insulated from the high cost of a drug, which negates purchaser efforts to promote value. We asked whether PBMs had programs in place to counterbalance copay assistance programs for both traditional and specialty drugs.

#### PBM as Fiduciary

Most plan sponsors are well acquainted with the concept of acting as a fiduciary. In this case, we asked about the PBM's willingness to assume that role. This concept is very new, and may be too complex ever to take root. Accordingly, no PBMs currently act as fiduciary, and only five of the PBMs would consider this concept.





## SPECIAL REPORT

### HOW PLAN SPONSORS CAN USE AUDITS TO ENHANCE PBM PERFORMANCE

NAVITUS

When it comes to pharmacy benefits, today's marketplace is demanding more transparency, greater accountability and higher performance. One way plan sponsors can achieve these goals is to audit their pharmacy benefit manager (PBM). Through an audit, plans can get visibility into how their pharmacy benefit is working, hold their PBM accountable to the agreed services and recover funds lost through processing errors and overpayments. Ultimately, plans can use audits to identify opportunities for improvement and strengthen PBM performance.

Pharmacy benefits for an organization can consist of millions of claims and hundreds of millions of dollars. With multiple groups and complex plan designs one processing or coding mistake can turn into a huge expense. Any PBM can make mistakes and regular audits provide visibility so they can be corrected. However, audits can do much more. They allow plans to measure PBM performance against the contract. With a thorough claims analysis, audits evaluate every contract component from pricing, discounts and rebates to performance guarantees, plan design, clinical and eligibility. In the most transparent arrangements, plans may have audit privileges down to the claim level for all claims. However, audit rights can vary among PBMs, depending on business model and philosophy. Some may only provide a "claims sample" or small percent of claims and handpicked contracts, which limits visibility into performance and reduces opportunities for improvement.

With so many audit components, it may be difficult to decide where to start. One of the most important areas is pricing. This involves a thorough review and analysis of what the pharmacy was paid versus

what the plan sponsor was billed. In a traditional arrangement, the PBM may take a spread and charge the plan sponsor more than the pharmacy was paid. In a pass through arrangement, the PBM bills the plan the same price it paid to the pharmacy. This visibility can help plans determine if this is the best arrangement to meet their goals.

To get started with an audit, plans should consider using a reputable third party firm. Typically audits take anywhere from three to six months to complete. Although time and resource intensive, audits can reassure proper performance, identify opportunities for improvement and help recover lost dollars. According to a large consulting firm estimate, plans can expect to identify issues with three to five percent of claim costs with the potential to recover one to two percent. On the other hand, with more fine-tuned management plan sponsors may find minimal to no errors.

Plan sponsors who want greater transparency and accountability from their PBM should consider conducting regular audits. This will ensure the PBMs alignment to their goals and put them in a position to demand higher levels of service and performance.

#### About Navitus Health Solutions

Navitus is a full-service, URAC-accredited PBM. With a full pass through approach, Navitus delivers comprehensive clinical programs and cost-saving strategies to lower drug trend and improve health.

To learn more, visit [www.navitus.com](http://www.navitus.com) or call 877-571-7500.



## SUMMARY OF ACTION STEPS

- 
- ▶ Ask your PBM where **biosimilars** are positioned, and whether they are making efforts to increase uptake.
- 
- ▶ As an indicator of quality, ask about your PBM's **Hepatitis C** completion rate *using the PQA Standards*. It should approach 99%.
- 
- ▶ Ask your PBM to use the **PQA measure** to track primary non-fulfillment, and implement strategies to reduce it.
- 
- ▶ Ask your PBM to manage **community pharmacies** to drive quality improvement, using a neutral third-party measurement entity.
- 
- ▶ Ask your PBM about its approach to **innovative contract arrangements**, such as acting as fiduciary, allowing direct contracting, and outcomes-based contracting, and discuss pros and cons to each.

# 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. More below



Over the past 25 years, the **NATIONAL ALLIANCE OF HEALTHCARE PURCHASER COALITIONS** (National Alliance), has provided expertise, resources and leadership for its 50 purchaser-led coalition members across the US, representing each community coalition at the national level. The coalitions represent 12,000 healthcare purchasers providing health coverage to over 41 million Americans. Purchasers range from small and mid-sized companies to very large organizations (with over 5,000 employees).

We are a non-profit 501(c)6 membership organization located in Washington DC, and have launched several national initiatives that educate and support community coalitions and their member employers. National Alliance supports the promotion of value-based purchasing of health care services and seeks to accelerate the nation's progress towards safe, efficient, high-quality health care and the improved health status of the American population. We are dedicated to making the coalition movement the vehicle for meaningful change in the health care system throughout the United States.



**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 Marriott and General Motors to 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.

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