Health Plan Hub
Featured Content Archive

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#GSD Featured Content Archive

The #GSD site was created in 2021 specifically for commercial growth resources including monthly featured content. Commercial growth assets are on the Health Plan Client Hub, and below you can find all the featured content posts from the GSD site.

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Navigating Structural Shifts: What UnitedHealth's Challenges Mean for Health Plans

September 3, 2024

Brent Gibson
Strategic Planning Director

What happened:

UnitedHealth Group's recent results underscore the structural challenges reshaping the health insurance landscape. The company's latest quarter revealed that rising medical costs and higher-than-expected care utilization are not short-term issues — they represent a structural shift in the market. Seniors are accessing more services, care intensity is increasing, and the assumptions many plans used for pricing and trend management are proving inadequate. These dynamics are creating ripple effects across Medicare Advantage, ACA exchanges, and commercial markets, signaling that all health plans need to rethink how they manage cost, risk, and value.

The root causes of United's performance reveal trends that extend across the healthcare ecosystem. Medical cost assumptions proved far too conservative, particularly in Medicare Advantage (MA) and ACA exchange markets, where utilization surged as seniors resumed deferred care and care intensity increased. Medical trend is now running near 7.5% — well above the 5% pricing baked into 2025 bids — and could approach 10% in 2026. Additional pressures included Medicare funding cuts, operational strain within Optum Health due to risk adjustment changes, and $1.2 billion in discrete charges tied to exchange losses and settlements. The company lowered its full-year outlook and signaled that meaningful earnings recovery may not occur until 2026.

In response, UnitedHealth has made significant leadership changes and strategic pivots. Wayne DeVeydt, a veteran with deep payer and private equity experience, was appointed CFO, while Stephen Hemsley returned as CEO earlier this year to restore operational rigor. The company is aggressively repricing MA and ACA products for 2026, exiting unprofitable segments, and tightening operational controls through independent audits. At the same time, it is accelerating investments in AI-driven cost management and recommitting to value-based care partnerships to improve efficiency and outcomes.

Evernorth perspective:

UnitedHealth Group's recent struggles highlight systemic pressures that all health plans — and their partners — must navigate. The sharp rise in medical costs, particularly in Medicare Advantage and ACA markets, is not a temporary spike but a structural shift. Utilization patterns have normalized at higher levels, and care intensity continues to climb, signaling that trend assumptions across the industry need recalibration. For Evernorth, this means helping clients anticipate and manage sustained cost pressures rather than viewing them as short-term anomalies.

Regulatory scrutiny is also intensifying. Investigations into risk adjustment practices and PBM transparency are reshaping compliance expectations.

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These developments will likely lead to tighter oversight, higher administrative costs, and potential reputational risks for plans that fail to adapt. Evernorth is positioned to assist plans as a compliance and risk management partner, offering solutions that enhance coding integrity, audit readiness, and transparency in pharmacy operations.

Finally, investor sentiment toward the sector has shifted, as evidenced by the market's reaction to UnitedHealth's performance. This creates a ripple effect: plans will face greater pressure to demonstrate financial discipline, diversify revenue streams, and deliver measurable value in care management. Evernorth can play a critical role by enabling operational efficiency, leveraging advanced analytics for trend mitigation, and accelerating the adoption of value-based care models that align incentives across stakeholders.

In short, the industry is entering a phase where cost containment, regulatory resilience, and value-based transformation are non-negotiable. Evernorth's role is to partner with health plans to not only navigate these challenges but to transform them into opportunities for growth, efficiency, and improved outcomes.

Health plan considerations:

For health plans, these developments serve as an important signal to reassess strategies and prepare for a changing market environment. The drivers of UnitedHealth's challenges — structurally higher medical costs, regulatory complexity, and risk adjustment volatility — are industry-wide realities. Plans should revisit pricing assumptions, strengthen utilization management, and ensure risk adjustment accuracy. Plans must prepare for a more competitive and compliance-heavy environment, where operational discipline and data-driven cost control will be critical to sustaining margins. Finally, plans should carefully assess their reliance on external partners and prioritize working with vendors that have a proven track record of delivering measurable outcomes and operational excellence.

In the *AI* of the Storm: Intelligently Navigating Artificial Intelligence

July 29, 2025

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Artificial intelligence (AI) is rapidly transforming how we interact with the world around us – whether through our phones, at the doctor's office, or even the workplace – it is a technology poised to reshape industries in unimaginable ways. Within our industry, however, the future of AI is nuanced with additional factors - shifting member and provider needs, advances in healthcare, and navigating the ever-changing complex regulatory environment.

…
For the times, they are a changin'.
-Bob Dylan
…

So, what does this mean for health plans and our industry? How do we adapt and harness the power of AI to improve how we deliver healthcare to those we serve. **First, we must understand what AI actually is…So, what is artificial intelligence?**

Artificial intelligence is an umbrella term used to describe the science of making machines smarter and more capable. As such, we find it best to break down the nomenclature into four different types of AI:

+ **Machine learning** – where computers learn from data to make predictions or decisions without being explicitly programmed (e.g., spam filter on Outlook).

+ **Deep learning** – subset of machine learning using neural networks to analyze complex patterns in large data sets (e.g., smartphone facial recognition).

+ **Generative AI** – AI that creates based on a prompt, based on patterns it has used from existing data (e.g., song, image, or text).

+ **Agentic AI** – AI that can autonomously plan, make decisions, and take actions to pursue goals over time (e.g., AI assistant to book flights and adjust schedules).

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With the terminology in mind – let's talk about the regulatory framework developing for artificial intelligence…

The short answer? It's behind. Science and innovation are rapidly outpacing the development of regulatory framework and legislators cannot keep up.

At the federal level, there has been a shift in the direction of AI legislation and perception due to changes in presidential administrations. States, most notably California and Illinois, have taken proactive stances on AI regulation. For example, California has implemented use of AI (i.e., likeness) laws, whereas Illinois has focused on implementation of laws to prevent discrimination (e.g., during the hiring process). Currently, we're seeing significant developments around the use of AI chatbots and the necessity of disclosure pertaining to their use.

What is Evernorth doing with this new technology to improve the PBM experience? Let's look to our RFP language…

+ **Call center enhancements:** *Our call center plans to leverage tonal analytics software, which will apply AI and machine learning on every call for immediate representative coaching and call adjustments. Our call center technology will listen to and evaluate for immediate opportunities to improve the member exchange, focusing specifically on improving empathy, dialogue speed, listening skills, silence, and tone/sentiment of discussion, and providing real-time guidance while the representative is still engaged with the member.*
+ **The story: We're using AI to meet members where they are at, making them feel heard, and solving for the "people gap!"**

+ **Increased adherence:** *Using our machine-learning capabilities, we identified more than 300 different factors to help determine the likelihood a patient will not fill a prescription. They range from basic demographic data to behavioral data (e.g., one's level of forgetfulness and tendency to procrastinate, gleaned from patient-specific surveys). We then assign risk scores to patients and target them with varying modes of outreach. We have reduced non-adherence by 37% and saved our clients more than $180 million. Employers continue to have concerns with the usage of direct-to-consumer (DTC) health solutions. Forty-nine percent of those surveyed are concerned with the possibility of DTC solutions not being used to manage conditions properly*.
+ **The story: We can impact members' health and lower overall healthcare costs by using AI in ways never thought possible 20 years ago!**

+ **Physicians and prior authorizations:** *Doctors want to make decisions that benefit their patients' health. We want to enhance, not replace, a physician's ability to make those decisions. We are using machine learning and natural language processing to alleviate some of the burden associated with prior authorizations. We're improving the process by using data to inform and support decision-making efficiency. It will improve the member experience to have these prior authorizations approved in an automated, faster way.*
+ **The story: We're using AI to streamline the delivery of healthcare – for members, for providers, and for those working in between**

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For health plans, constant evolution and adaptation will be key for success as AI continues to transform healthcare and the member experience. At Evernorth, change means understanding direction and technological advancements in healthcare techniques and medicine. We must also adapt and adjust to legislative and policy changes, including changes in administration at the state, federal, and even international levels.

Thoughtful, flexible innovation coupled with responsibility will transform the comprehensive care that Evernorth offers, while keeping the service of clients and members as our North Star.

So, what can Evernorth clients do? What's the best way we can make the most of our partnership?

As Evernorth continues to evaluate and responsibly evolve, we will continue to keep you updated on AI. In the meantime, we encourage plans to do the following:

+ Continually evaluate your RFP language and sales communication on this topic.

+ Evaluate if any of the above considerations are appropriate for your organization.

+ Review the technology content posted on the Health Plan Hub - HPAC Technology Forum replays:
  + **Blueprints in the Digital Age**
  + **Innovative Partnerships**
  + **Strengthening Security**

+ Reach out to your health plan Account Team with any questions.

Guarantees in Flux: How Biosimilars are Reshaping Rebate Economics

July 29, 2025

Erik Popson
Director, Pricing Consultation
Health Plan Growth

For many years, Stelara and Humira have been two of the largest drivers of specialty spend and trend. They also provided significant rebate value. Recently, Biosimilars for both products have come to market, altering pricing dynamics for many stakeholders – from Manufacturers to Health Plans, PBMs, and employer groups - mainly due to two factors:

1) While biosimilar drugs often come to market with lower list prices, they also have little to no rebate value; this will change previous forecasted rebate accruals, making existing rebate guarantees unachievable
2) As Biosimilars become more readily available - even preferred or required on many formularies - utilization is starting to shift drastically towards these products

Typically while evaluating a bid, underwriting teams take existing utilization and forecast future earned rebates based on factors including inflation, annual rate improvements, and industry trends to determine appropriate guarantee amounts. These projections are often assumption laden with inherent risks. Given the disproportionate levels of spend on Stelara and Humira, shift from these products to lower cost and subsequently lower rebated products has significant impact on rebate value. The key challenge is producing a bid financially appealing to your clients while also providing financial consistency.

The market standard to account for this is to offer Rebate Credits to account for rebate reduction as utilization shifts to Biosimilars (often known as ***Rebate Reconciliation*** methodology). This allows the contracted rebate guarantees to remain market competitive (high), while allowing the difference in rebate value between the Originator product (i.e. Humira) and the Biosimilar to be paid via statement credit.

For illustrative purposes, the below is an example of how the rebate credit can work:

			Calculated As:
A	*Humira Rebate*	$5,000	-
B	*Biosimilar Rebate*	$50	-
C	*Humira Claims*	10	-
D	*Humira Biosimilar Claims*	10	-
E	*Total Guaranteed Rebates*	$100,000	*A*C + A*D*
F	*Total Humira Rebate*	$50,000	*A*C*
G	*Total Biosimilar Rebate*	$500	*B*D*
H	*Total Rebate Credit*	$49,500	*E-F-G*

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An example of Rebate Credit contract language is as follows:

Rebate payments may be credited to reflect the introduction into the market of Rebate-eligible drugs that are therapeutically equivalent, lower Rebate alternatives to Brand Drugs, or to account for the reduction in a Brand Drug's list price. The Rebate credit will not exceed the aggregate Rebates for the applicable Brand Drugs.

RFPs will have a variety of definition or language requests, and it is important to ensure your offer has the appropriate language related to how you construct your offer. Your ESI Growth Team can help craft this language as necessary..

The alternative to Rebate Reconciliation is to adjust rebate guarantees up front based on the expected shift to the Biosimilar products. This is often referred to as **Adjusted** or **Restated Rebates**. In this arrangement, there would be no rebate credits when claims shift to the biosimilar, and the presumed rebates attributable to Humira or Stelara (or other biosimilars) are all removed; however, there could still be rebate credits applied in the future due to government or manufacturer action, or the introduction of drugs with no current biosimilar alternative.

Key Rebate Adjustment Concerns:

1) It can make bids seem less competitive vs. other bidders who are not taking this approach, leaving their rebates high with rebate credits in place
2) Future launches of new Biosimilar products for other drugs will force you to continually adjust your rebate guarantees
3) Relies on consultant to evaluate bids appropriately, and not over penalize bids with lower rebate guarantees due to the adjustment
    - Note that the corresponding ingredient cost projection should also be lower
4) Aside from explicit formulary requirements, it is difficult to predict how much shift will occur from the original product to the biosimilar
    - Potentially over assuming shift, causing rebates to be "over-adjusted" and less competitive vs. other bidders
    - Potentially under assuming shift, causing potential for significant underperformance on rebate guarantees

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Key Takeaways:

- Biosimilars will continue to grow in market share for years to come, and bid level strategies based on specific brokers and competitors are of utmost importance
- It is crucial to understand the impact biosimilars have on your bid strategy and financial risk – particularly related to rebate payments
- If using Rebate Reconciliation (keeping rebates high and using rebate credits to account for the difference)—you must ensure you have proper Rebate Credit definitions and language in your bids and contracts
- If Adjusting or Restating rebate guarantees—be sure to clearly communicate this in your bid to ensure proper evaluation by the consultant, and understand this will likely require ongoing adjustment as new biosimilars come to market
- Work with your ESI Growth Team to ensure appropriate responses to RFP questions around rebate payments in order to portray your bid in the most favorable light relative to your competition, while protecting your financial risk

View from the outside: Competitive intelligence quick hits

March, 2025

Competitor solution updates focused on affordability and transparency

WHAT HAPPENED: During Q4-2024 earnings calls, we heard several competitors give solution updates that focus on improving price transparency and overall drug affordability.

CVS pharmacy®

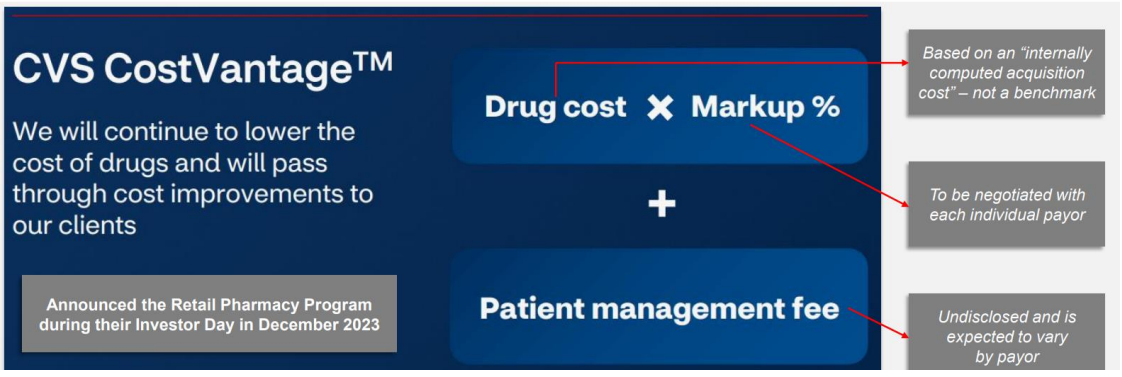
In January, CVS Health® announced that, starting this year, all commercial prescriptions at CVS Pharmacy® will be reimbursed through their CVS CostVantageTM model. While currently for commercial prescriptions only, CVS is targeting 1/1/2026 as the date Medicare and Medicaid scripts will flow through this model as well.

As a reminder, CostVantage is CVS's retail pharmacy reimbursement model where CVS pharmacies will be reimbursed based on an acquisition cost plus an undisclosed percentage margin (or markup) and a flat fee for pharmacy services. From a consumer perspective, the patient will not see a change at the point of sale; however, the variables of the cost equation are known only to CVS (see visual below):

+ Drug cost is based on an **internally computed acquisition cost**, not an industry benchmark.
+ Markup percentage is **negotiated with each individual payer**.
+ The patient management fee is **undisclosed** and is expected to vary by payer.

CVS's Cost-Based *Retail Pharmacy* Announcement

CVS pharmacies will be reimbursed for prescriptions based on an acquisition cost plus an undisclosed percentage margin and a flat fee for pharmacy services



Health plans may be asking why CVS is unveiling this new reimbursement model. It is to bring visibility and predictability to retail pharmacy margins, which have been a drag on company earnings over multiple recent quarters. Pharmacy and Consumer Wellness (Retail Pharmacy) segment margins have been declining, with further decreases expected, and CVS is using this new reimbursement model to address its struggling segment.

Optum Rx®

UnitedHealth Group® announced during their Q4 earnings call in January that Optum Rx® is committing to pass through 100% of rebates negotiated with drugmakers to clients by 2028. Optum Rx currently passes through 98% of rebates to clients, with the remaining 2% in a more traditional model—because that's their preference. Optum will be encouraging clients to pass along the rebates to patients at the point of sale.

According to UnitedHealth Group CEO Andrew Witty, this commitment is linked to the idea that people may lose track of money put into the ecosystem under the traditional rebate model, and that's the source of much of the frustration with how PBMs operate. Witty said this commitment "takes away the excuse of who really is setting the price" for drugs, shifting blame for high drug prices back on the manufacturers.

EVERNORTH PERSPECTIVE: In response to industry criticism of lack of transparency, Express Scripts by Evernorth® announced its new Pharmacy Benefits Summaries and Disclosures reports, which give patients and plan sponsors a clearer view into what their spending looks like and any discounts Express Scripts negotiated. The report will cover their total annual drug costs, including list prices; negotiated savings, including discounts and applicable rebates; what their plan paid; and total savings. Express Scripts will also generate annual standardized reports for plan sponsors that disclose costs and pharmacy claim–level data, which will allow for further insights beyond those the PBM already provides.

From an affordability perspective, Evernorth® Health Services pledged to give more patients a lower price for prescriptions even if they haven't reached their deductible. Patients will be protected from paying the high list price of their medication and will instead get access to the lower price negotiated by Express Scripts. This will ensure patients do not end up paying more than the employer would at a negotiated rate.

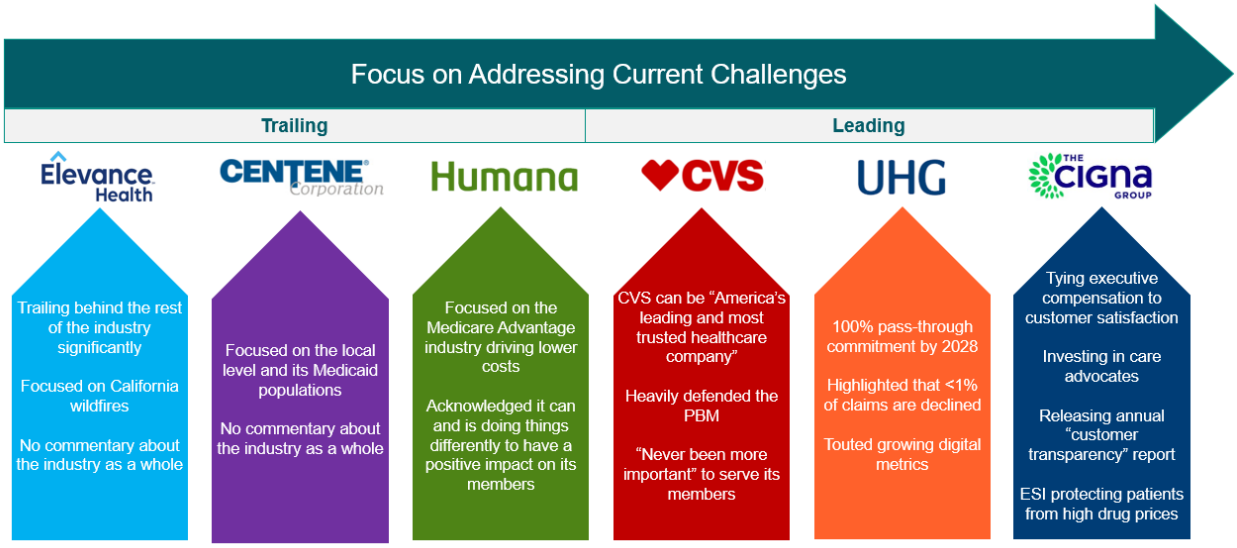
HEALTH PLAN CONSIDERATIONS: Health plans must continue to present strategic opportunities to clients that provide care and services to members that are less confusing, less complex and less costly. Health plans can empower their members by equipping them with tools and resources to make significant financial decisions regarding their health care. Health plans can also ensure that they are aligning themselves to key strategic partners, including Evernorth and Express Scripts, that are taking a leading role in making health care costs more affordable and transparent.

Competitor response to health care industry sentiment

WHAT HAPPENED: In the aftermath of the murder of UnitedHealthcare® CEO Brian Thompson in December, public scrutiny centered around the rising costs, care denials and, for some, the inaccessibility of health care. During the Q4-2024 earnings season, we heard from payers who had varying responses to these events, including opinions on who is responsible and what investments are being made to improve the system so that it works better for everyone.

See below for a visual illustrating the various competitor responses to the current environment

Competitor Response to Current Environment



Source: Based on commentary from latest releases and respective Q4 2024 earnings releases and transcripts

Competitor responses fall into three tiers:

- **<u>Leading Tier</u> addressed broad industry challenges** – The Cigna Group, UnitedHealth Group, and CVS
  - All three MCOs talked about the industry as a whole and the efforts each is working on to improve how the system works better collectively.
  - All three defended the role that PBMs play in lowering drug costs (i.e., drug manufacturers are primarily responsible for the rising drug costs).
  - Solutions introduced include the following:
    - The Cigna Group: Tying executive compensation to customer satisfaction (Net Promoter Scores); investing in more care advocates; publishing a new annual "customer transparency" report that offers greater clarity into how it operates, including details on services and resolution statistics; and transparency and out-of-pocket cost commitments from Express Scripts

EVERNORTH HEALTH SERVICES

    - UnitedHealth Group: Committed to “full PBM transparency” by introducing 100% rebate pass-through model for OptumRx by 2028; touted metrics/investments to improve consumer experience through digital channels

- **<u>Middle Tier</u> addressed industry challenges through the perspective on their product focus** – Humana and Centene
    - Humana highlighted industry and organizational challenges related to the Medicare Advantage market and cited proof points to suggest the value of Medicare Advantage over traditional Medicare.
    - Centene highlighted the company’s work toward serving its communities, but that was more focused on the local Medicaid teams’ efforts in developing programs at the state level.
- **<u>Bottom Tier</u> did not address industry challenges** – Elevance Health
    - Elevance only extended sympathies to those affected by the wildfires in southern California and did not comment further on industry challenges.

EVERNORTH PERSPECTIVE: Evernorth® Health Services and Express Scripts by Evernorth® continue to be leaders in driving better access to care, easier navigation, greater value for members, accountability and transparency. While most peer companies pledged to make changes and investments to ease customer pain points, Evernorth was the first to provide specific next steps. Along with tying enterprise leadership compensation to member satisfaction, we are making meaningful change to the member experience by adding new concierge teams to support customers experiencing challenges, as well as introducing enhancements to the digital status tracker that patients can use for care updates.

HEALTH PLAN CONSIDERATIONS: In these challenging and uncertain times, health plans should prioritize strategies to improve the member experience while also easing burdens on both patients and providers. These strategies can include data-driven personalization, digital self-service options and a customer-centric purpose. Health plans should also ensure that they are aligning themselves to key strategic partners, including Evernorth, that have signaled clear paths forward to easing member pain points and putting teeth behind their commitments.

View from the outside: Competitive intelligence quick hits

December, 2024

Recent competitor M&A strategy shift from primary care to home health and specialty

WHAT HAPPENED: In the years following the COVID-19 pandemic, integrated health care companies saw an opportunity to make investments in care-delivery assets, specifically in primary care, as a lever to manage members in low-cost settings, keep patients out of emergency rooms, and, as a result, lower costs and expand margins on those populations. The thought was that owning your own clinics would improve the patient experience and increase touchpoints with high-cost members who might otherwise wind up in the hospital, ultimately leading to improved outcomes. We saw multiple examples of competitors acquiring primary care assets with the above goals in mind, including the following:

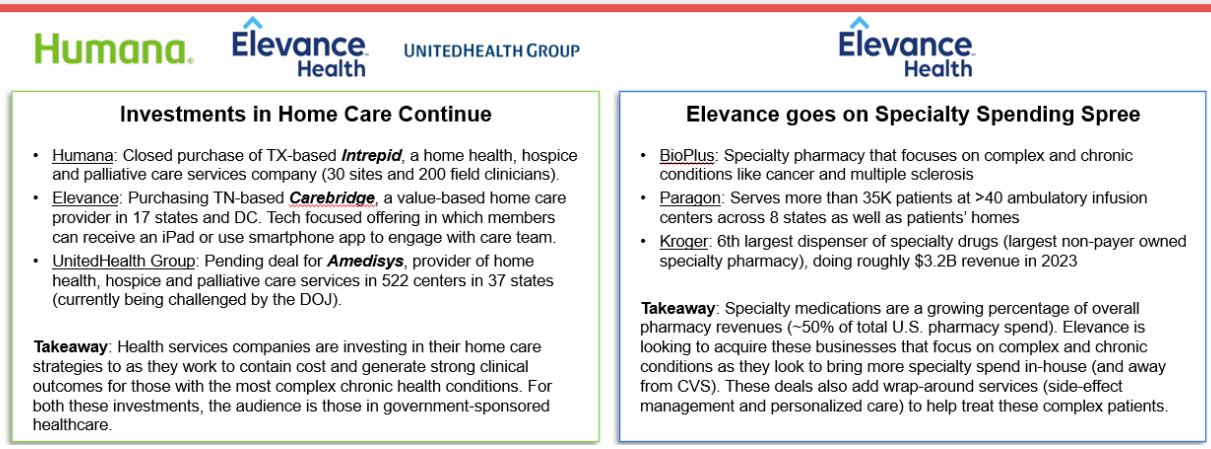
+ CVS Health acquired Oak Street for over $10B, projecting more than $500M in synergy potential between the organizations at the time.
+ Walgreens invested $5B in VillageMD, with plans to co-locate VillageMD clinics within Walgreens stores.
+ Walmart opened 51 primary care clinics in their superstores across five states, offering primary, dental and behavioral health care as well as select lab services.

To date, these investments have largely not performed to company expectations, with some of the competitors exiting their position entirely:

+ CVS Health: Oak Street continues to be unprofitable, and it has been acknowledged that the company grossly overpaid for this asset; however, according to leadership, their strategy of continuing to expand Oak Street's clinic footprint is moving forward.
+ Walgreens: Walgreens is attempting to reduce its position in VillageMD after taking a $6B impairment charge on the asset earlier this year. CEO Tim Wentworth said that VillageMD will not be a part of Walgreens' core strategy moving forward.
+ Walmart: Walmart announced it would close all 51 of its clinics and end virtual care offerings, citing the business was unprofitable.

EVERNORTH HEALTH SERVICES

Over the past several quarters, we have seen a notable shift from health services investments in primary care clinic ownership to investments in home health and specialty pharmacy assets. The below visual outlines the home health acquisitions of Humana, Elevance and UnitedHealth while also summarizing Elevance's three deals in specialty pharmacy.



Additionally, Elevance continues to prioritize care enablement over ownership of care-delivery assets: it recently launched Mosaic Health, a joint venture with private equity firm Clayton, Dubilier & Rice (CD&R), to bring together care enablement assets of Carelon Health and CD&R portfolio companies Millennium Physician Group and apree health.

EVERNORTH HEALTH SERVICES PERSPECTIVE:

Integrated players will continue to pursue care model improvements, specifically as they relate to managing the costliest members, many of whom have complex chronic conditions. On home health, the audience for these assets is primarily members in government-sponsored programs, including Medicare and Medicaid. As some plans continue to double-down on Medicare and Medicaid, many believe that care in the home at scale will ultimately lead to cost reduction. Competitors continue to view specialty pharmacy as a significant lever for revenue growth and margin expansion. In the case of Elevance, acquiring specialty assets (BioPlus, Paragon and Kroger) coincides with bringing specialty spend in-house—into CarelonRx and away from CVS Specialty. Additionally, these specialty deals add wraparound services that will help manage members with complex chronic conditions.

HEALTH PLAN CONSIDERATIONS:

We expect that integrated players will continue to highlight their flywheel of capabilities, including care delivery and pharmacy assets, when going out to bid to renew existing or win new business. Health plans should continue to emphasize their own value-of-integration story when going to market, along with promoting the capabilities of key strategic partners, including Express Scripts by Evernorth®.

EVERNORTH HEALTH SERVICES

View from the outside: Competitive intelligence quick hits

November, 2024

CVS ousts CEO as rumors of potential breakup swirl

On October 18, CVS Health announced that the company was replacing CEO Karen Lynch with Caremark President David Joyner. CVS, which cut its financial expectations for the third time this year in August, said that Q3 earnings will fall short of expectations. Earlier in October, multiple news outlets reported that Glenview Capital, a hedge fund that owns 1% controlling stake in CVS Health stock, met with CVS executives to explore operational improvement options. According to reports, CVS's board had already hired bankers to conduct a strategic review of the entire company, up to and including a potential breakup of assets. These headlines come amid significant financial struggles for the company, which has frustrated investors who have seen the company's stock value drop in half ($120 vs. $60) over the past two years. This has been the result of operational headwinds across all of CVS's business segments (see image below), leading to instability and uncertainty across the enterprise.

Q1

- **Lowers** '24 EPS guidance by -18% from its initial Investor Day projection
- MA **utilization higher** than expected
- Unlike most others, utilization is in outpatient **AND inpatient**
- MA STAR rating drop and Centene loss impact felt

Q2

- **Replaces President of Aetna**, Brian Kane – Karen Lynch to lead Aetna
- **Lowers** '24 EPS guidance by an additional -7%
- Seeks **PE investors** to grow Oak Street clinics

Q3

Prior to its Call

- **Replaces** CEO Karen Lynch with Caremark President, David Joyner
- Withdraws 2024 guidance
- Potential enterprise **break-up**
- **Downsizes** infusion business (Coram)
- Lays off 2,900 corporate roles

Q4?

What to Expect?

- New **Aetna CEO** is one of the top priorities
- Insights on **strategic review** efforts
- Context on the other potential leadership changes
- Rebound potential for the Health Benefits business after major Q3 headwinds

Mounting Challenges & Instability Across CVS:

- **aetna**: Medical costs above expectations. Now, focused on a path to margin recovery. **Expect member attrition due to pricing changes**
- **CVS caremark**: Unlike others, facing industry scrutiny as a PBM and retail pharmacy. **ESI tops CVS in PSG customer satisfaction scores**
- **CVS pharmacy**: Growing reimbursement and labor pressures. Growing store closures. **Retail offerings are available to ESI members**
- **Oak St. Health / minute clinic**: Needs external dollars for OSH growth looking to PE. Growing MinuteClinic closures. **Adding to financial pressures for the enterprise**

Potential Impact for Clients:

Poorer Service Performance

Employee Turnover | **Leadership Changes** | **Additional Lay-Offs**

Less Products | **Less Programs**

Investments Internally vs On Clients

=

Instability & Uncertainty

Industry experts believe breaking up the company would bring certain challenges. For example, dismantling the organization could leave certain units struggling independently given the interdependencies between them, which could in turn jeopardize customer retention and revenue streams. A breakup also raises concerns about a disruption of synergies between CVS pharmacy services and its PBM, CVS Caremark; such synergies have been at the center of CVS's PBM value proposition when selling to prospective clients. Additionally, with CVS investing more than $88 billion in acquisitions over the last six years (inclusive of the 2018 deal for Aetna for $69 billion), the company would first want to explore any strategic pathway possible before divesting assets so soon after acquiring them.

While insiders are skeptical that a breakup would actually happen, the fact that it is even being discussed is telling enough of the challenges the company is facing. In the near term, CVS announced plans to lay off 2,900 employees (~1% of its workforce, primarily in corporate roles) as part of a $2 billion cost-cutting initiative. Additionally, the company will be discontinuing certain infusion services within its Coram business and plans to close or sell 29 regional pharmacies in the coming months.

EVERNORTH HEALTH SERVICES PERSPECTIVE:

Creating efficiencies across businesses is easier said than done, and CVS will be focused internally on fixing issues across its assets in the near to mid-term. The managerial complexity of developing synergies across a complex health care enterprise such as CVS's may distract them from being able to provide the best service and innovation for its clients.

HEALTH PLAN CONSIDERATIONS:

Express Scripts by Evernorth® and its health plan partners are the unquestionable market leaders in driving affordability and accessibility, as well as innovating, in this dynamic industry and are a safe haven for clients. Thus, when CVS Caremark or Aetna is the incumbent, we must promote our stability and proven abilities.

Retail pharmacies struggle nationwide

Across the country, retail pharmacies are closing their doors, potentially resulting in access concerns for the patients who rely on them to fill their prescriptions. In the past few months, retail pharmacy giants CVS, Walgreens and Rite Aid have all announced significant reductions to their national store footprints: Rite Aid is closing ~25% of its stores nationally, Walgreens is closing ~14% and CVS is closing ~10%. The table below provides further details on the headwinds facing these national brands as well as details around store location closures.

CVS pharmacy	• **Reductions to Earnings Projections:** In October, withdrew FY24 adj. EPS guidance after lowering guidance each of the past two quarters – previous revisions had FY24 guidance declining -25% Y/Y
	  ○ Stock is down nearly 30% YTD, driven by headwinds across all segments
	• **Leadership Changes, Restructuring, & Layoffs:** Replaced CEO Karen Lynch with Caremark President David Joyner, while rumors suggest the board has explored breaking up enterprise assets
	  ○ Downsizing infusion business (Coram)
	  ○ Announced layoffs of 2,900 corporate roles
	• **Store Closures:** On-track to achieve three-year goal of closing 900 stores by the end of 2024 (~10% of national footprint), with the remaining stores all being profitable

Walgreens	• **Reductions to Earnings Projections:** Lowered its FY2024 adj. EPS guidance for the second time this year, with FY24 guidance representing -28% Y/Y decline, driven by retail pharmacy challenges
	  ○ FY25 guidance projected to decline -44% Y/Y, as retail pharmacy reimbursement pressures expected to persist
	• **Write-Down of VillageMD Asset:** Attempting to reduce its position in VillageMD, as it has not been profitable for WBA, and the company believes it is no longer core to WBA's long-term strategy
	• **Store Closures:** ~1,200 stores will close over next three years (~14% of national footprint), including 500 in fiscal year 2025
	  ○ ~25% of WBA stores are not currently profitable

RITE AID	• **Bankruptcy Filing:** Completed restructuring process after filing for bankruptcy in October 2023
	  ○ Restructuring process has eliminated $2.0B of debt and the company has $2.5B in exit financing supporting the business operations
	  ○ Sold Elixir PBM to MedImpact
	• **Changes Post-Bankruptcy**: Now a privately held company with "a rightsized store footprint, more efficient operating model, significantly less debt and additional financial resources"
	  ○ Company's CFO, Matt Schroeder, was appointed CEO as part of the transition
	• **Store Closures:** Closed 520+ locations in bankruptcy (~25% of the 2,111 stores open at the time of the bankruptcy filing)

Retail pharmacies are struggling for many reasons, including external environmental pressures and self-inflicted wounds:

- Store footprint overexpansion
- A declining member experience, both in store and online
  - Chronically understaffed stores
  - Limited shopper incentives
  - Increased shoplifting, with stores resorting to locking up merchandise
  - Inability to build a meaningful online presence
- Increased competition from e-commerce retailers and pharmacies (e.g., Amazon, Walmart, Costco); additionally, the recent announcement that Amazon and Walmart are expanding their same-day pharmacy-delivery programs
- Failed growth strategies, including enterprise investments in primary care assets
  - Walgreens invested $5.2B in VillageMD in 2021, and the asset has yet to turn a profit

EVERNORTH HEALTH SERVICES

    - CVS acquired Oak Street Health for $10.6B in 2023, and the clinics continue to be unprofitable (rumors include CVS needing capital if it intends to expand its clinic footprint)
- Retail pharmacy reimbursement pressures; for example, Walgreens leadership stated the company will “walk away from a negotiation if they cannot be reimbursed fairly and in a sustainable way”

EVERNORTH HEALTH SERVICES PERSPECTIVE:

Integrated players, such as CVS Health, which own both a health insurer and a national retail pharmacy chain, will always look to benefit their own insurance plans first and foremost, ahead of other plans. As these national pharmacy chains continue to face financial headwinds and look to gain margin in any way possible, other health plans need to be mindful of choosing the right partners.

HEALTH PLAN CONSIDERATIONS:

Express Scripts Pharmacy by Evernorth® is the market leader in home delivery. The rightsizing of a number of retail pharmacies in a health plan’s network provides an opportunity to promote home-delivery value proposition and, in turn, increase adoption among eligible populations and members who may be impacted by pharmacy closures.

Don’t Lose Out When Medicare Members Age In

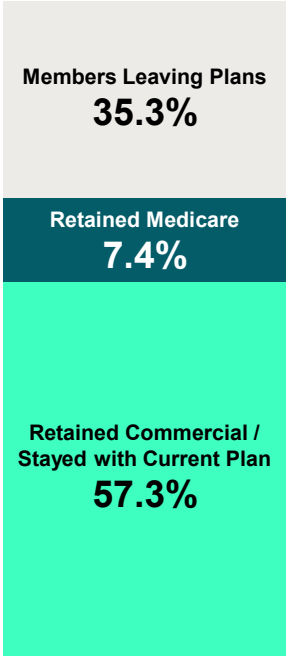
November 4, 2024

Frank Civitarese
Senior Advisor
Business Development

Fall is more than cooler weather, football and pumpkin spice lattes: It is also the Medicare Annual Enrollment Period (AEP). You may not be looking for a Medicare plan this fall, but how many of your commercial members are? How many members in your book are aging-in to Medicare, and will they pick your plan? Our book-of-business data suggests that the average health plan has a one-in-five chance of retaining Medicare eligibles when they elect to enroll. A focus on this population and the right strategy can help increase those odds in your favor.

What Does Our Health Plan Book-of-Business Data Tell Us?

We studied three years of our health plan enrollment data, examining plan choice by Medicare-eligible members. We identified members turning 65 and older and tracked their plan selections by year. As of 1/1/24, our data showed that the 57% of members who were in employer coverage or who delayed retirement chose to stay with their current plan; these are working seniors who are putting off retirement. For those who moved off their employer coverage, we saw only 7% choose a Medicare product with their issuer of record. The remaining 35% of members who moved left their issuer altogether.



Where do these members go? They are likely opting in to traditional Medicare or choosing a Medicare Advantage Prescription Drug (MAPD) product from another issuer. This information illustrates an opportunity to better understand member behavior to help retain more of your existing Medicare age-in members.

How Effective is Your Medicare Advantage Age-In Strategy?

Recent research from Deft indicates that nearly 70% of age-ins begin researching Medicare options six months before their 65th birthday. Whether they are enrolled in employer coverage, in Medicaid or through your marketplace business, early engagement is the key. Plans should tailor strategies to address concerns unique to each market and member cohort.

A well-structured age-in strategy is crucial for capturing and retaining members who are nearing 65 or ‘ageing-into’ Medicare. Attracting these enrollees at the right time is rooted in two key areas: early engagement and maximizing your competitive edge.

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Market Trends Impacting Age-In Strategies

Recent trends in the Medicare Advantage (MA) market highlight the importance of timely and targeted age-in strategies:

- **An emphasis on added benefits:** The growth of MA enrollment continues to outpace that of Original Medicare. More individuals turning 65 are opting for MA plans, driven by their added benefits, such as dental, vision and wellness programs. Plans need to capitalize on this trend by emphasizing these advantages in their age-in strategies.
- **Increased digital engagement:** As more baby boomers age into Medicare, their familiarity with digital technology is influencing their decision-making process. More than ever, prospective enrollees are using online resources to research and compare MA plans. Insurers must invest in a robust digital presence, including user-friendly websites, mobile apps and targeted digital marketing campaigns.
- **Early research and decision-making:** Deft Research illustrates how engaging members early and often is critical to success. It isn't enough to start messaging six months before a prospect's 65th birthday; earlier personalized messaging is needed to educate and guide members through the decision-making process.
- **Diversity:** With more people delaying retirement and continuing to work past 65, the age-in population is becoming more diverse in terms of income, health needs and plan preferences. Plans must be prepared to offer a variety of plan options and to tailor their marketing messages to different segments within the age-in group.

Retention and Engagement Best Practices

- **Welcome kits:** Send comprehensive welcome kits with plan details, contact information and tips on maximizing benefits.
- **Regular communication:** Maintain consistent communication through newsletters, emails and personalized messages, giving members access to resources and tools to help them make a more informed decision.
- **Feedback mechanism:** Implement channels for feedback, and address concerns promptly. Early positive experiences are crucial for retention.

We are here to help.

Reach out to your Medicare Growth Consultant to benchmark your age-in retention data against our book of business and take our self-evaluation to see where your best opportunities are. We can help guide you through industry best practices.

Our data-driven insights and your self-evaluation are designed to maximize your member engagement. As the MA market grows increasingly competitive, staying informed and adaptable will be key to maintaining your edge.

Giving Credit Where Credit is Due

A recap of recent industry events and their impact on rebate guarantees

August 28, 2024

Erik Popson

Director of Pricing Consultation
Health Plan Growth

Background

Over the last 12–18 months, major industry changes have impacted rebates, due largely to the advent of two market events. This briefing seeks to address these notable changes to support you as you continue to work through prospect and renewal opportunities.

First up is the **American Rescue Plan Act (ARPA), commonly referred to as the AMP CAP Removal.** As noted in our briefing from May 2023, ARPA removes the 100% cap on rebates as a percentage of the **average manufacturer price (AMP)** that manufacturers must pay in Medicaid rebates, thereby increasing the amount of rebates to be paid to states through Medicaid. To reduce their potential risk of paying increased rebates, many manufacturers have reduced the list price of their drugs (notably those manufacturing drugs for diabetes and COPD).

The second market event impacting rebates is the growing uptick of **biosimilar products available** in place of Humira®. Humira, a biologic drug that is typically the largest driver of specialty drug spend, now has a variety of biosimilars available, many of which are considered “low-WAC” products and often have no rebates available. As a result of these new, lower-cost biosimilar alternatives, what was once a large driver of specialty-rebate value for plan sponsors is now being significantly reduced or completely eliminated. The challenge for both PBMs and health plans has become forecasting what the impact of shifting to the low-cost biosimilar alternative will be while also showing competitive value during the bidder process.

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The following table serves as a high-level comparison of these two industry challenges:

Biosimilars	AMP cap
New alternatives of complex molecule drugs released into the market as competition to existing drugs (namely, Humira); not the same as a generic option	Drug price reduction as part of pharmaceutical manufacturers' response to legislative action, namely in two drug categories: Insulin and Asthma
Priced two ways: 1) In- line with existing products (referred to as high-WAC), often accompanied by a rebate 2) Low-WAC, often resulting in a net price comparable to the post-rebate high-WAC product	Takes previously high-list-price brand-drug medications and lowers the AMP by 50% or more, resulting in a lower expected rebate yield
New wave of biosimilars expected to enter the market in upcoming years, impacting other high-cost drugs, including Stelara® and Enbrel®	Currently a defined list of products comprising 73 drugs across 105 NDCs; possible that additional drugs are added in the future
Typically included in rebate minimum guarantees, though rebate credit language still expected to be acceptable in contracts	Reduced AMP expected to be factored into rebate guarantees as the list price reduction is present in 2024 data

Consultant feedback and expectations

Consultants are keenly aware of these events and typically ask pointed RFP questions or pose requirements about how they are factored into vendor bid submissions. Some examples include the following:

- "Bidder agrees that contract rebate guarantees are not subject to change because of known brand patent expirations and **introductions of their biosimilars** or generics into the market."
- "Bidder agrees if rebates are no longer available in the market that the Bidder will work in good faith with the Client and its Designee to establish a fair and equitable adjustment based on market conditions."
- "Confirm your offer accounts for the impact of Humira Biosimilar products, Stelara Biosimilar products and all known AMP Cap adjustments including Insulin products and respiratory agents."
- "After a Rebate Credit is accounted for in a Contract Year, any PBM pricing offered (whether initiated during a market check, renewal, or otherwise) in subsequent Contract Years will be underwritten into PBM's then current financial offer."
- "For the formulary you are bidding with, if Humira biosimilars are eligible for minimum per brand script rebate guarantees, confirm whether any rebate adjusting/offsetting/crediting can be applied."

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These questions and others like them are aimed at capturing the intent of your rebate offer and how you will treat price reductions moving forward. It is important that you respond in a way that casts your bid in the best light while protecting the risk you take on in your underwriting. Your Express Scripts by Evernorth® Growth Team is more than happy to assist in crafting appropriate responses as you continue to work through these competitive bid situations.

The latest and why it matters

In 2023 and early 2024, "**rebate credits**" were widely accepted to offset both market events, whereby the PBM could take credit for the difference between the prior cost of the drug and the new lower cost of the drug in the form of crediting the rebate dollars. It was deemed an equitable process because at the time of bidding, there would have been no way to account for these impacts when forecasting guarantees.

Now, more than halfway through plan-year 2024, with a greater ability to understand how rebate projections and accruals have been impacted, it is almost always expected that the known AMP cap reductions are accounted for in bids moving into 2025 and beyond. Important to note is that there are market realities that may continue to impact AMP cap, and as those changes come in, we will continue to offer our plans support in how to navigate.

The main challenge pertains to Humira **biosimilar utilization**, which is showing increases across the market mainly due to cost-management solutions put into place by plan sponsors (via excluding Humira from the formulary in favor of the low-WAC alternative) as well as new biosimilar launches available for $0 out of pocket, as announced by Evernorth® Health Services and through a similar program from Cordavis, a CVS subsidiary.

Since this shift is ongoing and expected to increase in coming years, it is best practice to continue to include protective rebate credit language in bids and contracts to account for future impacts that are very difficult to project. Coupled with impending biosimilar launches within the next two years for other heavily utilized, highly rebated products Stelara and Enbrel (among others), this will be even more crucial to creating winning bids while protecting underwriting integrity.

These questions and others like them are aimed at capturing the intent of your rebate offer and how you will treat price reductions moving forward. It is important that you respond in a way that casts your bid in the best light while protecting the risk you take on in your underwriting. Your Express Scripts by Evernorth® Growth Team is more than happy to assist in crafting appropriate responses as you continue to work through these competitive bid situations.

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Key takeaways

- Currently known AMP cap drugs needs to be factored into rebate projections and bids, and rebate credit language is likely to not be acceptable any longer; however, be mindful that additional products may be added in the future and language to protect against unforeseen reductions in rebates should be included. Biosimilars are still evolving, and while the impact is evident, a lot of variability in future utilization exists due to novel formulary updates and product solutions from various vendors.
- While biosimilars are still expected to be included in rebate guarantees, protective **rebate credit** language should still be included in bids and contracts to account for both increased Humira biosimilar utilization and future launches of biosimilars for other highly utilized specialty products

As you continue to work through these evolving market developments, please do not hesitate to work with your Express Scripts by Evernorth® Growth Consultant, who will engage our Health Plan Growth Pricing Consultation Team, led by Erik Popson. We are committed to helping you navigate these ongoing complexities to make you as competitive as possible in the market.

***Your growth team can also assist in determining how biosimilars and rebate adjustments are treated in your Master Agreement.**

Amrathla D. “The Impact of AMP Cap Removal on Medicaid Drug Prices” [Blog post]. IQVIA. April 24, 2023. https://www.iqvia.com/locations/united-states/blogs/2023/04/the-impact-of-amp-cap-removal-on-medicaid-drug-prices

The More You Know About Small PBMs

August 28, 2024

Janice Grochal

Principal, Commercial Growth Strategist
Health Plan Division

Brent Gibson

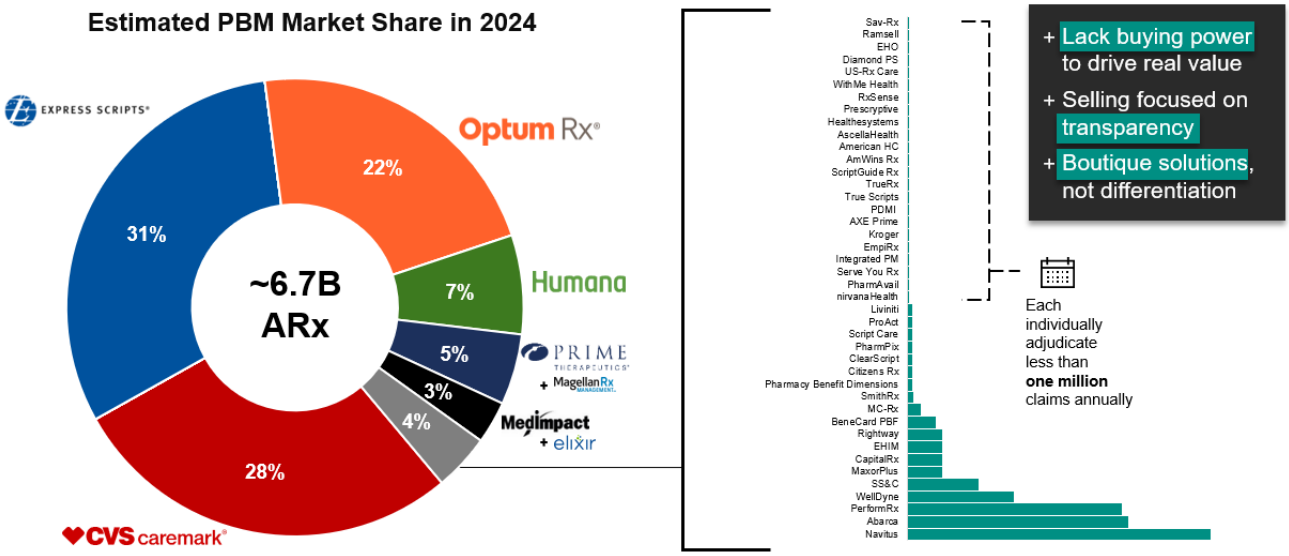
Strategic Planning Director

Being a market leader means continuing to deliver on your commitments of value, quality and service while meeting the needs of your stakeholders year after year. For all of us, it is a constant effort and one we take pride in, because we know it makes a difference to each patient.

As a leader in the market, you will constantly be challenged. The Health Plan Growth Team's role is to keep you informed of the market and competitors. Our latest competitive intel conversations have primarily focused on small PBMs in the market.

These PBMs make up a small percentage of the overall total prescription claims managed in 2023, as noted in *The 2024 Economic Report on U.S. Pharmacies and Pharmacy Benefit Managers*. By monitoring these competitors, we have found common themes they leverage to drive attention in the media and in the market to try and win. Each of these messages has multiple rebuttals to consider as you compete with small PBMs for business.

Smaller PBMs make up a very small fraction of the market



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Small PBM myth vs. facts

Myth: Only they can deliver financial transparency.

- **Fact:** These PBMs will often lead with "transparency" in their message, yet they buy through other entities, adding another layer of costs to the equation.
  - Example: Capital Rx and Navitus market their fully transparent pricing models, yet it is not widely understood that both use a third party for rebate aggregation and thus deliver less value to the plan sponsor.
- **Fact:** They tout unique models, but, in reality, they aren't actually differentiated.
  - Example: SmithRx's "innovative" Connect 360 suite of solutions does not offer anything that larger PBMs don't already offer: "We operate independently from insurance companies …"

Myth: Large PBMs and health plans use monopoly power and drive up costs.

- **Fact:** They claim their size/scale is an advantage, yet they lack the buying power to drive real value
  - Examples: Navitus calls for increased regulation against the largest PBM, yet they use one of those large PBMs for rebate aggregation; without the PBM, Navitus' model would not operate as it does today. Also, SmithRx highlights themselves as a "new type of PBM," yet they offer the same services as their competition on a smaller scale.
- **Fact:** Smaller PBMs continue to disassociate themselves from larger, well-established PBMs, but they still rely on them for service and negotiating power.
  - Examples: Navitus positions themselves as anti–big PBM/health plan, yet they're owned by a Fortune 15 company (Costco) and a very large health system (SSM Health). Meanwhile, MedImpact distances themselves from being viewed as a larger PBM but relies on the external network of pharmacies for specialty drug fulfillment (including CVS Specialty).
- **Fact:** These PBMs promote being able to provide personalized service to clients, but the small size of their workforce calls into question their ability to deliver.
  - Example: TrueScripts touts their "one ring advantage" (their ability to answer customer service calls within one ring 99% of the time), yet they have a smaller team of employees. Is this a model that can support the level of service our employers and members expect?

Myth: They are the only offering that delivers choice and innovation.

- **Fact:** They link their messaging to perceived unmet needs but are often unclear on the details.
  - Example: DisclosedRx markets that they are a "fully disclosed" PBM (as opposed to being fully transparent), yet they do not define what being "fully disclosed" means.

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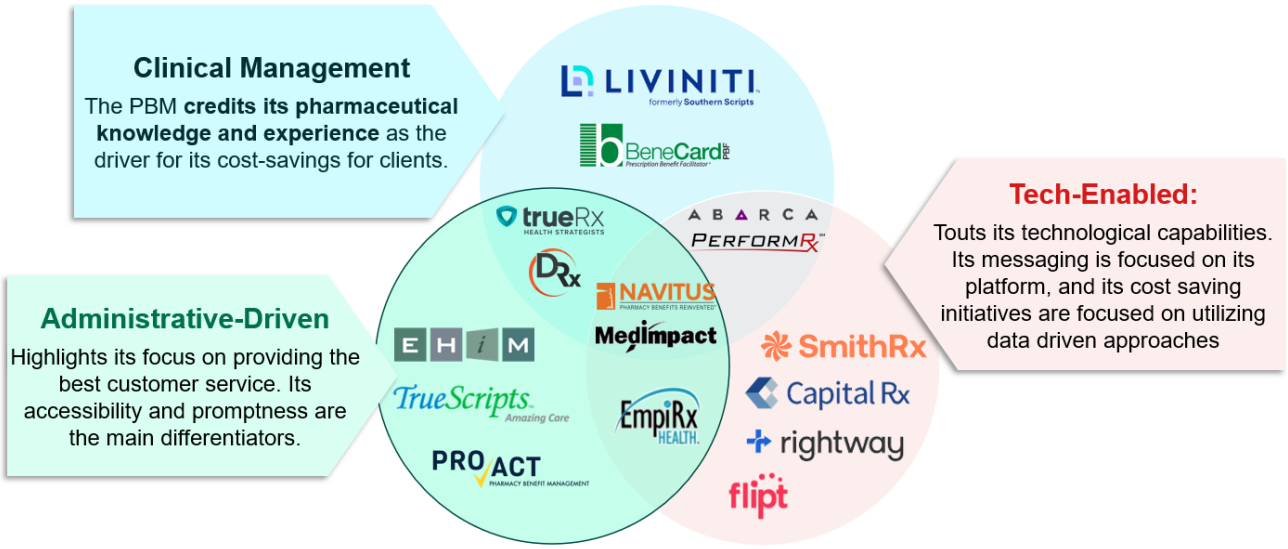
+ **Fact:** Small PBMs claim to have unique third-party partnerships to promote their position, but these are common practice in the industry.
    - Example: SmithRx touts their partnerships with “disruptors” (e.g., Amazon Pharmacy and Mark Cuban CostPlus Drug Company) to present themselves as innovative, yet these partnerships are simply pharmacy relationships (very standard in the market/not unlike other network relationships).

Myth: Their solution offering is world class.

+ **Fact:** They offer standard clinical programs repackaged as proprietary solutions.
    - Example: DisclosedRx’s Clinical Management platform offers standard solutions that are not differentiated from competitor offerings.

+ **Fact:** They suggest their experience and knowledge will drive improved savings even though many of these smaller players were only just stood up within the past few years
    - Example: DisclosedRx was founded in 2020, calling into question their experience and tenure of experience servicing clients through this model.

Outside of transparent pricing models, when small PBMs go to market, they typically lean in on specific value props to differentiate themselves.



Foundational considerations

Small PBMs that are making noise in the market do not have the scale or breadth of capabilities that health plans can offer clients. When your health plan encounters smaller PBMs, here are some foundational considerations you should consider:

1. **Lack of bargaining power:** Even though they attack large PBMs for their overall scale, small PBMs are buying through larger entities—and not making that widely known or understood.
    - Small PBMs outsource rebates and their network to other aggregators to gain the economies of scale that they lack.

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1. **Not always lowest cost:** Small PBMs lead with their "transparent" pricing models, yet up-front pricing does not always lead to the lowest cost.
   - While transparency is at the center of these smaller PBMs' sales pitch, fees and other costs added to the equation typically do not result in the lowest price.
   - At the end of the day, clients must look at the total cost of care.
2. **Limited capability suite:** Small PBMs often do not have the necessary expertise in house to drive clinical outcomes.
   - Small PBMs will outsource clinical and customer service capabilities, resulting in the fragmentation of services and, subsequently, experience and pricing concerns.
   - Internal programs at these PBMs are often not differentiated.
   - Express Scripts by Evernorth® and health plans combine rich patient data with clinical expertise to drive member engagement and enable quality, patient-centered care.
3. **Venture capital (VC) backed:** Many small PBMs are receiving funding from VC-backed investors.
   - Competitors including CapitalRx and SmithRx have had VC funding rounds, calling into question the longevity of these companies and whether they may be sold in the future for profit.

Positioning

We developed the following **small PBM positioning grid** to further illustrate their offerings and how to effectively sell against them.

	Capital Rx	NAVITUS	Medimpact	SmithRx	DisclosedRx
Marketing Message	+Cost-Plus Financial Model via **NADAC pricing** +Proactive Service Model (**AE's are pharmacists**) +Faster and easier implementation via **JUDI**	+**Zero-spread, pass-through** pricing model +**Lowest-net-cost** philosophy +Touts **clinical care model** (e.g. adherence support)	+Largest **independent PBM** +**Promotes expertise** in health plans, gov. programs, and employers +**Enhanced capabilities** via Elixir acquisition	+**Anti-big PBM** focused on **transparency** +**100% pass-through,** flat fee pricing model +Highlights advanced **tech member tools**	+100% rebate and pricing **pass-through model** +One source of revenue via **single admin fee** +Promotes **specialty savings program**
Economics	+**Accessing rebates** through a third-party entity +NADAC data from **<4% of pharmacies nationwide** and based on old data (**not real-time**) +Pay a **broker fee**	+**Pass-through** pricing +**Accessing rebates** through a third-party entity +Overall **PMPM fee** +Pay a **broker fee**	+**Pass-through and traditional** pricing +**Accessing rebates** through a third-party entity +Pay a **broker fee**	+**Pass-through** pricing +**Accessing rebates** through a third-party entity +**PMPM service fee plus claims admin fee** +Pay a **broker fee**	+**Pass-through** pricing +**Accessing rebates** through a third-party entity +**PMPM service fee plus claims admin fee** +Pay a **broker fee**
Alliances / Partnership	+Large PBM is a **minority investor** +JUDI licensed to Large PBM, making it **no longer unique to CapitalRx** +Partnered with **MCCPDC**	+Partnership with **Costco pharmacy** (part owner) +Partnered with **CassianRx** on patient platform +Joined **CivicaScript** as a founding member in 2022 +Archimedes for specialty UM +Lumicera Health Services for specialty pharmacy	+Partners with external specialty pharmacy network due to **lack of drug access** (Humana, McKesson, CVS, etc.)	+Partners with "disaggregators," (e.g. **Amazon/MCCPDC**), only a **standard in-network pharmacy deal** +Partnered with Banjo Health (**prior auth. tech**)	+Partners with disaggregators to provide services +CEO was **former Chief Strategy Officer** of TrueScripts +**Outsources many key functions**, including mail-order
Service Considerations	+Serial **entrepreneur** CEO, could explore a sale of the company in the future +**Prime/JUDI integration** may impact service quality	+**Specialty pharmacies** (Lumicera/Caremetx Health) are **sub-scale**, lacking drug access and clinical capabilities +**No VBC programs**	+**Customer service metrics significantly lagged ESI** in most recent PSG PBM survey	+**VC-funding backed**, which may result in investors exploring a sale to maximize profit	+**Limited Technology** – relies on website entirely for information and member portal +**Does not offer app** for members

Don't wait: Now is the time to take action

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Proactively share your performance with the market, clients and advisors. Highlight your years of experience and performance in managing cost and delivering care. Use these insights to create plan-specific sell-against messages for each competitor. Your experience and value run deep.

Recent Evernorth® Health Services examples shared in the market include the following:

- Express Scripts by Evernorth Members Paid Less for Prescriptions in 2023 Despite Drug Price Increases | Evernorth
- PBM clients agree: Protect our pharmacy benefit tools | Evernorth

Continue to allow groups to choose from different financial models to best suit their needs, including fully transparent offerings. Express Scripts by Evernorth offers a spectrum of contracting models for groups to choose from, ranging from a traditional model that prioritizes affordability to innovative new models that prioritize simplicity without compromising on transparency. Ask your account team about the ClearCareRx™ suite of contracting packages.

Encourage plan sponsors to continually evaluate low-cost benefit designs. Most plan sponsors remain addicted to rebates and could benefit from a clearer understanding of a holistic view of the true cost of care. Continue to educate your groups on the value of driving to the lowest net cost to protect the plan from future costs in a constantly shifting drug market. Providing the lowest option within the benefit prevents groups from carving out services and allows your Service Team to best support members in their care journeys.

Be bullish on specialty. We know every health plan and sponsor in the country is grappling with the rising cost of specialty medications. The prices of these medications are set by the manufacturers. While pharmaceutical companies continue to raise list prices year over year, we work behind the scenes to fight the trend by driving competition, negotiating with drugmakers and incentivizing the use of less expensive medicines that deliver the same clinical value.

For example, since June 2024, Accredo by Evernorth® has had Humira® biosimilar available for $0 out- of pocket for eligible patients. The high- and low-concentration interchangeable biosimilar is produced by Quallent Pharmaceuticals, through agreements with multiple manufacturers, and its list price is about 85% lower than Humira's.

In this ever-changing health care market, being knowledgeable, flexible, innovative and committed to delivering on what matters is critical. We will continue to partner with you and offer solutions and guidance to meet your, your employer's, and your patient's needs. Continue to work with our Growth and Account Team on specific needs.

Manufacturer and vendor direct-to-consumer hubs: Source or sore spot?

July 10, 2024

Brent Gibson
Director
Strategy & Intelligence

Two major pharmaceutical companies have made announcements introducing new direct-to-consumer (DTC) platforms in recent months:

+ **LillyDirect**: In January 2024, Eli Lilly launched LillyDirect, a DTC pharmacy and referral network of in-person and telehealth clinicians. These tools are intended to increase access to 14 of the company's drugs, including its newly approved anti-obesity medication Zepbound®.
+ **Pfizer for All**: In April 2024, Pfizer filed a trademark with the US Patent and Trademark Office for "Pfizer for All," an online store that will offer prescribing services, fulfillment and shipment. Expected product offerings include oral COVID-19 treatment, migraine nasal spray and oral migraine medication. Pfizer plans to roll out this platform by the end of the year.

In addition to big pharma DTC plays, digital pharmacies (hims & hers, Ro, Amazon Pharmacy, etc.) have positioned themselves in serving therapeutic areas, such as personal care (mental health, hair loss), sexual health (erectile dysfunction [ED]) and reproductive health (birth control), which are well suited for the DTC model.[1] hims & hers is also getting into the weight loss game, announcing in May that it is offering weight loss medications in the form of a compounded GLP-1.

These DTC strategies are part of a broader effort in the industry to increase utilization, bypass benefits, increase expectations with consumers that all utilization is appropriate and increase manufacturer profits. These platforms also tout the ability to offer personalized engagement with consumers above and beyond the traditional health plan-PBM relationship. But these platforms come with potential drawbacks.

+ **Supply issues**: For these DTC platforms to be successful for both big pharma and consumers, it all comes down to supply. Zepbound was the catalyst for Eli Lilly to launch its platform, messaging that it wanted to "increase access"; however, access to Zepbound can no longer be promised as demand continues to far exceed supply. A disclaimer on the LillyDirect site indicates a national supply shortage impacting third-party providers, with vendors showing no Zepbound supply available and indicating that there is no timetable for supply to return. Lack of Zepbound supply means existing patients can't get medication and new patients can't start on it. When this occurs, patients either stop the medication, use a competitor's product, use less of the medication or turn to compounding.

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+ **Friction in the consumer experience**: While these platforms boast convenience and an enhanced consumer experience, they may actually lead to increased friction for consumers obtaining their prescriptions, especially if they take more than one drug. Currently, LillyDirect offers 14 Eli Lilly drugs on its platform, while Pfizer's platform only plans to offer a handful of drugs at this time. If you are a consumer who takes multiple medications and these platforms do not have the full array of drugs, you must go to multiple platforms or pharmacies to fulfill your drug needs. Additionally, it falls on the consumer to do their homework on cost (Which platform has my meds at the lowest cost?).
+ **Fragmented clinical care**: Even though LillyDirect includes a referral network of in-person and telehealth clinicians, these DTC platforms and digital pharmacies will provide less holistic clinical care to patients than the health plan. Patients who require additional support could find themselves at heightened risk of off-label use, which may lead to adverse health outcomes or severe side effects.
+ **Pricing and utilization concerns**: LillyDirect provides a referral list of in-person and telehealth providers, suggesting access will be considerably easier. But these arrangements will lead to biased prescribing practices influenced by drug company promotions. Paired with DTC marketing, this will result in higher use of expensive branded drugs as opposed to cheaper alternatives. Additionally, LillyDirect incorporates Lilly's copayment assistance programs, which could potentially destabilize efforts by PBMs and health plans to manage cost-control initiatives.[2]
+ **Regulatory compliance**: Regulatory compliance is a major concern, as pharmaceutical advertising and marketing are subject to stringent regulations to ensure patient safety and transparency. In November 2023, the Food and Drug Administration announced a new rule that calls for marketers to communicate drug information in a way that is easier for consumers to comprehend. This rule went into effect in May 2024. However, while the new rule addresses television and radio spots, it doesn't cover potentially misleading social media content promoting prescription drugs, including new GLP-1 treatments for weight loss.[3]

Take action

+ Health plans are positioned well to create an employer and consumer care and education campaign to counter DTC campaigns.
+ Sales and account teams can create a Facts vs. Myth Summary to assist with talking points to ensure the employer benefits are preserved and members are not placed in the middle due to fragmented care.

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Take action

+ Data and analytics can be used to target groups that do not have the standard utilization management designs in place and prepare for group and broker conversations on the value of driving to the lowest net cost within the benefit.
+ Evernorth® Health Services has been successful at driving down costs for customers. Data confirms that Express Scripts by Evernorth® members with employer-sponsored insurance saw an ~1% decrease in out-of-pocket costs for their prescription medicines last year, driven by our innovative solutions.[4] Health plans should further investigate offerings that drive to lowest net cost within the benefit and ensure patient safety and care are being addressed. Coordinating multiple offerings through the benefit manages costs and builds assurance with employers that employees are being cared for according to the benefit structure. Learn more about Evernorth solutions:
  - EncircleRx
  - Humira Biosimilar Available at $0 Patient out of Pocket Cost for Eligible Accredo Patients
  - ClearCareRx Contracting
  - Simply Save Rx

Sources

1. Pfizer and Lilly are elbowing into the direct-to-consumer market. Will it work? (BioPharma Dive)
2. Do Direct-to-Consumer Pharmacies Present More Challenges for Patients? (PharmExec)
3. Prescription drug ads should soon start looking noticeably different (Axios)
4. Express Scripts by Evernorth Members Paid Less for Prescriptions in 2023 Despite Drug Price Increases (Evernorth Press Release)

Is there value in fragmenting benefits?

June 3, 2024

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Market awareness:
Based on recent media posts, many employers are evaluating the economic value of **point solutions** as a supportive layer to employer benefit designs. Point vendors heavily target employers, brokers and consultants by suggesting large savings to offset employer costs for health coverage. But do they offer greater value than what is available through the health plan portfolio, or are they simply diverting care and coverage away from the plan and placing the patient in the middle?

The health challenges employers are facing require innovative thinking. That's why we must be relentless in creating bold, flexible and **connected** pharmacy, care and benefit solutions that meet employer needs. A holistic view of the benefit to ensure your plan design offers permeate both the pharmacy and medical benefits is important. Health plans can present a multitude of solutions to help achieve employer goals, but it is equally important to engage and educate members throughout their benefit.

Sampling of point solutions:
Vendors have developed point solutions to address perceived gaps in the marketplace, including lack of affordability, transparency and coordinated clinical management. Examples of point solutions include:

- **Cash pay pharmacies:** Mark Cuban Cost Plus Drug Company (MCCPDC) and CivicaScript
  - Provide discounts to consumers without insurance, and highlight discounts on drugs which are attracting media and Capitol Hill attention
- **Discount aggregators**: GoodRx and SingleCare
  - Collect cash-price discounts from vendors and make them available to consumers at point of sale
- **Alternative funding**: Payer Matrix
  - Eliminates cost of the drug to the plan (excluding any fees); the patient incurs minimal out-of-pocket cost
- **Utilization management**: VIVIO and ArchimedesRx
  - Offers specialty drug management programs
- **Disease management**: Livongo, Virta and Omada
  - Provides solutions for specific chronic conditions and disease states

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Research shows

Highlights from the *2023–2024 Evernorth Health Care in Focus Report* include the following:

- Employers continue to have concerns with the usage of direct-to-consumer (DTC) health solutions. Forty-nine percent of those surveyed are concerned with the possibility of DTC solutions not being used to manage conditions properly.
- Health plan leaders (HPLs) say their organizations are quite concerned about DTC health care solutions. Their concerns also center around DTC solutions not being used to manage conditions properly, leading consumers to a personal care decision based on limited information.
  - 62% are concerned about solutions not managing conditions properly.
  - 52% are concerned employer members may actually end up paying more.

Opportunities exist to evolve existing health plan offerings and leverage Evernorth® Health Services capabilities

Your plan can leverage Evernorth capabilities to provide an alternative integrated solution to carve out vendors that will address one or multiple marketplace needs. For example, to address lack of affordability, Evernorth solutions include **Price Assure**; to address lack of coordinated clinical management, Evernorth solutions include the **Digital Health Formulary** and **Accredo by Evernorth®**; and to address lack of transparency, Evernorth solutions include **ClearCareRx** and **ClearChoice**.

- Through **ClearCareRx**, clients pay what Express Scripts by Evernorth® pays for prescriptions in this 100% transparent pricing model, equating to clearly defined costs and a single administrative fee. The solution has no required retail network, 100% of Express Scripts rebate value is passed back to payers, and is 100% auditable.
- **ClearChoice** pricing simplifies the amount plan sponsors pay for all medications dispensed via Express Scripts Pharmacy by Evernorth®, both brand and generics. The pricing approach is based on the medication's acquisition cost, plus a flat dispense fee and shipping fee.

Our take

We have seen a variety of entrants and pricing mechanisms in the marketplace that tout perceived savings on a limited number of medications. The reality is, none of these entrants or mechanisms can drive affordability and predictability like an integrated health plan can. They can't provide the same level of patient care; they don't have the same breadth and depth of capabilities plans have; and they can't deliver better results for clients and patients.

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From a **member experience perspective**, a multi-vendor approach with numerous hurdles in coordination can lead to a fractured experience. Examples of member experience friction points can emerge within communication, prior authorizations, pharmacy networks, billing and clinical programs. Members or employees of clients who use a fragmented model may end up not knowing which vendor to turn to for different services. Additionally, multiple vendors can lead to a lack of accountability, with different partners passing off responsibility if given the chance.

From a **vendor management perspective**, coordinating many different parties, some of whom have overlapping or competing businesses, could prove challenging. Much of the coordination responsibility may land on already strained Human Resources teams, leading to more stress on overworked staff. Additionally, many of the partnering vendors have competing businesses, which could lead to conflicts of interest as they all attempt to carve out a larger slice of the pharmacy pie.

From a **budget perspective**, utilizing a fragmented vendor model could add cost while not necessarily delivering on savings or improved outcomes. Frequently, they represent a limited financial view to employers and do not account for the existing guarantees provided by the plan. Teams rarely fully account for implementation/integration costs and particularly overlook the ongoing administrative costs related to working with multiple vendors. Ultimately, smaller vendors have limited buying power, while higher affordability levels are achieved through partnering with a large-scale health plan.

Working with an integrated organization allows clients to alleviate many of these concerns. Member experience is enhanced due to care being coordinated across the multiple touch points, while members or employees are guided and educated every step of the way. With an integrated entity, data is shared internally between departments and teams to capture and improve outcomes. Additionally, employers can utilize Express Scripts' Digital Health Formulary through their health plan to address their most pressing clinical challenges. Finally, guarantees with large PBMs offer clients savings they can review in detailed reports showing how these guarantees are calculated.

Fragmentation is leading to an increasingly complex and expensive health care landscape. At a time when most of our clients are seeking to streamline and consolidate offerings, this piece-meal approach will result in less coordination of care for members and no guarantee of a return on their investment as compared to an integrated health plan solution.

Take action

Provide education - Support employers' education needs for employees through up-front, well-established resources, such as health plan customer service, online patient and provider web tools, and high touch points through care management and provider engagement teams to support patients. Using these established resources builds further employer and patient trust and shares information on choices and alternatives. All results will then demonstrate points of contact and outcomes your plan delivers.

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Demonstrate innovation and flexibility - Work to meet employer needs. The value the health plan provides is fueled by the strength you offer driving affordability through your scale and innovation, clinical expertise, and specialty capabilities. Remind employers of how these high-value low-cost options can easily be incorporated into the benefit to maximize outcomes and holistic care:

+ Exclusive specialty network
+ Narrow retail network
+ Generic-driven formulary
+ Cash pay solutions for both traditional and nontraditional medications
+ Drug conversion solution
+ Online pricing feature that provides medication pricing and access to care support

Proactively engage - Demonstrate your suite of offerings, clinical experience and outcomes.
Be an active participant in advising employers about their benefit design. Plans can no longer rely on brokers and consultants to be the drivers with your groups; direct and regular connection with employers builds trust and offers them proactive data-driven insights to help them navigate their benefit design decisions. Account teams can provide support with financial modeling and member impact.

Fragmentation is leading to an increasingly complex and expensive health care landscape. At a time when most of our clients are seeking to streamline and consolidate offerings, this piece-meal approach will result in less coordination of care for members and no guarantee of a return on their investment as compared to an integrated health plan solution.

Understanding the basics of prescription drug importation and how to respond

May 2, 2024

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In January 2024, the U.S. Food and Drug Administration (FDA) authorized Florida's plan to import certain prescription drugs directly from Canada. FDA Authorizes Florida's Drug Importation Program | FDA.[1] What does this mean for plans, groups and members?

A reminder on the basics of drug importation:
There are four primary pathways to lawfully importing a prescription drug into the United States:

- Personal importation policy (PIP)
  - While it is generally illegal for individuals to import FDA-approved drugs for personal use, the Medicare Modernization Act of 2003 directs the FDA to exercise enforcement discretion to allow personal importation if the drug or device is clearly for personal use and does not appear to present an unreasonable risk to the individual. For unapproved drugs or devices, FDA guidance permits individuals to import a 90-day supply for personal use to treat a serious condition when an effective treatment is not available domestically, the product doesn't represent an unreasonable risk and the product is not promoted to U.S. residents. The FDA has stated the PIP is not intended for importation of lower-cost, foreign-made versions of FDA-approved drugs. Several states have attempted to implement PIPs, but they have all been shut down due to a lack of realized savings, nonrenewal of programs or legal challenges. Additionally, there are several private importation vendors, including CanaRx, ScriptSourcing and CRX, that are leveraging the PIP to create personal importation solutions to offer employers. The FDA has yet to publicly comment on the legality of these programs.
- Manufacturer reimportation
  - Manufacturers are permitted to reimport U.S.-manufactured drugs that were previously sent abroad.
- Importations to ease drug shortages
  - The FDA is empowered to permit temporary importation and commercial distribution of unapproved drugs to alleviate a drug shortage.
- State Importation Programs (SIP) pathway
  - The most discussed pathway is authorized under Section 804 of the Federal Food, Drug, and Cosmetic Act and federal regulations that were finalized in 2020. This pathway allows states and other identified parties to establish time-limited programs for the importation of certain prescription drugs from Canada, provided that the SIP's sponsor demonstrates to the FDA that the SIP "will result in a significant reduction in the cost of eligible prescription drugs to the American consumer" without posing any "additional risk to the public's health and safety."[2]

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FDA SIP authorization detail for the state of Florida:

- SIP authorization is valid for two years from the date the FDA is notified of the first shipment of drugs to be imported.
- As part of the authorization, Florida's Agency for Health Care Administration must ensure imported drugs comply with FDA specifications and labeling requirements as well as submit a quarterly report to the FDA providing cost savings and safety information.
- Oversight will be conducted by the FDA to ensure the Florida program complies with applicable FDA regulations.
- Florida intends to begin by importing prescription drugs in a small number of drug classes, including medications to help individuals who have chronic health conditions, such as asthma, COPD, diabetes, HIV/AIDS and mental illness. The state must submit specifics to the FDA on which drugs it intends to import before the program can begin.
- Florida's initial program is intended to import drugs for individuals receiving publicly funded services, such as those within the Department of Corrections. Florida then plans to expand the importation program to include the state Medicaid program. No timeline for that expansion has been provided.

Current state of SIPs:

- Florida's SIP approval is likely to spur additional state activity on importation.
- To date, eight other states – Colorado, Maine, New Hampshire, New Mexico, North Dakota, Texas, Vermont and Wisconsin – have laws allowing for a drug importation program, and many are seeking, or planning to seek, similar FDA authorization.
- Colorado is the furthest along among other states. On February 27, 2024, Colorado submitted an amended version of its SIP application to the FDA, which was first filed in December 2022. At the FDA's request, Colorado reduced the number of drugs it is seeking to import from 112 to 24, targeting conditions such as blood clots, cystic fibrosis, respiratory illnesses, diabetes and cancer. The revised application also acknowledges the difficulties the state has faced in discussions with both manufacturers and the Canadian government in moving the program forward, should the FDA approve.
- Drug Channels' *The 2024 Economic Report on U.S. Pharmacies and Pharmacy Benefit Managers*[3] indicated, "Consistent with our analysis in previous reports, we do not believe that these importation actions are feasible or cost effective. The economic benefits of importation are likely to be small or non-existent." Barriers to seeing value include the following:
  - Historically, the pharmaceutical industry has fiercely objected to these types of programs and could challenge the FDA authorization.

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- Canada has also expressed some concerns with the program:
  - "Canada's drug supply is too small to meet the demands of both American and Canadian consumers," wrote Maryse Durette, a spokeswoman for Health Canada. "Bulk importation will not provide an effective solution to the problem of high drug prices in the U.S."[4]
  - The Canadian government has indicated it is likely to further restrict exports if they begin to affect Canadians. They have stated the numbers do not work out for a nation of nearly 40 million people to supply medications for a state like Florida with 22 million, much less for 49 other U.S. states.
- In addition, many drug manufacturers have already added terms to their contracts with Canadian wholesalers to prohibit exportation of drugs to the United States. Colorado noted this as a challenge in their most recent annual report[5] of their own efforts to create such a program.

What must be considered:

Health plan impact from Florida's SIP authorization:
There is no imminent impact to clients from the FDA's authorization of Florida's SIP. Based on current information, Florida plans to limit the scope of their importation program to government-funded programs. Although this could change, more information is necessary. There are many unanswered questions, such as interaction of the program with other government and private health insurance plans, final drug lists, and identification and adjudication of claims for the imported products, to name a few. The state will also need to address how it intends to effect importation in the face of manufacturer and Canadian government resistance.

Clinical safety concerns:
With any proposal to import prescription drugs, there are several clinical safety concerns to be considered, including the following:

- There is a risk of reduced adherence because some patients question the efficacy and safety of imported medications.
- If imported drugs are carved out from the traditional pharmacy benefit, this could lead to fragmented care for drugs that are part of a treatment regimen.
- There is the potential for treatment delays due to extended shipping and customs processes.

Loss of integrated value and additional fees:
In addition, there are potential financial and clinical implications from partnering with a private importation vendor, including:

- Vendors that charge a flat administrative fee with no guarantee on savings.
- Impacts to financial and performance guarantees that could require renegotiation of existing arrangements.
- Loss of integration value that could lead to fragmented care, member disruption, and additional costs on both the pharmacy and medical side.
- Care that may be medically unnecessary or clinically inappropriate if drugs fall outside of existing utilization management standards.

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How you can take action:

Continue to highlight your low-cost options. Yes, employers may be aware, but this presents an opportunity to reposition these options to address this new trend.

+ Mandatory generics
+ Use of most cost-effective channel
+ Incorporation of innovate solutions into existing benefits (e.g., Price Assure, ClearChoice and ClearCare)

+

Importation vendors are engaging them with carve out incentives. So track and share your years of clinical outcomes and the experience you continuously deliver, and proactively engage your consultants and brokers on your holistic offer.

Our efforts are aligned with you and your teams on how to best address high-cost medications. We are committed to providing members lower costs while keeping prices predictable and simple within the benefit design. We do this in partnership by keeping a close eye on market events like importation. Engage your growth and account team to support your analytic and solutions needs.

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UPDATE – Inflation Reduction Act: Impact beyond Medicare plans

May 2, 2024

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In our last post on this topic, we discussed that, pending a change in regulation, creditable coverage will impact both Retiree Drug Subsidy (RDS) plans and Medicare eligibles currently enrolled in their employer's benefit. That remains true.

In 2023, 600K members turned 65 within the Express Scripts by Evernorth® book of business. Of those members, nearly 50% retained commercial coverage. When we look at our health plan book, more than 6% of members (non-Medicare carriers) are 65+.

Not surprisingly, feedback on this topic has been mixed across our clients. Some see it as a commercial discussion, some see it as a Medicare opportunity, some see opportunities on both sides and others don't think the juice is worth the proverbial squeeze. There isn't a right answer. There is only a potential consideration, and we want our clients to explore if it makes sense for them and their growth goals.

To assist in deciding if your plan should pursue this topic further, we've mapped out the below.

Commercial considerations:

1. How many members in your commercial population are 65+?
2. If their plan is not creditable, will the employers educate the members on their options? Can you educate the members as a value-added service?
3. Do you send notices of creditable coverage today for your employer groups?
4. Do you handle creditable coverage attestations for your employer groups?

Potential revenue generating

5. If there is a large 65+ population in a non-creditable plan, will those members enroll elsewhere, thus impacting your underwriting strategy (noting that a Medicare eligible takes four times the prescriptions of the average active member)?
6. Do you make a splash about this potential disruptor with your broker community, thus establishing yourself as a trusted advisor?

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EGWP considerations:

1. If there are populations with multiple Medicare eligibles, does this impact your EGWP pipeline?
    a. For PDP EGWPs, there is a retiree status requirement in Chapter 12.
    b. Medicare Advantage (MA) organizations are subject to a different statutory waiver authority under Section 1857(i) of the Act. This allows these entities to enroll both current (i.e., active) employees and retirees (and their spouses and dependents) of an employer/a union group health plan sponsor in individual MA, “800 series” and Direct Contract MA plans, provided such individuals are eligible for Medicare Parts A and B.
2. Is there a subset of your RDS book that will no longer be creditable and thus no longer eligible for subsidy but who must be covered due to collective bargaining?
    a. Is it worth it for them to make the plan creditable to garner the 28% subsidy, or
    b. Can you upsell the group into an EGWP to increase their savings?

Individual Medicare considerations:

1. Are you tracking existing member age-in trends (where do they go when they leave commercial coverage)?
2. Will your employer contracts allow you to direct market to their membership as they approach 65 or to contact in a bulk fashion those members who are 65+ in non-creditable groups?
3. Would the employer welcome a custom insert in their Notice of Creditable Coverage, NOCC (or NONCC) that provided information on how to learn more about your Medicare plan?
4. Are there similarities between your Medicare and commercial benefits that can be touted (e.g., medical network, use of home delivery, enhanced services)?
5. Could you host a specific benefit fair for Medicare eligibles in employer groups across your enterprise where you walk through your Medicare plan offerings, explain what they need to do when they are Medicare eligible, discuss what options they have, etc.? (Note: I once worked with a plan that had birthday parties a few times a year – complete with cake – and helped their new Medicare eligibles understand their options and get enrolled.)

Other considerations:

1. Are these members paying their Part B premium today? If not, would this be something that would be an issue under your plan (i.e., are you offering buyback)?
2. Considering the size of your 65+ active population, is this change material to your enterprise forecasts?
3. Could you partner with these employers to make your individual plan the base plan offering for their Medicare eligibles and provide services to manage an HRA or like account in tandem to meet employer coverage requirements (a la Aon/Mercer retiree exchanges)?
4. Are there ERISA or other requirements employers need to be aware of as they contemplate this change?

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What next?

1. Express Scripts will continue to ideate on opportunities that this change creates.
2. Plans should evaluate if any of the above considerations are actionable for them and start planning this summer, ahead of AEP.
3. You should reach out to your health plan growth consultant or a member of your Account Team with questions.

2024 Pharmacy Trends: What to Expect This Year and Beyond

April 4, 2024

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Here are five trends that we believe health plans should be paying attention to in 2024. They will require a clear path of care and cost management for your customers:

- Rise in transparent pricing models
- Ongoing affordability concerns
- GLP-1 adoption
- Increased investment in digital navigation capabilities
- Role of community pharmacists

1. **The market continues to prioritize transparent pricing to contain cost as well as the long-term goal of improving quality.**

   Lawmakers and employers alike are calling for increased prescription drug pricing transparency. The Biden administration continues to prioritize the need to lower prescription drug costs, a key pillar of the president's health care agenda and reelection platform. Given this is a presidential election year, this topic will continue to trend as a priority for other candidates too as they seek to secure votes. Additionally, almost three-fourths of employers see requirements for more transparency in PBM pricing and contracting as a priority.[1] While "transparency" has morphed from a term that disruptors used to differentiate themselves, all top PBMs have become more innovative about transparency and their commitment to low net cost for clients.

   How to be proactive: Transparency doesn't equal lower cost in many instances. Continue to demonstrate innovation and flexibility for your groups or they will go searching elsewhere.

   The value your health plan provides is fueled by the strength you have to drive affordability due to your scale, innovations, clinical expertise and specialty capabilities. Employers appreciate your clinical excellence and proven outcomes; don't be shy demonstrating your years of experience with these.

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There is a lot of energy around pricing transparency, but the education on how benefits are structured today is equally important to convey. Make available a low-cost benefit option (narrow network and low-cost formulary with advanced utilization management) for employers seeking lowest net cost plan management and holistic care that demonstrates clinical outcomes. Work with groups and consultants to review alternative pricing models in 2024 should they be of interest.

Opportunity: Don't miss the opportunity to help your groups understand the value they receive from your overall pricing today. We are aligned and support your efforts for transparency, driving to lowest net cost, choice, flexibility and consumer engagement. Employers have choice on the pricing type to best suit their needs. Express Scripts by Evernorth® has several solutions to offer more choice. ClearNetwork is a recent pricing model using industry-standard benchmark pricing for individual medications, plus a flat fee. Other Clear suite offerings include ClearCareRx and ClearCost. Ensure your pharmacy sales support and sales teams are educated on options and can help guide clients.

2. **Affordability within benefit design continues to be a concern for employers, along with a need to balance cost with employee/patient care and wellness.**

Over the past decade, employer-sponsored insurance premiums have risen above the rate of inflation and outpaced wage growth. The rising price of health care, rather than an increase in utilization, is responsible for approximately two-thirds of per-person medical and pharmacy claims spending growth. Employers experienced an increase in the median percentage of health care dollars spent on pharmacy, from 21% in 2021 to 24% in 2022.[1] Various pharmacy management strategies, such as plan design changes to address costly medications and treatments, are planned by employers for 2024. Human resources decision-makers are consistently struggling with balancing cost containment and supporting employee health and wellness needs, along with prevention.

How to be proactive: It is critical to be an active participant in advising employers on their benefit design. Proactively engage and demonstrate your suite of offerings, clinical experience and outcomes. Engage groups and consultants to determine if additional solutions can be "stacked" or bundled to drive affordability, better care, and reduced plan and member costs. Price Assure is an offering that minimizes the need for members to price shop and helps prevent claim erosion to discount cards outside of the benefit.

Opportunity: Make available a low net cost plan design that includes a narrow network, a high- performance formulary, advanced utilization management and a member engagement strategy.

Include in this bundled offering Simply Save Rx, a holistic solution package of industry-leading capabilities that drive drug cost savings for plans that are standard in the market.

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From a specialty viewpoint, partner with a best-in-breed specialty pharmacy that can drive additional financial value to your plan through the following:

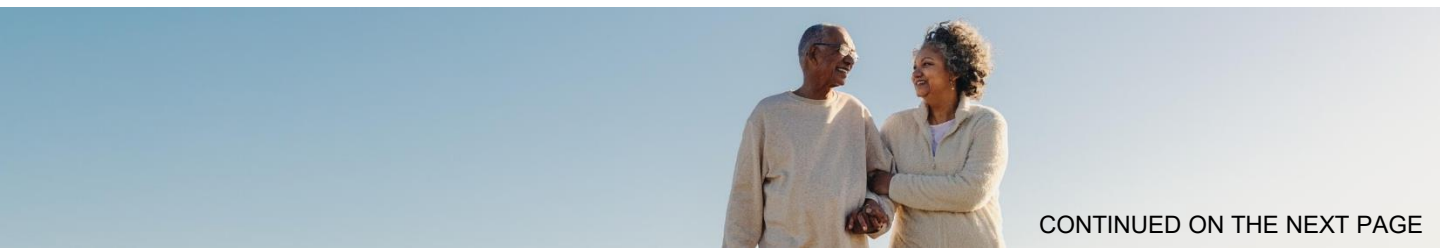
- Providing deep discounts and flexible pricing arrangements
- Maximizing specialty generic and biosimilar conversion rates beyond the general market
- Maintaining broad access to limited distribution specialty products – multi-pharmacy patients are more prone to nonadherence, which can lead to unnecessary medical costs
- Offering free ancillary services, such as copay assistance coordination, social worker support and nutritional counseling

3. **Consumers are increasingly interested in the myriad of existing and potential GLP-1 uses.**

2024 will continue to be a dynamic year for glucagon-like peptide 1 (GLP-1) discussions across clients, patients, providers, insurers and drug manufacturers. First used to treat type 2 diabetes, these medications have also been approved by the U.S. Food and Drug Administration for weight management (Saxenda, Wegovy, Zepbound) and cardiovascular risk reduction (Ozempic, Wegovy). Additionally, GLP-1s show promise and are being researched for a multitude of conditions, including neurological disorders (Alzheimer's, Parkinson's, addiction), kidney disease and fatty liver disease. As more GLP-1 drugs get approved for new indications, consumer interest and utilization may increase. J.P. Morgan estimates that 30M Americans, or 9% of the total U.S. population, will be using GLP-1s by 2030. Therefore, important cost conversations will continue with your health plan, employers and customers as you grapple with the high prices of the drug class in the short-term. Utilization management capabilities will be brought into the mainstream conversation, with insurers looking at wraparound solutions to accompany the medications.

How to be proactive: Providing responsible GLP-1 coverage to patients who can benefit the most while carefully controlling spend is going to be critical as indications expand. Groups and consultants appreciate proactive insights on data to uncover their utilization and how they compare to the market. Therefore, ask your Account team about consultative reporting.

Then, in anticipation of these evolving uses, evaluate opportunities to expand your trend management strategies, such as appropriate utilization (prior authorization, step therapy), lifestyle modification (Omada), member engagement and waste management (prior authorization, quantity limit, and enhanced fraud, waste and abuse).



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Opportunity: EncircleRx is a program aimed at helping employers and patients achieve superior clinical outcomes and more financial predictability with condition-specific solutions. Cardiodiabesity (cardiovascular disease, diabetes and obesity) management is a key component in this strategy and includes the first-ever GLP-1 financial guarantee offered by a PBM.

4. **Digital health and health care technologies will play a critical role in educating employees about and engaging them in their benefits.**

   Human resources decision-makers (HRDMs) see digital health as an avenue to improve the health of those who use those solutions, to "level the playing field" in terms of access and affordability of care, and to provide additional information to employees as a trusted source and advisor. Better community health and easier interactions with health care providers are ranked as the top two benefits of digital health solutions among HRDMs. According to Evernorth®Health Services research, health plan leaders are likely to prioritize investment in digital care management tools in the near future as they look to streamline sources of employee benefit information.

   How to be proactive: Health plans continue to be the ideal hub for an employer's digital solutions and an active leader in communicating and educating members on available tools. Your plan's care teams (customer service, nurses and care management) are critical players in further educating members on their benefits and getting more members online who can benefit from the experience. Once online, members can quickly view existing benefit coverage, identify current medications, be alerted to more cost-effective alternatives and price new medications. (Each medication priced will confirm the member's existing coverage.)

   Also provide a compelling value proposition to your clients around the sophisticated approach you are taking with digital health. Remember that digital health vendors are going directly to larger employers when the best place to receive this support is from you in a connected fashion.

   Opportunity: To take the burden off the health plans, the Evernorth Digital Health Formulary team, comprised of physicians, pharmacists and user experience experts, thoroughly vet new vendors that come to market. Evaluation includes stringent security and privacy compliance by each digital health company, end-to-end contracting, and competitive pricing and value for best-in-class digital health solutions.

5. **Pharmacists, with the help of supportive technologies, will continue to play an increasingly larger and more active role in delivering effective and efficient patient care.**

   Pharmacists, many of whom operate in "medical deserts," can play a pivotal role by serving as the connection point between primary care gaps, medication management complexities and value-based model goal attainment.[2]

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A medical desert can be either a rural or an urban area where access to medical care is not close or easily accessible via public transportation. Three-quarters of consumers anticipate pharmacies will begin offering services similar to primary care doctors in the next five years.[3]

How to be proactive: As pharmacists take on certain select prescription care and delivery services that previously required a primary care doctor, they will be looking for support from health plans. Incorporating pharmacists into team-based care models is a recommended health plan strategy for improving health care access and quality while reducing health care costs. Health plans can employ associates whose role is to assist pharmacists in setting up their drug therapy management programs, and they can provide additional resources and incentives for achieving performance and quality goals.

Opportunity: PBMs build networks of pharmacies to provide consumers convenient access to prescriptions at discounted rates. We want to do more with pharmacies and for pharmacists. Therefore, through the IndependentRx initiative, we will offer increased reimbursement opportunities and additional care services to rural independent pharmacies – and create an Independent Pharmacy Advisory Committee to expand the role of rural, suburban and urban pharmacies in the health care system. Additionally, offering MoreThanRx products and services in independent pharmacies increases access to certain routine, preventive and chronic care services — driving new business growth opportunities for pharmacy owners.

Take action

Health plans are well positioned to address these market trends effectively, affordably and holistically.

Continue to work with your account team and growth expert to review insights, competitive intel and opportunities to best address needs and trends in your market.

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ICHRA: What is it, and how can it help grow my book of business?

April 4, 2024

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Background:

In 2019, the Internal Revenue Service and the Departments of the Treasury, Labor, and Health and Human Services issued final rules to expand individuals' access to health care by allowing health reimbursement accounts (HRAs) to be integrated with individual health insurance coverage. These arrangements are known as individual coverage HRAs, or ICHRAs. Employers offering an ICHRA reimburse employees with pretax dollars to cover the cost of individual health insurance premiums and qualified medical expenses.

Employers of any size can reimburse employees for some or all of the premiums employees pay for health insurance they purchase on their own. ICHRAs represent a departure from previous Affordable Care Act (ACA) implementation rules that forbid employers from reimbursing employees for individual market premiums.

- There are no limits on how much an employer can reimburse under an ICHRA (unlike a Qualified Small Employer Health Reimbursement Arrangement [QSEHRA], which does have limits).
- An employer can offer both a group health plan and an ICHRA, but they have to offer them to different classes of employees so no employee is choosing between the group plan and the ICHRA. A few class examples include Full-Time, Part-Time, Seasonal, Rating Area (geographic location) and Salaried.

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- While all HRAs must be offered equally and fairly to all employees, QSEHRAs and ICHRAs are different: QSEHRA eligibility can only be scaled based on family size or age; ICHRA offers more efficiency with its class feature, which allows employers to divide employees into custom classes that receive varying rates of reimbursement. Employee classes must be based on legitimate job-based criteria, such as hours worked or geographic location; they cannot be used to discriminate against unhealthy employees.
    - Scenario: An employer's plan has gotten increasingly expensive because of remote workers and the need to maintain a large, national PPO network. Remote employees could be offered an ICHRA via the Rating Area class.

Industry trends:

There are an estimated 500,000 people enrolled in an ICHRA today, and the Congressional Budget Office projects this will increase to 2 million by 2032. The option works best in areas where individual market premiums are lower than small group rates; this is largely in states that have used the ACA's 1332 waivers to create reinsurance programs.

Adding ICHRA enrollees to the ACA enrollment mix is expected to reduce full-priced individual market premiums while increasing premiums for the small group market. The current thinking is that groups taking up the ICHRA option may be healthier than the overall small group market, meaning they would put upward pressure on those rates. The effect on the individual market will rely on the same factors.

Centene, the nation's largest marketplace health insurer has partnered with Take Command Health to enter the Indiana market with an ICHRA offering. Centene is hiring a staff VP to oversee ICHRA strategy nationally. And Oscar Health is planning for ICHRAs to fuel their future growth in the Marketplace in 2025 and beyond.

Is this for me?

ICHRA is a growing market segment and could be a way to diversify your portfolio if it fits within your larger strategy and goals. For business owners, the ICHRA health insurance model brings predictable costs, flexible and efficient design, and budget control – likely leading to an increase in ICHRA adoption. If you offer ACA plans today, you may already be receiving ICHRA enrollees. The real question is whether you should have a specific strategy (network, plan design, price point) to attract ICHRA enrollees who are shopping the exchange.

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Current estimates suggest as many as 70% of ICHRA plans are purchased off the exchange. Thus, having a competitive and rich plan design off the exchange in addition to your on-exchange portfolio is advisable. Many ICHRA participants will likely choose a Gold plan with a broader network because that will be most similar to their previous commercial coverage.

Next steps:

- Consider if a specific ICHRA Strategy is necessary for your plan.
- Determine if you'd like to be proactive about ICHRA (marketplace lean) or reactive to ICHRA (sell against lean).
- Reach out to your Account Team or designated marketplace growth consultant to dive into your market and potential opportunities.

2024 Marketplace sets another record by surpassing 21M enrollees

February 22, 2024

Ryan Bell

Senior Growth Consultant for Marketplace
Regulated Markets Growth

Avreet Mortensen

Senior Growth Consultant for Marketplace
Regulated Markets Growth

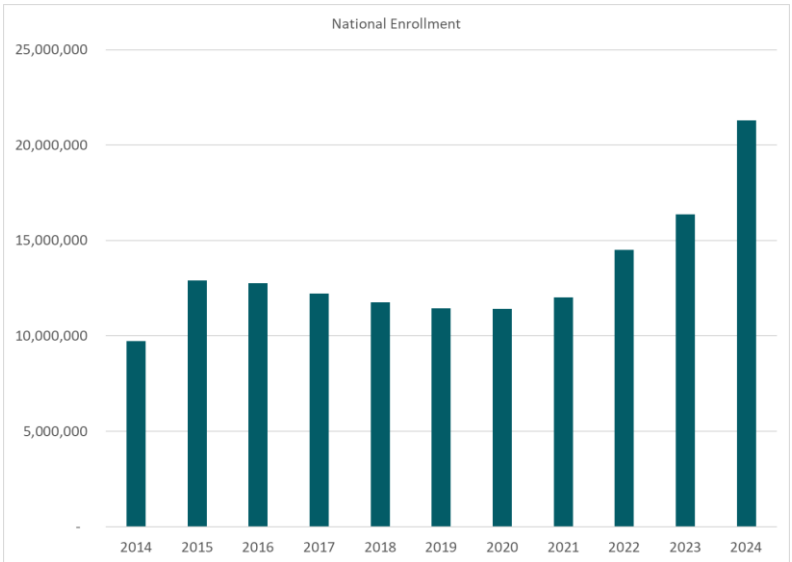
The bottom-line up front

The Health Insurance Marketplace added over 4M enrollees year over year (YoY), bringing the 2024 national enrollment number to 21.3M—another year of record growth.

Did you know, as an Express Scripts® client, you have a Marketplace Growth resource? Our team will help you analyze your current and future markets to help you meet your growth goals, including in the fast-growing Marketplace.

Historical context

The national Marketplace has historically hovered around 12M enrollees. However, the past three Open Enrollment Periods saw significant increases in enrollment: 14.5M in 2022 (21% growth YoY), 16.4M in 2023 (13% growth YoY) and 21.3M as of 01/13/2024 (30% growth YoY).



Fifteen states (AL, AR, AZ, FL, GA, IA, IN, LA, MS, NC, OH, SC, TN, TX, WV) have seen

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their enrollment double in the past four years, with Texas tripling in size to a whopping 3.5M lives in 2024 – up from 1.1M in 2020 (see Table 1). Additionally, in 2020, 7 states covered more than 300k lives; by early 2024, 17 states covered more than 300k lives.

The significant growth of the Marketplace offers more insurers the opportunity to reach scale in their markets. Furthermore, market entry into a new state *could* be more justified if there is ample opportunity in the market.

- Smaller markets that now offer opportunity to reach scale:
  - **Iowa**: 49k in 2019 to 111k in 2024 (126%)
  - **Louisiana**: 83k in 2021 to 212k in 2024 (156%)
  - **Mississippi:** 84k in 2018 to 286k in 2024 (242%)
- Medium markets that have continued to grow:
  - **Georgia**: 458k in 2019 to 1.3M in 2024 (185%)
  - **South Carolina**: 214k in 2020 to 571k in 2024 (167%)
  - **Tennessee**: 200k in 2020 to 555k in 2024 (177%)
- Large markets only getting larger:
  - **Florida**: 1.9M in 2020 to 4.2M in 2024 (120%)
  - **Texas**: 1.1M in 2020 to 3.5M in 2024 (212%)

What has caused the growth, and why now?

- **Impact of legislation:**
  - The Inflation Reduction Act and the American Rescue Plan Act continue to keep Marketplace coverage more affordable, including longer Special Enrollment Periods; however, enhanced subsidies are currently set to expire at the end of 2025.
  - Medicaid redetermination and the end of the federal Public Health Emergency related to the COVID-19 pandemic have shifted low-income individuals from Medicaid to Marketplace.
- **Investment in Marketplace:**
  - Continued commitment to marketing and navigator funding at the federal level
  - Easier shopping experience through companies including HealthSherpa, which enrolled more than 7M people in 2024
- **Issuer commitment to Marketplace:**
  - The number of counties with four or more insurers continues to increase (ie, issuer stability, with exceptions).
  - Greater collaboration and communication with state Departments of Insurance (DOIs) ensure rate stability and minimal post-subsidy impacts to premiums.

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Future implications

Will the Marketplace continue this accelerated growth going forward? Most likely no. But gone are the days of large national exits and aggressive startups buying growth, pricing to a loss and sorting out risk adjustment later. (Note: Not a recommended strategy!) With each successful Open Enrollment, the Affordable Care Act (ACA) becomes more and more engrained in the fabric of the health care landscape. Stability and predictability are key to ensuring a thriving and sustainable Health Insurance Marketplace.

Several factors will influence future enrollment

- **Political landscape:**
  - 2024 presidential election
  - House and Senate races and control of Congress
- **Legislative impact:**
  - Enhanced subsidies set to expire at the end of 2025 unless Congress takes further action
  - Cost-sharing reduction (CSR) “silver loading”
- **State-specific actions:**
  - Continued transition to state-based exchanges
  - Potential Medicaid expansion
- **Changes to market morbidity:**
  - 2023 Medicaid redeterminations
  - Impact of potential Medicaid expansion
  - Individual coverage health reimbursement arrangement (ICHRA) adoption

What now?

Reach out to your Account Team or designated Marketplace Growth Consultant to dive into your market and opportunities.

Understanding CVS Transparency Solutions

February 22, 2024

Janice Grochal

Director, Commercial Growth
Health Plan Division

Brent Gibson

Director
Strategy & Intelligence

The news

During CVS Health's Annual Investor Day, the company announced two new solutions that promote transparency: **CostVantage** is a cost-based retail pharmacy reimbursement model, and **TrueCost** is a PBM program option for employers that would like a cost-plus pricing model.

Through CostVantage, CVS pharmacies will be reimbursed by PBMs and payers using a transparent formula built on the cost of the drug, a set markup, and a patient management fee. The new model will be rolled out in 2025 to commercial payers and could look different payer to payer. While CVS touts the benefit as increasing transparency for consumers, some believe more benefit will be realized through higher margins via CVS retail and that this solution will not ultimately lead to lower costs for all consumers. If CVS moves forward with this retail strategy, they could potentially limit their participation in traditional network arrangements.

CVS Caremark's new PBM model called TrueCost offers client pricing reflecting the true net cost of prescription drugs, promising visibility into administrative fees and pricing that reflects the true acquisition cost, provided by CostVantage. Very little details are known about how TrueCost works; however, this model follows the same blueprint of other cost-plus models, including Express Scripts ClearNetwork℠.

Express Scripts® partners with pharmacies to drive savings and access and works to make sure every member has convenient access at the lowest available cost. ClearNetwork is the latest addition to the Clear Suite of offerings. We believe every group's needs are different and that they should have multiple pharmacy benefits options, delivered through their health plan, that work for their employee population.

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While simple, acquisition cost–based models may work well for some, others may prefer the savings and pricing guarantees associated with the current industry approach to managing drug spend. That's why Express Scripts has supported and introduced multiple pricing and transparency models over the years that are both flexible and affordable.

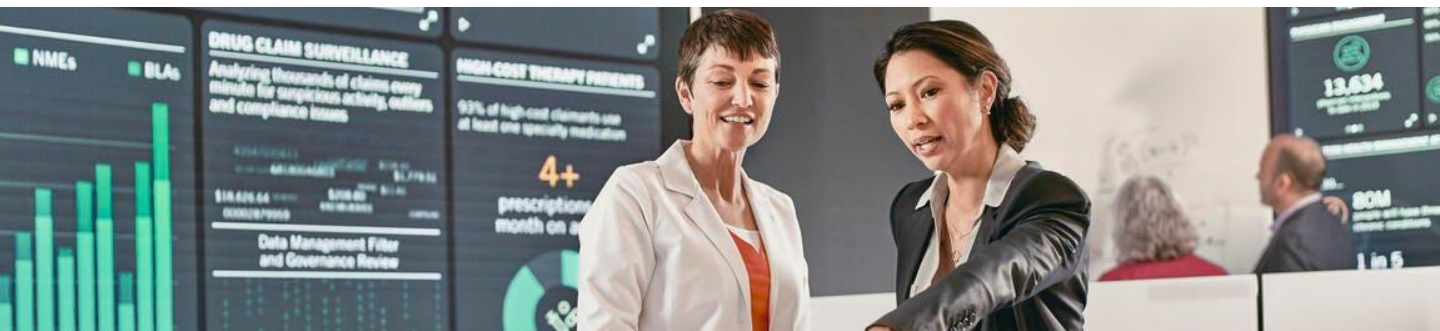
With each pricing and affordability option, we believe the key focus should be on the following:

- **Simple drug-pricing arrangement** understood by the group and demonstrated by the health plan: Drug prices are based on nationally agreed-upon industry benchmarks, and there's no PMPM enrollment fee.
- **Seamless member experience**: This provides members with access to medications when they need them—and how they best prefer to receive them: through participating retail pharmacies, by mail, or via specialty pharmacies.
- **Ultimate flexibility**: Enrollment does not require major benefit changes while providing patients access to information online or through customer service.

Current Express Scripts by Evernorth Clear Suite Solutions:

ClearCareRx	Comprehensive/end-to-end PBM contracting model. Predictable costs for prescription drug benefits—plus clinical and financial guarantees.
ClearChoice Pricing	Financial model for home delivery. Focused on mail-order prescriptions through Express Scripts® Pharmacy home delivery. Drug-level pricing based on Express Scripts® Pharmacy acquisition costs.
ClearNetwork	Simple financial model for pharmacy network. Pharmacy drug-level pricing model based on industry benchmarks. Available for all brand, generic and specialty drugs and at all contracted retail, mail and specialty pharmacies.

Your Express Scripts growth and account teams will continue to provide latest insights so that you can stay ahead of stakeholder questions and ensure your plan's market offering meets employer expectations.



Inflation Reduction Act: Impact beyond Medicare plans

Brittany Neu
Senior Director
Regulated Markets Growth

January 30, 2024

The news

On January 1, 2025, the Inflation Reduction Act (IRA) will change Medicare Part D benefits substantially through a provision called Part D redesign. Within Part D redesign, a $2,000 out-of-pocket prescription maximum will become a standard offering across all Medicare plans. This is a drastic change from current state, where there is no true out-of-pocket maximum on Part D.

Health Plans that service Medicare members have been living and breathing IRA since it was signed into law in 2022, but not all employers and commercial teams have the same level of visibility because these changes seemingly do not apply to them.

The IRA is arguably the largest piece of reform to the Medicare program since the inception of Part D in 2006. You'll notice the language "seemingly doesn't affect" active lives. To illuminate a few important points and avoid unintended consequences, we put together the below information.

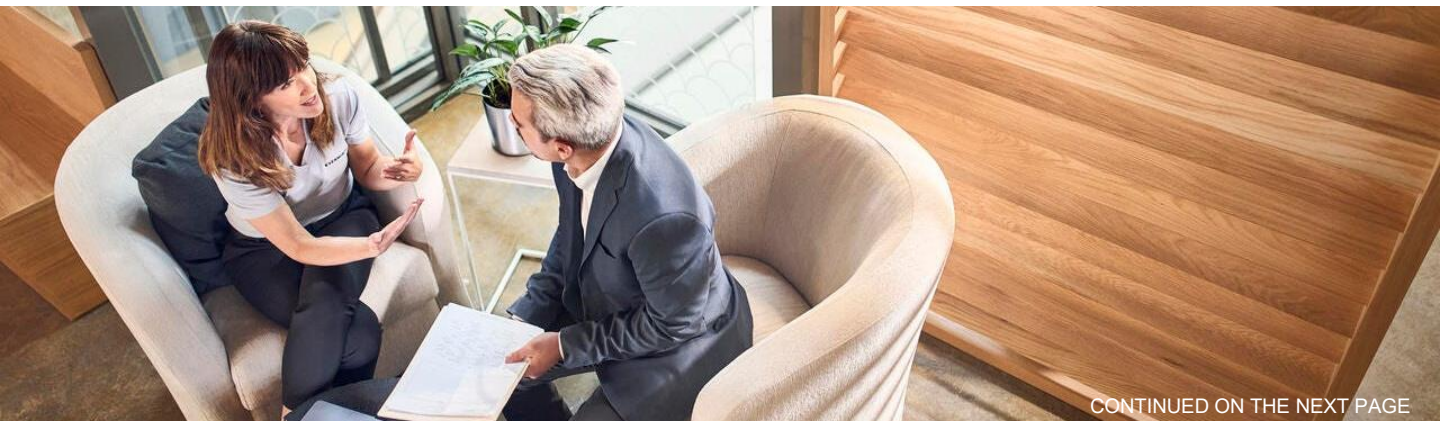
What do I mean by that?

As we are talking about legislation, we can't ignore the Medicare Modernization Act (MMA) of 2003. One of the pieces of this regulation that impacts employers is the Notice of Creditable Coverage (NOCC). The MMA requires entities (whose policies include prescription drug coverage) to notify Medicare-eligible policyholders annually whether their prescription drug coverage is creditable. In short, this means employers must communicate that their coverage is as good as the standard Medicare prescription drug coverage or not. Employers and unions must provide a notice of creditable or non-creditable coverage to their Medicare eligible (and their dependents) population (including COBRA) prior to 10/15 each year.

Why does the NOCC matter?

Outside of being a legal requirement, if a Medicare-eligible member is in a plan that is not creditable, they may be subject to a Late Enrollment Penalty (LEP). A LEP can be assessed to any Medicare eligible who had a gap in creditable coverage of 63+ days from their initial Medicare eligibility. LEPs compound with each uncovered month and, once assessed, follow the member for life as an increase (penalty) to their monthly Medicare premium. As such, when a plan is non-creditable, Medicare eligibles often drop their employer-sponsored coverage and enroll in an individual Medicare plan to avoid being assessed a LEP.

Further, Retiree Drug Subsidy (RDS) plans must meet the creditable coverage standard to receive the 28% subsidy paid to offset the cost of covering their retirees.



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Why are you talking to me about this now?

Plans that don't offer retiree coverage

The average retirement age varies by state, but it ranges from 61 to 67. If a member was in a non-creditable plan and did not go and get their own coverage, when they finally enroll in Medicare upon their retirement, they will be assessed a monthly premium of >$8.

When you consider that the standard defined benefit is getting a $2,000 cap in 2025, many plans that ARE creditable today will NOT be creditable after January 1, 2025. Without a change in guidance, the IRA will impact all Medicare eligibles and the plans in which they reside.

Plans that offer Retiree Drug Subsidy (RDS)

Pending a change in regulation, the 1M lives enrolled in RDS plans today will face a potential shake-up. The RDS has remained relatively untouched since the "double tax loophole," which allowed RDS subsidies to be both tax exempt and tax deductible, was removed through the Affordable Care Act.

This move was the first domino in a large market movement to Employer Group Waiver Plans (EGWPs). We could see this again in 2025. If an RDS plan does not meet creditable coverage, it is not eligible to collect RDS subsidies. Many of these plans are collectively bargained and have limited funds to continue to provide retiree coverage. These plans will have to enhance their design to remain creditable and collect subsidies. Alternatively, they can consider moving to an EGWP and collect incremental subsidies to maintain the solvency of their funds.

What should I do?

- Health Plans should be talking to their employer groups about this unintended consequence, regardless of if they offer true retiree coverage or not. Regulatory action provides an opportunity to be a partner and an expert, uncovering issues early so they can be appropriately managed.
- Health Plans need to provide product messaging to clients through creditable coverage attestations or notices.
- Sales teams should be combing the RDS pipeline and using this as a prospecting and conversion topic.
- Medicare and age in teams should be looking at creative solutions to help employers that will not change their designs to make them creditable. Assess the value of these lives to your enterprise. How can YOUR plan be the plan elected by members who would have otherwise remained your customers through their employer coverage?
- Reach out to the Health Plan Growth Team to ask questions, to strategize or to discuss this in more detail.

Exploring the impact of the CVS Caremark announcement to remove brand Humira from some formularies

ShaunTay Canady

Senior Director, Clinical Account Management & Strategy

January 30, 2024

The news

CVSCaremark recently announced they will remove brand Humira from some, not all, of their national commercial template formularies effective April 1, 2024, in favor of Humira (adalimumab) biosimilars. In a press release, CVS Caremark said Humira will continue to be an option for its customers with Choice and Standard Opt Out commercial formularies, as well as those who wish to remain aligned to Humira. Humira is used to treat several immune conditions, including ankylosing spondylitis, Crohn's disease, hidradenitis suppurativa, juvenile idiopathic arthritis, psoriasis, psoriatic arthritis, rheumatoid arthritis, ulcerative colitis and uveitis.

The move follows and is related to an August 2023 agreement for AbbVie (manufacturer of brand Humira) to supply Cordavis, a CVS Health Company, with a committed volume of co-branded Humira. The co-branded product is anticipated to be available in the second quarter of 2024. This will not be a biosimilar but rather a Cordavis version identical to Humira.

Cordavis has also contracted with Sandoz to commercialize and bring to market in the first quarter of 2024 the low wholesale acquisition cost (WAC) biosimilar Hyrimoz under a Cordavis private label. CVS will be preferring Sandoz biosimilars, including Hyrimoz (Cordavis) across its commercial formularies; however, it is unclear at this point how either the co-branded Humira version or the Hyrimoz (Cordavis), private label will be priced.

Express Scripts is committed to helping more members access biosimilars and deliver competitive net cost strategies. As a long-time advocate for greater adoption of biosimilars, Express Scripts took immediate action and added traditional and low WAC biosimilar versions to its National Preferred Formulary as preferred products upon their original launch in July 2023. The Express Scripts National Preferred Formulary prefers the following biosimilar versions of Humira, alongside AbbVie's Humira. This strategy optimizes our ability to deliver a competitive net cost position for clients regardless of whether a prescriber selects the innovator product or a biosimilar.

- Cyltezo (Boehringer Ingelheim): low-concentration formulation, interchangeable
- Adalimumab-adbm (Boehringer Ingelheim): low-concentration formulation, unbranded
- Hyrimoz (Sandoz): high-concentration formulation
- Adalimumab-adaz (Sandoz): high-concentration formulation, unbranded

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The biosimilar pipeline remains robust. In mid-2024, there are additional interchangeable designations anticipated from the FDA for existing Humira biosimilars as well as potential approval and marketing of other inflammatory condition products in the near future. As new biosimilars continue to become available, we will maintain our rigorous clinical review process to ensure formulary decisions are guided first and foremost by safety and clinical efficacy. Then, after clinical considerations, we identify high-value therapies for our national formulary offerings that can help reduce costs. Express Scripts is well positioned to continue our competitive contracting strategy to provide our clients options and savings opportunities within this costly space.

As we navigate the ever-changing landscape, we recommend plans continue to:

- Keep your sales teams informed of your biosimilar strategy and the value it delivers
- Partner with your providers to capture and incorporate feedback into your benefit strategy (as applicable)
- Collaborate with your Express Scripts account team regarding strategies that best benefit your members and organization

Medicaid Unwinding: Why it Matters for Commercial Plans

Stephanie Schlomer
Senior Growth Consultant, Regulated Markets Growth
September 5, 2023

Guest Post Bio: Stephanie joined Express Scripts in August of 2022 and currently serves as a Senior Growth Consultant within our Regulated Markets Growth team, specifically focusing on Medicaid. Her experience is vast, including time spent in the public health sector and most recently as a Medicaid Policy Director for a national Medicaid plan.

Background:

To maintain Medicaid eligibility, Medicaid beneficiaries traditionally go through what is called 'redetermination' every year. Beneficiaries must submit required information (e.g., income) to effectively prove that they remain eligible for Medicaid. If Medicaid beneficiaries do not provide the required information or if the information provided indicates they are no longer Medicaid eligible, Medicaid coverage is terminated.

The Situation:

During the COVID-19 pandemic, the Families First Coronavirus Response Act (FFCRA) provided states with enhanced federal medical assistance percentages (FMAP). The enhanced funding allowed states to better respond to the pandemic. But there was a catch. In order to receive the enhanced funding, states had to follow several requirements, including the maintenance of eligibility (MOE) requirement, also known as the continuous coverage requirement. The continuous coverage requirement prevented states from disenrolling Medicaid beneficiaries through redetermination. While states had the option to opt out of the enhanced federal funding and resulting continuous coverage requirement, none elected to do so.

Medicaid Unwinding – Bringing Medicaid Enrollment Back to Pre-Pandemic Levels:

Initially, the continuous coverage requirement was directly linked to the COVID-19 public health emergency (PHE). As long as the PHE stayed in effect, states had to follow the continuous coverage requirement to receive the enhanced funding. Everything changed in December 2022 when the Consolidated Appropriations Act (CAA) was signed into law. The CAA decoupled the continuous coverage requirement from the PHE and allowed states to resume redeterminations effective April 1, 2023 – despite the PHE still being in effect. At that time, over three years after the continuous coverage requirement went in place, states were allowed to begin processing Medicaid redeterminations.

However there was a problem, enrollment had increased substantially without redeterminations – Medicaid/CHIP enrollment rose by 23.3 million people from February 2020 to March 2023. Also complicating the matter, the Centers for Medicare & Medicaid Services (CMS) gave some states flexibility in their redetermination process. This created a patch work of redetermination processes across the country.

Regardless, states have until March 31, 2024 to begin redeterminations for each individual beneficiary and must complete the entire process by May 31, 2024.

The enhanced funding states were receiving is gradually being phased out through December 2023, as Medicaid enrollment will remain higher in states for quite some time.

1. Kaiser Family Foundation
2. The Centers for Medicare & Medicaid Services

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Kinks in the Process:

With April 2023 in the rear view mirror and redeterminations progressing, there continue to be kinks in the process. As of August 23, 2023, at least 5.3 million Medicaid beneficiaries have been disenrolled. While some of those disenrollments may have been for valid reasons like eligibility, many have not. Some beneficiaries have been disenrolled due to procedural reasons despite still being eligible, like not completing renewal paperwork or submitting required documentation. Kaiser Family Foundation reports that 74% of those disenrolled as of August 23, 2023 were for procedural reasons.

Medicaid beneficiaries attempting to renew their coverage have been vocal about their frustrations with the redetermination process. Notable concerns include, but are not limited to:

- State staffing constraints and excessive call center wait times
- Confusing processes (many gained coverage during the pandemic and have never been through the redetermination process)
- Issues obtaining required documentation (e.g., bank statements)
- Unnecessary documentation being required (e.g., if someone is receiving other assistance like unemployment, states should already have the requested information)
- Websites not being mobile-friendly or beneficiaries not having access to required equipment to upload or scan documentation
- Never receiving renewal paperwork at all

Why it Matters for Commercial Plans:

This is specific to Medicaid, right? While redeterminations are specific to Medicaid, the impact is being felt across the industry. Individuals who are disenrolled from Medicaid are likely to seek other insurance coverage or risk becoming uninsured. Coverage options for disenrolled Medicaid beneficiaries range from Medicare plans if they qualify, Marketplace/Exchange plans, or employer-sponsored plans if applicable.

Losing Medicaid coverage is considered a qualifying life event and triggers a special enrollment period (SEP) to allow the individual time to obtain coverage. Employers are required to offer impacted employees at least 60 days to enroll in their health plan options. If employees do not enroll within the time period allotted for the SEP, they must wait for the next annual open enrollment period. So at the end of the day, redeterminations present an opportunity for commercial plans to grow their membership.

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What Plans Should Do:

Being uninsured and without health insurance coverage can be devastating. Uninsured individuals are less likely to seek and receive necessary medical care and more likely to postpone care because of cost concerns. Not having coverage may lead to worse health outcomes and can have direct downstream impacts on employers like increased absences from work, decreased productivity, and higher overall costs for an employer.

Plans can help in several ways, including:

1. **Create** marketing and education pieces to share with their employer groups and brokers to educate them on details around redetermination.
2. **Review** who declined coverage prior to and during the COVID-19 pandemic to understand who may need targeted outreach.
3. **Assist** with benefit enrollment materials.

Contact your growth team to learn more about how your plan can ensure they are prepared.

3. Kaiser Family Foundation

Breaking News: AMP Cap Removal Implications

Chris Zuidema
Business Development Director, Commercial Gowth Health Plan Division
May 2, 2023

The News:

As a result of provisions within the American Rescue Plan Act (ARPA), certain pharmaceutical manufacturers have responded with reduced drug list prices and their accompanying rebates. These pricing and rebate cuts will have a meaningful impact on the makeup of your go-forward pharmacy drug spend and rebate offsets.

Quick Recap – What is it?

When the American Rescue Plan Act was signed into law, the cap on rebates as a percentage of Average Manufacturer Price (AMP) that manufacturers must pay in Medicaid Rebates has been removed for 2024. Due to this change, drug manufacturers have responded with a reduction in their drug list pricing and as a result, their associated drug rebate amounts. These reductions will have an impact in certain categories of drugs – namely Diabetes and COPD/Asthma, but potentially others.

History behind the move

Under the current Medicaid program, pharma manufacturers pay rebates at both the state and federal government levels as a portion of the Average Manufacturer Price (AMP). The maximum required rebate as a percentage of AMP has been capped at 100% since 2010, but ARPA's removal of that cap presents financial exposure to pharma manufacturers as payment amounts wouldn't have a ceiling. Manufacturer's rebates are generally paid as a percentage of a drug's price; and lowering that underlying pricing effectively reduces their exposure. It's also important to note, the AMP Cap removal impacts pricing and rebates for all lines of business, not just Medicaid.

How does it impact me?

This is a market event resulting from a change in law and applies only to drugs with price changes resulting from removal of the AMP Cap. With this reset of pricing in highly-rebated drug categories, there's a material impact on rebate revenue and the rebate guarantee amounts currently in the marketplace tied to this "pre-2024" drug pricing.

- Eli Lilly, Novo Nordisk, and Sanofi have all announced list price reductions for their insulin products ranging from 65% to 78% and we expect manufacturer's rebates to decrease for these products.
- We anticipate additional manufacturers may take action in other clinical classes, but we don't expect the same degree of price reductions that have been observed in the insulin category.

Our take

We view the legislative impact of this financial shift from retrospective rebates to lower upfront drug costs as a positive change. Health Plans have a choice on how to respond to the impending reduction in drug pricing and rebates on these certain drug categories. There are two approaches that have emerged as PBMs have begun to react to this change in law.

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1. The first approach has been a proposed retroactive reconciliation that accounts for the reduced rebate revenue on affected products when calculating the total rebate value. The PBM would calculate the difference in rebate revenue on impacted drugs, and use this drug cost savings as a rebate offset when accounting for, and calculating rebate settlements. The objective is to demonstrate cost neutrality where the value of reduced list prices and their direct rebate impact are included in the value calculation of rebate guarantees that were established prior to this market event.
2. The second method is a pure recalculation of the rebate guarantees that takes into accounts the reduction in available rebate monies and resets the contractual guarantee amounts. This approach to the ARPA law change is exercised under reservation of rights language that covers the PBM or contract holder if there's an industry change, market event, or change in law.

We expect PBMs and Coalitions to take the first approach outlined above, and we've received feedback from national consultants and client advisory firms that supports the adoption of this strategy. As time elapses and client contracts renew, we anticipate PBMs and Coalitions to restate rebate guarantee amounts based on the lower drug list pricing.

Knowing that both approaches require a change from the status quo, the second approach would require substantial work to occur between now and the end of the year for both you and your plan's clients. Importantly, restating rebate guarantees in the near-term may put your downstream client proposals at a disadvantage when being compared to the financial offer of a competitor that's using a retroactive reconciliation strategy. Secondly, some clients and their brokers may have difficulty understanding the background of this change and the restated rebate approach may be viewed negatively. Another consideration for a restated rebate guarantee approach is the potential for future action on additional rebated drugs or classes at a separate forthcoming date. This would be an additional event that requires subsequent rebate guarantee modifications and client agreement amendments.

While we have a good indication on how PBMs and plan sponsors are likely to respond to this law change and the associated rebate reduction in the short term, it's too early to know which methodology or whether possible new alternatives will become the preferred approach. Although, the AMP Cap removal is a very recent market event that rebalances the economic levers on drug spend, it's encouraging to see the market reacting with transparent responses to the upcoming change.

Call to Action:

Formulate a Strategy. Knowing how PBMs are approaching this change in law will help you create a plan and we will keep you informed with updates as you craft your response to the market.
Work with your Account Executive. Your AE will help you navigate this change and support you as you determine the best course of action for your health plan.
Work with the Growth Team on your approach to your downstream clients and consultant partners. The Growth Team is poised to help you optimize your go-to-market strategy in response to these types of industry events

Breaking News: New Mark Cuban Cost Plus Drug Company partnerships

Janice Grochal
Director, Commercial Growth - Health Plan Division
May 2, 2023

The news:

Last week Mark Cuban Cost Plus Drug Company (MCCPDC) announced it has partnered with 36 pharmacies in Florida, Indiana, New Jersey, and Texas to build an initial pharmacy network where members can use their Team Cuban Card (membership card) to fill prescriptions for local pickup.

What it is:

The Mark Cuban Cost Plus Drug Company (MCCPDC) is a drug platform that mainly consists of generics with only a small number of brand name medications. MCCPDC was launched in January 2022 and was co-founded by radiologist Alexander Oshmyansky and Mark Cuban. The company purchases pharmaceuticals directly from manufacturers, with a stated goal to lower the price of generic drugs to consumers by bypassing PBMs and utilizing a cost-plus pricing strategy. The company currently offers 460+ generic drugs and three brand-name medications. MCCPDC sells drugs at the purchase price, plus a flat 15% margin, and a pharmacy labor fee (currently $3 but company has been signaling that this may increase soon), plus a shipping charge (averages $5). MCCPDC currently fulfills prescriptions through TruePill's network of accredited pharmacies. The company touts over 2M registered accounts, but the actual number of pharmacy customers is significantly less than 2M.

MCCPDC has announced numerous partnerships within the past six months, including collaborations with diabetes and chronic disease management company Diathrive Health, cancer care support company OncoPower, digital testing company Binx Health, and payment technology platform RevSpring. The company has partnered with four smaller PBMs – EmsanaRx, Rightway, RxPreferred Benefits, and SmithRx – to provide cash-pay pharmacy pricing within the PBMs' benefits programs. MCCPDC announced its first health plan partnership with Capital Blue Cross in October 2022, noting Capital's members would be able to use their insurance cards at MCCPDC directly as of the start of 2023.

Cuban has previously acknowledged the company's limitations in only having mail-order capabilities, and has noted that employers have asked about pharmacy pick-up capabilities. This is MCCPDC's attempt at building relationships with independent pharmacies. MCCPDC hopes to entice pharmacies to join their network by offering them an option to purchase medicines at lower prices than those they would pay their usual wholesale suppliers.

History behind the move:

The Mark Cuban Cost Plus Drug Company (MCCPDC) is the latest in a long list of companies trying to solve the issue of affordability outside of traditional health benefits. Previous entrants include Walmart's Low Cost Generic program which launched in 2006 and charged $4 for select medications. GoodRx entered the market in 2011 and provides a free-to-use website which tracked prescription drug prices across the US and provides drug coupons for discounts on medications. Amazon initially enters the cash space in 2020 with an offering through their platform and has expanded since.

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New entrants have capitalized on the disconnect between total cost management and individual price points realized by the patient at point-of-sale. The ability to “cherry pick” specific drugs and realize savings often causes patients to question the value of their benefits, however less than 5% of claims for commercial coverage are adjudicated by discount cards, indicating that the majority of member find better value leveraging their insurance coverage.

While MCCPDC generates a lot of press, it is in no position to provide all of the services that payers deliver today. MCOs have demonstrated they are best suited to drive overall cost savings and clinical care through integrated benefit offers that help patients to stay healthier, receive better care and get more value from their spend. However with direct consumer advertising, an increase in HDHPs, and sponsors focus on rebates to drive down cost, members have greater responsibility to actively manage costs and will look outside their pharmacy benefit for sources of savings.

Our take:

While the Mark Cuban Cost Plus Drug Company (MCCPDC) continues to make headlines, it is important to think through how it falls into your greater healthcare ecosystem. Some items to consider when crafting your strategy:

Understanding the impact Mark Cuban Cost Plus Drug Company has on your members

- Express Scripts is able to add any pharmacy that meets credentialing and base financial requirements to our networks. It is important to note that the MCCPDC is not a pharmacy and thus does not meet credentialing requirements. MCCPDC currently uses TruePill as their back-end pharmacy. In December of 2022, the DEA started an investigation into TruePill for its involvement in the unlawful dispensing of prescription stimulants. The MCCPDC contracting with multiple brick-and-mortar stores will increase ways in which drugs can be dispensed through the MCCPDC but still does not address the fact that MCCPDC is itself not a pharmacy.
- Until such time as the MCCPDC becomes a pharmacy, claims filled through that program continue to be outside of the benefit (even if reimbursed through paper claims). There are multiple benefits for a claim being filled through ESI adjudication platform that are lost when filled outside of the benefit. These measures include robust safety checks as well as condition management and clinical engagement.
- Costs may not actually be lower for members after accounting for dispensing and processing fees. The newly contracted MCCPDC pharmacies will receive an $8 dispensing fee (may be more based on the type of drug), and in keeping with the transparent pricing model, the Team Cuban Card site outlines that the medication cost as follows: (Drug Cost) + (15% Markup) + ($8 Dispensing Fee) + ($1 Processing Fee). While the drug cost itself may be less through MCCPDC, the higher dispensing fee may offset much of the savings.

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There are ways for Health Plans to address affordability issues which reduce the relevance of MCCPDC.

- For self-funded groups, benefit design and member cost share are set by the employer. Adjusting deductibles and copays downward reduces the benefit of cash pay programs.
- There are a number of solutions which address member affordability and can be deployed. These solutions include:
    - Copay Assurance - Cap monthly out-of-pocket costs for prescription drugs at $25 for preferred brand drugs and $5 for preferred generics and specialty generics for consumers on traditional or non-high deductible benefit plans.
    - Low Cost Generics - Caps out-of-pocket to $10 per 90 days for prescribed generics for clients enrolled in exclusive home delivery
    - E-vouchers - The Express Scripts® Pharmacy accepts third party drug coupons and discounts so members are able to receive additional savings where applicable
    - Price Assure^{SM} - A solution to include available prescription discount card pricing intelligence, powered by Express Scripts Price Assure^{SM}, into our member pricing logic. Tracks claims within the benefit, even if they are leveraging an Express Scripts Price Assure^{SM}, price point. Addresses member abrasion caused by price shopping outside of the benefit for lower prices in the discount card market
    - Patient Assurance - Provides members with predictable out-of-pocket costs throughout the year, and ensures they pay no more than $25 per 30-day Rx for participating products
    - Smartshare Rx® - Rebate-sharing program at point-of-sale
    - SaveonSP - Leverages manufacturer copay assistance for high-cost specialty drugs, driving down plan spend and resulting in $0 member responsibility

Regardless of how your organization addresses member affordability, it is crucial that your front line can articulate those solutions and the value your organization brings

Call to action:

- Take assessment of your plan's current patient affordability solutions and strategies. Continue to expand the suite of offerings to meet and exceed market demands.
- Proactively articulate your affordability strategy with your consultant partners.
- Reach out to your growth consultant to continue the discussion.

ClearCareRx Launch

Chris Hespe
Vice President, Health Plan Growth, Interim
April 20, 2023

Last week Express Scripts announced the launch of ClearCareRx, a transformative approach to pharmacy benefit management based on transparency, alignment, and accountability. Here's what you need to know to build a strategy around how you discuss with employer groups and brokers/consultants.

What it is:
ClearCareRx (CCRx) looks to shift the discussion away from unit cost guarantees and instead intensify focus on trend, lowest net cost, and clinical outcomes. In this model, employer groups with more than 10k members may elect a new pricing model where groups receive pass-through pricing at retail, mail, and specialty and pay an admin fee. Within the admin fees, there are clinical targets and financial targets. ESI sets aggressive targets together with each client to meet their financial drug spend goals and select clinical outcomes goals, which are based on the performance guarantees (PGs) managed by their dedicated Population Health Manager (PHM). The arrangement will be available for groups with a 1/1/24 effective date and should start appearing in RFPs this summer.

Express Scripts will be requiring certain programs as part of the offering to drive down cost including HC360 Flex, advanced plus or unlimited utilization management, SafeGuardRx, and Exclusive Accredo. We also expect that certain Rx Coalitions will offer, adopt and position ClearCareRx as a choice in their offerings, though it is too early to tell which ones.

Some history behind the move:
While ClearCareRx goes live 1/1/24, this concept is not new and has been in the market for years. The concept of total cost of care guarantees was presented at Elevate in 2019. In addition to Express Scripts, a number of players in the market have attempted to change how deals are spreadsheeted. CVS offered a "guaranteed net cost" in 2018 based on an average script price (ASP) and MaxorPlus offered a pharmacy trend guarantee as well.

Our take:
These offerings to move away from unit cost guarantees to drug trend, clinical outcomes and operational value continue to drive headlines, but have failed to gain adoption across the employer space. With that said, Health Plans are particularly well suited to play in the space if they so choose based on their commitment and focus on driving lowest net cost in the fully insured space. Here are our suggestions on how to best address within your market:

- For interested employers, highlight the value of your fully insured offerings. A fully insured offering intrinsically includes a trend guarantee since employers pay a set PMPM amount.

- For employers who prefer to stay self-funded but want the benefits of a trend guarantee, you may either:

    - Offer Express Scripts' CCRx for a sub-portion of your ASO book. For employers greater than 10k Express Scripts' is able to model out client-specific guarantees. For employers smaller than 10k, the plan is able to aggregate employers and as long as the aggregate population is over 10k Express Scripts will be able to model and manage under one PBM contract. Any populations enrolled in CCRx will be excluded from the HP's wholesale arrangement and be subject to the same clinical program requirements.

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    - Alternatively, the plan can work up its own trend guarantee. The math would follow the same process as underwriting a fully insured population. Benefit to the employer would be a reduction to the risk premium since the plan no longer bears full risk but ties to a variable admin fee. This was evaluated and scoped out by a sub-section of our plans post Elevate 2019.

- In both cases, continue to:
    - Highlight your ability to drive lowest net cost through your value proposition and the value of integration.
    - Be aggressive in unit cost guarantees as that is still the main way consultants evaluate deals.

Call to action:

- Formulate a strategy and articulate that strategy with your consultant partners.
- Reach out to your growth consultant to continue the discussion.

Building a medical rebate strategy

Dean Catalano
Senior Director, Medical Pharma Strategy and Contracting
March 30, 2023

Guest Post Bio: Dean joined Express Scripts in June of 2020 as a negotiator for medical benefit contracting. He is now the Senior Director leading Contracting as well as the ESI client arm of the medical benefit. He has over 12 years' experience in pharmacy, medical and value based contracts.

Your medical rebate strategy can no longer be an afterthought
Historically, rebates have been focused on pharmacy products, with very few falling on the medical side. However, greater innovation has led to both increased competition and increased costs. The increased competition, notably with biosimilars, has led to an increased number of available medical rebates. The medical rebate opportunity has increased so much in fact that Synergie Medication Collective, announced in January of this year, was created as a new medication contracting organization purely focused on medical rebates. Given this opportunity in the market, more and more health plans are starting to think strategically about managing medical rebates.

The word is out: employer groups and medical rebates
There is a wide spectrum of knowledge when it comes to this evolving area. Savvy employer groups understand the importance of medical rebates as a tool to reduce medical spend, and are beginning to include medical rebate guarantees in RFPs. Yet there are also uninformed employer groups which don't manage medical rebates at all. Regardless of employers' knowledge, plans need to be ready to educate and take advantage of this opportunity.

Every client will be different, and medical rebate strategy is different than pharmacy rebate strategy. With pharmacy rebate strategy, pharmacy rebates are often paid on a per brand claim basis. If there are less brand claims, the plan pays less, so there's less risk.

There are different 'rules of the road' for medical rebate strategy and incentives can be aligned differently. Medical rebates are based on buy and bill claims and reimbursement to providers is based on CMS' published average sales price (ASP) plus a percent dependent on the payer's fee schedules.

Medical rebates and provider discounts lead to ASP erosion which increases ingredient cost savings but can lead to too much ASP erosion if the pharmaceutical company has aggressive discounts in the market. This can lead to the product not being viable for providers to administer through buy and bill.

Pharmaceutical companies actively manage their ASP considering all discounts paid. This situation could lead to a different discount strategy in the future to keep the product viable. Therefore, health plans need to rationalize their medical rebate strategy so they don't get caught flat-footed.

The need for a cross benefit strategy
Employer groups that use one health plan for medical benefits but contract with another for medical benefit rebates could run into trouble if strategies conflict or their carriers don't communicate well. The best medical *rebate* strategy needs an aligned medical *benefit* strategy in order to be effective.

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Carving out the pharmacy benefit can also lead to issues with optimization. For example, Infliximab products are cheaper on the medical side due to very low ASPs compared to wholesale acquisition cost (WAC) reimbursement on a pharmacy claim. If different carriers have different strategies, opportunities for savings like this may be missed. Companies will need to all align on a single strategy, so it's easier to have it all in one shop.

In a perfect world, medical cost management strategy, pharmacy cost management strategy, pharmacy rebate strategy, and medical rebate strategy would all align. This creates new opportunities for plans, such as price differences from one benefit to the other. Having full visibility into the management and rebate strategy for both pharmacy and medical enables plans to ensure that they are taking advantage of these opportunities. Health plans need a universal strategy for their fully integrated clients.

Health plans are best positioned to solve this new challenge

Health plans are best positioned to integrate all of the strategies, but they need to ensure that they are truly integrated to make good on this opportunity. A fully integrated health plan has programs and systems in place to manage across lines of business and flag medications on the medical side to contractually be able to maximize rebates and manage site of care. In order to do this effectively, a health plan must have access to real time medical and pharmacy data as a carved-in benefit package.

If your plan is still in the planning stages or if you'd like to evaluate and evolve your strategy, don't hesitate to reach out to your growth team.

Specialty Generics: What you need to know

Scott Stapleton
Specialty Solutions Director. Pharm.D

January 25, 2023

Guest Post Bio: Scott Stapleton has been with the organization for more than 13 years and served in various roles including Specialty as well as PBM operations

An introduction to the specialty generic landscape
As spending on specialty drugs continues to skyrocket, employers and their consultants are seeking out new ways to cut costs. At Elevate, we discussed some of the options employers have, such as copay assistance programs and biosimilars. Now, there's a new hot topic that pharmacy consultants are zeroing in on - specialty generics - and health plan sales teams need to be up to date.

While a hot topic with consultants, specialty generics have historically been a limited opportunity for payers to cut costs due to a number of factors. First, many specialty drugs fall into the biologics category and rely on the biosimilar development and approval pathway vs. the simpler and faster abbreviated new drug application (ANDA) pathway used for generic medications. Second, unlike most traditional generics, specialty generics are not always less expensive for patients than branded medications due to the high prevalence of copay assistance programs for branded medications. These programs can bring patient true out-of-pocket costs close to zero while the plan cost remains high. This historically has resulted in slower adoption of specialty generics by patients and providers which has stifled competition and kept drug prices higher for longer.

We are also seeing newer tactics by innovator manufacturers to limit specialty generic products. Celgene's Revlimid, for example, recently lost patent protection which allowed the launch of 2022's first specialty generics, yet payers so far have largely been unable to benefit because of Celgene's settlement agreements with generic manufacturers limiting the amount of generics it can supply to the market. We do not expect enough generic drug supply to have a true impact on competition and pricing until closer to 2026.

United Therapeutics is another example where a manufacturer was able to extend the market dominance of its infused product Remodulin, despite patent expiration and the launch of generic competition. The manufacturer did this by deploying tactics to limit the availability of the associated durable medical equipment required to administer the product. United Therapeutics disrupted the supply chain for the specific cartridge required to administer the drug subcutaneously. Generic adoption was delayed until Accredo and Sandoz partnered to get a new cartridge cleared by the FDA, enabling patients and physicians to switch to the generic alternative. Unfortunately, in the past couple of months additional constraints have taken effect preventing the release of infusion pumps back into the market, once again slowing generic conversions.

Source: U.S. Drug spend estimates are based on IQVIA data (2021 values; prior years use pre-launch values), manufacturer reported U.S. sales or a percent of manufacturer reported worldwide annual sales of the drug. The patent expiration dates of the products is current as of June 2022. The availability of generics is highly variable due to litigation, patent challenges, or other factors. Brand names used for drugs are for illustrative and educational purposes only, and are not meant to be promotional in any way.

Despite the challenges, the pipeline of specialty generics has been steadily growing with a potential of $21.5 billion in savings from 42 recent approvals since 2018, plus nearly $43 billion in additional savings from 61 projected approvals between 2022 and 2026.

While we're not there yet, specialty generics remain top of mind for clients and consultants, so plans need to be ready.

Creating your talk track

Given that specialty generics are top of mind for consultants and with the expected growth of that segment, it is imperative that your front line has a talk track to show your expertise in this evolving area. In general, you should be able to address three things:

1. Your plan's continued evaluation of the specialty generics pipeline
2. How your formulary incorporates current specialty generics and how that impacts cost
3. Your plan's copay assistance program and other solutions your organization has to control specialty costs

These three topics will enable you to build your specialty generic value prop. If your organization does not yet have a specialty value prop that is inclusive of specialty generics, please reach out to your Growth Consultant to start a conversation.

Engaging with hospital systems: showcasing knowledge and experience

Eric Depke
Senior Director
Health Systems

September 30, 2021

Guest Post Bio: Eric has been with Express Scripts for over 13 years, managing hospital system clients for the last 8, and began leading the team in 2018.

Just like labor groups and public sector, hospital systems are unique buying groups, but their uniqueness brings different challenges and nuances. Like health plans, when you see one health system, you have seen one health system. That's why understanding the individualized needs of these groups is so important to be successful in this area. You must show your willingness to be flexible and customize your offerings.

When engaging with hospital systems at any stage in the buying process, it's important to remember these key themes in order to really hit the mark with your messaging:

Knowledge and experience - They are looking for knowledge and experience in their area, so having a sales and account management team focused on just hospital systems is an ideal state. Recognizing this isn't always feasible, at minimum, having a team of experts who understand their business model is essential. Remember, the audience you are talking to is different and will likely include physicians and in-house pharmacists. So, strategies and tactics that work for most employers may not always work here. A good example is home delivery, when they have an in-house pharmacy.

340B - This is much more than just an in-house pharmacy, it's a potential additional revenue stream you can unlock for these groups that goes beyond just pharmacy and medical services, by creating new value on all drugs adjudicated through their hospitals. Expertise is critical here, as the ins and outs of everything that goes into setting up and running an in-house pharmacy using 340B is extremely complex. This goes for groups who have not even started or considered utilizing 340B, to groups using it today but are trying to navigate the intricacies. Bringing in an expert can really help seal the deal, and can also increase your stickiness. Because you are providing more than just benefits, you are a key player in an additional revenue stream.

Physician engagement - While this is a hot topic for many employers, it's even more important and nuanced for hospital system groups. Doctors are not just a stakeholder – they are also members of the plan. This means members are not only the ones taking the medications but also the ones prescribing, adding a new unique dynamic. Your execution of the pharmacy benefit here has a huge downstream effect, because when the physicians are the members, it effects their own care but also the care they provide. Additionally, when you bring up solutions to create efficiencies like EMRs, ePA and real-time benefit check, you are talking directly to the physicians and staff who will benefit from them.

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You should be utilizing data, *“we see you have a 50% e-prescribing rate, but we have many groups with rates in the 80% range, we can help you get there.”* Make sure you and your teams are familiar with all the systems they are using and how you are integrated with those systems today, which can be different state-by-state, so keep that in mind. Much like 340B, physician engagement goes beyond benefits – your solutions can create time efficiencies and money savings because they will be implemented inside their company. If a solution saves time in a doctor’s office or hospital, this is saving time in THEIR workplace.

A health plan is the ideal partner for hospital systems because you bring the value of integration and expertise of the entire healthcare system. Remember who you are selling to and that you are selling much more than medical and pharmacy benefits; this will set your plan up for success in this complex area.

Of course that’s just the beginning, reach out to your Growth Team today to dive deeper into hospital systems.

Niche PBMs: another “new” pricing model - NADAC

Adam Bredesen

Director, Health Plan Growth – Commercial Markets

September 30, 2021

Surprise, surprise! There is another “new” PBM called CapitalRx with a “new” way of pricing drugs claiming to be the best option. This “new” way of pricing is nothing more than changing the pricing benchmark from AWP (average wholesale price) to National Average Drug Acquisition Cost (NADAC). NADAC is a survey that the U.S. Centers for Medicare & Medicaid Services (CMS) sends out to roughly 2,500 retail community pharmacies every month and requests respondents to report their per unit invoiced drug costs.

This trend has progressed past just a gimmick by CapitalRx. Several states are considering or have passed legislation mandating that reimbursement rates to pharmacies can be no less than NADAC reported rates for the Medicaid line of business. A driving force behind the change is pharmacy lobbyists. We have seen this come up in Michigan, West Virginia, and most recently in Arkansas where NADAC is now a minimum reimbursement threshold for all PBMs administering plans for healthcare payers, inclusive of self-funded employer groups.

There are several issues with this pricing methodology:

- The NADAC survey does not capture anything regarding rebates or other potential discounts such as volume discounts.
- The reported information is not validated against any source of truth or database. Response rates are typically 18%-24% according to CMS during an average month as it’s voluntary to respond.
- Unfortunately for this model, large pharmacy chains who have negotiated better pricing terms are going to be less willing to report their unit costs, therefore the responses to the NADAC survey are coming from smaller chains who have less industry leverage.
- NADAC pricing is also creating a windfall in terms of reimbursement, mainly to larger chains because on average the NADAC rates are based on smaller, less leveraged pharmacy pricing responses. In this industry, we all know that volume drives better reimbursement rates.

NADAC pricing is based on a survey with a ~20% response rate and mostly consisting of smaller pharmacies with little leverage, self-reporting their pricing

NADAC pricing does not bring any new clarity to the industry as it just puts a different spin on pharmacy pricing. NADAC pricing does not represent net new value to payers. Nobody has gone to the source (drug manufacturers) to negotiate some new pricing mechanism. They are just using aggregated, historical unit costs from a small amount of retail pharmacies.

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Instead of using average wholesale price (AWP) or wholesale acquisition cost (WAC) they are just using NADAC as their unit drug cost. This isn't anything better than what is currently in the market, it's just different. It's a marketing ploy as a new way to be transparent. Their revenue stream is an admin fee, and a high one at that, as we have seen upwards of $5.50 per Rx. The dispensing fee to the pharmacy is also incredibly highly as our competitive intelligence has shown over $9.00 per Rx. So, they show a very deep drug discount per claim but then make up for it all via dispensing fees and admin fees. This is just like a pass-through PBM pricing model only more expensive to the client. It's unknown if clients are even seeing any reduced costs with this NADAC pricing structure. Transparency at the cost of higher overall pharmacy expenses for a client is not a fair trade in our eyes.

Let's be real for a second – good pricing is good pricing. Period. The industry is caught up in the mechanics of how to arrive at a "good deal" whether that is through Spread, Pass-Through, Acquisition Cost, NADAC, etc. There is a lot of money being poured in to the marketing messages around the perceived best approach. The bottom line is you need to have a sell against plan discussing why this is not beneficial for clients to pursue and also be able to demonstrate and prove how you are delivering a stronger financial offering. Do not give them a reason to go-to-market and seek out a better deal.

As always, if you need help combating these messages or want to dig deeper, please reach out to your Growth Team.

SOURCES:
i. CMS Retail Price Survey National Average Drug Acquisition Cost (NADAC) Overview; https://www.medicaid.gove/medicaid/prescription -drugs/downloads/retail-price-survey/nadac-overview-operations.pdf
ii. Arkansas Department of Commerce; https://insurance.arkansas.gov/uploads/pages/bulletin_13-2021_nadac.pdf
iii. CMS Retail Price Survey National Average Drug Acquisition Cost (NADAC) Overview; https://www.medicaid.gove/medicaid/prescription -drugs/downloads/retail-price-survey/nadac-overview-operations.pdf

Selling to the public sector: know your audience and the rules

Jessica Danz
Strategy Director
Public Sector & Federal

July 2021

Guest Post Bio: Prior to taking on her current role as a public sector sales strategist, Jessica spent 17 years in the proposal and sales enablement space focusing largely on publicly-funded opportunities. This experience gives her a unique perspective to understand the buying and procurement habits of publicly-funded plans.

For most plans, regardless of market segment, budgets are a top priority and budget constraints are a persistent reality. But when tax payer dollars fund all or even part of the budgets, there is a heightened sensitivity to how dollars are spent. Administrators of publicly-funded plans — state, county, city, municipality, public education systems —are tasked with being good stewards of the tax payers' money and must demonstrate this to their boards and to legislators. Yet at the same time rich benefits are offered to many public sector employees in exchange for a lower salary when compared to the private sector. This means publicly-funded plans are often looking for a partner who will help them maximize their budget dollars, remove waste from the benefit, and improve health outcomes. And as publicly-funded entities, this often entails a highly regulated procurement process.

Navigating a Public Sector Procurement

Regardless of their satisfaction with their current health plan, public sector entities are often required to go out to bid every three to five years. And the procurement process is strictly regulated to create an even playing field and avoid protests. If a bid is subject to protests, it may result in an award being overturned and the RFP being reissued…at that cost of the plan. To avoid this, public sector plans often follow state procurement guidelines to which all bidders must adhere or risk disqualification. So it is important to understand (and follow) the rules of the procurement. Some common procurement rules include:

Quiet Periods: During this period, which may begin ahead of the RFP being released and run through contract award, bidders are prohibited from speaking with the plan except through authorized means. This makes the Bidders' Question period during the RFP extremely important, as it may be your only time to get clarification, and seek additional information.

Public Domain Laws: Public sector RFPs and proposals are subject to the Freedom of Information Act (FOIA) as well as similar state-specific public information laws. This means that your proposal will be available in the public domain. To protect your proprietary information, understand the FOIA laws by which the RFP is bound and how you can redact confidential information. This is also a great way to obtain CI on your competition.

Negotiations & Contracting: It's not uncommon for the RFP and the proposal to become part of the contract. Therefore, it's important to know if there will be a negotiation period or if your proposal responses are final and binding. Typically, this is outlined in the RFP, but if it's not, consider asking a bidders' question.

M/WBE: Public sector RFPs often have goals for use of Minority- and Women-owned Business Enterprises, awarding points to vendors who contract with M/WBEs. If an RFP has M/WBE goals, highlight your usage and also evaluate what your options are for partnering with minority businesses to administer parts of the plan. For example, could you contract with an M/WBE to do some of your printing or some actuarial work?

Focus on what Matters to the Plan

When developing your proposal, focus it around central themes that matter to the plan. You can develop these themes through information gathered during prospecting, research, or within the RFP itself (some RFPs even give you the score weighting, allowing you to place financial value where it matter most). Focus on 3-4 themes and weave them throughout your technical and financial offer. For example, publicly-funded plans are known to value flexibility and transparency — they want a partner that makes their lives easier.

Additional insights and pro tips:

- Innovation may take a back seat, especially innovative solutions that come at a cost, they want proven solutions that will save them money.
- While cost is important, public plans also want to avoid member noise and disruption. Develop a member-centric strategy that can also help plans manage to their budget.
- Focus on their unique needs. There's no quicker way to turn off a plan administrator than to try and shoehorn their plan with solution which don't address their current needs
- Public sector clients typically have to answer to both their board and to state and federal legislators. Additionally, independent pharmacy lobbyists and organizations have their ear and can be noisy.
- Tenures are long, sometimes spanning entire careers, meaning the same staff are often involved in several procurement and contract cycles. So it is important to know any history with the prospect, both positive and challenging.
- Consider forming a market segment team dedicated to the public sector who understands the unique business models, budget cycles, and the way they work.

Just like with labor groups, public sector groups have multiple dynamics at play and the key is to find that balance. For more information and insights or to take a deep dive into public sector groups and how to be successful, reach out to your Growth Team.

Importing medications into the U.S., but at what “cost”?

Kathy Moreland

Director, Health Plan Growth – Commercial Markets

August 27, 2021

You may have heard the term “drug importation” in recent months, but what is that referring to? It’s simply obtaining medications from a company outside of the U.S. and importing them into the U.S. This may seem harmless, but is there a hidden cost associated with this practice?

It is unlawful to import human drug products unless they are FDA-approved, properly labeled, listed, and imported by or for an FDA-registered manufacturer. In spite of these legal restrictions, we are aware that several International Prescription Providers (IPPs) have entered the U.S. market to promote and facilitate drug importation from outside of the U.S., including countries like Canada and the Cayman Islands. These companies may include CanaRx, ISaveRx, Price MDs, RxDepot, and others. We understand that IPPs may improperly rely on the FDA’s discretionary –limited use– personal importation policy to support their business operations. Express Scripts does not believe that the discretionary personal importation policy provides a patient safety and a lawful regulatory pathway to support importation of drugs for personal use. Our foremost concern is about the safety and well-being of our members, and the importation of drugs puts our members at risk. Based on this, we have made a decision not to partner with or support any IPP programs.

Things to remember when asked about Drug Importation:

- Drugs imported under the discretionary Personal Importation Policy (IPP) are unapproved drugs, which:
    - are not approved for use and sale in the United States.
    - are not reviewed by the FDA for safety, effectiveness, quality, or adequate labeling.
    - do not follow the same supply chain security requirements that approved drugs must, which makes them vulnerable to counterfeiting.
    - are not included in U.S. government monitored adverse event reporting or product tracing systems.
- Drugs may be too strong, not strong enough, or adulterated.
- Drugs may not be accompanied by approved, adequate directions for use or safety labeling.
- International shipments can take several weeks and are subject to U.S. and foreign custom check points, along with inspections and seizures, which could result in disruption or delays of important therapies.
- There’s a greater risk of storage and handling issues, which means the drugs could be in shipment longer and there’s a higher frequency at which the drugs change shipping carriers.
- Limited information is available to pharmacists to perform any comprehensive drug utilization reviews to determine if the drug may cause a drug-to-drug interaction, is contraindicated, or is otherwise inappropriate for use in the patient.
- There’s a limited access to pharmacist consultation, which, coupled with inadequate labeling, could put patients at greater risk for misuse.

While we all want to provide access to affordable medications and know that members are always in need of lower cost drugs, there is so much more to consider when it comes to drug importation than just price to ensure the safety and overall satisfaction of your groups and members. Please reach out to your Growth Team if you want to discuss this topic in greater depth.

Fighting fire with fire: let's talk about the myths of carve-out

Chris Hespe

Senior Director, Health Plan Growth – Commercial Markets

July 2021

There is a lot of "fake news" making its way around the web regarding carve-in. Messaging like this has recently been posted on coalition websites:

- In a carve-in arrangement, the plan sponsor has little visibility into the performance of their pharmacy benefit. There are no client-specific rate or rebate guarantees. There usually aren't auditing rights. Maybe most importantly, they don't have the oversight of their plan, and there's no way to hold the health plan accountable for the performance of their pharmacy benefit.
- Carve-out gives more visibility into the pharmacy contract. They have auditing rights, and typically discounts and rebates are guaranteed at the client level. This gives the plan sponsor the necessary insight into how their plan is being run from a clinical perspective, giving them more options as it relates to proactive and tailored clinical management.
- Health Plans will claim they are doing some kind of behind-the-scenes analysis that helps control spend and member experience, it's really a red herring. The data on the pharmacy side is coming from an outside source, even in your carved-in arrangement. So when you carve-out, if any of that claims data is being given to the medical carrier, that connection can still be maintained.
- When it gets down to it, are the medical vendor or carrier or TPA systems and associates the ones who should be answering questions on pharmacy? Or would you rather be getting that from pharmacy experts?

Reading things like this can be infuriating, we share the feeling. But what can you do about it? Well for starters you know best why each of these is complete BS, But because these messages are already out there, they "own" the story, so consider giving them a taste of their own medicine. We can do the same thing with carve out, like this:

A pharmacy coalition's biggest and often times only selling point is their purchasing power – they get you the best price because of their large member base. Often times it's more about the lives threshold of a particular group that drives pricing and not that the coalition's overall purchasing power. Remember, coalitions can and do run on fairly slim margins. The largest coalition in the U.S. only has about 3 million members, whereas some Health Plans have nearly that many member on their own, plus plans who are partnered with PBMs like Express Scripts have the power of 30 million members. If their best selling point is purchasing power which isn't even that powerful, what else are they even bringing to the table?

- Well sometimes its “custom solutions” – but often times, this is completely miss-leading, these custom solutions are not custom at all, they are the exact same UM, network and formulary solutions PBMs offer, just with a different name. Solutions which by the way Health Plans can offer as well (as part of your toolbox in addition to your own homegrown product offerings). The difference being Health plans truly do customize these programs by adding in a more complete care component.
- So with no real custom solutions and “purchasing power” equal to or less then the competition, what are you getting with a pharmacy coalition? The answer is hidden fees. There are coalition fees, clinical/AUM fees, formulary management/drug list fees, (for their “custom” solutions”) and many times these fees are removed from a carve outs financial analysis leading to unfair comparisons to a Health Plan offer or current arrangement. Additionally, we are just enabling a system where unnecessary players are introduced in to the supply chain, taking a cut of the cash flow, and in the end that cost drives up spend and makes pharmacy contracts more expensive for plan sponsors and members. Why introduce ANOTHER player (i.e. coalitions) to the chain to syphon off some money without driving incremental value to anyone?

The above bullets are yours to use, put your plans spin on these points and get them out there, fight fire with fire. Remember we are here to help, engage your commercial growth director for help with this and more ways to fight the “fake news” coalitions are pushing out there.

Keeping both sides happy: best practices for selling to labor groups

Jim Engler

Director, Health Plan Account Management

June 4, 2021

Guest Post Bio: Before coming to the Health Plan Division, Jim spent 16 years managing labor clients on the direct side. This experience gives him a unique perspective on both sides of these complex groups.

We all know in sales that the customer is king. This is not a novel idea, but in today's hypercompetitive market we sometimes forget how nuanced certain buying groups can be: labor is a great example. In order to be successful in this market, you must be aware of the key aspects that make labor group buyers vastly different from other buyers. The main reason is the added Complexity of labor unions. With a typical employer they have an HR/benefits team. It's their job to provide what's best for their employees, but also manage a budget and are often asked to cut costs. However, with a labor fund, their sole reason for existence is to provide the best benefits or their members, while balancing financial Contributions negotiated with the management side via Collective bargaining agreements. So how do you navigate and succeed in this complex labor world?

It all starts with great relationships. Selling to a labor group is not possible without a great working relationship with various contacts, including the fund administrator and trustees. The fund administrator is employed by the health and welfare fund of the union, and is responsible for all things related to benefits, pension, etc. The trustees are either union leaders or management representatives, and ultimately make the benefit decisions, which are then implemented by the fund administrator. It is key to understand the important roles all of these contacts play in the buying decision process. Ultimately, unions are focused on preserving the benefit for their members, while management is focused more on cost savings; you will need to walk a fine line and present options to meet both of these needs.

Labor group best practices and insights:

- Your reputation is crucial – labor unions talk to each other and word of mouth is a powerful element at play.
  - Use this to your advantage by utilizing case studies and social norming statistics when selling to a labor group. They are certainly not first adopters but will never want to feel left behind.
- Build a rock solid relationship with the fund administrator and use this to get a better idea of the dynamics at play – are there ongoing labor disputes causing high tensions? Can you talk about solutions with some disruption? Or are they overly sensitive to member noise at this time?

Labor group best practices and insights (continued)

- No matter what the current climate, always present solutions with options in a range of savings vs member disruption.
    - A union is focused on member satisfaction but part of this is member costs, so pitching solutions with member savings (in addition to plan savings) can create a win-win and make both sides of the room happy.
    - Lead with cost savings when telling your VOI story. That will be most important to everyone and the key selling point to get you in the door.

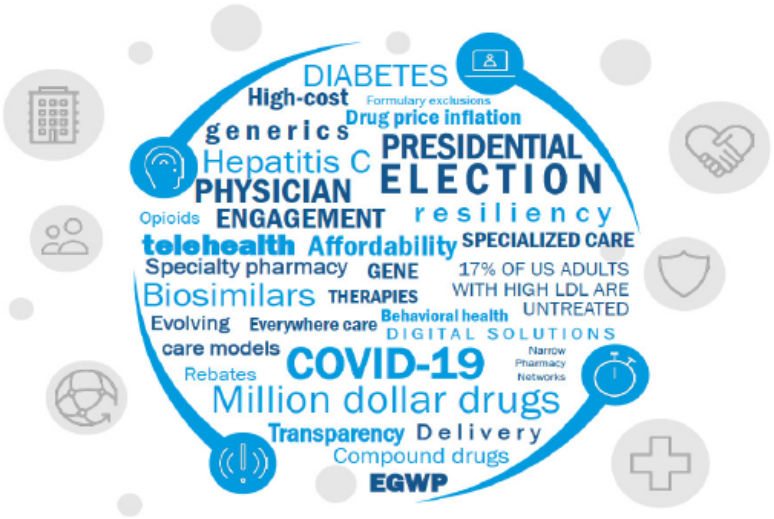
There is one more relationship at play here which is key to your success and it should be no surprise to anyone: consultants. Fund administrators heavily rely on their consultant to help guide them and navigate the difficult waters between what the union and employers want out of their health benefits. You therefore must also have a strong relationship with these consultants to stand any chance. Keep in mind some consulting houses have a more intense focus on labor groups, so consider developing a proactive strategy to show these firms you understand the unique needs of labor groups.

Staying knowledgeable and up-to-date on all sides of the labor market is essential to staying competitive in this space. For more information and insights or to take a deep dive into labor groups and how to be successful, reach out to your Market Development Director.

Your solution offering is the pathway to growth, but how do you know if you stack up?

Janice Grochal
Director, Health Plan Growth – Commercial Markets
June 4, 2021

While the pandemic changed our lives in so many ways, it also exacerbated certain areas, one of those being healthcare costs and the need for plan sponsors to find cost savings from their benefits. Once focused on rich benefits to attract and retain talent, in a market with all-time low unemployment rates, employers will now be looking for cost saving levers in response to these increasing healthcare costs. We are also seeing a shift from the single vendor model to multiple carve-outs and direct contracting. No longer are health plans only competing against other health plans, but they are also competing with point-solution vendors and the healthcare providers themselves. Roughly 41 percent of large employers plan to use cost-management tactics to reduce projected health plan cost increases, as of November 2019. *this statistic is expected to rise. All of these factors lead down the same path: solutions.



Now more than ever, it is vital to ask the questions, "Do we have solutions in place to address these critical client needs?" and "Do our clients and brokers know what solutions we have or are building to address their pain points?". While providing effective pricing with each of your pharmacy bids is a top priority, having solid solutions and innovation allows you to continually support your client's top needs and reduces the likelihood of them looking elsewhere. What historically had been a non-consideration strategy for a group may very well be an opportunity worth evaluating now.

By continually evolving your pharmacy cost-savings opportunities you're not only providing clients and prospects a desirable financial offer, but also helping them reach optimal member outcomes throughout the life of their contract with you. Competitive financials + solid, innovative solutions + demonstrated results = empowered clients effectively managing their trend year-over-year with you as their trusted guide.

A regular product assessment layered with market insight is an effective way to evaluate, develop, and organize solutions to ensure you are always putting forth a competitive offering to address market needs. That's why we have created the **Market Development Solution Assessment** which goes beyond assessing your current offerings; it allows you to:

- Identify gaps, insights and top priorities based on what your competitors are offering
- Provide leverage to engage your organization for product development
- Be a driver of sales knowledge by providing a framework for training
- Create a roadmap to ensure each of your bids and RFP responses are market competitive
- Build a framework that drives new, interesting, and proactive conversations with groups, prospects, and brokers
- Create a group-specific roadmap to assist with group planning three years out
- Evaluate the ability to create value from a margin and guarantee perspective
- Further develop reporting and proof points that demonstrates your ongoing value
- Develop a growth strategy guide to show how your plan performs in crucial solution areas compared to the market

A solution assessment is an ongoing process and should be part of your core business practices to remain market competitive. The **Market Development Solution Assessment** was introduced in 2018 and has been a tool used by many health plans to prioritize pharmacy solutions. The 2021 assessment has a new design, includes the latest market solutions, summarizes opportunities, and highlights insights to assist with your product portfolio evaluation. Your Market Development Director is happy to schedule time with your plan to walk through the assessment, identify your opportunities, and help you prioritize your next steps.

Small PBMs talk a big game to your clients and prospects

Kathy Moreland

Director, Health Plan Growth – Commercial Markets

April 30, 2021

It seems like every day I hear about another "new" PBM in the marketplace. They say they are a disruptor that "does things differently", "has the key to unlocking the best pricing" and "will bring transparency to the industry". Unfortunately most of these claims can't be backed up. Many of these new, small PBMs have a telling partner behind the scenes…Private Equity firms. These firms see the intense competition, and that many large PBMs have the cash flow to buyout perceived competition once these PBMs begin to grow large enough to pose a threat, as these recent headlines show.

CISION PR Newswire

Southern Scripts Accelerates Expansion with Water Street Healthcare Partners

Advent International

Advent International and Great Hill Partners Announce Recapitalization of RxBenefits, a Leading Pharmacy Benefits Optimizer

These start-ups operate more like a flashy, new technology company than an actual PBM. They portray a fancy front-end operation, but seem to farm out every aspect of their PBM operations. This creates yet another player skimming a piece of the pharmacy pie in the supply chain, who is not delivering any incremental value to consumers. They put a catchy brand name on top of it all, almost always using "Rx" in their name, and then bring it to market to see if it gains traction. They simply want to land several large clients, make a name for themselves, and then here comes the spoiler alert: *they want to be purchased*. This has been the storyline for so many technology start-up companies, especially out of Silicon Valley, and now pharmacy is being seen as a new pathway for this type of start-up activity by investment firms.

As a Health Plan, you have many advantages against these small PBMs:

- You have a proven medical/pharmacy integrated value message that shows real dollar savings.
- You have staff clinicians and dedicated pharmacy teams to customize your pharmacy offerings to best fit the needs of your clients.
- You know your regional marketplace. Your goal is to provide long-term better health and greater value for members and payers, not to get bought out.
- Your economy of scale and leading clinical solutions in partnering with Express Scripts is unmatched.
    - Express Scripts processes 23% (1.5b out of 6.3b) of all prescription drug claims in the U.S. This signals more negotiating power for better pricing and financial value you can deliver to clients.
    - Most small PBMs adjudicate well under 1m claims annually, sometimes operating from what appears to be a strip mall setting. This does not signal strength, stability, or value.

Southern Scripts HQ (Google map street view)

So, how can you combat these PBMs?

- You educate your clients and prospects on your track record, as well as your strength and longevity.
- Show strength and transparency by highlighting the advantages you have listed above.

You should also have your clients and prospects ask these new, flashy PBMs questions like:

- What is your 5-year growth plan?
- Do you have staff pharmacists, underwriters, operations, and actuaries for pharmacy?
- Will you provide 3 large client references, who have been with you at least 5 years?
- Can I see some proof points on how you have improved care and saved other clients with your solutions?

Don't let these "all talk" PBMs woo your clients and prospects; expose them for what they truly are and why partnering with you, backed by Express Scripts, is so much different and better.

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Just like your favorite pro athlete, training is critical to your success

Adam Bredesen

Director, Health Plan Growth – Commercial Markets

April 30, 2021

At the peak of his dominance in the NBA, basketball legend Kobe Bryant reportedly still practiced for 4 hours a day: this was in addition to working out, film study and playing actual games. Why? **Because despite being a top performer in his industry, he knew you can always get better with training**. This is true for any industry, especially one where things change every day and new trends are constantly emerging.

In order to tell your integrated story, your sales teams must be well-versed in both medical and pharmacy, and how they work together to create value and provide better care. If plans are carving out because they believe they are getting "expertise" from PBMs, the best way to combat this is to become pharmacy experts as well.

Of course, we have some tools and strategies to help – starting with our robust online pharmacy and integration training series. These short, fun, interactive modules cover everything from PBM basics to pharmacy solutions, to advanced pricing strategies to developing a consultant engagement strategy. And now we are bringing it all together with our latest addition: Dazzle Your Prospects like a Star. This module follows our friend Angie as she navigates trying to land a game-changing prospect, while covering RFP best practices, new pricing strategies, clinical solutions and revisits past topics from previous sessions. In the coming weeks, your Market Development Director will be reaching out to your plan to implement a strategy to deliver this module (and any of the other seven) to your sales teams.

While these online trainings are a great tool, they are just a piece of the puzzle. In order to be successful, you must build a strategy around these modules to ensure completion and retention of the content, but also to keep the conversation going beyond these trainings. Other plans have seen great success by utilizing these best practices:

- Appoint a pharmacy training lead within your organization to create accountability.
- Use hard deadlines for the completion of training modules or series.
- Promote the completion of the training within your organization as a true value added development tool.
- Provide incentives, such a raffle, for everyone who has completed the requested training.
- Continue to engage your Market Development Director throughout the process and meet with them after the completion of the training series, to create a follow-up training plan that digs deeper in areas where your plan needs additional training.

Success begins with knowledge. As advocates for your plan's growth, achieving pharmacy expertise across your sales organization and go-to-market teams is one of our top priorities. Please engage with Market Development, if you have not already done so, to ensure you are doing everything you can to arm your teams with this critical knowledge. And be on the lookout for more information on how you access Module 8.

New DTR data further solidifies VOI story

Todd Chan

Director, Health Plan Growth – Commercial Markets

March 24, 2021

I hope you have had a chance to, or will make time to, explore this year's Drug Trend Report. There are some great insights, including how "progressively managed" plans saw a -9.2% trend, as well as, insights on the regulated lines of business with total trend for Medicare and Medicaid coming in under the commercial book of business. Keep in mind, everything else you see in the report is for our entire "commercial book", which includes health plans and direct PBM clients. I want to call out a few things especially important for health plans, including some information not available in the public report:

1) Specialty spend is now 50/50

After years of inching closer and closer, we are finally at the point where spend is split 50/50 between specialty and traditional drugs. The commercial book's specialty spend is just above 50%, whereas the health plan-only book is just below. This greatly enhances your Value of Integration story – with half of all drug spend falling in categories with high medical spend, including 30% in just inflammatory and oncology alone, the need for holistic, single-vendor management is more imperative than ever.

We have updated our Value of Integration (VOI) slide library in our VOI toolkit – reach out to your Growth Team if you do not have access to this or would like the updated version. Our Lead Marketing Consultant, Corey Graves, is available to sit down with you and your marketing teams to go over how to best utilize this data to tell your VOI story.

2) Health plan and commercial trend are equal

In the past, we have often seen our commercial trend come in lower than the health plan trend – but last year, health plan trend beat out commercial trend significantly and while both numbers were up this year from increased utilization, we now see the two sets are essentially equal at 4.0% and 4.1%, respectively. This further continues to disprove the narrative that carve-out better controls pharmacy spend.

3) PMPY spend is once again lower for health plans

For the 5th year in a row, total per member per year drug spend for health plans was lower than the commercial book. This year it's 14% lower, at just over $1,000. Despite fluctuations in trend, health plans have spent less overall on drugs than our commercial book for half a decade, another irrefutable stat to display the Value of Integration.

Our Value of Integration white paper has been updated for 2021 and includes the recent stats mentioned above as well as some other new additions. The updated version can be downloaded below in the Thought Leadership Corner.

Remember, this is only scratching the surface of a full Value of Integration story. The numbers in the white paper and Drug Trend Report once again prove that employers receive greater value when carved-in. Make sure you are leveraging your own proof points to demonstrate how the trend continues, or is even better, when employers carve-in with your plan. We have also created slide templates, which you will find a link to under this post, to help you showcase these numbers.

But, this is only part of the comprehensive Value of Integration story you should be telling in the market. You must show how you pair this value with superior care, and what you do differently and better than other plans. You need to have a simple, consistent story and communication strategy across multiple mediums backed by your plan's specific data and case examples. If you can't say with confidence you have this, reach out to your Growth Team and we can help jumpstart your efforts to ensure you are bringing the best pharmacy and integration story to your market.