Published June 2022

2022 Results

Trends in Drug

Benefit Design Report

PSG
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Preface

About PSG

PSG is the leading pharmacy intelligence and technology company solving one of healthcare's biggest challenges – rising drug costs. We provide innovative drug management solutions to employers, health plans, and labor unions who rely on our team of trusted advisors to improve their financial performance.

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Acknowledgment

PSG gratefully acknowledges the respondents who contributed their time and expertise to complete the survey that provides the basis for this report. We are also thankful for the sponsorship of Rx Savings Solutions for making this research possible. However, final responsibility for the content of this report rests with PSG.

Suggested Citation

Pharmaceutical Strategies Group. 2022 Trends in Drug Benefit Design Report. Dallas, TX: PSG.
Available from www.psgconsults.com

For questions relating to the report, please contact:
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Sponsor

Rx Savings Solutions, 5440 W. 110th Street, Suite 200, Overland Park, KS 66211

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Introduction

Pharmaceutical Strategies Group (PSG) is pleased to present the 2022 Trends in Drug Benefit Design Report, which details traditional (non-specialty) drug benefit trends and strategies. This report, previously published under the Pharmacy Benefit Management Institute (PBMI) brand and **first conducted in 1995,** demonstrates PSG's ongoing goal of generating meaningful conversations and providing valuable insights about drug benefit design and management.

Since we first produced this report over 25 years ago, drug benefit design has become much more complex. Many more drugs are available, and decisions about program structure, cost sharing, formulary design, and clinical and trend management are more numerous and complicated than ever. The last few years have added the further complication of a pandemic, the effects of which are still being realized. **In this environment, all stakeholders — employers, PBMs, health plans, pharmaceutical manufacturers, pharmacies, health care providers, and consumers — play important roles in the decisions that are ultimately made about drug benefit design.** Plan sponsors must constantly review trends and adjust plan design and programs to meet current needs and marketplace conditions.

This report focuses on drug benefit design for the 2022 benefit year among employer, union/Taft-Hartley, and health plan respondents. Where noteworthy, it also compares current findings to findings from the 2018 report, when this research was last conducted. Issues specific to specialty medications are explored in detail in a separate report — Trends in Specialty Drug Benefit Design. These reports as well as prior annual reports and other research conducted by PSG can be found at www.psgconsults.com.

Introductory Letter

From Michael Rea, PharmD – Founder & CEO, Rx Savings Solutions

To fellow stakeholders in the pharmacy benefit community:

Welcome to the 2022 Trends in Drug Benefit Design report. Rx Savings Solutions is pleased to sponsor this year's edition and the insights it delivers to so many of our colleagues throughout the industry.

As regular readers of this report have observed, trends and the numbers that drive them change over the years, but the main challenge persists: Plan sponsors must balance reducing prescription drug costs with improving access and affordability.

Plan designs evolve, solutions come and go, and priorities shift. At the end of the day, consumers shoulder an increasingly unsustainable share of medical and pharmacy costs.

Many findings in this report reflect an increasing emphasis on supporting members, notably the focus on their experience and satisfaction, along with the growing utilization of member-centric solutions that complement the plan design to reduce costs.

While the challenge remains, opportunities have never been more numerous. The research conducted by PSG will help inform drug benefit design decisions that work toward an elusive but important goal, one that is underscored by the impact of COVID-19 and the Great Resignation.

On behalf of all stakeholders, we thank PSG for this valuable information that helps us better meet our objectives.

Best regards,
Michael Rea
Founder & CEO
Rx Savings Solutions

Medication is priceless.

If people can afford it.

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Rx Savings Solutions

No one cares more about drug costs than the patients who depend on prescriptions. **When they're engaged and empowered to spend less, plan sponsors save even more.**

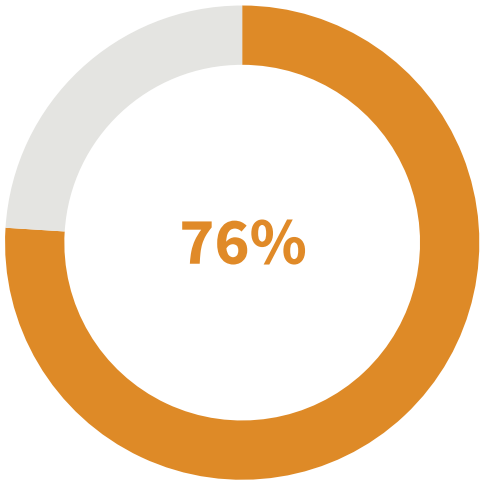
Learn more at rxss.com/value

Executive Summary

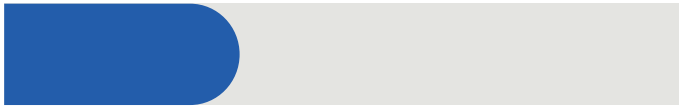
Executive Summary

The 2022 Trends in Benefit Design report is divided into 6 sections, each covering a different element of drug benefit design and implementation.

In the Designing the Drug Benefit section, we highlight major sources of influence in respondents' design and evaluation of their organization's drug benefit and report on foundational attributes such as the benefit funding structure and whether plan sponsors purchase stop-loss insurance.



76% use a drug benefit consultant



36%

36% participate in a coalition or collaborative to negotiate their drug benefit

58%

58% design their drug and medical benefits together

Executive Summary

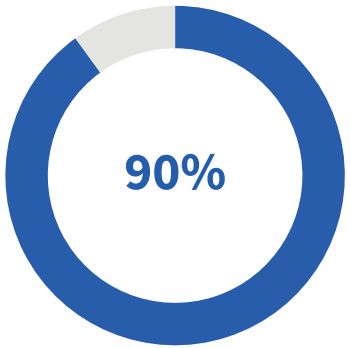
In the Drug Benefit Management in High-Deductible Health Plans section, we report on the types of plans offered by plan sponsors and respondents' perceptions of and challenges with high-deductible health plans.

35%

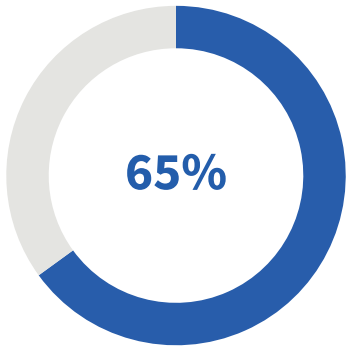
35% agree or strongly agree that HDHPs manage overall drug trend

51%

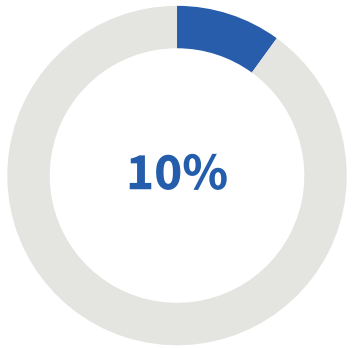
51% agree or strongly agree that HDHPs help members



90% offer a PPO



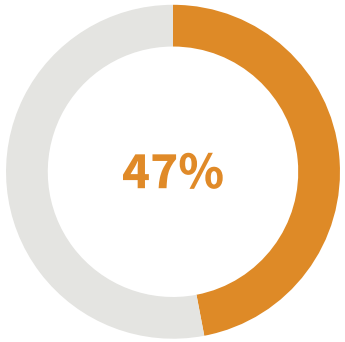
65% offer a HDHP with HSA



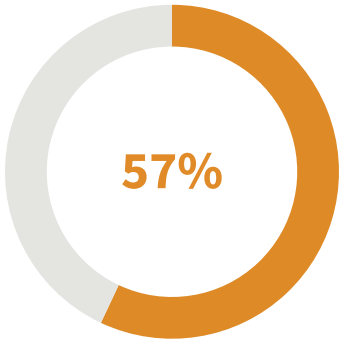
10% offer a HDHP with HRA

Executive Summary

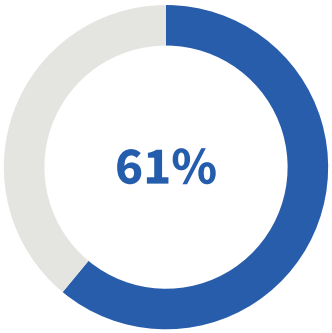
In the Cost Sharing section, we discuss sources of influence on cost-sharing decisions, cost-sharing mechanisms and amounts, pharmacy networks, channels used to fill prescriptions, promotion of cost-sharing transparency tools, and the cost-sharing changes respondents are considering.



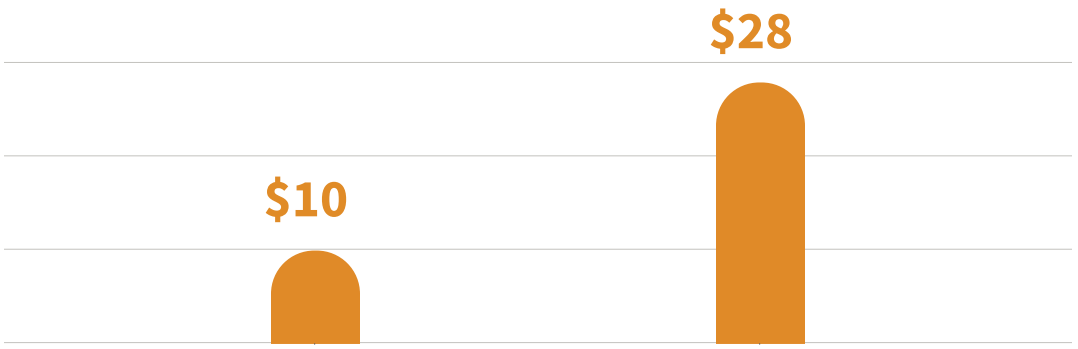
47% limit retail 90 fills to one or two major pharmacy chains



57% promote cost-sharing transparency tools



61% use a copay cost-sharing structure for retail 30

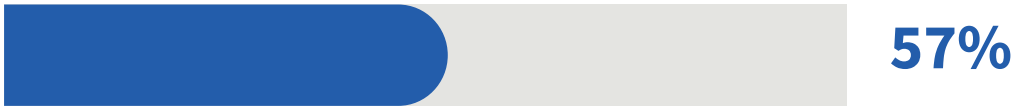


The average retail 30 copay is $10 for tier 1 drugs

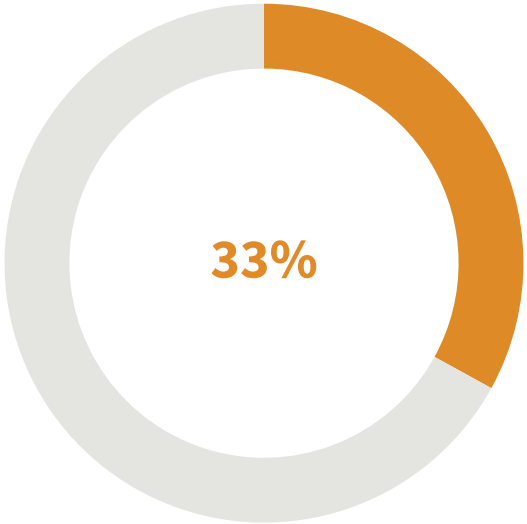
The average retail 30 copay is $28 for tier 2 drugs

Executive Summary

In the Clinical and Trend Management section, we delve into pharmacy benefit management goals and priorities as well as use of, barriers to, and ideas for improvements in trend and utilization programs.



57% cite member acceptance as a barrier to trend and utilization management programs



33% say reducing inappropriate utilization is their top goal outside of managing overall trend

Executive Summary

In the Drug Access and Pricing section, we cover network design and pharmacy reimbursement structure, formulary decisions, discounts and rebates, and sources of PBM contract revenue.

67-71%

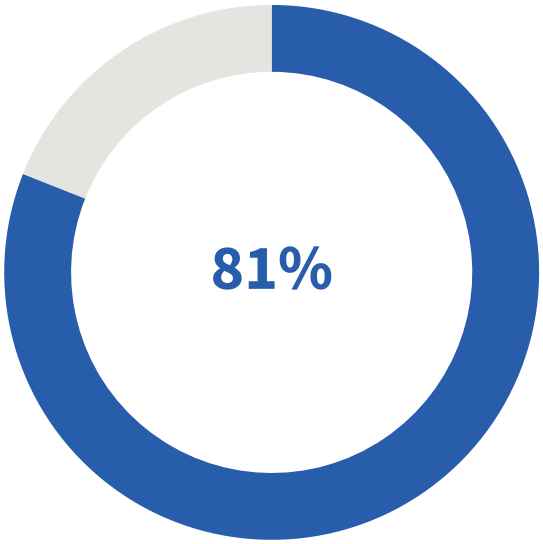
Average discount off AWP ranges from 67–71% for generic drugs

21-24%

Average discount off AWP ranges from 21–24% for branded medications

69%

69% cite member dissatisfaction as their top challenge with formulary exclusions



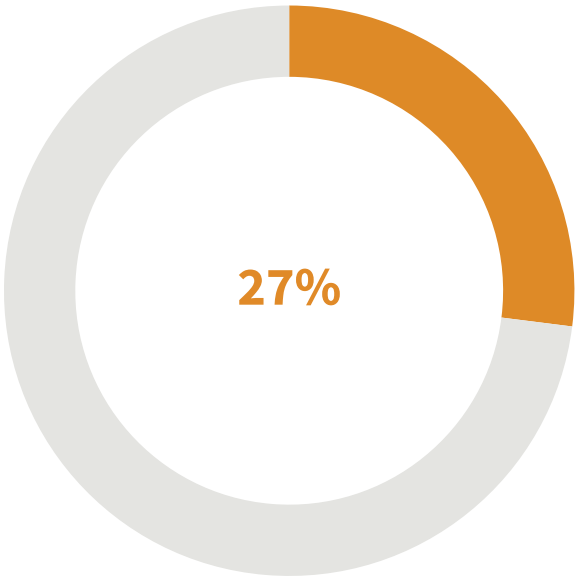
81% use formulary exclusions

Executive Summary

Finally, in the Spotlight on Trends Impacting Benefit Design section, we explore impacts of the COVID-19 pandemic and the importance of member experience.

41%

41% say the importance of member experience has increased somewhat or greatly since the start of the pandemic



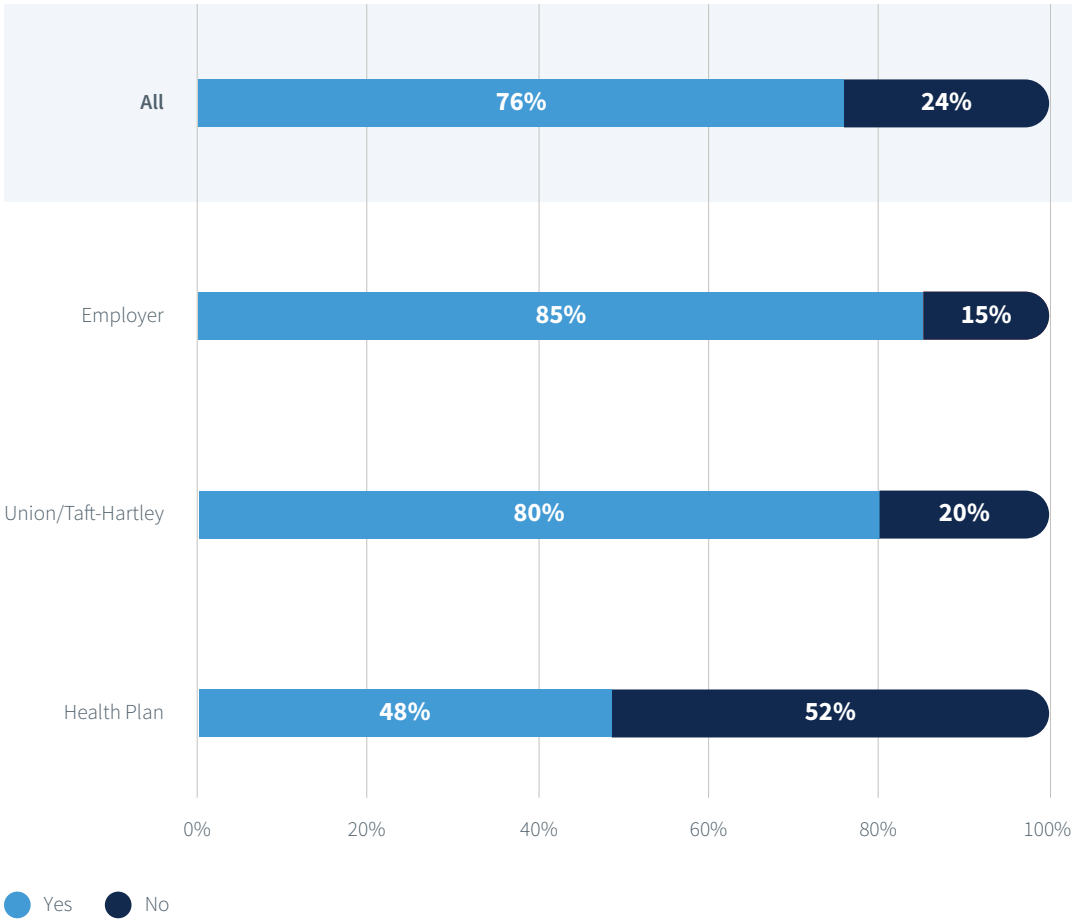
27% report the Great Resignation has impacted their benefit strategy

Designing the Drug Benefit

Drug Benefit Consultants

Plan sponsors face challenges and must consider many factors (e.g., budget, projected and past trend, and member characteristics) when designing the drug benefit. As various stakeholders in the United States strategize about how to reduce drug costs, plan sponsors try to design the drug benefit to manage those costs now and meet goals around both access and affordability. A task of this magnitude and importance warrants expert advice from many sources, notably consultants. As shown in Figure 1, most respondents used a benefit consultant, though this differed by respondent group: the vast majority of employer and union/ Taft-Hartley respondents used a benefit consultant, compared to approximately half of health plan respondents.

Figure 1 Use of Drug Benefit Consultant *(n=137)*



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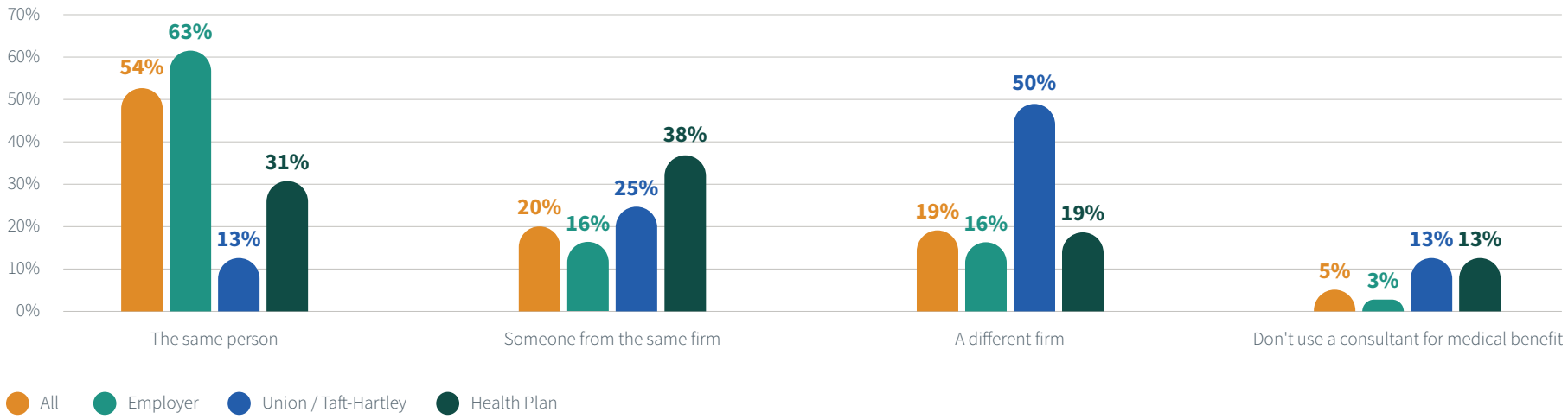
Medical Benefit Consultants

Among respondents who used a benefit consultant, about half used the same person to help evaluate and design their medical benefit (see Figure 2). Again, responses differed across respondent groups: employer respondents most commonly used the same person, union/Taft-Hartley respondents most commonly used a different firm, and health plan respondents most commonly used a different person from the same firm. Smaller employers and large employers also differed, with smaller employers much more likely to use the same person (79% vs. 46%) and much less likely to use a different firm (5% vs. 27%).

Figure 2 Use of Medical Benefit Consultant *(n=104)*

Not shown: 2% of respondents selected "not sure."



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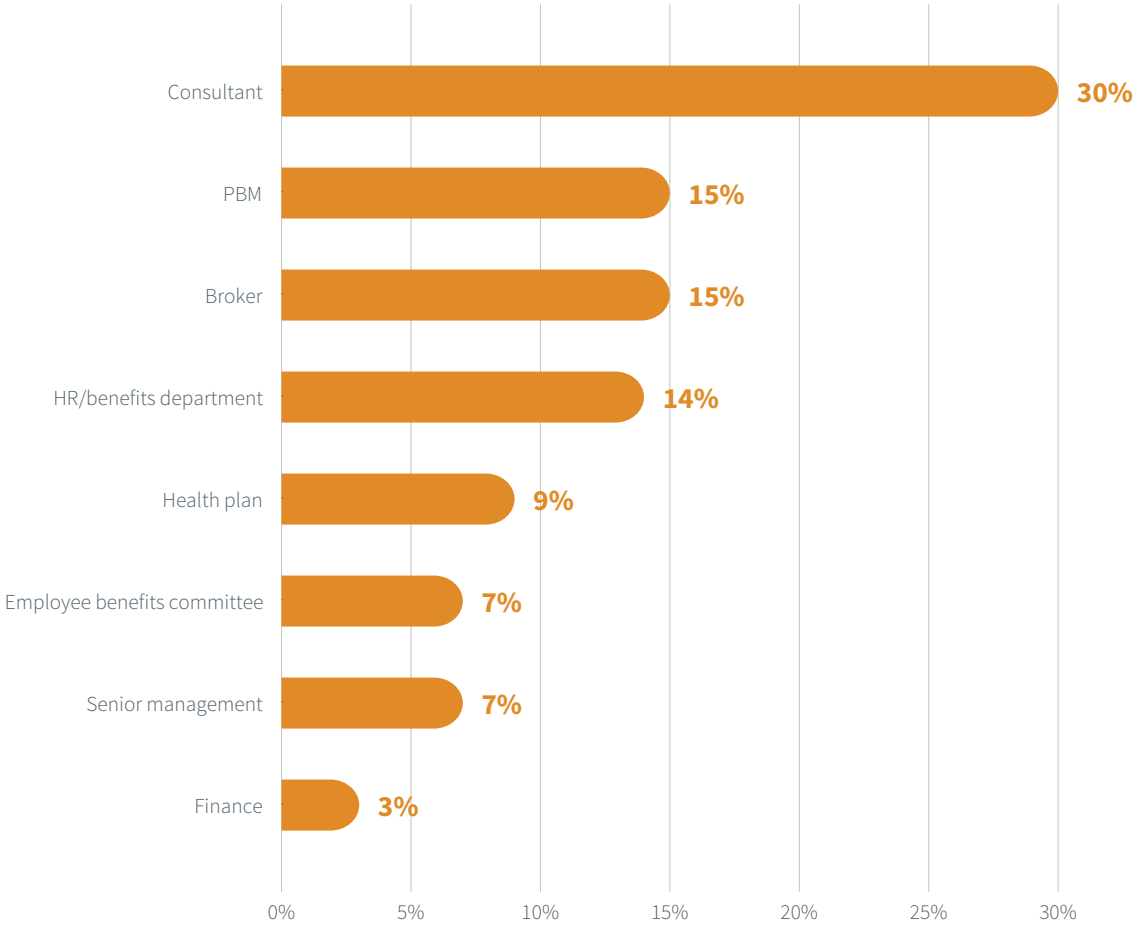
Drug Benefit Design Influences

Consultants were not plan sponsors' only source of guidance, but they were the source most often selected as the most influential in helping respondents evaluate and/or design their organization's drug benefit (see Figure 3). Other common selections were PBM, broker, and HR/benefits department. Responses on this question differed markedly between smaller employers and large employers. Large employers were more likely to select consultant (36% vs. 28%) or PBM (15% vs. 9%) and less likely to select broker (15% vs. 26%) or HR/benefits department (13% vs. 23%).

Figure 3 Most influential in Drug Benefit Design *(n=137)*

Not shown: 1% of respondents selected "other."



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Relationship Between Drug and Medical Benefit Design

The drug benefit can be designed in concert with the medical benefit or separately from the medical benefit. As shown in Figure 4, 58% of respondents overall designed their drug benefit and medical benefit together, but this varied by respondent group. Also, within the employer group, large employers were more likely than small employers to design the drug and medical benefits together.

Drug and Medical Benefit Designed Together — By Employer Size

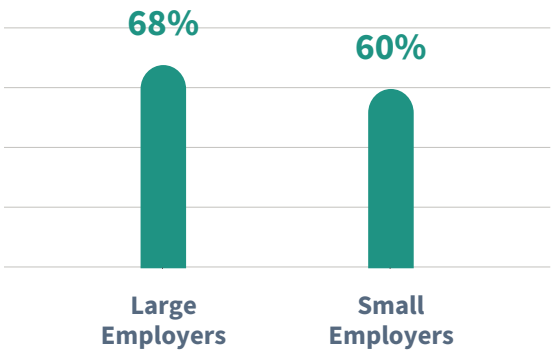
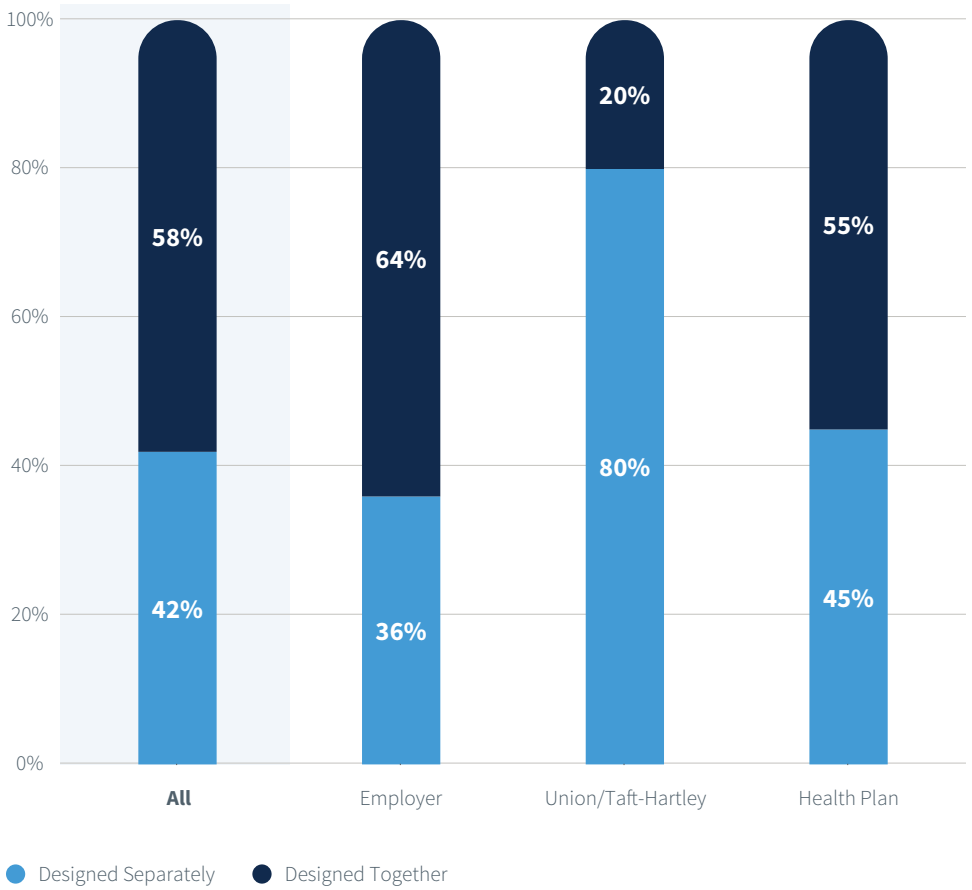


Figure 4 Drug and Medical Benefit Design *(n=137)*



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Coalition Participation

Plan sponsors can choose to work with a coalition or other group purchasing organization. Just over one-third of respondents said their organization was part of a coalition or collaborative for negotiating their PBM contract (see Figure 5), up from 27% when we last conducted this survey in 2018. Within the employer group, large employers were more likely than smaller employers to take part in such a group.

Participation in Coalition/Collaborative for PBM Contract Negotiation — By Employer Size

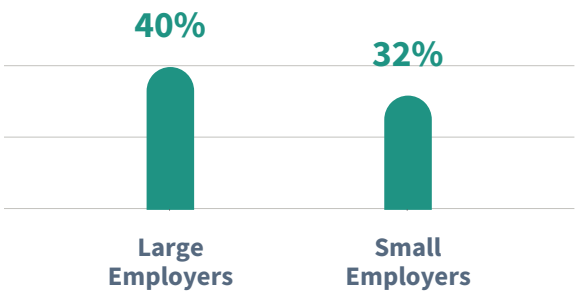
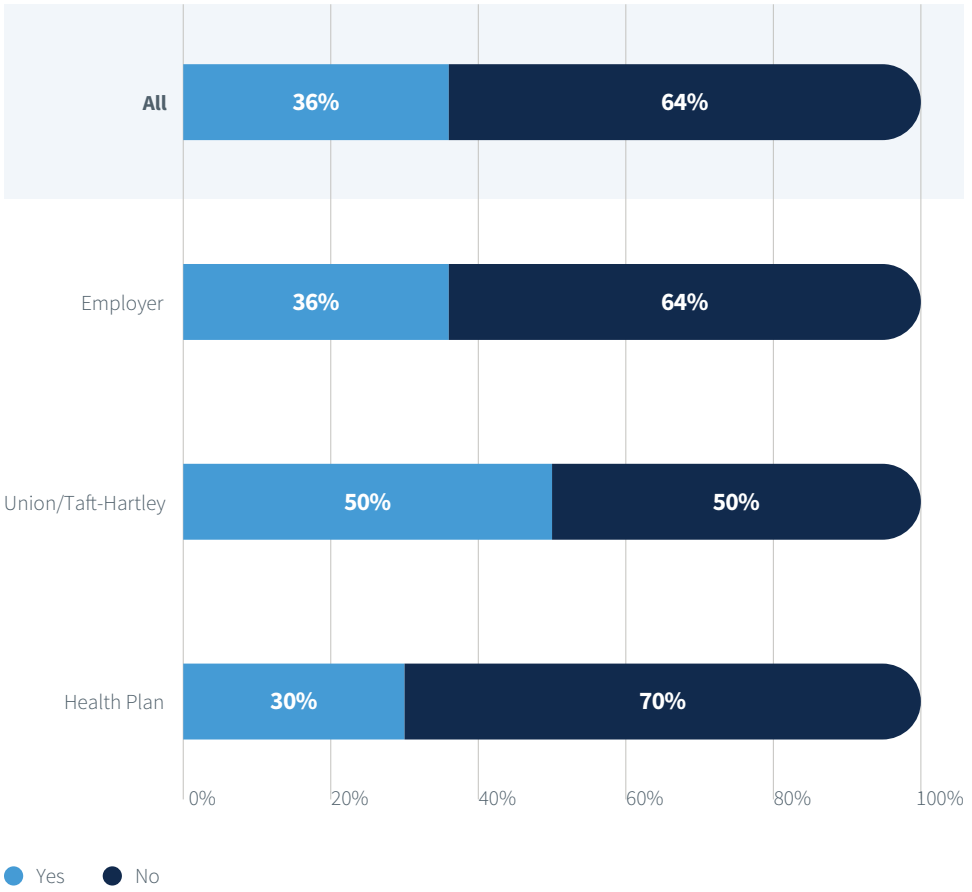


Figure 5 Participation in Coalition/Collaborative for PBM Contract Negotiation *(n=137)*



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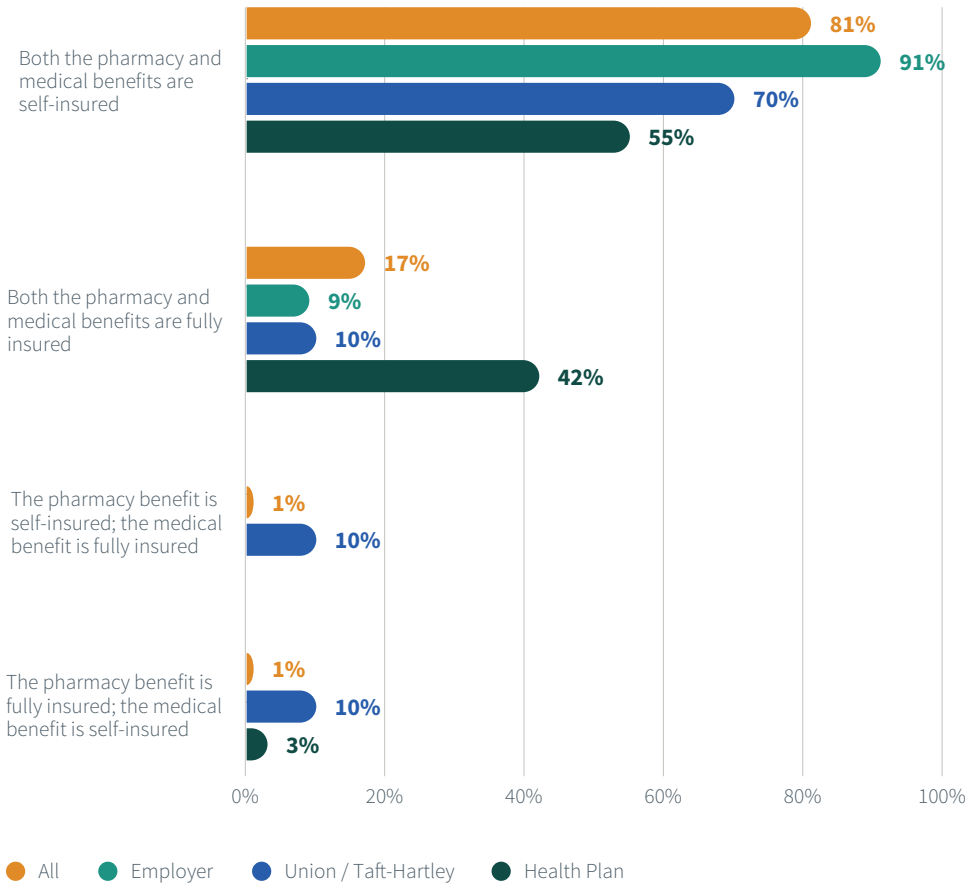
Benefit Funding Structure

Plan sponsors must also decide how to fund the plan's medical and pharmacy benefits. Self-insured plans take on more financial risk but may have lower overall costs if managed effectively. As shown in Figure 6, the vast majority of employer respondents indicated both benefits were self-insured, while health plan respondents were nearly evenly split between benefits being self-insured and fully insured. Within the employer group, 98% of large employers reported both benefits were self-insured, compared to 85% of smaller employers.

Figure 6 Benefit Funding Structure *(n=137)*



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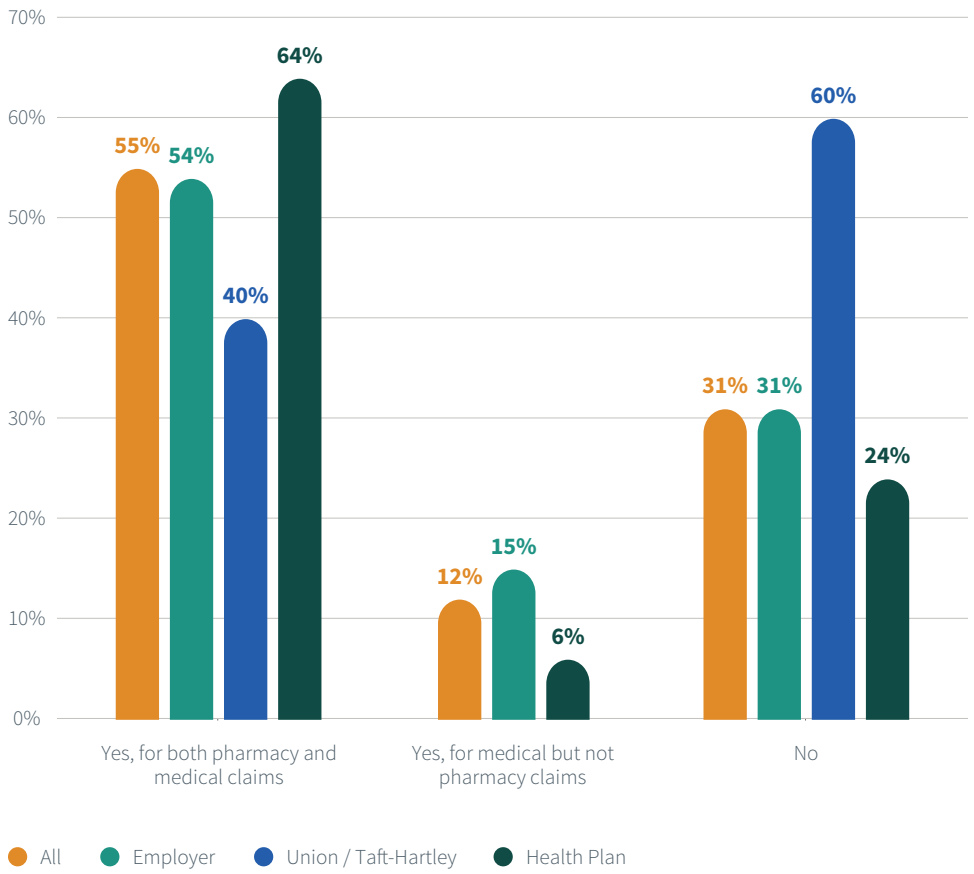
Stop-Loss Insurance

Plans can mitigate their risk of financial loss due to catastrophic illness or unpredictable medical or pharmacy claims by purchasing stop-loss insurance. Overall, 55% of respondents purchased stop-loss insurance for both pharmacy and medical claims, and health plan respondents were more likely than respondents from other groups to purchase this insurance (see Figure 7). Smaller employers were more likely than large employers to purchase stop-loss insurance for medical but not pharmacy claims (21% vs. 9%), and large employers were more likely to not purchase this insurance at all (40% vs. 21%).

Figure 7 Purchase of Stop-Loss Insurance *(n=137)*

Not shown: No respondents purchase stop-loss insurance for pharmacy but not medical claims, and 1% of respondents were not sure if they purchase stop-loss insurance.



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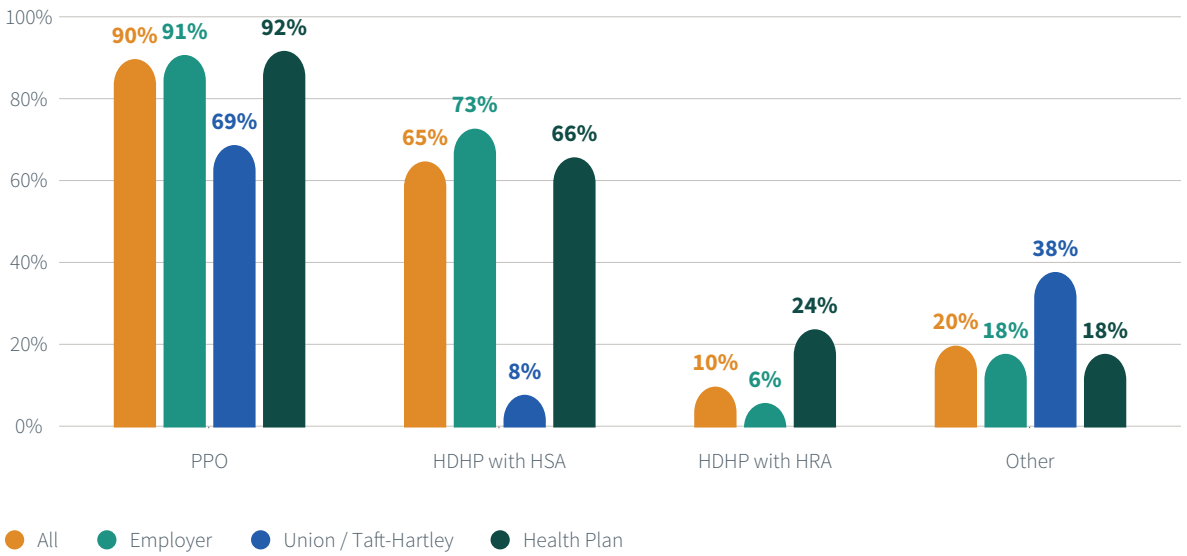
Drug Benefit Management in High-Deductible Health Plans

Health Plan Types Offered

One major benefits trend has been increased use of high-deductible health plans (HDHPs), which the Internal Revenue Service defines as plans with a deductible of at least $1,400 for an individual and $2,800 for a family.[1] Through more member cost sharing, HDHPs try to decrease the use of low-value care and encourage consumers to actively consider both cost and quality when making health care decisions. HDHPs may be combined with a health savings account (HSA), which is a personal savings account for health care expenses funded by the member's pre-tax dollars, or a health reimbursement arrangement (HRA), which is an account owned and funded by the member's employer but held in the member's name. The combination of HDHP and HSA or HRA is intended to provide financial protection against high health care costs while encouraging good consumer behaviors.

Organizations often offer multiple types of plans. As shown in Figure 8, nearly all employers and health plans offered a PPO plan, and most offered a HDHP with HSA. Compared to other groups, health plans were more likely to offer a HDHP with HRA. Also, union/Taft-Hartley respondents selected "other" at higher rates, most often describing an HMO offering. Smaller employers were more likely than large employers to offer a PPO plan (98% vs. 85%), while large employers were more likely than smaller employers to offer a HDHP with HSA (87% vs. 58%).

Figure 8 Types of Plans Offered *(n=153)*



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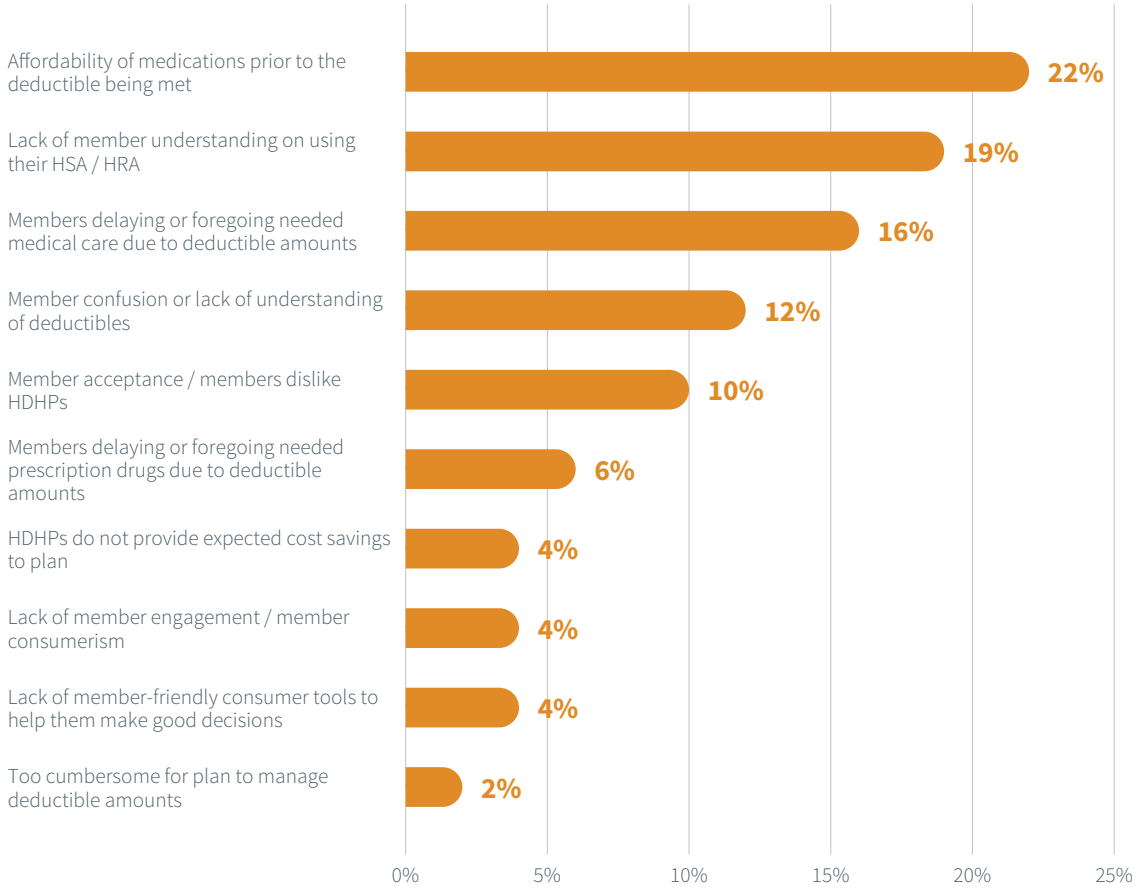
Challenges with High-Deductible Health Plans

When asked to rank the challenges associated with HDHPs, respondents selected affordability of medications prior to the deductible being met most frequently, followed by lack of member understanding regarding their HSA or HRA and members delaying or foregoing care due to deductible amounts (see Figure 9).

Figure 9 Top Challenge with High-Deductible Health Plans *(n=140)*



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High-Deductible Health Plan Outcomes

Though the majority of respondents reported offering a HDHP, they expressed mixed views on whether these plans achieve their advertised aims. As shown in Figure 10, only 35% of respondents agreed or strongly agreed that HDHPs are an effective way to manage overall drug trend. A somewhat larger percentage (51%) agreed or strongly agreed that HDHPs are an effective way to help members become better health care consumers and make wiser medication choices (see Figure 11).

For both of these questions, health plan and union/Taft-Hartley respondents expressed less confidence in HDHPs, compared to employer respondents. Responses to these questions indicate somewhat lower confidence in HDHPs compared to when this survey was last conducted in 2018, where agreement was 41% for the managing overall drug trend question and 58% for the helping members become better health care consumers question.

Figure 10 High-Deductible Health Plans Manage Overall Drug Trend *(n=140)*

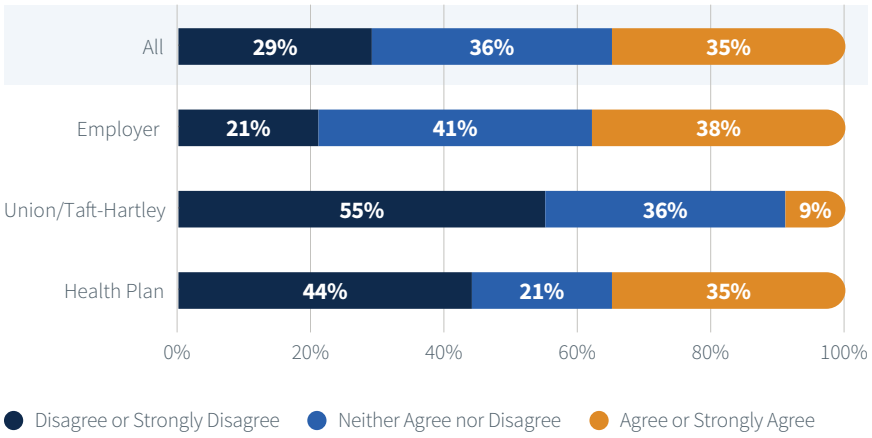

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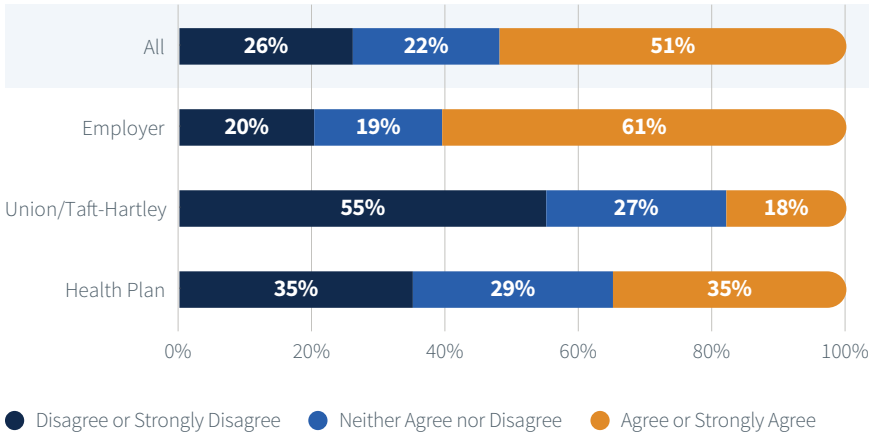
Figure 11 High-Deductible Health Plans Help Members *(n=140)*



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High-Deductible Health Plan Successes and Challenges

We also asked respondents to share the successes or challenges their plan has experienced with HDHPs. Respondents' comments gave context to their previous answers and revealed 5 major themes:

Complexity/Lack of Understanding and Impact of Education

"Lack of member understanding of how plan actually works, and what their true expenses will be"

"More employees are getting prescriptions filled on a regular basis now that they understand the purpose of the HSA and cost savings tools"

Costs and Savings (or Lack Thereof)

"Employees get frustrated with paying the high costs of their drugs before they hit their deductible"

"We have lowered our out-of-pocket costs as members make better decisions about their health care"

Delay of Care and Lack of Adherence

"We've heard of members not wanting to pick up medications because they go towards their deductible and it's too expensive to pick up. I feel like the members on the POS plan end up being more compliant with their medications."

Impacts on Drug Choice and Payment Strategies

"The manufacturer coupons make it possible for members to bypass paying their deductible and put them in the coinsurance phase earlier"

Member Interest and Satisfaction

"Once an employee gets through the first year (toughest do to contributing to HSA) employees embrace the plan. Only a small % ever leave the HDP (less than 2%) each year."

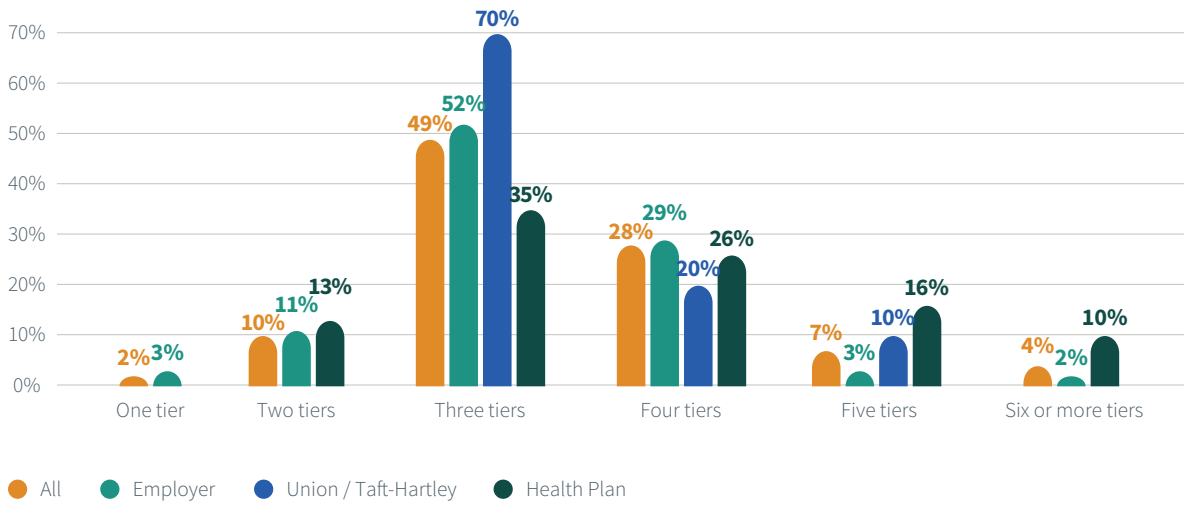
Cost Sharing

Plan Tier Design

Cost sharing is the most visible part of the drug benefit for members and is a financial burden for some members. Nearly two-thirds of adults take at least one prescription drug, and member cost sharing gets quite a bit of attention; however, 69% of those who take a prescription drug say affording them is somewhat or very easy.[2] Member cost share (i.e., out-of-pocket costs separate from the amount members spend on their monthly premium) comes in various forms — primarily copayments, coinsurance, and/or deductibles. The aims of cost sharing are to defray some costs for plan sponsors, keep premiums affordable, reduce the use of unnecessary drugs, and provide financial incentive to choose a lower-cost place of service and lower-cost drugs when available.

Cost sharing is commonly based on the tier placement of the drug, and plans vary in how many tiers they use. As shown in Figure 12, the most common structure across all respondent groups was three tiers, but responses varied by group. Notably, employer respondents were much more likely than health plan respondents to have 3 tiers and much less likely to have 5 or 6 or more tiers.

Figure 12 Number of Tiers for Drugs Covered by the Plan *(n=134)*



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Retail 30 Cost Sharing

Cost sharing can be structured as a flat dollar amount (copay) or as a percentage share of the cost (coinsurance). For retail 30 fills, nearly two-thirds of respondents used a copay, but this varied by respondent group and subgroup (see Figure 13): 4 out of 5 health plan respondents used a copay compared to just 2 out of 5 union/Taft-Hartley and large employer respondents. The overall results were nearly identical for retail 90 fills (61% copay) and mail-order fills (62% copay), and these channels also showed the same patterns of group differences.

Retail 30 Copay Cost-Sharing Structure — By Employer Size

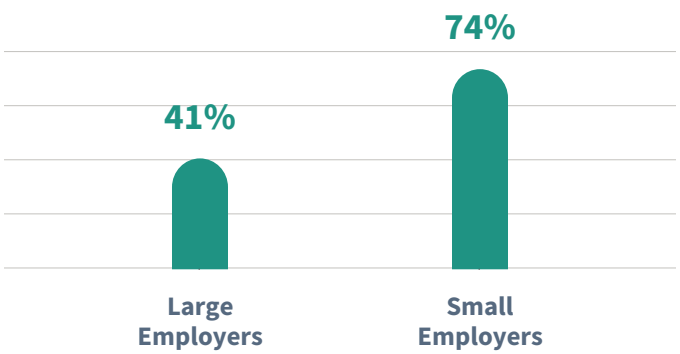
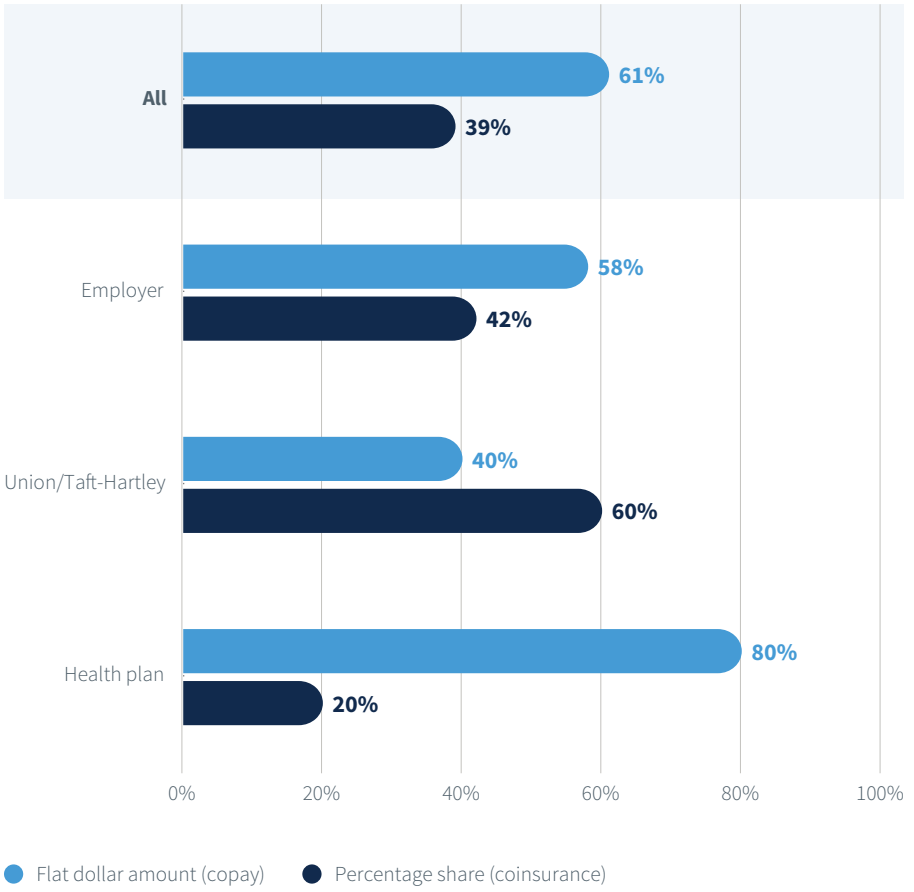


Figure 13 Retail 30 Cost-Sharing Structures *(n=132)*



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Cost Sharing Amounts

The average amount of cost sharing varies based on the drug tier and the channel used to fill the prescription. Further complicating matters, the drug classes that are covered in each tier vary across plans. Figures 14 and 15 show the average copay and coinsurance respectively for retail 30, retail 90, and mail-order for the first two tiers of drugs (where there is the least variation in which drug classes are included). Copays and coinsurance percentages were higher for Tier 2 drugs compared to Tier 1 drugs. Copay amounts for retail 90 and mail-order were approximately twice the price of retail 30, providing savings to members of about one 30-day copay for every 90-day prescription filled. Coinsurance percentages were similar across channels.

Figure 14 Average Cost Sharing for Copay

Note: Ns varied based on tier and dispensing channel, ranging from 50 to 76.

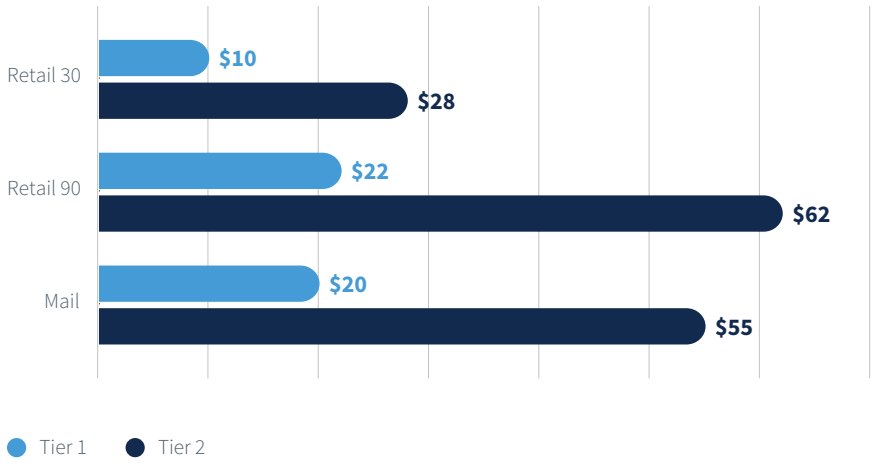

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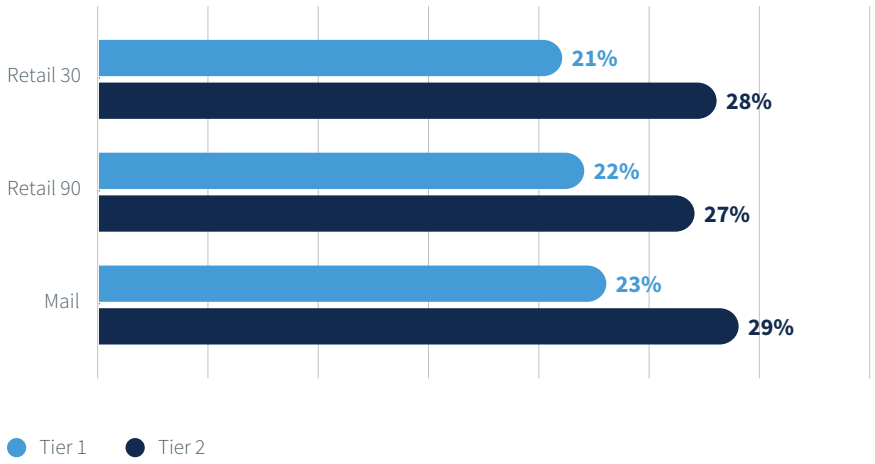
Figure 15 Average Cost Sharing for Coinsurance

Note: Ns varied based on tier and dispensing channel, ranging from 32 to 45.



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Retail 90 Pharmacy Networks

In the retail 90 channel, plans have the option of restricting where prescriptions can be filled. This strategy can be used in addition to network contracting to reduce overall costs by favoring pharmacies that offer lower drug costs and/or dispensing fees. As shown in Figure 16, nearly half of respondents overall limited where 90-day prescriptions can be filled. However, there were substantial differences by respondent group and employer size, with large employer and union/Taft-Hartley respondents most likely to have such restrictions.

All Network Retail Pharmacies Permitted for Retail 90 Fills — By Employer Size

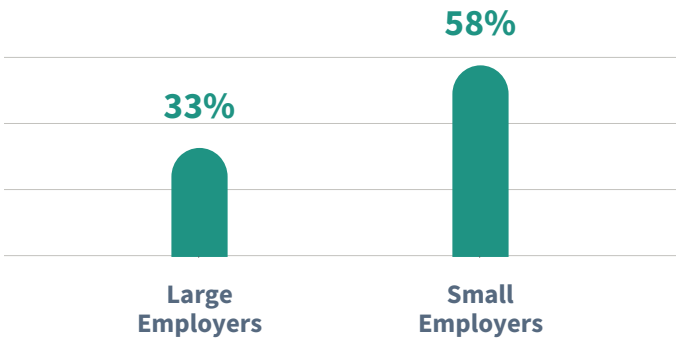
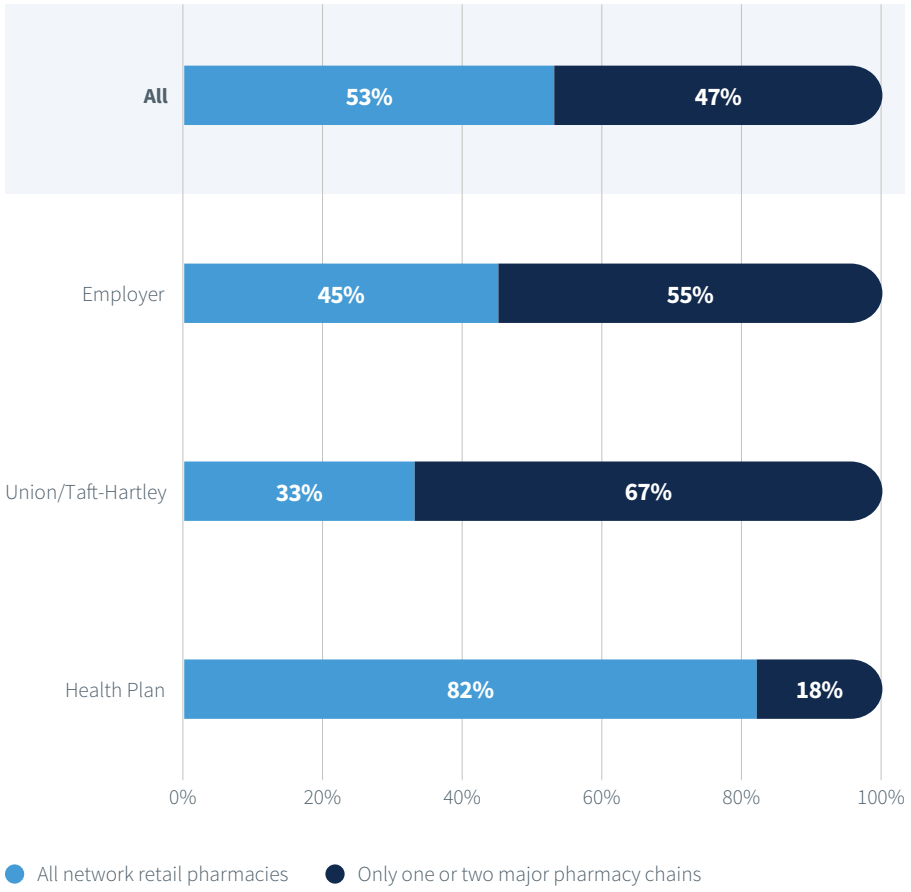


Figure 16 Pharmacy Network Options for Retail 90 Fills *(n=97)*



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Retail 90 and Mail-Order Design

Another plan design decision for retail 90, a decision that also applies to the mail-order channel, is whether to make use of the channel mandatory for some or all maintenance medications. The majority of respondents reported that use of these channels was voluntary.

Again, there were notable differences by respondent group and employer size (see Figures 17 and 18). Health plan respondents and, to a lesser extent, smaller employer respondents were more likely to say use of these channels was voluntary.

Figure 17 Retail 90 Design *(n=97)*

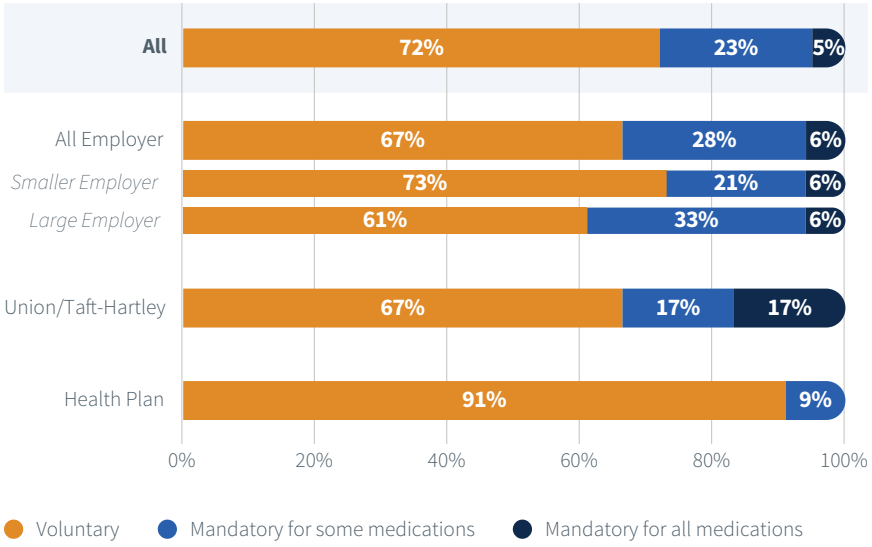

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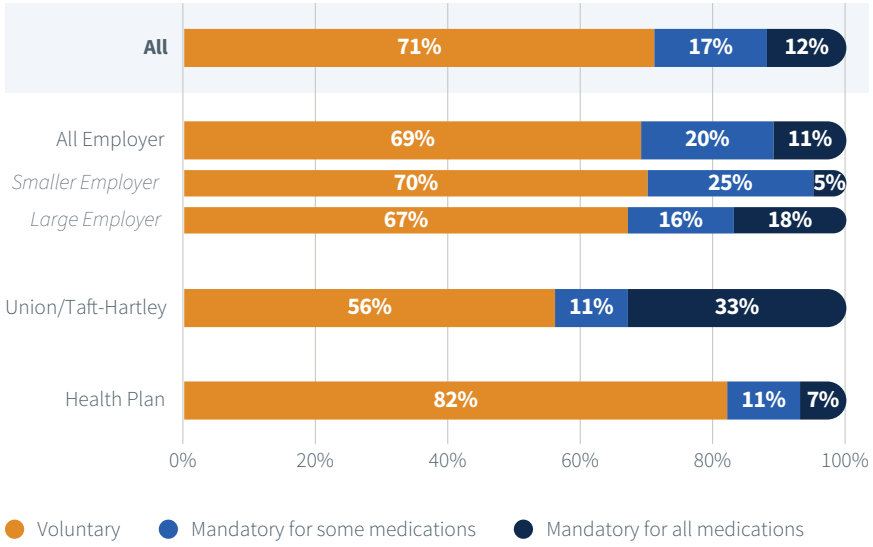
Figure 18 Mail-Order Design *(n=126)*



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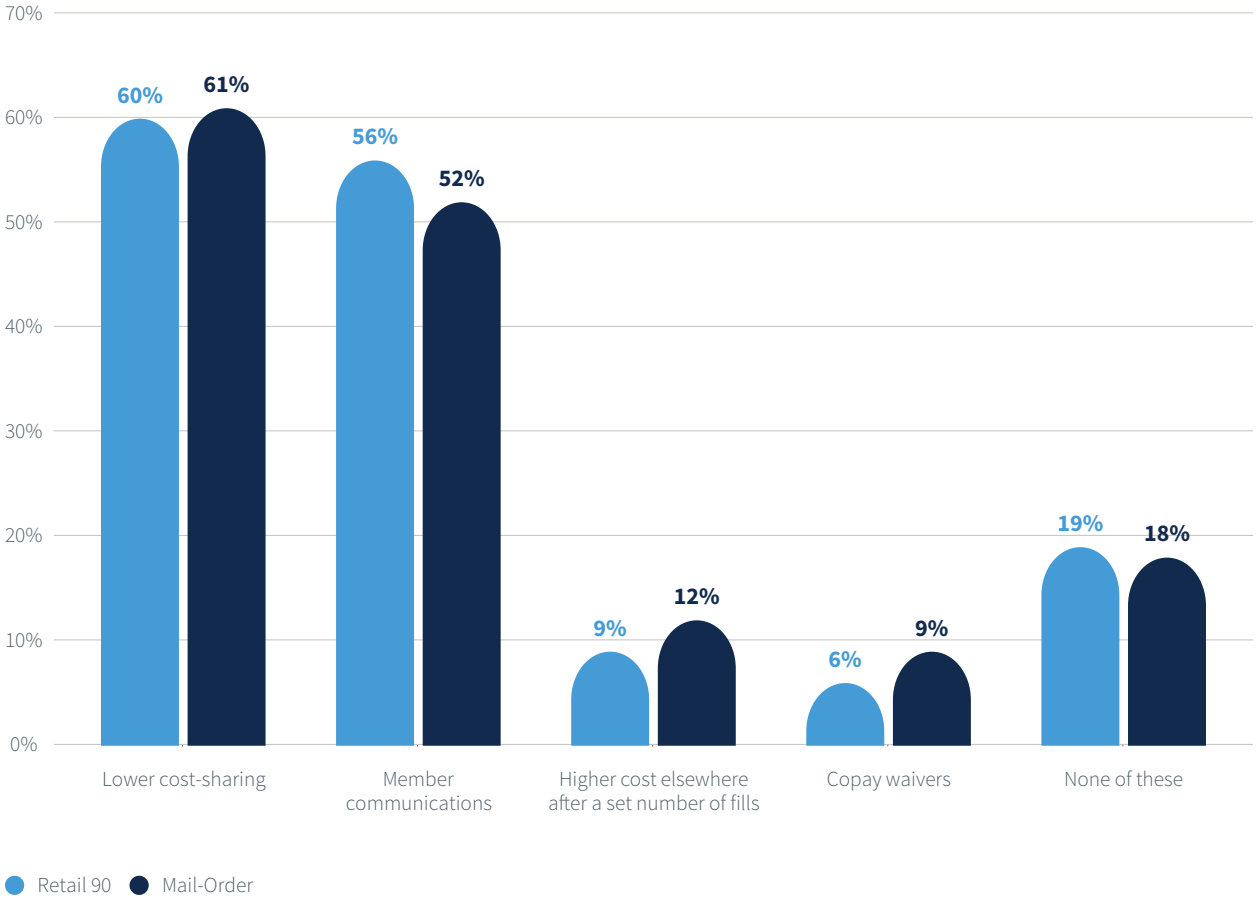
Retail 90 and Mail-Order Utilization Increase Strategies

When asked about strategies used to encourage use of retail 90 and mail-order, the vast majority of respondents selected at least one strategy (see Figure 19). Lower cost sharing and member communications were the most commonly used strategies, and copay waivers were used the least.

Figure 19 Strategies Used to Increase Utilization *(retail 90: n=70, mail-order: n=89)*



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Deductibles

Another cost-sharing mechanism is a deductible, requiring the member to pay up to a specified amount prior to the plan covering any portion of the medication costs. The majority of respondents did not use a pharmacy benefit deductible, and of those who did, most reported that it was a deductible shared with the medical benefit rather than a separate pharmacy benefit deductible (see Figure 20). The large employer subgroup was the only segment to break this pattern: 56% of large employer respondents used a pharmacy deductible (43% shared with medical, 13% standalone). Average deductibles across all respondent groups are shown in Figure 21. Among respondents who did not use a pharmacy deductible, just 10% said they were considering adding one in the next few years.

Figure 21 Deductible Amounts *(combined: n=32, pharmacy only: n=12)*

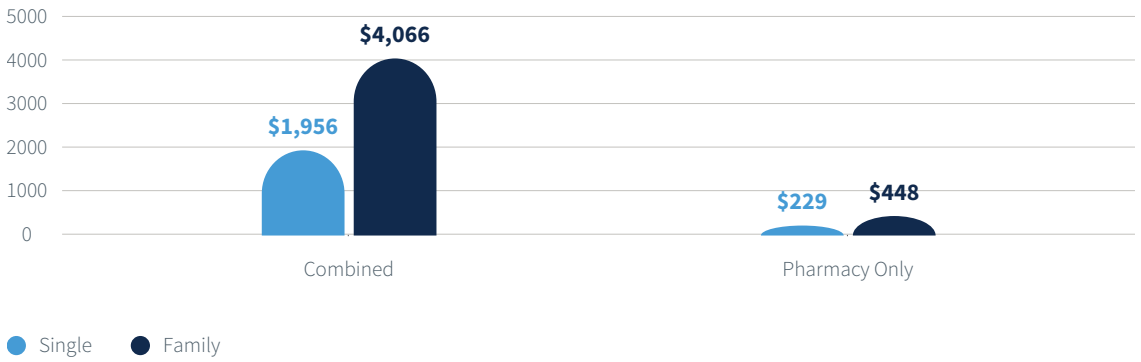

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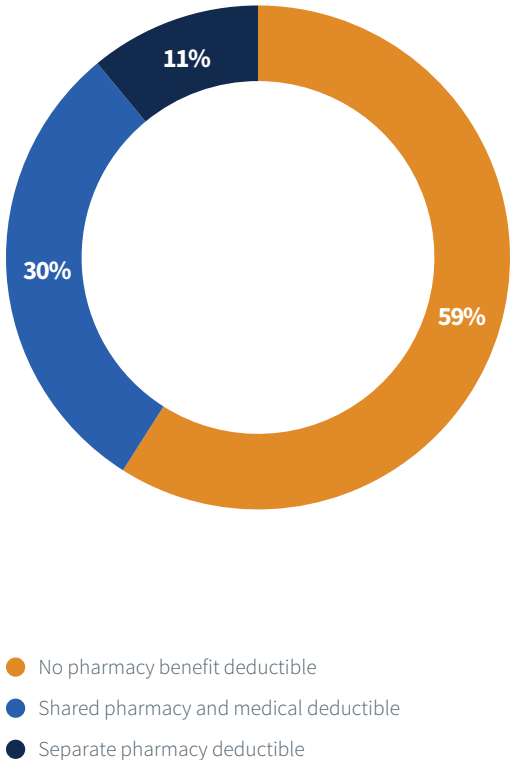
Figure 20 Use of Deductible *(n=132)*

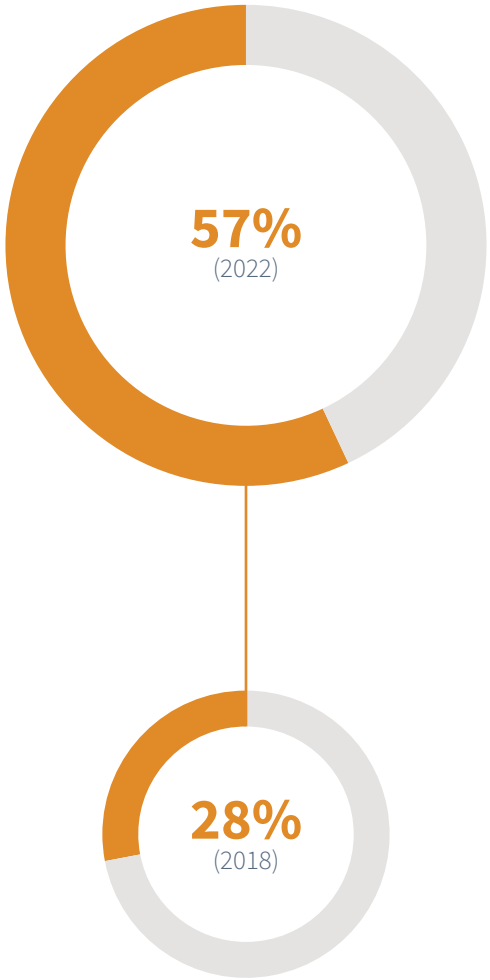


Pharmaceutical Strategies Group. 2022 Trends in Drug Benefit Design Report. Dallas, TX: PSG.

Cost-Sharing Transparency Tool Promotion

Cost-sharing transparency tools can help members manage their cost sharing, and 57% of respondents promote these tools, up from 28% in 2018. This large increase is likely due to increases in the number of tools available and in education about these tools in the years since we last conducted this survey. In this year's survey, the percentage of respondents reporting promotion of these tools did not vary substantially by respondent type. However, within the employer respondent group, large employers were more likely than smaller employers to promote these tools (67% vs. 52%). This represents a reversal of the pattern seen in 2018, where smaller employers were more likely than large employers to promote these tools (34% vs. 20%). When asked which cost-sharing transparency tools they promote the use of, respondents' answers revealed 3 primary themes: PBM tools, health plan tools, and other industry tools. In responses about industry tools, Castlight, GoodRx, and Rx Savings Solutions were each mentioned by multiple respondents.

Promotion of Cost-Sharing Transparency Tools



Cost-Sharing Changes

When asked if they were considering changes to their cost-sharing arrangements in the next 2–3 years, respondents showed indecision, with nearly half saying they were not sure yet (see Figure 22). Among those who were considering cost-sharing changes, the most commonly selected change was adding additional tiers (see Figure 23).

Figure 22 Considering Cost-Sharing Changes *(n=132)*

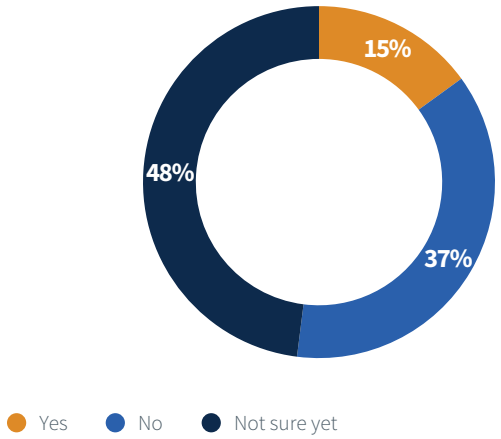


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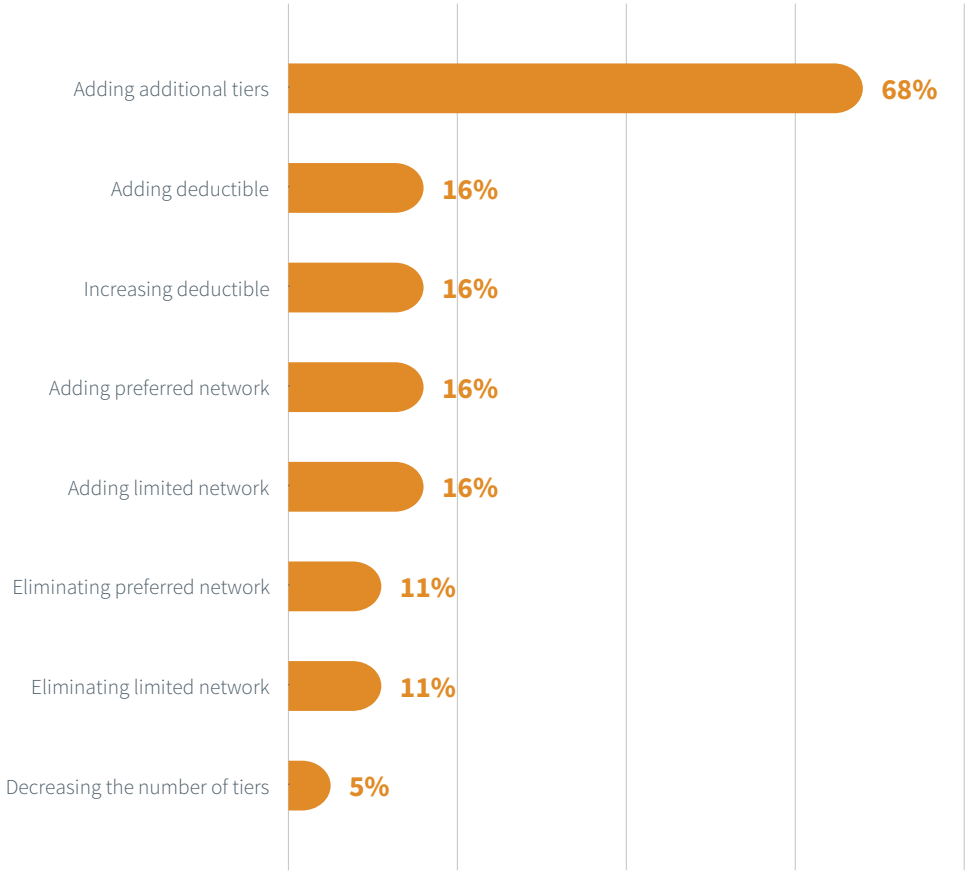
Figure 23 Cost-Sharing Changes Under Consideration *(n=19)*

Note: When interpreting these results, be considerate of the small number of respondents to whom this question applied.



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Cost-Sharing Decision Influences

Cost-sharing decisions can be complex, and respondents reported many sources that influence their cost-sharing decisions. As shown in Figure 24, PBM or health plan recommendations was selected by the largest percentage of respondents, followed by consultant or broker recommendations.

Responses differed by respondent group. For example, employer respondents were more likely than health plan respondents to select claims history or consultant or broker recommendations, while health plan respondents were more likely to select population health forecasts and strategies.

Figure 24 Influences for Cost-Sharing Decisions *(n=132)*

	All	Employer	Union/Taft-Hartley	Health Plan
PBM or health plan recommendations	**67%**	**66%**	**70%**	**67%**
Consultant or broker recommendations	**62%**	**70%**	**60%**	**40%**
Claims history	52%	55%	30%	47%
Corporate budgets	45%	57%	0%	27%
Industry-specific benchmarks	44%	48%	20%	40%
Corporate benefits philosophy	43%	50%	0%	37%
Corporate benefits objectives	43%	48%	20%	37%
Member cost-sharing targets	42%	45%	40%	33%
Population health forecasts and strategies	24%	24%	0%	33%
Other (please specify)	2%	1%	10%	3%

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Clinical and Trend Management

Clinical and Trend Management Goals

Clinical and trend management programs focus on ensuring that guidelines for clinical appropriateness are followed, managing drug quantity limits and frequency of refills, and encouraging the use of lower-cost drugs where available and appropriate. Respondents recognized the importance of this area of pharmacy benefit management: 88% reported that managing overall trend and drug costs was either their top priority or among their top 3 priorities, and when asked to rank goals outside of managing overall trend, they selected reduce inappropriate utilization at the highest rate as their top-ranked goal (see Figure 25).

Top goals outside of managing overall trend varied somewhat across respondent groups. Most notably, health plan respondents selected reduce inappropriate utilization more often than respondents from other groups. Within the employer group, one major difference appeared: smaller employers were much more likely than large employers to select improve member engagement as their top ranked goal (22% vs. 9%).

Figure 25 Top Goal Outside of Overall Trend/Drug Cost Management *(n=136)*

	All	Employer	Union/Taft-Hartley	Health Plan
Reduce inappropriate utilization	**33%**	**31%**	**20%**	**42%**
Improve specialty drug adherence and persistency	16%	18%	10%	12%
Improve member engagement	**15%**	**15%**	**40%**	**6%**
Improve patient satisfaction	10%	8%	20%	15%
Increase transparency	10%	13%	0%	6%
Reduce patient out-of-pocket costs	10%	11%	10%	6%
Manage site of care/place of service	6%	4%	0%	12%

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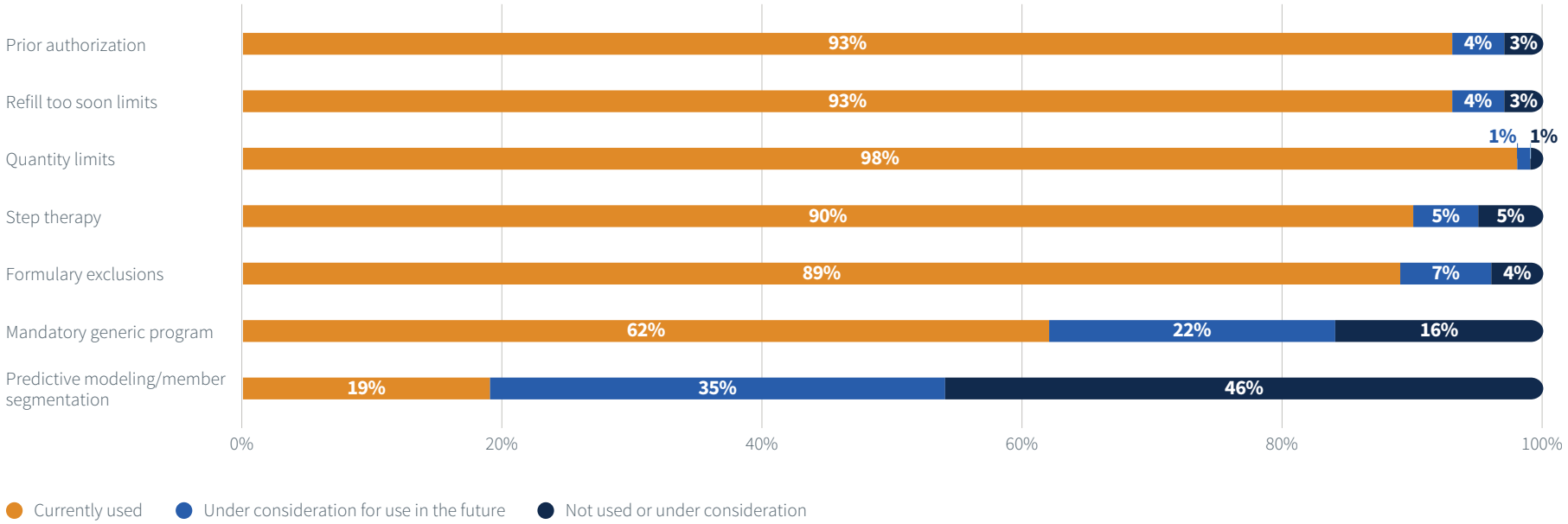
Trend and Utilization Program Use

Many trend and utilization programs are available for plan sponsors. As shown in Figure 26, nearly all respondents used quantity limits, refill too soon limits, and prior authorizations. The vast majority also used step therapy and formulary exclusions. Responses varied relatively little across respondent groups, but within the employer group, smaller employers were less likely than large employers to use prior authorization (87% vs. 96%), step therapy (78% vs. 96%), and predictive modeling/member segmentation (13% vs. 23%).

Figure 26 Use of Clinical and Trend Management Programs *(n=134)*



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Trend and Utilization Program Barriers

Although use of trend and utilization programs is high, plan sponsors still face obstacles in this area. Most respondents reported experiencing at least one barrier, and member acceptance was the most frequently cited (see Figure 27). When we last conducted this survey in 2018, just 44% of respondents selected member acceptance as a barrier, so this year's result of 57% demonstrates a substantial increase in experience of this issue. Rates of selecting each barrier varied some by respondent group (see Figure 27). and substantially within the employer group between smaller and large employers (see Figure 28).

Smaller employer respondents selected member acceptance at the highest rate of all respondent groups, while health plan respondents selected this less often than all other respondent groups. Both smaller employer respondents and health plan respondents selected ability to demonstrate ROI at higher rates than did large employer respondents.

Figure 28 Trend and Utilization Program Barriers by Employer Size *(n=93)*

Not shown: 9% of smaller employer respondents and 17% of large employer respondents said they had no barriers, and 4% of large employer respondents selected "other."

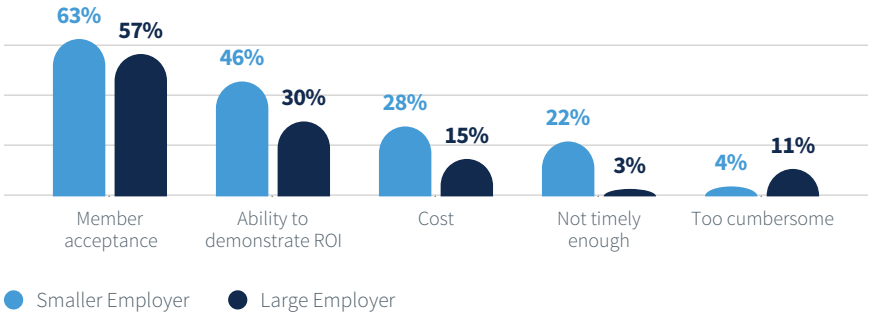

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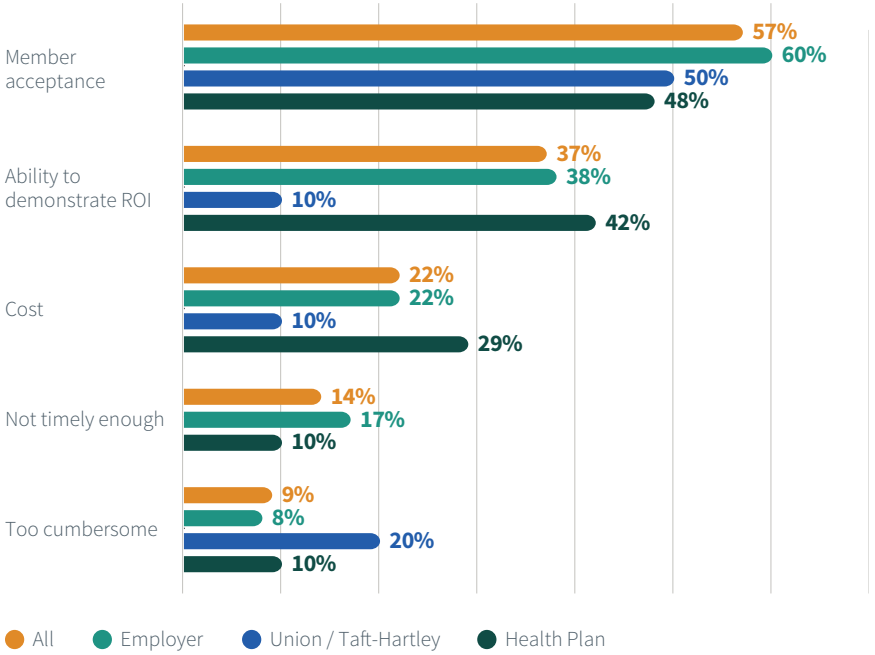
Figure 27 Trend and Utilization Program Barriers *(n=134)*

Not shown: 16% of respondents said they had no barriers, and 2% of respondents selected "other."



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Desires for Trend and Utilization Programs

We also asked respondents what new trend and utilization programs and/or changes to current programs they would like to see. Their responses revealed 7 primary themes, which are listed below along with representative quotes.

Better Approaches and New Tools to Educate and Engage Members

"Improve member engagement in clinical programs that affect cost and quality of life"

New Offerings for Tracking and Controlling Utilization

"Better step programs with better explanations for denials of certain drugs"

More Transparency and Accountability about Costs and Outcomes

"Improved transparency and financial reporting on total cost of care"

New or Modified Financial Programs/ Arrangements

"How to better manage member and employer costs by leveraging pharma discounts"

More Help with Specialty Drugs

"Better management of specialty drugs and informed management of new drugs coming to market"

Real-Time Tools and Information

"A program that can be more real-time for effectively managing costs"

Provider-Related Solutions

"More education for prescribers to help them understand the financial impact of their prescribing patterns"

Drug Access and Pricing

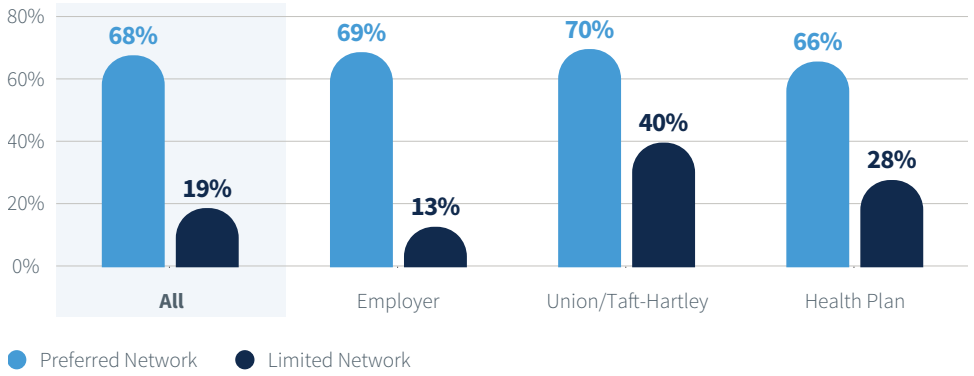
Pharmacy Network Designs

Developing and managing the formulary, determining where members can access drugs covered under the drug benefit, and deciding how those drugs are paid for are complex aspects of drug benefit design. On behalf of their clients, PBMs contract with retail pharmacies. These contracts are based on two main components: design and discounts.

Network design determines where members can fill prescriptions and at what level of cost sharing. The 3 primary types of pharmacy networks are open, preferred, and limited. Open networks typically include all major chain pharmacies and most independent pharmacies. With a preferred network, members are encouraged — typically through lower cost sharing — to use a subset of participating pharmacies that are willing to reduce their reimbursement in exchange for the possibility of higher prescription volume. Limited networks (which we define as a network from which at least one major pharmacy chain is eliminated) are the most restrictive, requiring members to use specific participating pharmacies for benefit coverage.

As shown in Figure 29, 68% of respondents used a preferred network, up substantially from 53% when we last conducted this survey in 2018, with little difference by respondent group. A smaller proportion of respondents used limited networks, and here responses differed substantially across respondent groups. Additionally, within the employer group, smaller employers were more likely than large employers to use a preferred network (74% vs. 64%) and less likely to use a limited network (7% vs. 19%). Respondents reported that members pay an average of 39% more out-of-pocket at nonpreferred pharmacies compared to preferred pharmacies.

Figure 29 Retail Network Design *(n=135)*



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Discounts

Guaranteed discounts are those that the PBM is contractually obligated to provide to the plan. These discounts are typically expressed as a percentage off the Average Wholesale Price (AWP), which is a list price benchmark for many drug transactions. Approximately three-quarters of respondents' plans had a guaranteed generic discount (see Figure 30), and the average discount off AWP ranged from 67% to 71% based on channel (see Figure 31). These averages are 8–10% higher than when we last conducted this survey in 2018, likely due to increased competitiveness in the market driving PBMs to offer greater discounts. For branded medications, just over half of respondents' plans had a guaranteed discount (see Figure 30), with average discount off AWP ranging from 21% to 24% (see Figure 31).

Figure 31 Average AWP Discount

	Retail 30	Retail 90	Mail Order	Specialty
Generic	67%	69%	71%	N/A
Branded	21%	21%	24%	22%

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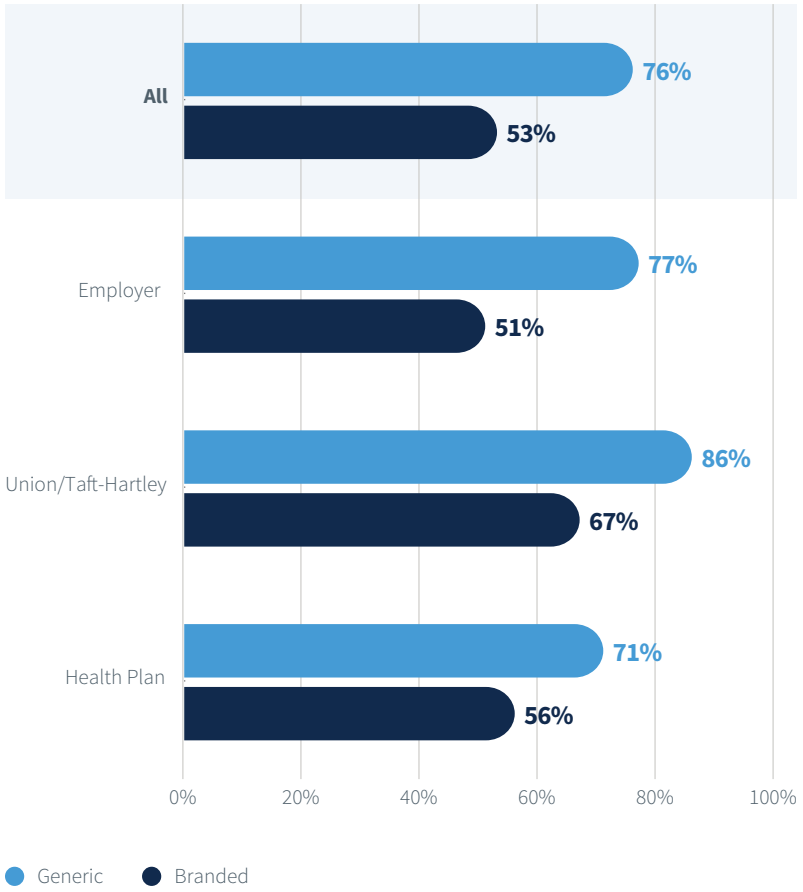
Figure 30 Have Guaranteed Discounts
(generic: n=115, branded: n=100)



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MAC Pricing

Another pricing metric is the Maximum Allowable Cost (MAC) price, the maximum payment amount for a given generic medication. As shown in Figures 32 and 33, respondents' overall use of MAC pricing ranged from 37% for specialty generics to 79% for retail 90 and mail-order generics, with substantial differences based on respondent group and, within the employer group, by employer size.

Figure 33 Use of MAC Pricing by Employer Size *(n=44)*

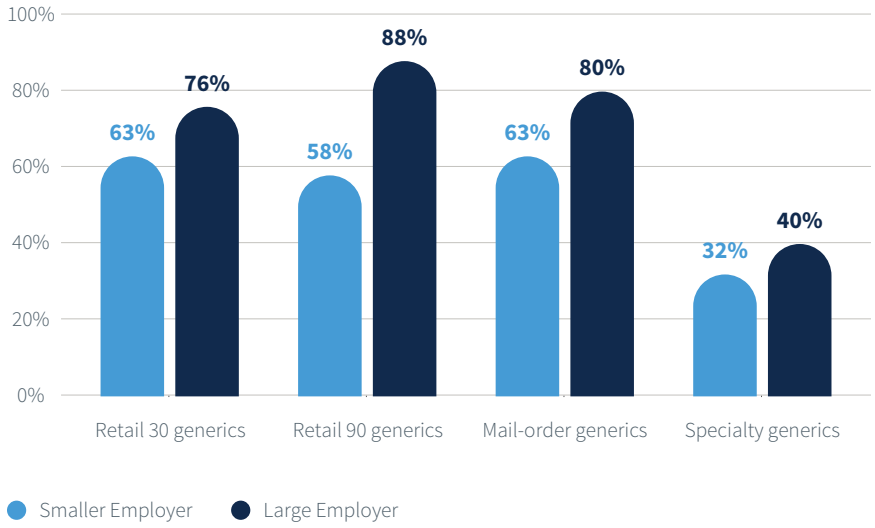

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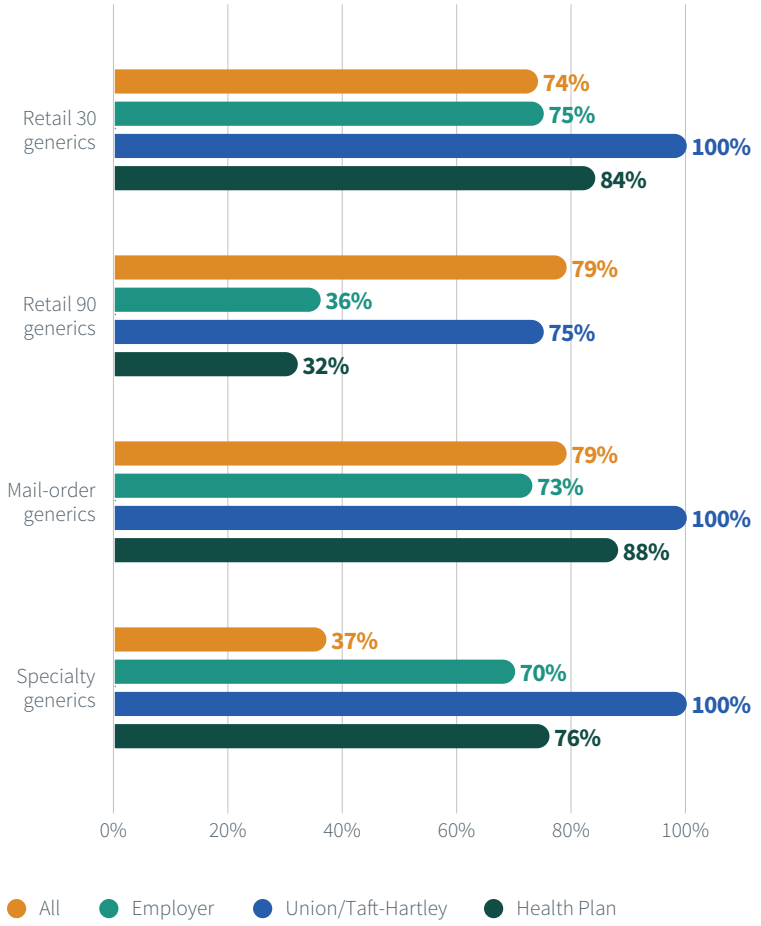
Figure 32 Use of MAC Pricing *(n=73)*



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Rebates

Rebates are typically negotiated as part of formulary contracting agreements, and sometimes a portion or all of the savings is passed on to the plan sponsor. Rebate terms vary based on how the PBM contract is written. Contracts may guarantee a flat dollar amount or a percentage share of rebates, with or without minimum guarantees. The vast majority of respondents received rebates on traditional (non-specialty) drugs (see Figure 34). Within the employer respondent group, large employers were more likely than smaller employers to receive these rebates (98% vs. 85%). Across respondent groups, the most common rebate arrangement was 100% of rebates with a minimum guarantee (see Figure 35). As shown in Figure 36, smaller and large employers differed substantially on this item, with smaller employers more likely to have percentage share or 100% of rebates with no guarantee arrangements and less likely to have a 100% of rebates with minimum guarantee arrangement.

Figure 34 Receipt of Traditional (Non-Specialty) Drug Rebates *(n=125)*

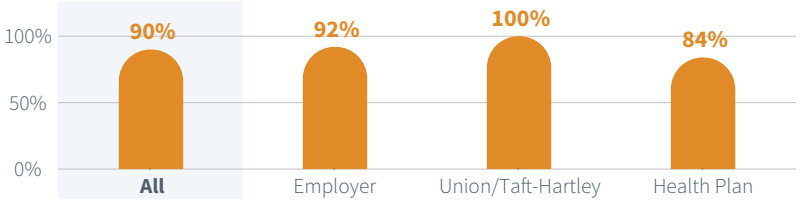

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Figure 35 Rebate Structure *(n=106)*

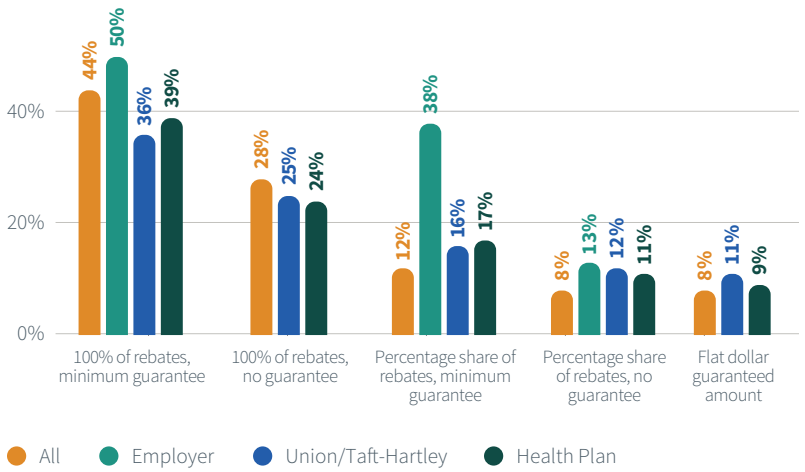

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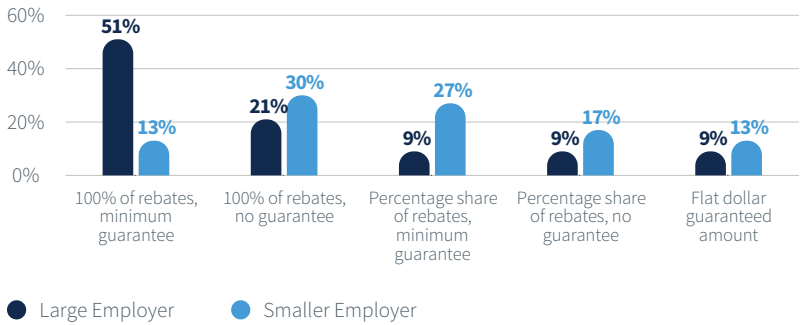
Figure 36 Rebate Structure by Employer Size *(n=73)*



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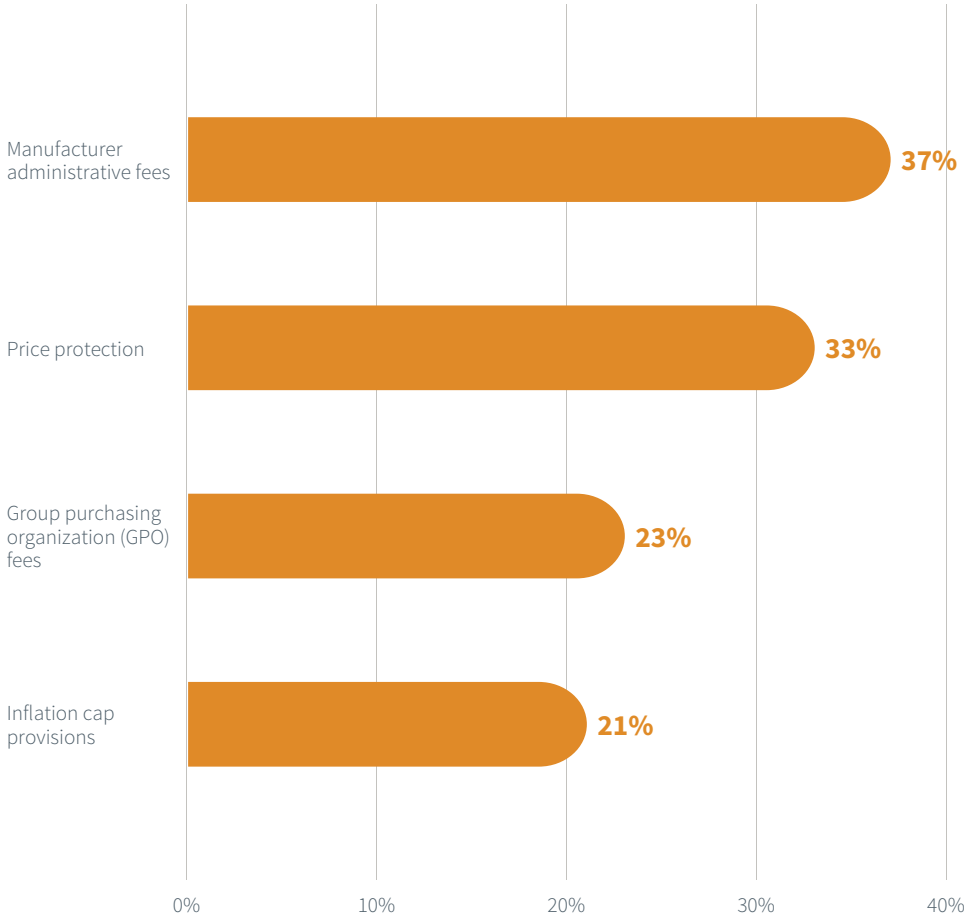
Price Protection Provisions

Price protection provisions are sometimes included in PBM contracts as a way to provide some cost stability by putting a cap on how much manufacturers can increase the cost of a medication during the term of the contract. PBM contracts may also include other fees, such as manufacturer administrative fees and/or group purchasing organization (GPO) fees. As shown in Figure 37, a minority of respondents reported that their PBM contract included these revenue sources. Among those whose PBM contracts mentioned such provisions, 85% said the revenue gets passed back to the plan, and of those, 79% said an outside party validates the accuracy of the revenue passed back to the plan. When asked if they felt the plan benefits from price protection and/or inflation provisions, 77% of those who had price protection provisions and 76% of those who had inflation provisions said yes.

Figure 37 PBM Contract Revenue Sources *(n=135)*



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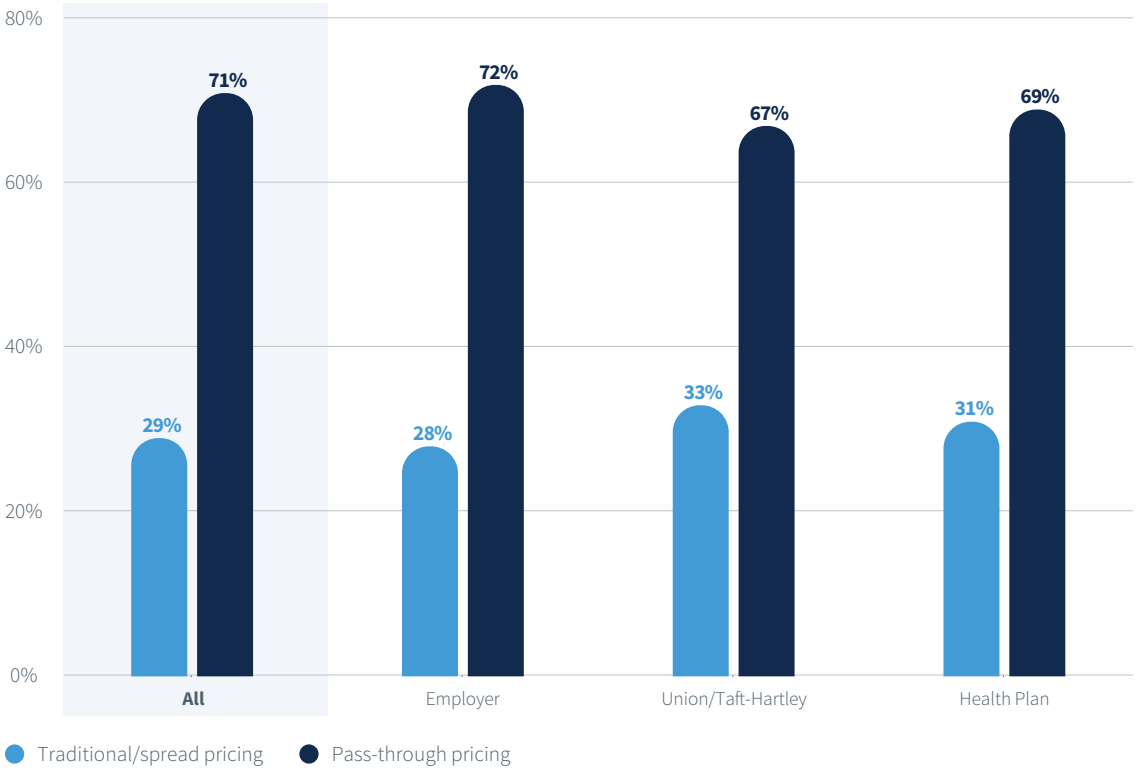
Pharmacy Reimbursement Structures

For pharmacy reimbursement, PBM contracts may include either traditional markup ("spread" pricing) or pass-through pricing. In traditional/spread pricing, the amount paid by the plan sponsor to the PBM for the prescription is greater than the amount paid by the PBM to the pharmacy. The difference ("spread") is how the plan sponsor compensates the PBM. In pass-through pricing, the PBM provides all discounts, rebates, and other revenues to the plan sponsor and is compensated through administrative fees. As shown in Figure 38, 71% of respondents used pass-through pricing, and there were no major differences based on respondent group.

Figure 38 Type of Pharmacy Reimbursement *(n=120)*



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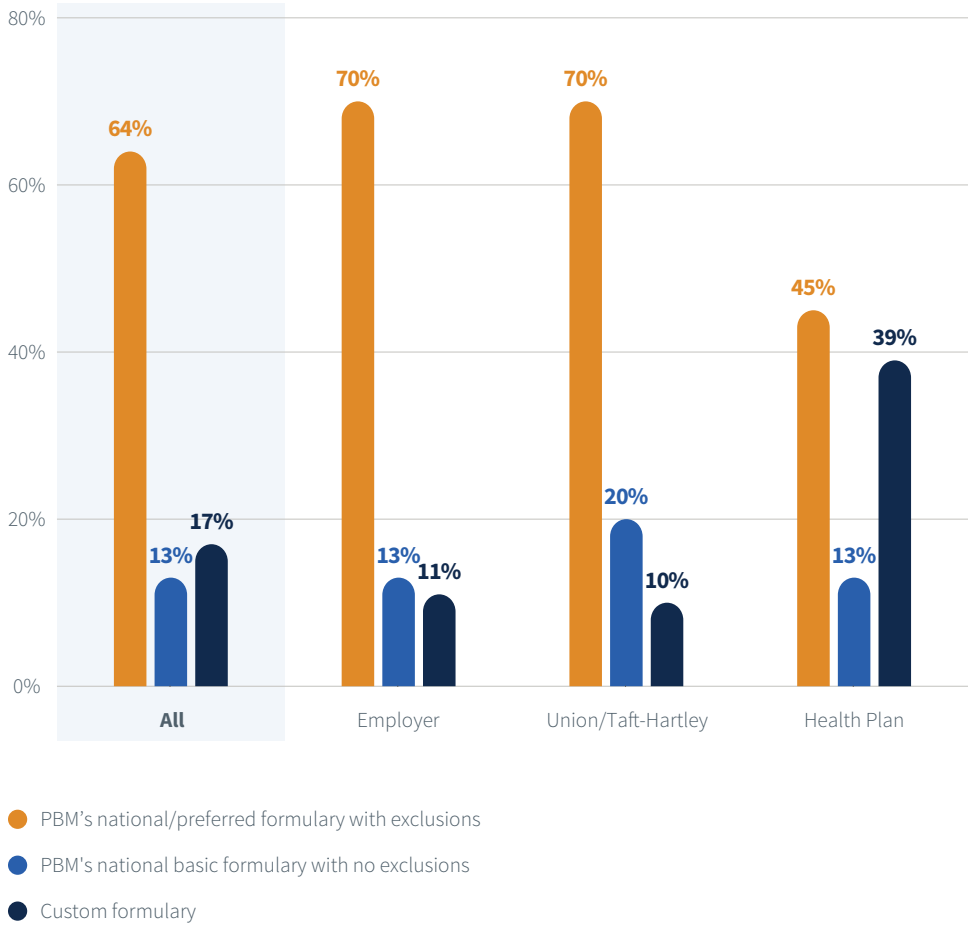
Types of Formularies

Formulary decisions are another important aspect of drug management from both a contracting perspective (e.g., rebates may influence or be influenced by formulary placement) and a member cost-sharing perspective. When asked how large a role they feel their formulary plays in managing traditional drug cost trend on a scale from 1 *(no impact)* to 5 *(critical tool),* 38% of respondents chose the top rating of 5, and 74% selected either a 4 or a 5.

Plan sponsors can use their PBM's standard national/preferred formulary, develop a custom formulary, or use some other formulary such as that developed by their health plan. As shown in Figure 39, 77% of respondents used their PBM's national formulary with or without exclusions, while 17% used a custom formulary (the remainder of respondents indicated they were not sure or selected "other"). Compared to health plans, employers were much more likely to use their PBM's national formulary with exclusions and much less likely to use a custom formulary.

Figure 39 Type of Formulary Used *(n=134)*



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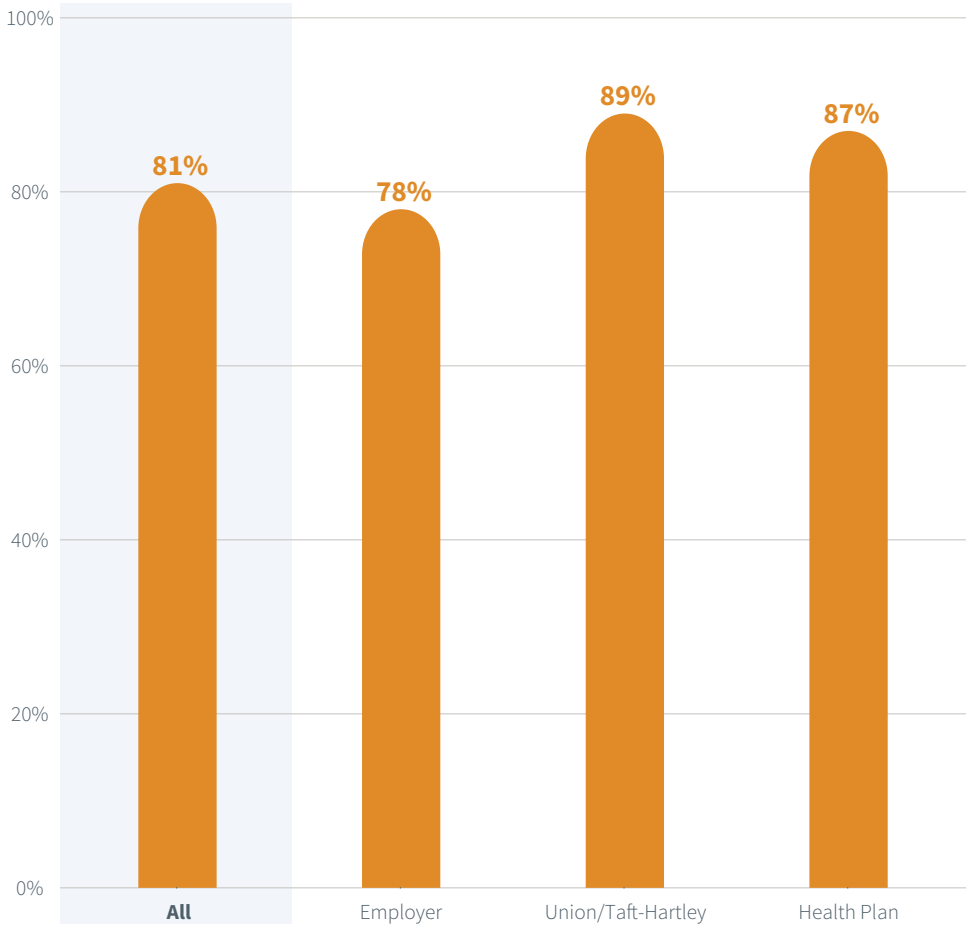
Formulary Exclusions

Formulary exclusions are a tool frequently used to manage drug costs, provide leverage for price concessions or higher rebates, and support clinical decisions. As shown in Figure 40, 81% of respondents reported their plans had formulary exclusions for traditional (non-specialty) medications, with higher rates among union/Taft-Hartley and health plan respondents compared to employer respondents.

Figure 40 Use of Formulary Exclusions *(n=122)*



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Formulary Exclusion Challenges

Although they can provide benefits, formulary exclusions also present challenges. Across respondent groups, member dissatisfaction was the most commonly endorsed top challenge associated with formulary exclusions (see Figure 41).

However, rates of selecting this item ranged from just 46% for health plan respondents to 77% for employer respondents. Health plan respondents selected appeals and physician complaints at higher rates than employer respondents.

Figure 41 Number One Challenge with Formulary Exclusions *(n=99)*

Not shown: 2% of respondents selected "other."

	All	Employer	Union/Taft-Hartley	Health Plan
Member dissatisfaction	**69%**	**77%**	**75%**	**46%**
Appeals	10%	8%	0%	19%
Clinical disruption	6%	5%	13%	8%
Physician complaints	6%	3%	13%	12%
Timing of new formulary decisions	3%	3%	0%	4%
Adherence	3%	2%	0%	8%
Implementation issues	1%	0%	0%	4%

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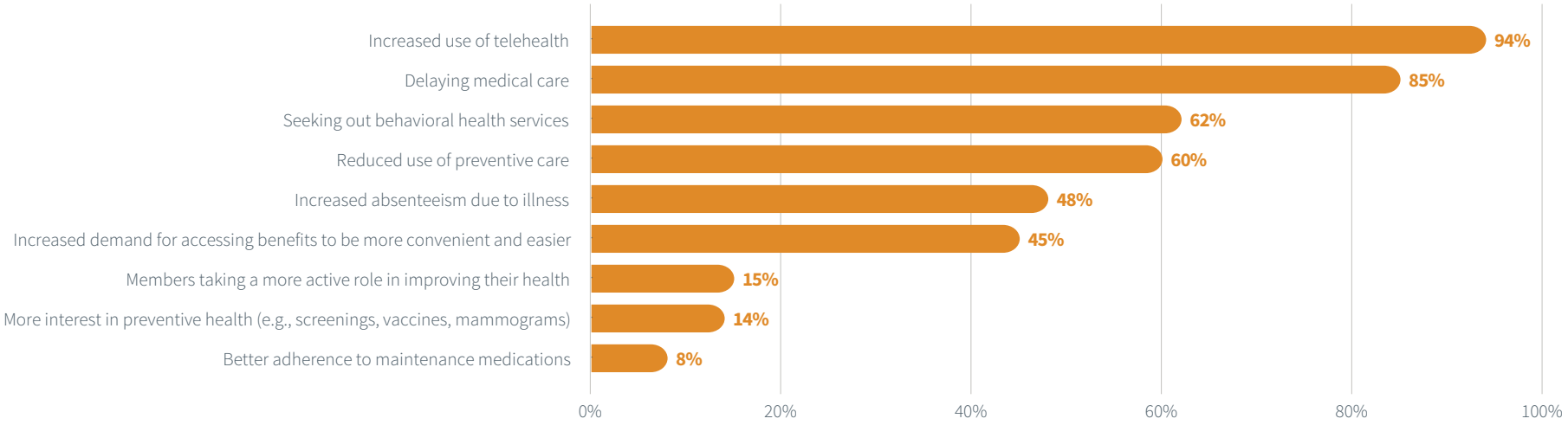
Spotlight on Trends Impacting Benefit Design

COVID-19 Influences on Member Behavior

Our world has changed dramatically in just a few years. The COVID-19 pandemic caused shifts in behavior and ways of thinking that may impact pharmacy benefit design. We asked respondents a series of questions to better understand what changes they have seen and what, if anything, they are doing in response to those changes.

When asked how they thought the COVID-19 pandemic had influenced member health behavior, respondents' most common answers were increased use of telehealth and delaying medical care (see Figure 42). For most response options, rates of endorsement were similar across respondent groups. However, reports of reduced use of preventive care varied substantially by group, ranging from 47% among health plan respondents to 76% among large employer respondents.

Figure 42 COVID-19 Pandemic Influences on Member Health Behavior *(n=132)*



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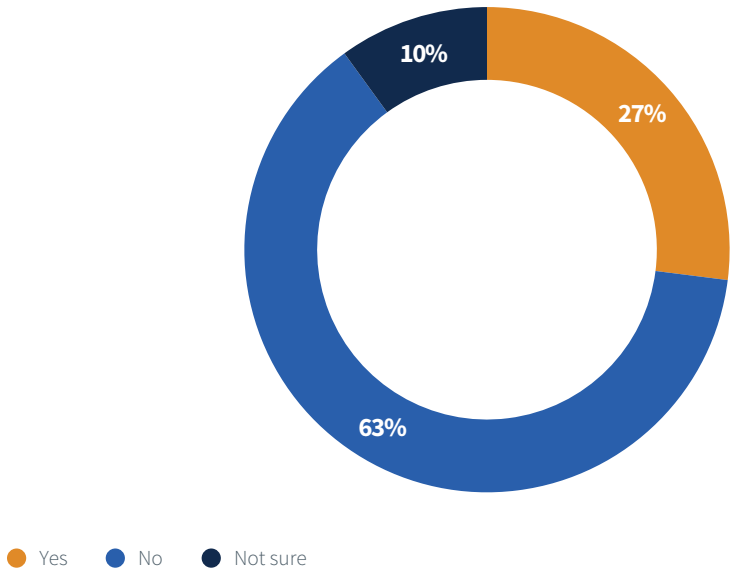
Impacts of Great Resignation

One of the trends sparked by the pandemic is employees leaving their jobs at record-breaking rates, referred to as the "Great Resignation." When asked if the Great Resignation had impacted their organization's benefit strategy, just 27% of respondents said yes (see Figure 43). Employer respondents were more likely than health plan respondents to report this impact (32% vs. 17%).

Figure 43 Great Resignation Impacted Benefit Strategy *(n=132)*



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For those who said the Great Resignation had impacted their benefit strategy, we asked them to explain in their own words how the Great Resignation had impacted their organization. Many of their comments spoke to the issues they face, such as increased turnover and difficulties with recruitment, but some did mention benefits specifically.

Representative comments include:

"Adding to our benefits package to help retain our workforce"

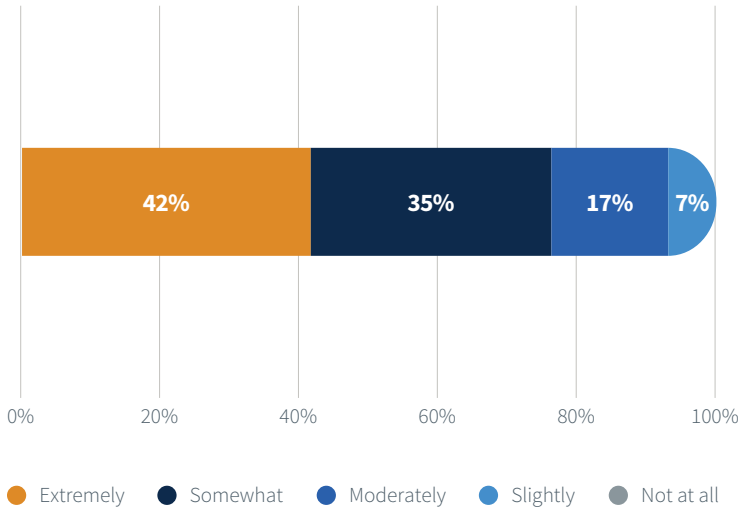
"We implemented a rate hold on health premiums"

"Improved benefits design, PPO plan, reduced deductibles"

Importance of Member Experience

Member experience can be a factor in decisions about benefits. When asked how important member experience and/or engagement was in decision-making processes about point benefit solutions, 42% of respondents said it was extremely important, and no one said it was not at all important (see Figure 44).

Figure 44 Importance of Member Experience / Engagement in Point Benefit Solution Decisions *(n=130)*



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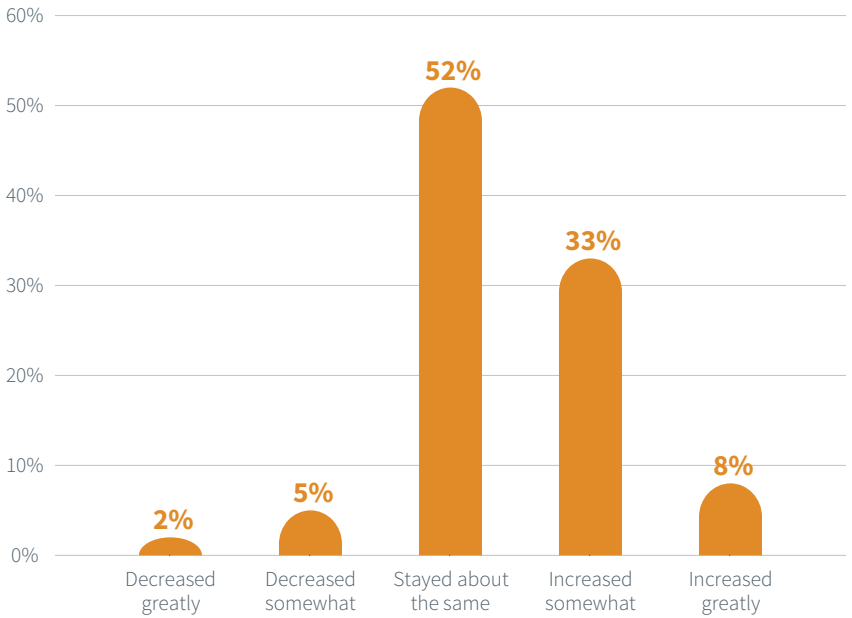
Finally, we asked respondents how much the importance of member experience had changed since the onset of the COVID-19 pandemic. As shown in Figure 45, the majority said it had stayed about the same, and a third said it had increased somewhat.

Figure 45 Changes in Importance of Member Experience Since COVID-19 Pandemic Onset *(n=124)*



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Appendices

Appendices

PSG has conducted research on drug benefit design for over 25 years. Recognizing the challenges plan sponsors face in designing the drug benefit in a rapidly evolving environment, we use this Trends in Benefit Design research to provide an in-depth look at trends and best practices. Additionally, this research gathers insights on priorities, strategies, concerns, and perspectives about current and future developments that impact design and management of the drug benefit.

Methodology

PSG conducted this drug benefit survey in February and March of 2022. The 2022 survey was developed, tested, and fielded by PSG research staff. The comprehensive survey instrument contained nearly all the questions from the 2018 survey (the most recent year this research was conducted) plus several new questions. The survey collected information on drug benefit plan design for prescription drugs dispensed through retail, mail-order, and specialty pharmacy distribution channels. Respondents answered questions about:

- Drug benefit design decision-making, goals, and challenges
- Networks, contracts, and reimbursement strategies
- Member cost sharing
- Clinical and trend management strategies and tools
- Use of and perceptions about HDHPs
- Trends impacting and future considerations for drug benefit design

As in previous years, strategies specific to specialty medications were not explored in this research. PSG publishes a separate annual specialty drug report, Trends in Specialty Benefit Design. The most recent specialty report can be found on PSG's website: www.psgconsults.com.

This research's primary source of contacts was PSG's proprietary database of drug benefit decision-makers. We contacted potential respondents via email with an invitation containing an embedded link to the survey and a unique password assigned to each potential respondent. Respondents were offered a small incentive for completing the survey to express our appreciation for their time. The survey was available from February 4, 2022, through March 4, 2022. We are grateful for the participation of drug benefit leaders who provided not only question responses but also comments regarding the questions themselves.

The survey sample included 153 benefits leaders representing plan sponsors of an estimated 35.1 million covered lives. Respondents were individuals representing employers, unions/Taft-Hartley plans, and health plans, and they had to report being responsible for managing their organization's pharmacy benefit to participate in the survey. Covered members for these respondents included active and retired employees and their dependents. Plans that covered only retirees, workers' compensation cases, and/or publicly covered groups (i.e., Medicare and Medicaid) were excluded. Because some respondents may be responsible for more than one plan, we asked them to answer questions about the single largest plan that offered medical and pharmacy benefits based on the number of covered lives.

Data were stored on a secure, password-protected database and reviewed for low-quality and out-of-range responses prior to data analysis. Respondents are included in the results for any question to which they provided a valid response. In most cases (unless specifically reported), responses of "don't know" or "not applicable" were excluded.

Analyses were conducted using SAS version 9.4 software (SAS Institute Inc., Cary, NC) and the analysis tool embedded in the online survey platform (Qualtrics, Provo, UT). Percentages shown in the text and tables are rounded to the nearest whole number, so figure and table totals may not equal 100% due to rounding. Analyses were conducted on the total sample and split by plan sponsor type and employer size. **We defined smaller employers as having 5,000 or fewer lives and large employers as having more than 5,000 lives.**

Appendices

Report Sponsorship and Editorial Independence

PSG gratefully acknowledges the support of Rx Savings Solutions for its sponsorship to cover costs incurred in the production of this report. Neither Rx Savings Solutions, nor any other third party, has access to PSG's research respondent database, individual responses, or raw survey data. Additionally, Rx Savings Solutions provided no input on the conclusions drawn from our analyses. This policy protects the confidentiality of survey respondents and ensures the independence and objectivity of this report.

Respondent Profile

As noted previously, respondents represented several types of plan sponsors, broken down as follows: smaller employer (*n*=50, 33%), large employer (*n*=52, 34%), health plan (*n*=38, 25%), union/Taft-Hartley (*n*=13, 8%). Although all respondents were responsible for their organization's pharmacy benefit, the amount of time they devoted to this area varied. Nearly half of respondents (46%) reported they spend a quarter or less of their time focused on drug benefits, another quarter (26%) spend between a quarter and a half of their time on drug benefits, and the rest spend more than half of their time on drug benefits.

Plans were diverse in terms of where their largest number of eligible members reside (see Figure 46). Of the plans represented in respondents' survey answers, 59% were HDHPs. Plan sponsors can integrate the drug benefit with the medical benefit (carved-in drug benefit) or can use separate contracts or even different entities to administer the benefits (carved-out drug benefit). As shown in Figure 47, 63% of respondents reported their drug benefit is carved out.

Figure 46 Geographic Regions of Plans Represented in the Survey *(n=131)*

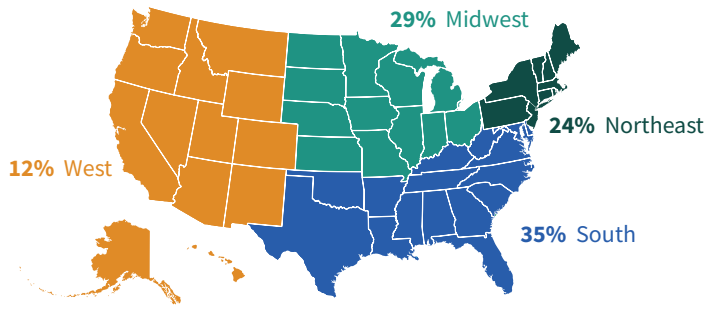

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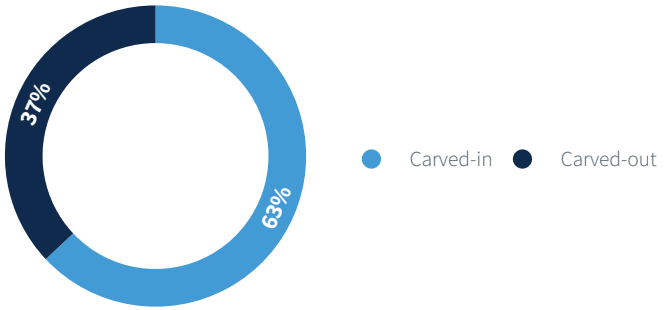
Figure 47 Drug Benefit Relationship with Medical Benefit *(n=137)*



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Appendices

Acronym Glossary

AWP	Average Wholesale Price
GPO	Group Purchasing Organization
HDHP	High-Deductible Health Plan
HRA	Health Reimbursement Arrangement
HSA	Health Savings Account
IRS	Internal Revenue Service
MAC	Maximum Allowable Cost
PBM	Pharmacy Benefit Manager
PPO	Preferred Provider Organization
PSG	Pharmaceutical Strategies Group
ROI	Return on Investment

Sources

1. Healthcare.gov. High-Deductible Health Plan (HDHP). Accessed April 27, 2022. https://www.healthcare.gov/glossary/high-deductible-health-plan/.

2. Kaiser Family Foundation. Public Opinion on Prescription Drugs and Their Prices. Accessed April 27, 2022. https://www.kff.org/health-costs/poll-finding/public-opinion-on-prescription-drugs-and-their-prices/.