



Trends in Drug

Benefit Design Report

2023 Results
Published Spring 2023

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 and clinical outcomes.

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.

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Sponsor

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A Letter From Our Sponsor

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

To our industry colleagues:

Rx Savings Solutions is honored to sponsor the PSG Trends in Drug Benefit Design report once again this year. On behalf of all stakeholders, I want to thank Pharmaceutical Strategies Group for the work that goes into producing this report, one that so many of us in the pharmacy benefits space find so valuable.

Even a casual glance at this year's key findings reveals longstanding challenges as well as some that were unforeseeable even a short time ago. Some will no doubt become bigger focal points in the coming years.

Perhaps more than ever, **there is a noticeable undercurrent of change in the market environment**, one driven by consumers and patients whose share of prescription drug costs continues to grow. They are searching for relief and turning to sources both within and outside of the traditional drug benefit.

How do we evolve the benefit along with consumers, in ways that produce greater access and affordability but also control payer spend? It's a goal all of us in the pharmacy benefit ecosystem have a hand in achieving.

Welcome to the 2023 report. **I know the insights provided on the following pages will help inform many important decisions in the year ahead.**

Best regards,

Michael Rea
Founder & CEO, Rx Savings Solutions





You can change lives without changing your benefits.

Rx Savings Solutions reduces prescription costs for millions of members and the plans that cover them. Our combination of clinical technology, multichannel engagement and 1:1 member support can change lives and improve health outcomes.

All with zero disruption to your existing benefits.



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Introduction

Pharmaceutical Strategies Group (PSG) is pleased to present the 2023 Trends in Drug Benefit Design Report, which details traditional (non-specialty) drug benefit trends and strategies. This annual report, previously published under the Pharmacy Benefit Management Institute (PBMI) brand and **first conducted in 1995**, demonstrates PSG's ongoing commitment to generating meaningful conversations and providing valuable insights about drug benefit design and management.

Since we first produced this report over 25 years ago, the drug benefit has become much more complex to design and manage. Many more drugs are available, and decisions about program structure, cost sharing, drug access and pricing, formulary design and management, and clinical and trend management are more numerous and complicated than ever. Many new offerings have come to the market to help address the growing cost and complexity of the drug benefit for both payers and members. However, there is no silver bullet to address all concerns, and benefit leaders must constantly review trends and adjust plan design and programs to meet current needs and marketplace conditions. **In this environment, all stakeholders — employers, health plans, PBMs, pharmaceutical manufacturers, pharmacies, health care providers, and consumers — play important roles in the decisions that are ultimately made about the drug benefit.**

This report focuses on the traditional drug benefit for the 2023 benefit year among employer, union/ Taft-Hartley, and health plan respondents. In many cases, results are shown for both the overall sample and for employers and health plans separately, as there are meaningful differences between these groups. Where noteworthy, the report also compares current findings to findings from the 2022 report. Issues specific to specialty drugs are explored in detail in a separate report — Trends in Specialty Drug Benefits. These reports as well as prior annual reports and other research conducted by PSG can be found at www.psgconsults.com/research.

Executive Summary



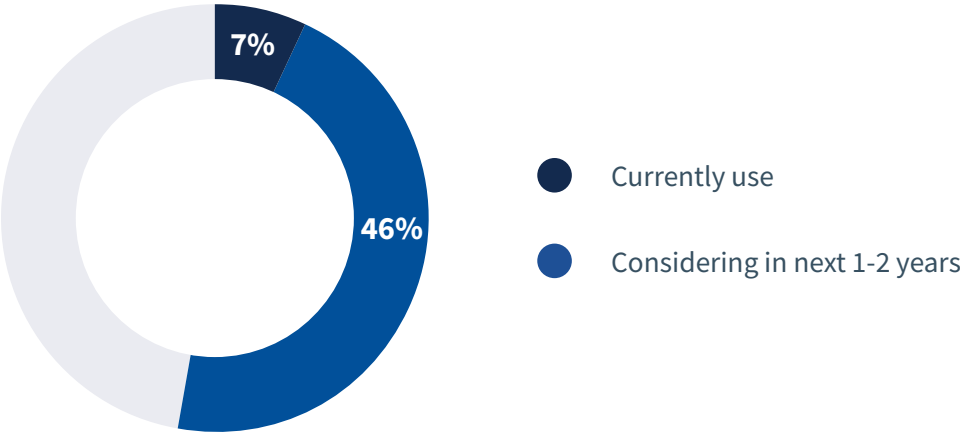
Executive Summary

Plans have a plethora of options to consider and decisions to make when designing the drug benefit

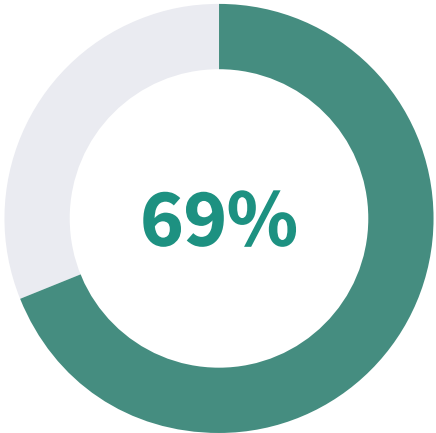
Percentage of respondents who have heard of gene therapy financial protection products:



Gene therapy financial protection product use:



Percentage of respondents who are aware of digital therapeutics:



Digital therapeutics coverage:

23%

Currently cover

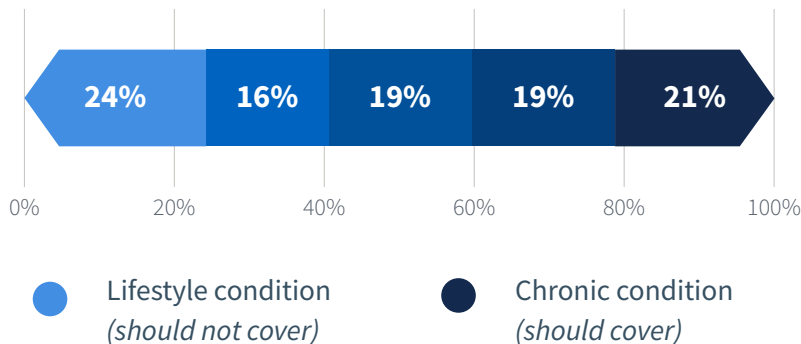
39%

Considering in next 1-2 years

Executive Summary

Plans vary widely in their strategies in response to the emergence of effective medications for weight loss

Respondents were divided almost evenly across the scale on whether they see weight loss as a lifestyle condition that should not be covered or a chronic condition to treat



Top reasons for excluding FDA-approved weight loss medications from coverage:

1. Consider the medications to be lifestyle drugs — which are excluded from coverage
2. Too expensive to cover for all members for whom the medication would be prescribed

FDA-approved weight loss medications coverage:

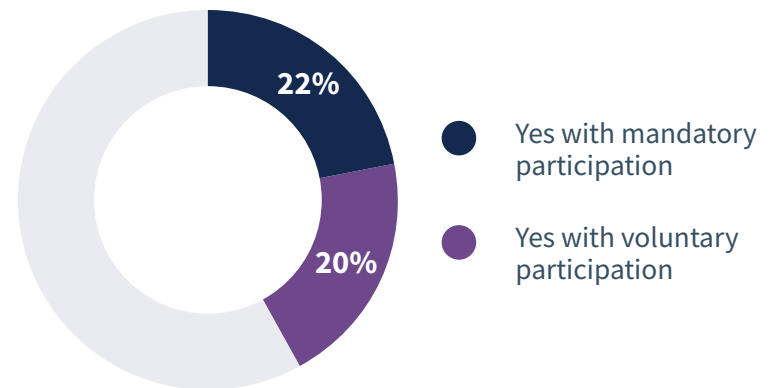
43%

Currently cover

28%

Considering in next 1-2 years

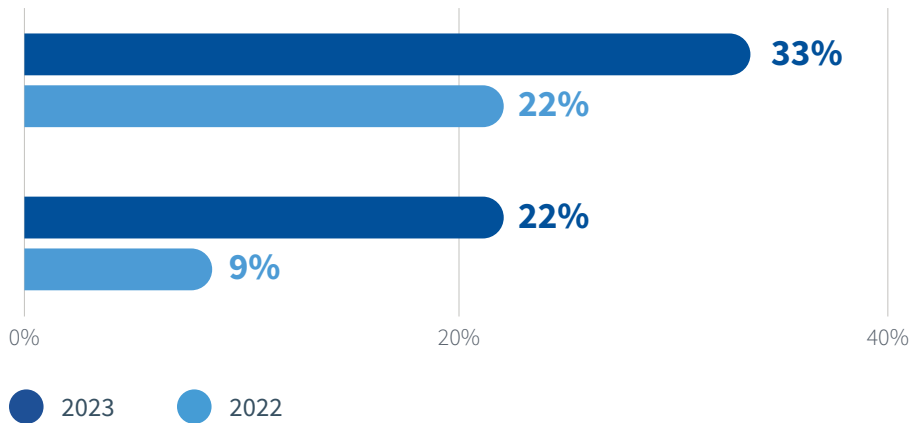
Participation in a lifestyle modification program as a prerequisite for weight loss medication coverage:



Executive Summary

Managing drug utilization is increasingly complex

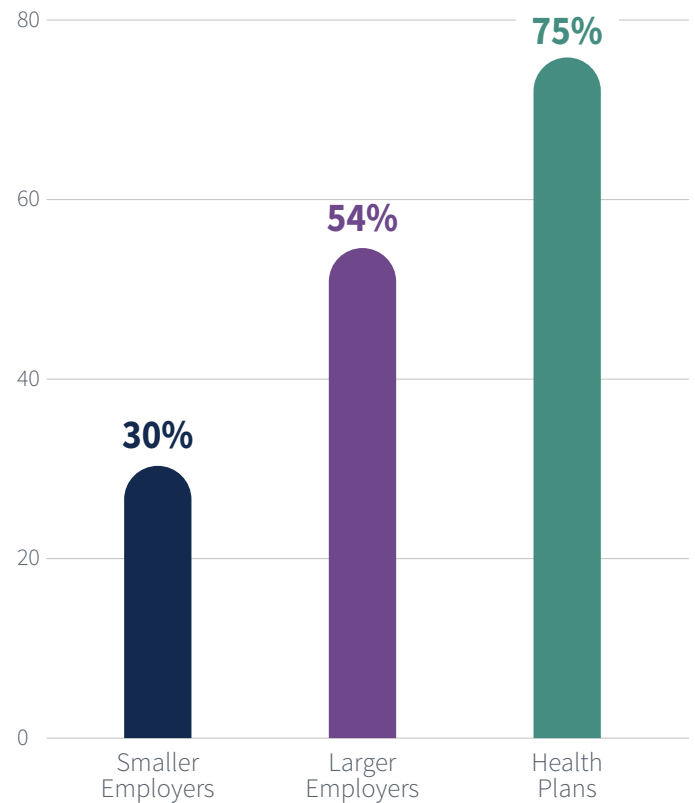
Percentages of respondents reporting cost and cumbersome as barriers to utilization management programs increased from 2022 to 2023



Most desired improvements and changes for utilization management programs:

1. Better approaches and tools to educate and engage members
2. More transparency and accountability regarding costs and outcomes

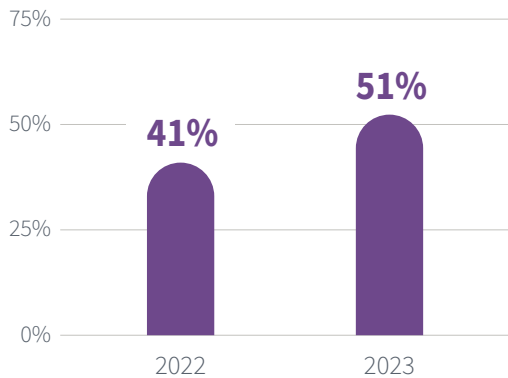
Take steps to identify and reduce wasteful spend in the formulary:



Executive Summary

Plans are making changes to their cost sharing approaches and considering additional cost sharing changes

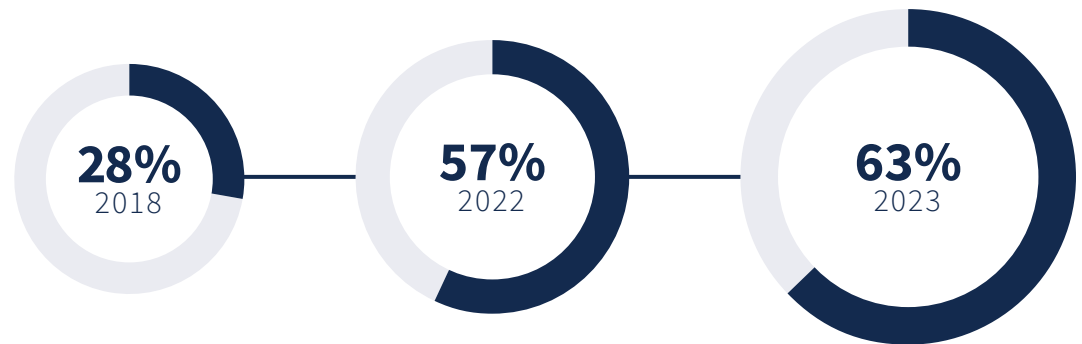
Use of a pharmacy deductible
(separate from or combined with the
medical deductible):



Percentage of respondents considering
one or more changes to cost sharing:



Promotion of cost-sharing transparency tools:



Most common cost sharing changes under consideration:

40%

Increasing copay or coinsurance

22%

Increasing number of tiers

22%

Increasing deductible

20%

Adding a preferred network

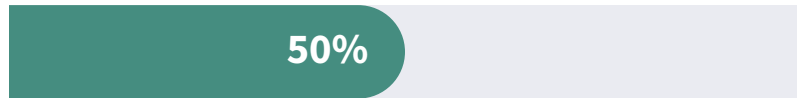
Executive Summary

Plans are uncertain about the future of copayment assistance programs and are beginning to consider how to address social determinants of health

Perceptions of copayment assistance programs:



Respondents who see copayment assistance programs as slightly or moderately sustainable



Respondents who have heard about potential reductions in offerings of copayment assistance programs

Concerns about reductions in offerings of copayment assistance programs:

member and
plan costs

member
medication adherence

member
dissatisfaction

Organization puts a moderate amount or a lot of emphasis on addressing social determinants of health to promote health equity among members:

59%

Health Plans

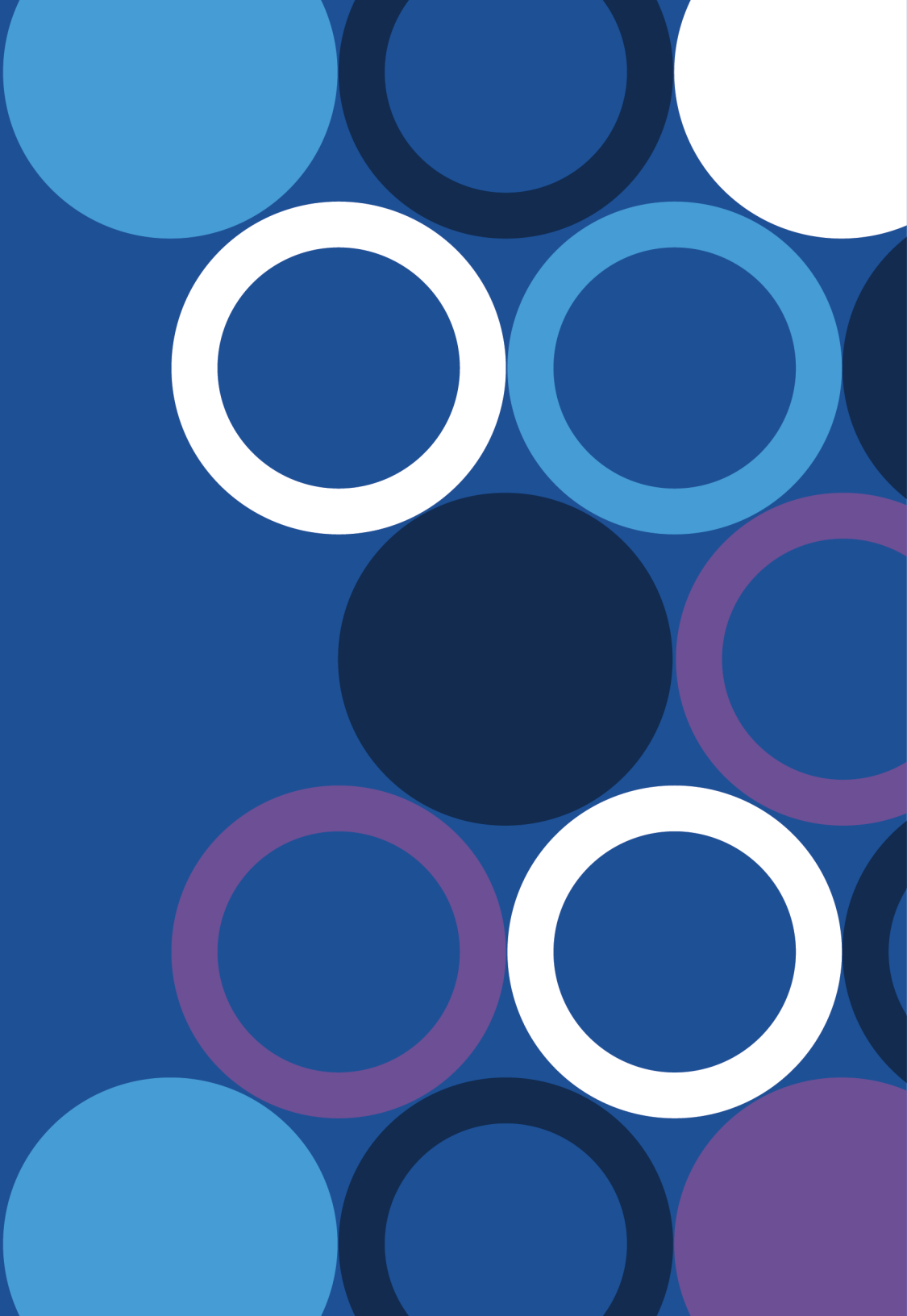
39%

Employers

Top needs related to social determinants of health:

1. Education on what plans can do to address social determinants of health
2. Specific recommended strategies for addressing social determinants of health

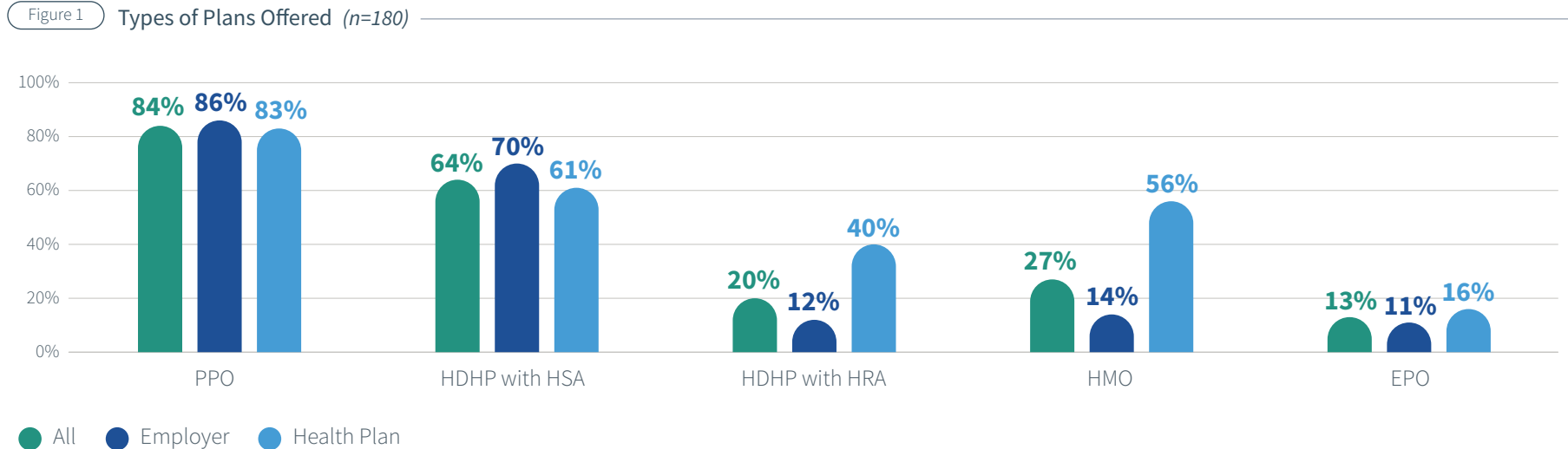
Designing the Drug Benefit



Health Plan Types Offered

One of the most fundamental benefit design decisions is what type(s) of health plans to offer. In addition to or instead of traditional plan types such as PPO and HMO plans, plan sponsors can choose to offer high-deductible health plans (HDHPs), which the Internal Revenue Service defines as plans with a deductible of at least \$1,500 for an individual or \$3,000 for a family.¹ 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.

Organizations often offer multiple types of plans. As shown in **Figure 1**, nearly all employers and health plans offered a PPO plan, and most offered a HDHP with HSA. Health plans were more likely than employers to offer a HDHP with HRA or an HMO plan, and larger employers were more likely than smaller employers to offer an HMO plan (19% vs. 9%). The percentage that offer a HDHP with HRA increased from 10% last year (in the 2022 report) to 20% this year.



Pharmaceutical Strategies Group. 2023 Trends in Drug Benefit Design Report. Dallas, TX: PSG.

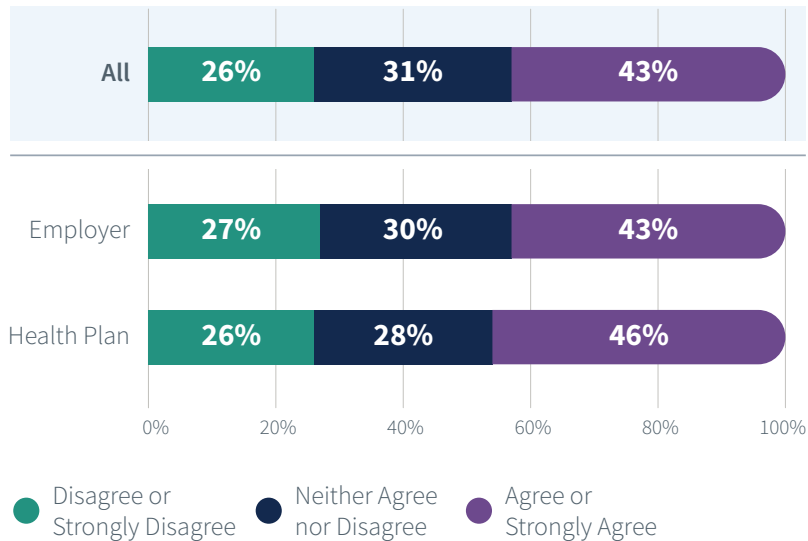
¹ SHRM. IRS Announces Spike in 2023 Limits for HSAs and High-Deductible Health Plans. <https://www.shrm.org/resourcesandtools/hr-topics/benefits/pages/2023-irs-contribution-limits-for-hsas-and-high-deductible-health-plans.aspx> Accessed April 7, 2023.

High-Deductible Health Plan Outcomes

Through more member cost sharing, HDHPs aim to decrease the use of low-value care and encourage consumers to actively consider both cost and quality when making health care decisions. However, respondents expressed mixed views on whether these plans achieve their stated aims. As shown in **Figure 2**, only 43% of respondents agreed or strongly agreed that HDHPs are an effective way to manage overall drug trend. While low, this percentage represents a modest increase compared to last year, when

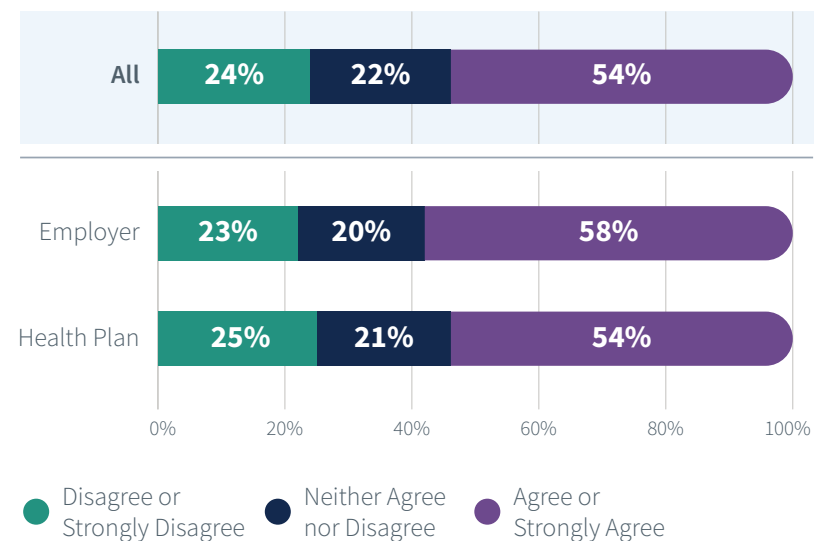
35% agreed or strongly agreed with the statement. A somewhat larger percentage (54%) agreed or strongly agreed that HDHPs are an effective way to help members become better health care consumers and make wiser medication choices (see **Figure 3**). Although employers and health plans did not differ notably on these questions, within the employer group, smaller employers were more likely than larger employers to agree or strongly agree that HDHPs are effective in these areas.

Figure 2 High-Deductible Health Plans Manage Overall Drug Trend (n=180)



Pharmaceutical Strategies Group. 2023 Trends in Drug Benefit Design Report. Dallas, TX: PSG.

Figure 3 High-Deductible Health Plans Help Members (n=180)

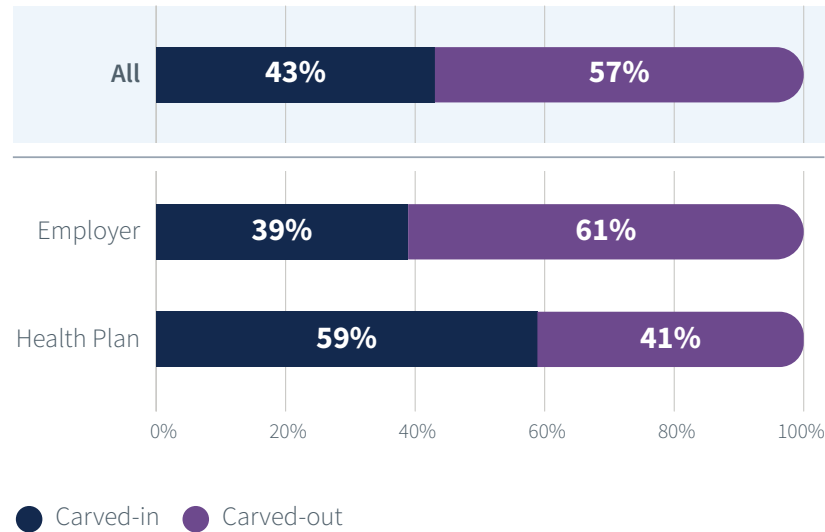


Pharmaceutical Strategies Group. 2023 Trends in Drug Benefit Design Report. Dallas, TX: PSG.

Relationship Between Drug and Medical Benefit Design

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 4**, 57% of respondents reported their drug benefit is carved out, with a higher rate of carveout among employers compared to health plans. Within the employer group, larger employers were more likely than smaller employers to have a carved-out drug benefit (70% vs. 51%).

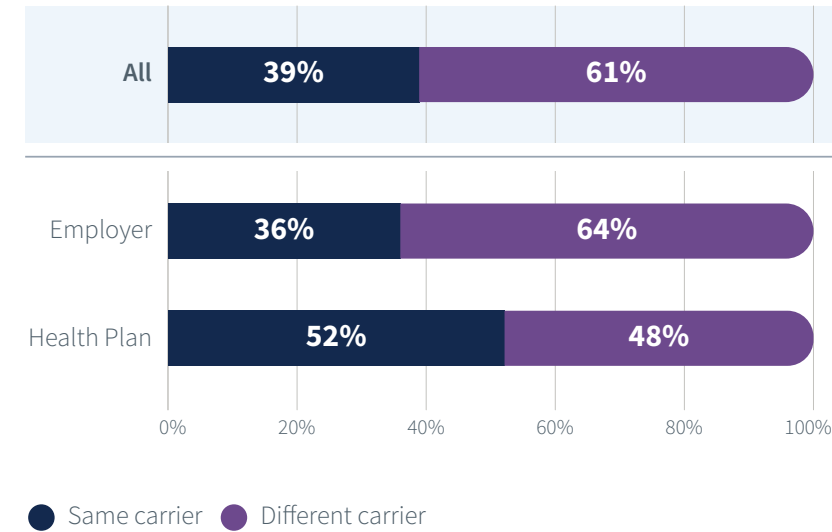
Figure 4 Drug Benefit Relationship with Medical Benefit (n=167)



Pharmaceutical Strategies Group. 2023 Trends in Drug Benefit Design Report. Dallas, TX: PSG.

The drug and medical benefits can be managed by the same carrier or by different carriers. As shown in **Figure 5**, 61% of respondents reported that the plan's drug and medical benefits were managed by different carriers, with a larger percentage of employers than health plans reporting the benefits are managed by different carriers. Within the employer group, larger employers were much more likely than smaller employers to use different carriers (75% vs. 51%).

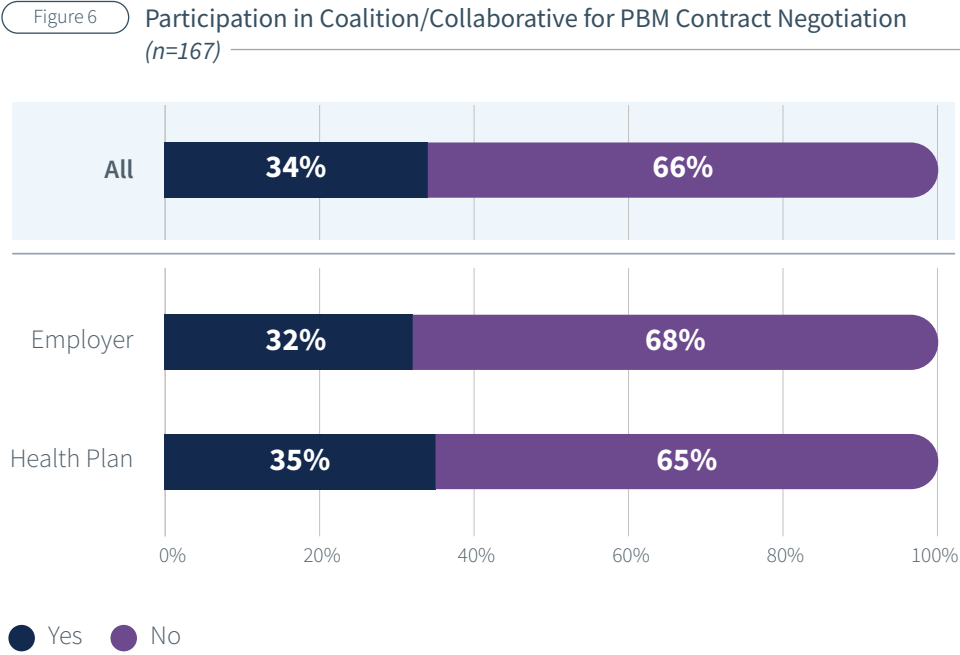
Figure 5 Drug and Medical Benefit Management (n=167)



Pharmaceutical Strategies Group. 2023 Trends in Drug Benefit Design Report. Dallas, TX: PSG.

Coalition Participation

Plans can choose to work with a coalition or other group purchasing organization. As shown in **Figure 6**, 34% of respondents reported their organization was part of a coalition or collaborative for negotiating their PBM contract, with little difference between employers and health plans. Smaller and larger employers did not differ on this question — 32% of each were part of a coalition/collaborative — and this represents a slight decrease among larger employers compared to last year, when 40% participated in such a group.

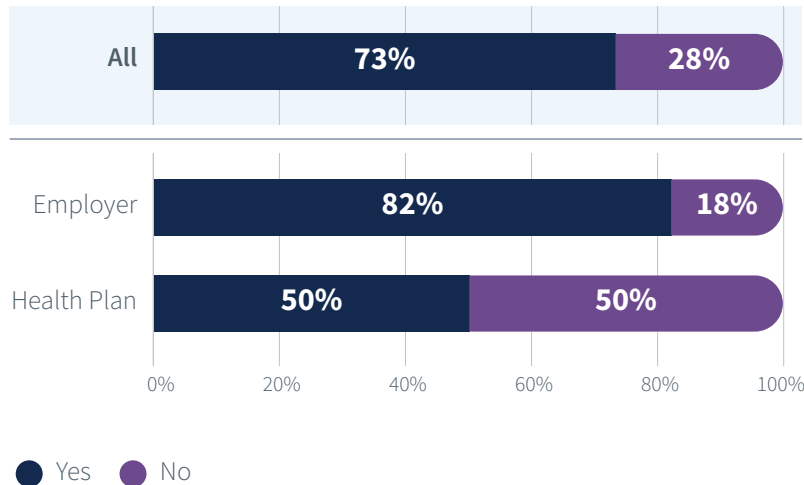


Pharmaceutical Strategies Group. 2023 Trends in Drug Benefit Design Report. Dallas, TX: PSG.

Use of Drug and Medical Benefit Consultants

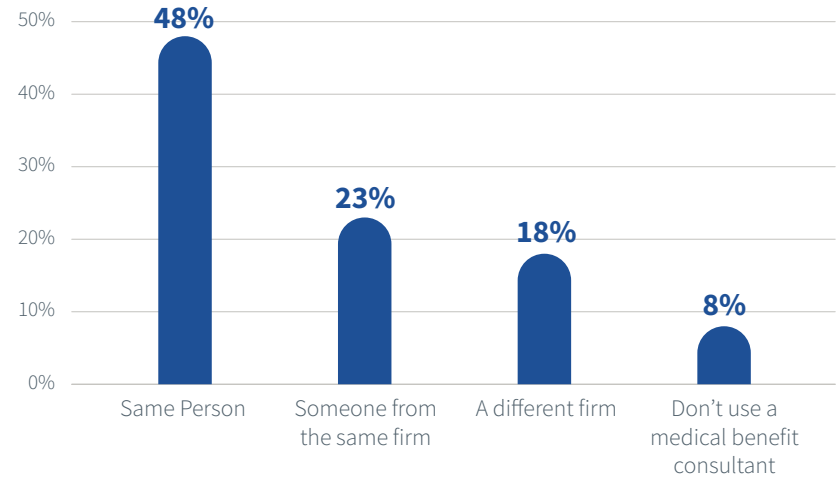
When designing the drug and medical benefits, plan sponsors must consider many factors (e.g., budget, projected and past trend, and member characteristics) while working to manage costs and meet goals around both access and affordability. A task of this magnitude and importance warrants expert advice from many sources, notably consultants. As shown in **Figure 7**, most respondents used a drug benefit consultant, though this differed by respondent group: the vast majority of employer respondents used a benefit consultant, compared to approximately half of health plan respondents.

Figure 7 Use of Drug Benefit Consultant (n=167)



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Figure 8 Use of Medical Benefit Consultant Among Employers (n=84)



Not shown: 4% of respondents selected "not sure."

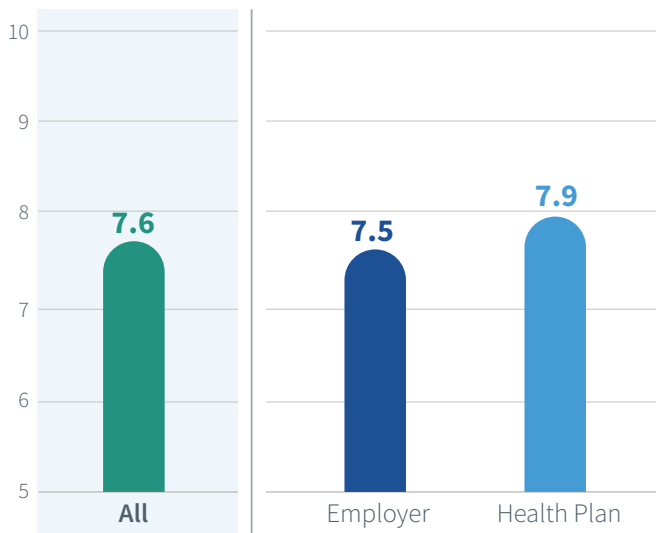
Pharmaceutical Strategies Group. 2023 Trends in Drug Benefit Design Report. Dallas, TX: PSG.

Employers may also choose to use a consultant to help evaluate and design their medical benefit, and the vast majority of employer respondents reported using a medical benefit consultant (see **Figure 8**). About half of employers used the same person for both drug and medical benefits consulting, and another quarter used someone from the same firm. Compared to larger employers, smaller employers were much more likely to use the same person (68% vs. 30%) and much less likely to use a different firm (3% vs. 30%).

Drug Benefit Design: Importance and Influences

To better understand how respondents perceive the drug benefit relative to their broader benefit strategy, we asked them to rate how integral pharmacy benefit design is in supporting their broader benefit strategy on a scale from 1 (*not at all*) to 10 (*extremely*). As shown by the averages in **Figure 9**, respondents perceived the drug benefit design as being quite integral to their overall benefit strategy.

Figure 9 Average Rating of How Integral Pharmacy Benefit Design is to Broader Benefit Strategy (*n=166*)



Pharmaceutical Strategies Group. 2023 Trends in Drug Benefit Design Report. Dallas, TX: PSG.

Figure 10 Drug Benefit Design Influence Rankings (*n=167*)

	Employer	Health Plan
1	HR/benefits department	Health Plan
2	Broker/consultant	PBM
3	PBM	Broker/consultant
4	Non-HR executive leadership	HR/benefits department
5	Health Plan	Employee benefits committee
6	Employee benefits committee	Non-HR executive leadership

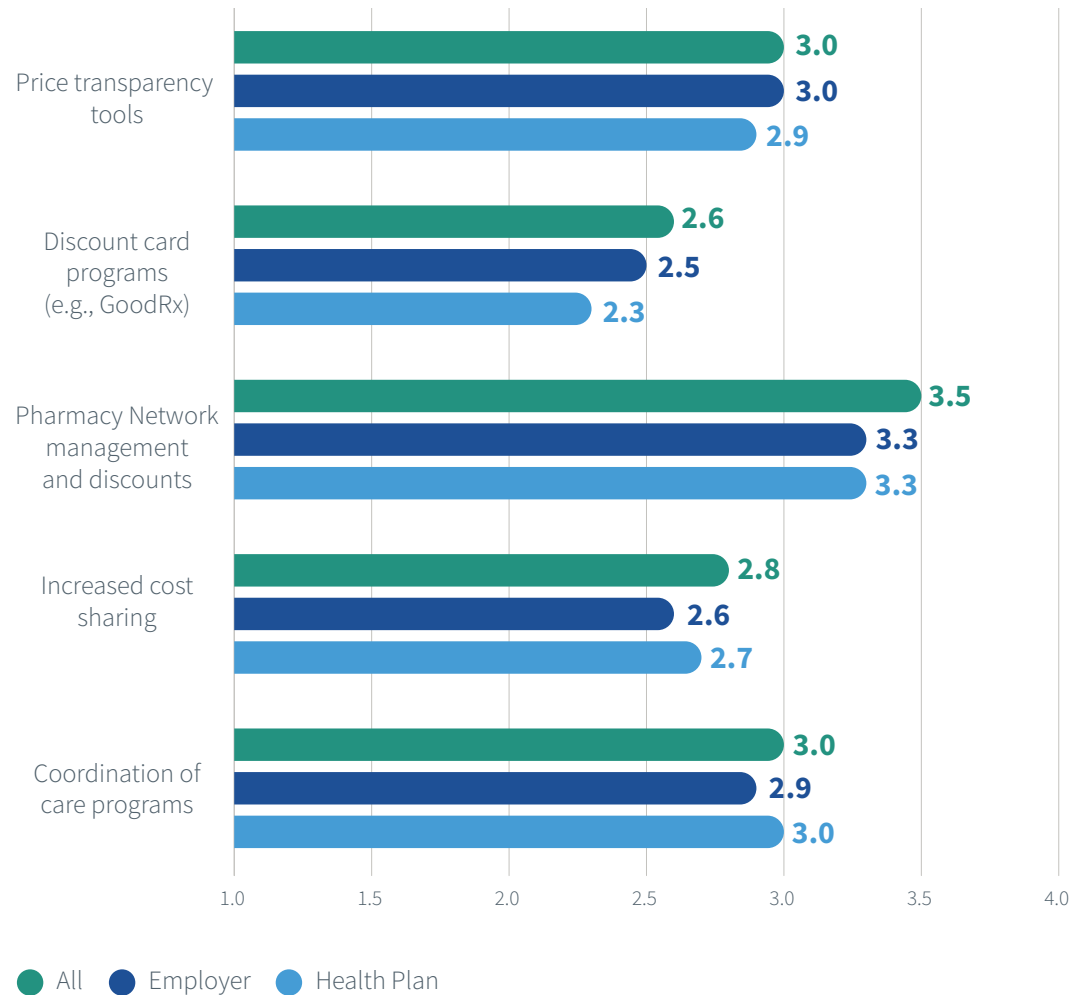
Pharmaceutical Strategies Group. 2023 Trends in Drug Benefit Design Report. Dallas, TX: PSG.

Designing the drug benefit is a task of substantial magnitude and importance. Such tasks warrant advice from many sources, and we asked respondents to rank various sources of influence in the evaluation and design of their organization’s drug benefit. As shown in **Figure 10**, broker/consultant and PBM were ranked highly by both employers and health plans as sources of influence in this area.

Effectiveness of Cost Reduction Tactics

Managing overall drug trend is a major focus for plans, and various solutions are offered in service of that goal. We presented respondents with several available tactics for reducing drug costs and asked how effective they believed each one to be on a scale from 1 (*not at all effective*) to 4 (*very effective*). As shown by the averages in **Figure 11**, respondents perceived pharmacy network management and discounts as the most effective of the tactics shown and discount card programs as the least effective, with only small differences between employers and health plans. Within the employer group, smaller employers gave higher average ratings than larger employers to price transparency tools (3.2 vs. 2.8) and discount card programs (2.7 vs. 2.4).

Figure 11 Average Perceived Effectiveness Ratings for Drug Cost Reduction Tactics (n=167)

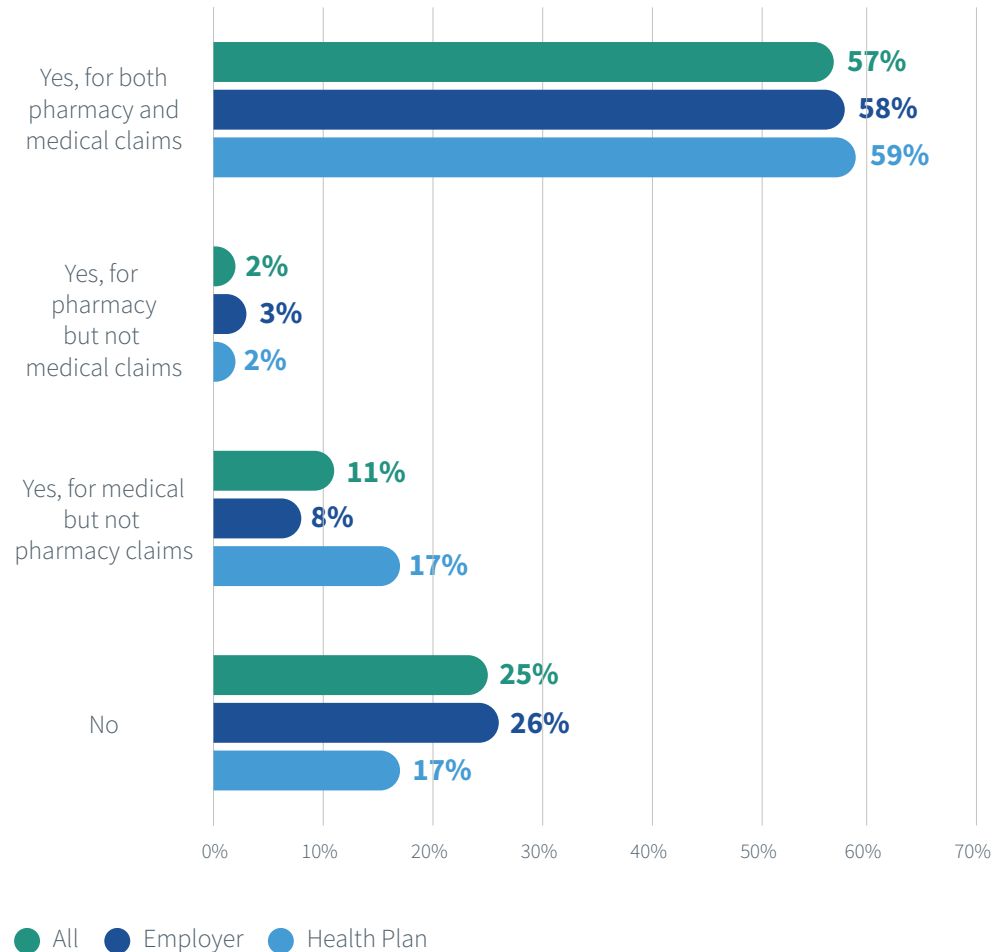


Pharmaceutical Strategies Group. 2023 Trends in Drug Benefit Design Report. Dallas, TX: PSG.

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, 57% of respondents purchased stop-loss insurance for both pharmacy and medical claims (see **Figure 12**). Health plans were more likely than employers to purchase stop-loss insurance for medical but not pharmacy claims, and employers were more likely than health plans to not purchase stop-loss insurance for either pharmacy or medical claims. Smaller employers were much more likely than larger employers to purchase stop-loss insurance for both pharmacy and medical claims (77% vs. 43%), and larger employers were much more likely to not purchase this insurance at all (38% vs. 13%).

Figure 12 Purchase of Stop-Loss Insurance (n=167)



Not shown: 5% of respondents were not sure if they purchase stop-loss insurance.

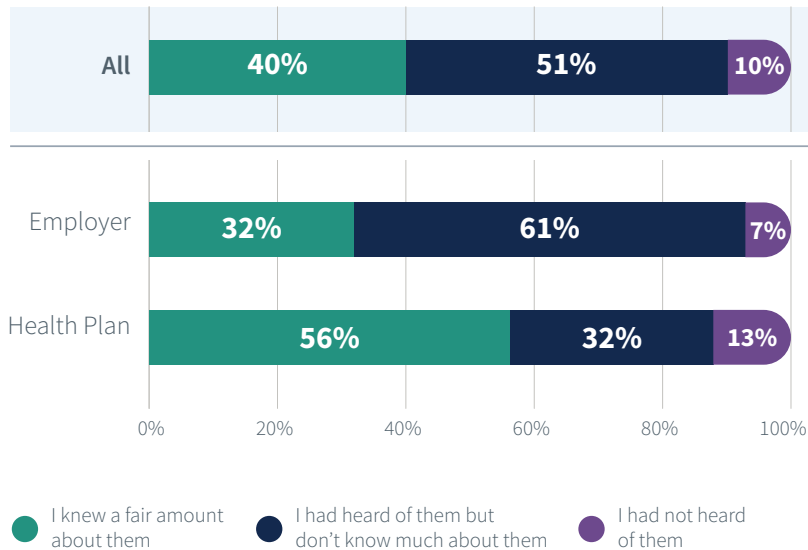
Pharmaceutical Strategies Group. 2023 Trends in Drug Benefit Design Report. Dallas, TX: PSG.

Gene Therapy Financial Protection Products

With new cell and gene therapies currently entering the market and many more on the way — the number of these therapies on the market is likely to increase to over 60 by 2030² — multiple entities (e.g., stop-loss providers and PBMs) are now offering financial protection products specifically for cell and gene therapies.

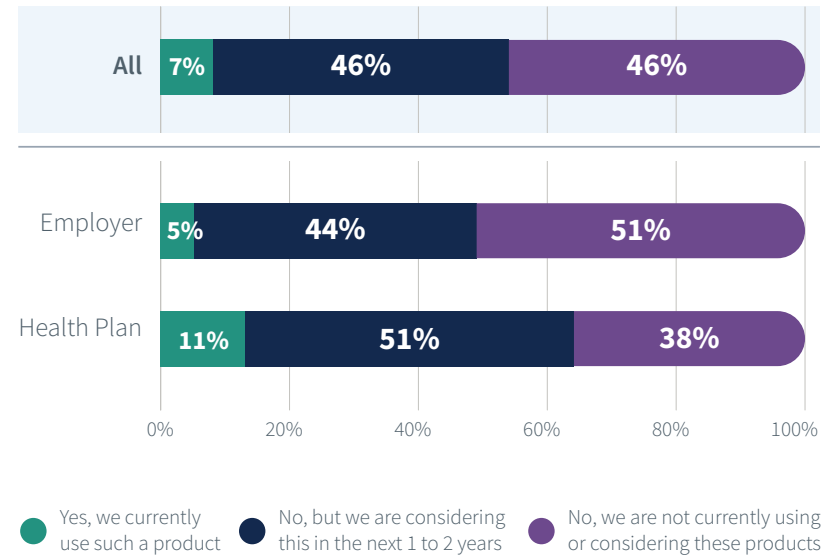
As shown in **Figure 13**, the vast majority of respondents were aware of these products, but just 40% knew a lot about them. Among those who were aware of cell and gene therapy financial protection products, just 7% currently use them but another 46% are considering it in the next 1 to 2 years (see **Figure 14**).

Figure 13 Awareness of Cell and Gene Therapy Financial Protection Products (n=167)



Pharmaceutical Strategies Group. 2023 Trends in Drug Benefit Design Report. Dallas, TX: PSG.

Figure 14 Consideration and Use of Cell and Gene Therapy Financial Protection Products (n=151)



Pharmaceutical Strategies Group. 2023 Trends in Drug Benefit Design Report. Dallas, TX: PSG.

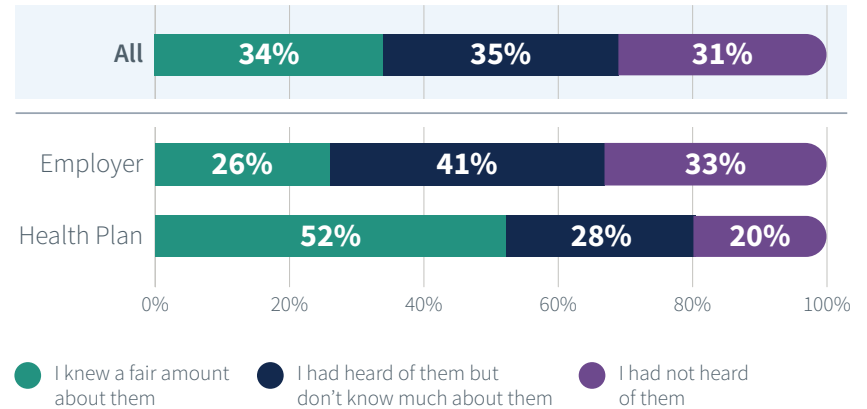
²Young, C.M., Quinn, C. and Trusheim, M.R. Durable cell and gene therapy potential patient and financial impact: US projections of product approvals, patients treated, and product revenues. Drug Discovery Today. 2022;17(1):17-30.

Digital Therapeutics

Digital therapeutics are evidence-based therapeutic interventions driven by software programs to treat, manage, or prevent a disease or disorder. Digital therapeutics are separate from diagnostics, telehealth, and other forms of care (e.g., medications and devices) but may be used in concert with them.³ Although the global digital therapeutics market is expected to grow from about \$4 billion in 2021 to almost \$42 billion in 2030,⁴ prominent digital therapeutics companies face substantial barriers to widespread success, as evidenced by Pear Therapeutics — one of the first digital therapeutics companies — filing for bankruptcy in 2023.⁵

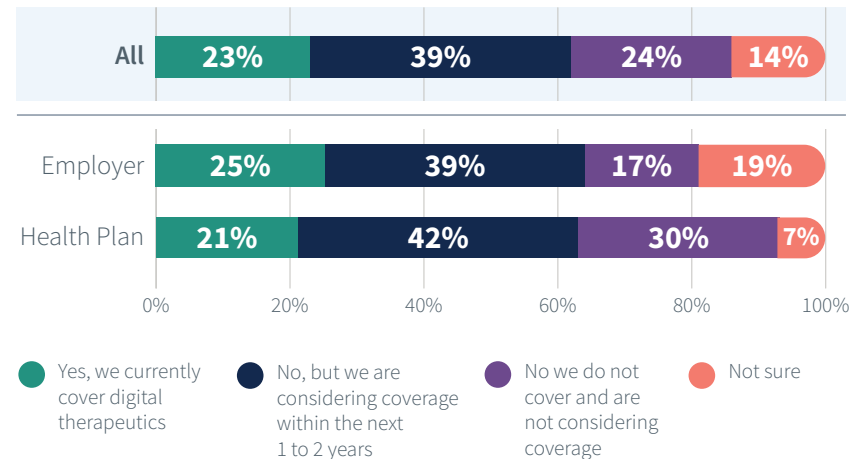
We asked respondents about their awareness of digital therapeutics and, for those who were aware of these offerings, whether the plan covers them. As shown in **Figure 15**, 69% of respondents were aware digital therapeutics (with higher awareness among health plan respondents compared to employer respondents), but just 34% knew a lot about them. Smaller employers were more likely than larger employers to report that they had not heard of digital therapeutics (43% vs. 25%). Among those who were aware of digital therapeutics, just 23% reported the plan currently covers these offerings, but another 39% said they were considering coverage in the next 1 to 2 years (see **Figure 16**).

Figure 15 Awareness of Digital Therapeutics (n=167)



Pharmaceutical Strategies Group. 2023 Trends in Drug Benefit Design Report. Dallas, TX: PSG.

Figure 16 Coverage of Digital Therapeutics (n=116)



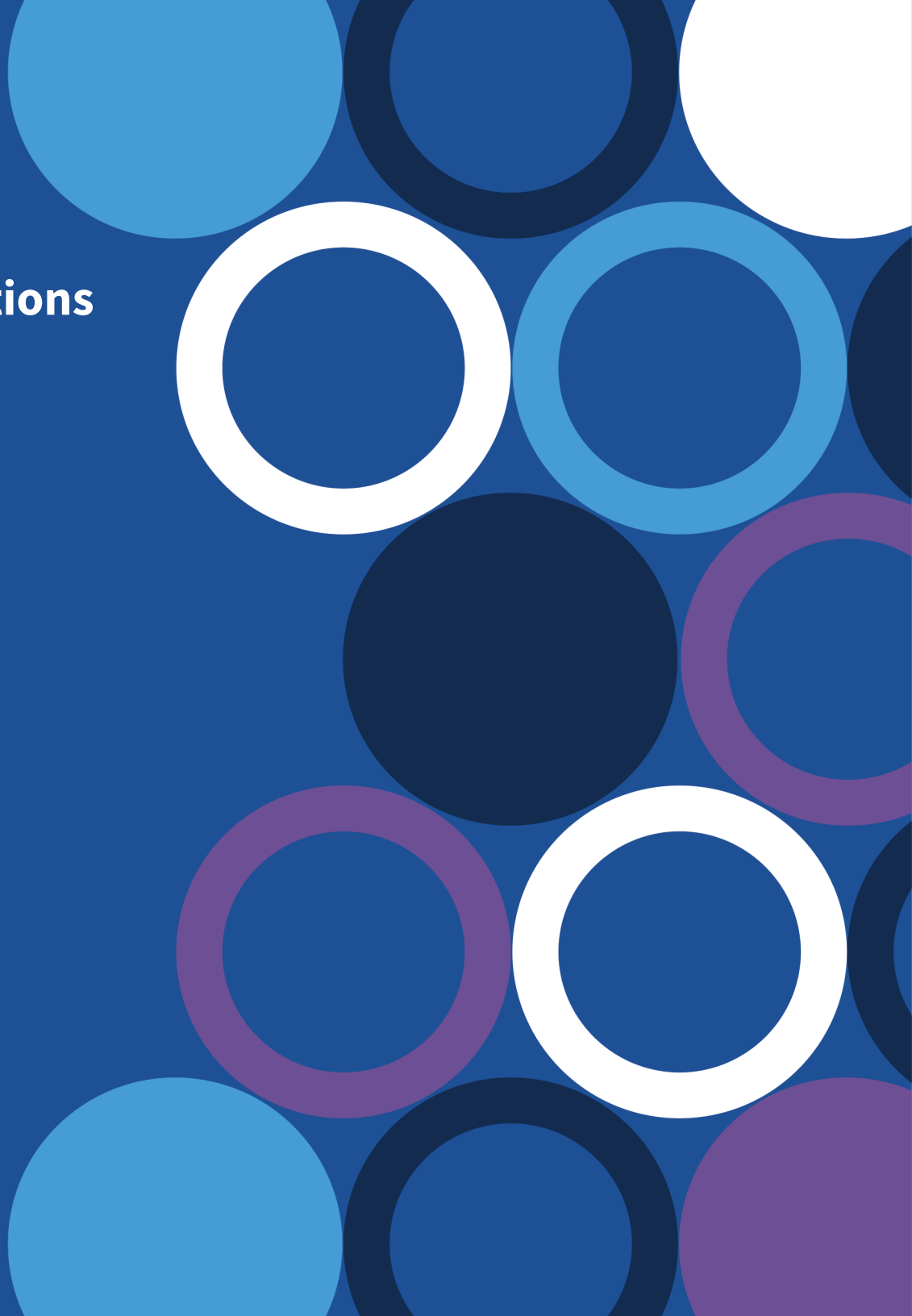
Pharmaceutical Strategies Group. 2023 Trends in Drug Benefit Design Report. Dallas, TX: PSG.

³ Digital Therapeutics Alliance. Understanding DTx: What is a DTx? <https://dtxalliance.org/understanding-dtx/what-is-a-dtx/> Accessed April 7, 2023.

⁴ The Brainy Insights. Digital Therapeutics Market. <https://www.thebrainyinsights.com/report/digital-therapeutics-market-12677> Accessed April 7, 2023.

⁵ Mobi Health News. Pear Therapeutics Files for Bankruptcy. <https://www.mobihealthnews.com/news/pear-therapeutics-files-bankruptcy> Accessed April 21, 2023.

Spotlight: Weight Loss Medications



Weight Loss Medications: Introduction

Obesity is one of the biggest public health problems in the United States. Around 40% of adults in the United States have obesity,⁶ and the condition is associated with serious health consequences (e.g., increased risk for cardiovascular disease, Type 2 diabetes, and many types of cancer) and a large economic impact (over \$170 billion in 2019 dollars for obesity-related medical costs).⁷ Achieving substantial weight loss through diet and exercise is notoriously difficult, but drugs that produce substantial weight loss are now becoming part of the obesity treatment landscape, and the world is taking notice. Both industry and general public media sources are giving tremendous attention to these drugs, and people are seeking information about them: For example, members of Rx Savings Solutions searched for Ozempic (discussed below) in their portal nearly as many times in the first 3 months of 2023 as they did for the entire year in 2022.⁸

The drugs now taking the world by storm for weight loss began as Type 2 diabetes drugs. Semaglutide was first approved by the FDA for the treatment of Type 2 diabetes as Ozempic then later approved under the brand name Wegovy for weight loss. Another drug, Mounjaro (tirzepatide), which is currently approved for the treatment of Type 2 diabetes but has been studied for weight loss, will likely join the ranks of Ozempic and Wegovy as household names for weight loss drugs. These drugs can produce substantial weight loss, 15-20% of total body weight on average, but they also come with costs exceeding \$10,000 per patient per year.^{9,10} The drugs could produce huge benefits for people with obesity but also present a major cost challenge given the large percentage of the population that is eligible for them. Recognizing the choices and challenges plans are beginning to face in this area, we asked respondents a series of questions about their perspectives and approaches related to weight loss medications.

Substantial weight loss

15–20%
of total body weight
on average

Cost

>\$10,000
per patient per year

⁶Centers for Disease Control. Adult Obesity Facts. <https://www.cdc.gov/obesity/data/adult.html> Accessed May 7, 2023.

⁷Centers for Disease Control. Consequences of Obesity. <https://www.cdc.gov/obesity/basics/consequences.html> Accessed May 7, 2023.

⁸Rx Savings Solutions email communication April 2023.

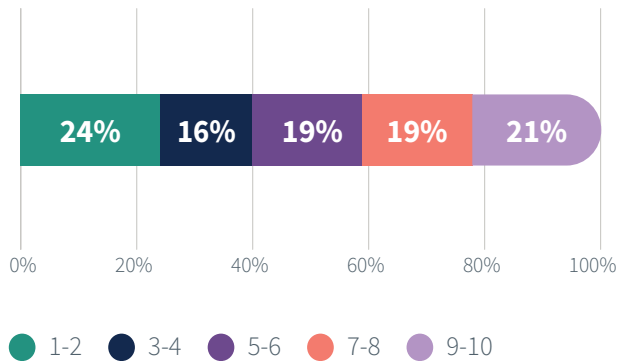
⁹Wall Street Journal. The 'King Kong' of Weight-Loss Drugs is Coming. <https://www.wsj.com/articles/ozempic-mounjaro-weight-loss-drug-wegovy-eli-lilly-66f2906> Accessed May 11, 2023.

¹⁰PSG Artemetrx book of business analysis based on 2022 calendar year utilization.

Coverage of Weight Loss Medications

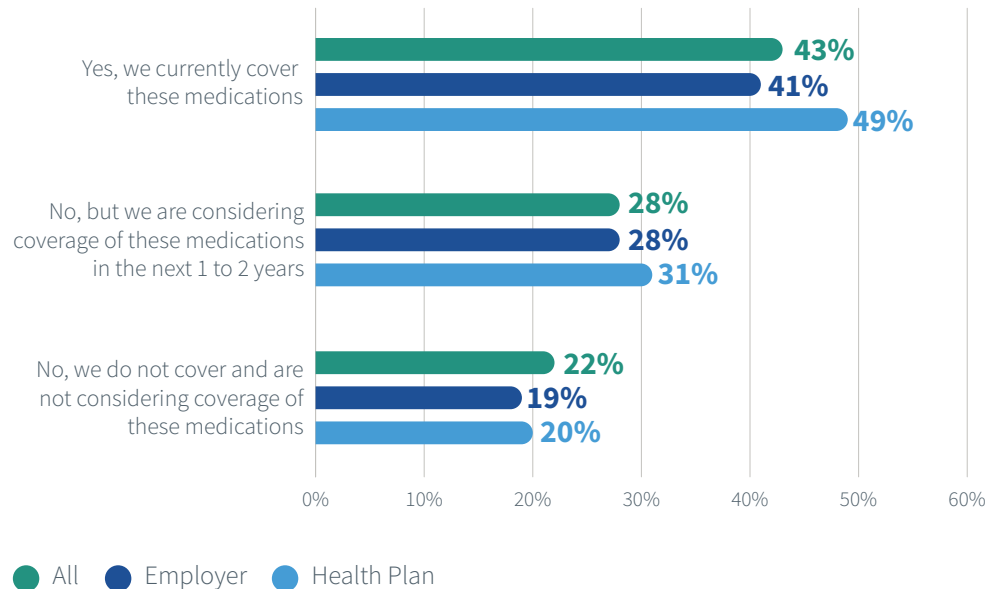
Although the American Medical Association officially recognized obesity as a disease in 2013, the mindset of obesity as a chronic condition rather than a lifestyle issue has not been universally adopted. We asked respondents how their organization views coverage of pharmaceuticals as it relates to weight loss on a scale from 1 (*lifestyle condition — should not cover*) to 10 (*chronic condition to treat — should cover*). The average rating was 5.4, and responses were remarkably evenly distributed across the rating scale (see **Figure 17**), demonstrating wide variation in how plans view obesity and the use of pharmaceuticals to treat the condition.

Figure 17 Views of Coverage of Pharmaceuticals for Weight Loss (n=147)



Pharmaceutical Strategies Group. 2023 Trends in Drug Benefit Design Report. Dallas, TX: PSG.

Figure 18 Plan Coverage of Weight Loss Medications (n=149)



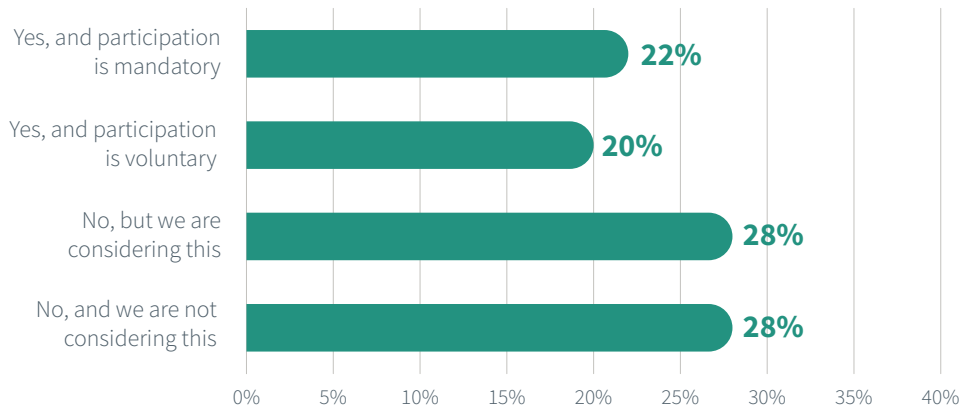
Not shown: 7% of respondents were unsure of the plan's status regarding coverage of weight loss medications. Pharmaceutical Strategies Group. 2023 Trends in Drug Benefit Design Report. Dallas, TX: PSG.

Next, we asked whether the plan currently covers or is considering coverage of medications that are FDA-approved for weight loss. As shown in **Figure 18**, 43% of plans currently cover these medications and another 28% were considering doing so in the next 1 to 2 years, with only minor differences between employers and health plans. Within the employer group, although smaller and larger employers were nearly equally likely to be currently covering weight loss medications (42% vs. 40%), smaller employers were less likely than larger employers to be considering this coverage (20% vs. 36%).

Weight Loss Medication Coverage Prerequisites and Limits

We asked respondents who reported their plan covers weight loss medications a series of additional questions about this coverage. Lifestyle modification has long been a hallmark of obesity treatment, and we asked whether member participation in a lifestyle modification program was a prerequisite for coverage of weight loss medications. Plans were divided on their approach in this area (see **Figure 19**), with nearly equal proportions reporting yes with mandatory participation, yes with voluntary participation, no but considering this, and neither currently doing nor considering this. Health plans were more likely than employers to have a program with mandatory participation (32% vs. 16%), and employers were more likely than health plans to be neither using nor considering this strategy (35% vs. 20%).

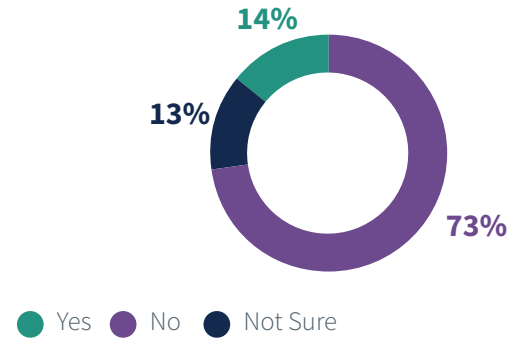
Figure 19 Lifestyle Modification Programs as a Prerequisite for Weight Loss Medication Coverage (n=64)



Not shown: 2% of respondents were not sure if the plan had a lifestyle modification program participation requirement.

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Figure 20 Does Plan Have Limitations for Weight Loss Medication Coverage (n=64)



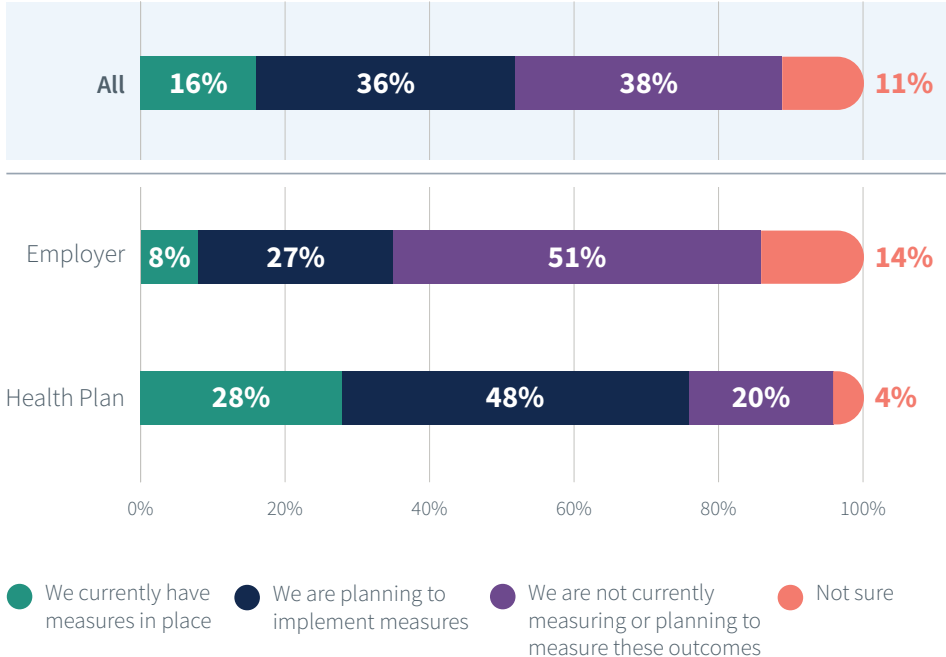
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Plans can also choose to place limits on coverage of weight loss medications in terms of dollars and/or duration of treatment. As shown in **Figure 20**, just 14% of plans that covered weight loss medications had limitations to the coverage. In a follow-up question, those who indicated they had limitations on coverage most often described duration and quantity limits.

Weight Loss Medication Outcomes

For respondents whose plan covers weight loss medications, we also asked whether they were currently measuring outcomes of weight loss medications or planning to do so. As shown in **Figure 21**, just 16% currently do so, but another 36% were planning to implement measures, and health plans were more likely than employers to currently have or be planning to implement measures. We asked those who currently have measures in place how satisfied they were with the outcomes of weight loss medications to date and found that 50% were somewhat or very satisfied, 20% were somewhat dissatisfied, and 30% said it was too soon to tell.

Figure 21 Measurement of Weight Loss Medication Outcomes (n=64)

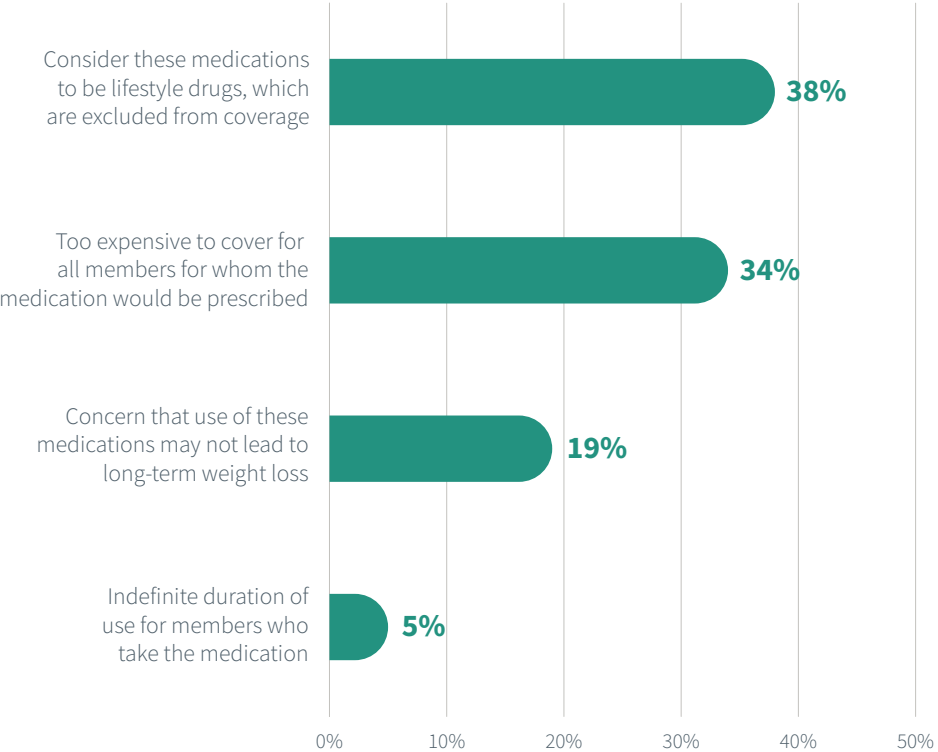


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Reasons for Excluding Weight Loss Medications from Coverage

As noted previously, over half of plans do not currently cover FDA-approved medications for weight loss. When asked their top reason for excluding these medications from coverage, most selected either considering these medications to be lifestyle drugs, which they exclude from coverage, or believing it would be too expensive to cover for all members for whom these medications would be prescribed (see **Figure 22**). Employers were more likely than health plans to select concern that use of the medications may not lead to long-term weight loss (24% vs. 12%), while health plans were more likely than employers to select that it would be too expensive to cover all eligible members (46% vs. 31%).

Figure 22 Top Reason for Excluding Weight Loss Medications from Coverage (n=74)

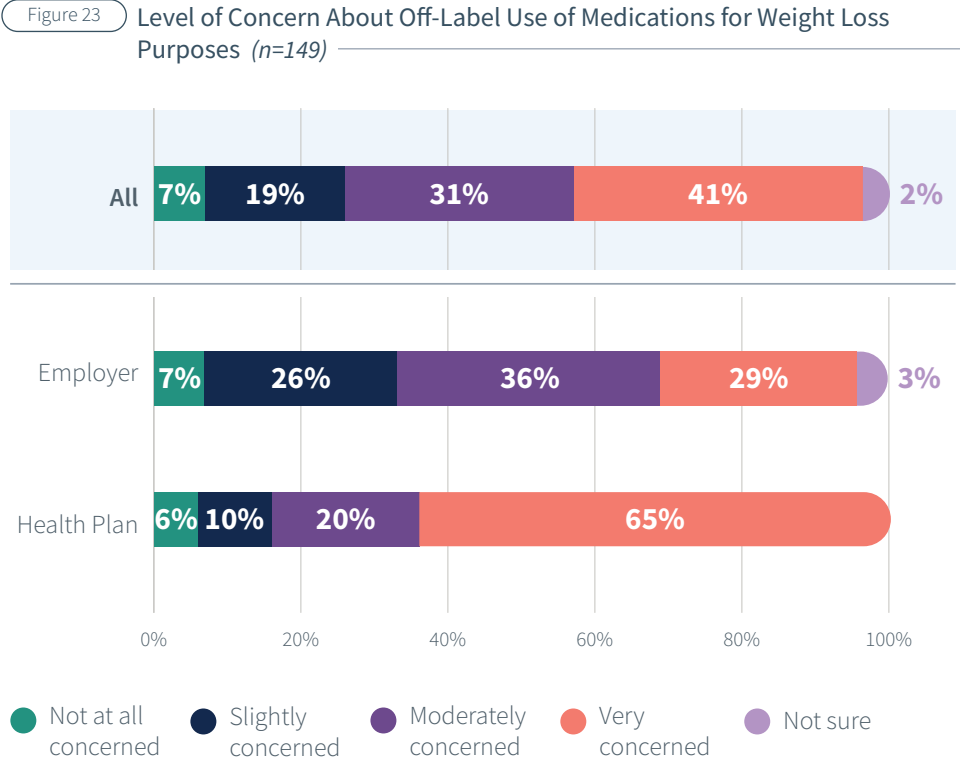


Not shown: 4% of respondents selected "other" and described different top reasons for excluding weight loss medications from coverage.

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Concern Regarding Off-Label Use of Medications for Weight Loss Purposes

Finally, shifting from the focus on coverage of medications that are FDA-approved for weight loss, we asked all respondents to rate their concern about off-label use of medications for the purposes of weight loss on a scale from 1 (*not at all concerned*) to 4 (*very concerned*). As shown in **Figure 23**, the majority of respondents were moderately or very concerned about this, with greater concern among health plans compared to employers.



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Cost Sharing

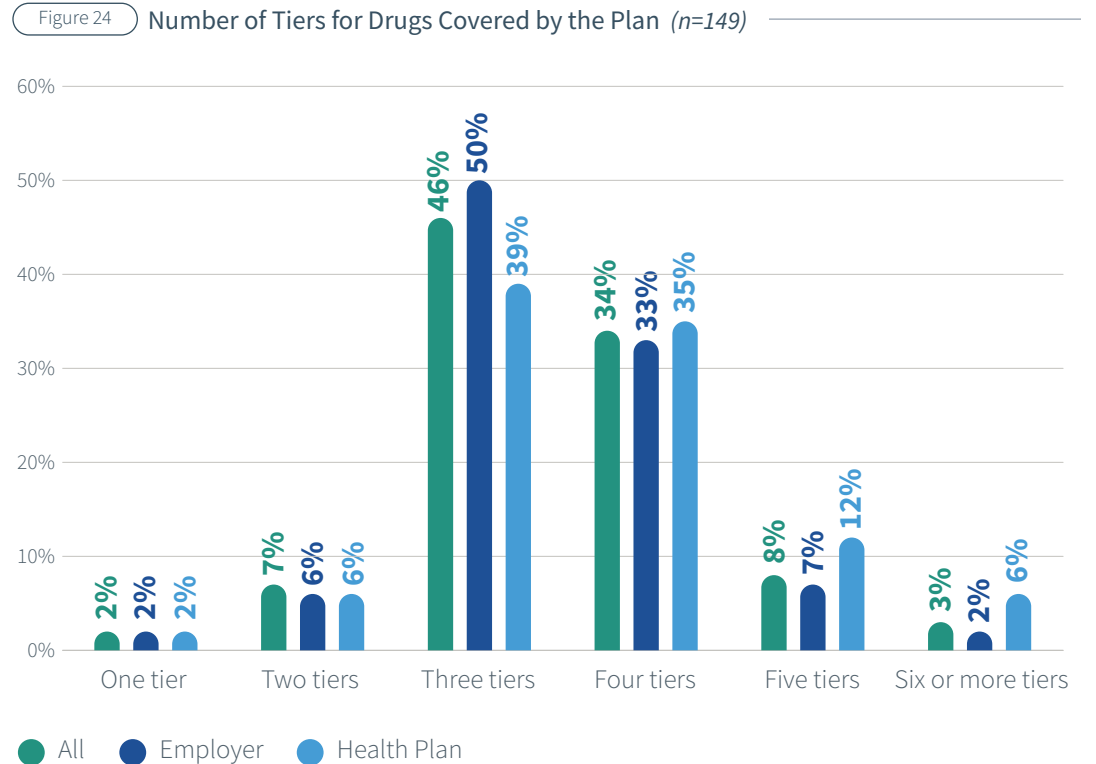


Plan Tier Design

Cost sharing is the most visible part of the drug benefit for members and can be a financial burden. 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 possible.

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 24**, the most common structure across respondent groups was 3 tiers, but responses varied by group. Notably, employer respondents were more likely than health plan respondents to have 3 tiers and less likely to have 5 or 6 or more tiers. When asked how many tiers included specialty drugs, the majority of respondents (65%) reported that specialty drugs were included on a single tier.

For their HDHP members, some plans implement a preventive drug list where certain medications are offered for free or at low cost for members. Among respondents reporting on a HDHP in this survey, 57% reported they had implemented a preventive drug list, and another 24% were considering implementation of such a list.



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Cost Sharing Structures

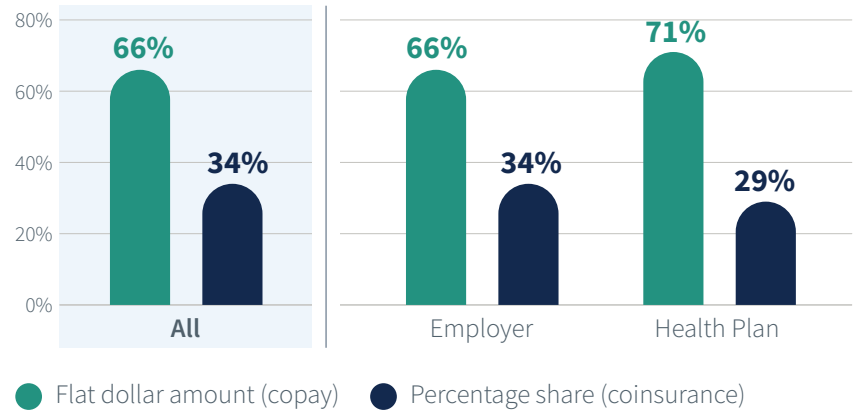
Cost sharing can be structured as a flat dollar amount (copay) or as a percentage share of the cost (coinsurance). For retail 30 fills, two-thirds of respondents used a copay, but this varied by respondent group and subgroup (see **Figures 25** and **26**), with larger employers the least likely to use copay structure. As shown in **Table 1**, about three-quarters of plans allowed 90-day fills at retail pharmacies, and nearly all allowed use of mail-order pharmacies, with slightly higher use of the copay structure for mail-order. Compared to last year, this year's results show increases in the percentages using the copay structure, particularly among larger employers.

Table 1 Retail 90 and Mail-Order Cost Sharing Structures (n=149)

	Allows Use of Channel	Uses Copay Structure: All	Uses Copay Structure: Employer	Uses Copay Structure: Health Plan
Retail 90	77%	68%	65%	76%
Mail-Order	96%	73%	72%	78%

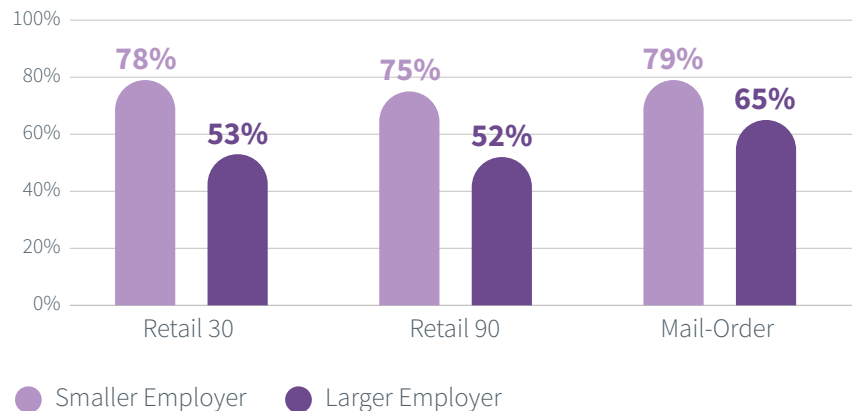
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Figure 25 Retail 30 Cost Sharing Structures (n=149)



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Figure 26 Use of Copay Cost Sharing Structure by Employer Size (n=90)



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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. Additionally, the drug classes covered in each tier vary across plans. **Figures 27** and **28** show the average copay and coinsurance respectively for retail 30, retail 90, and mail-order for the first 3 tiers of drugs.

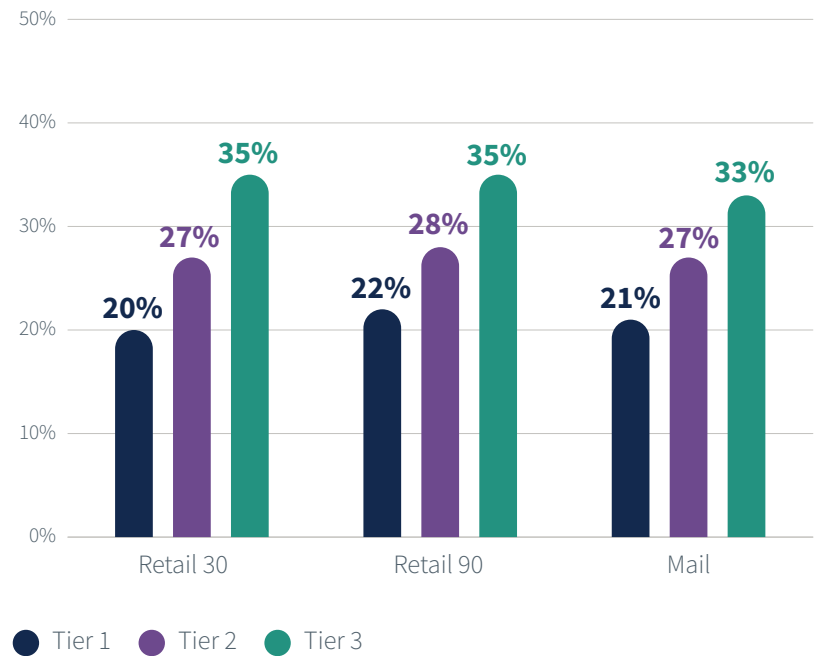
Figure 27 Average Cost Sharing for Copay



Note: Ns vary based on tier and dispensing channel, ranging from 60 to 91.

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Figure 28 Average Cost Sharing for Coinsurance



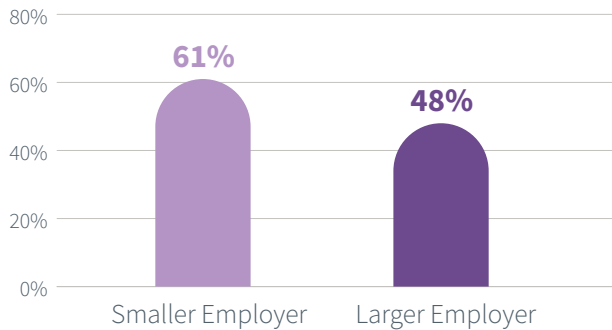
Note: Ns vary based on tier and dispensing channel, ranging from 29 to 41.

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Retail 90 Pharmacy Networks

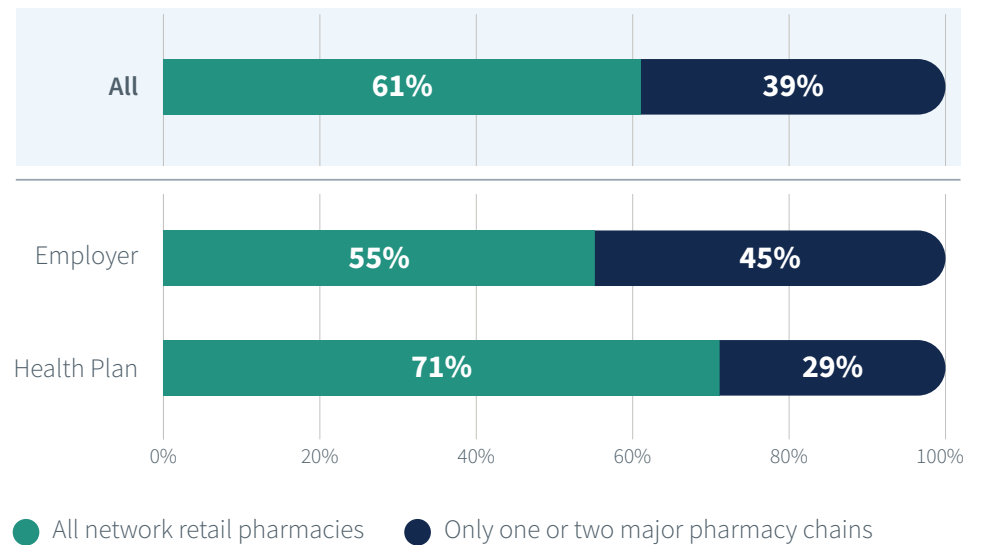
In the retail 90 channel, plans have the option of restricting where prescriptions can be filled. This strategy can be used in addition to network contracting to reduce overall costs by favoring pharmacies that offer lower drug costs and/or dispensing fees. As shown in **Figures 29** and **30**, 61% of plans allowed 90-day prescriptions to be filled at all network retail pharmacies, with higher rates among health plans and lower rates among larger employers. Compared to last year, the percentage of employers allowing 90-day fills at all network retail pharmacies increased, driven by a 15% increase among larger employers, while the percentage of health plans allowing this decreased by about 10%.

Figure 29 All Network Retail Pharmacies Permitted for Retail 90 Fills — By Employer Size (n=65)



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Figure 30 Pharmacy Network Options for Retail 90 Fills (n=114)

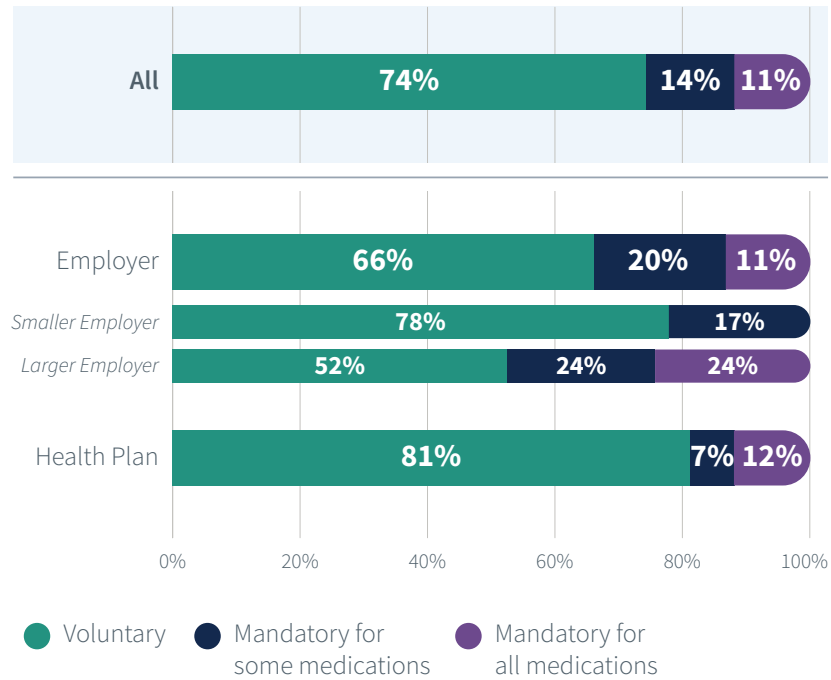


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Retail 90 and Mail-Order Design

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 31** and **32**).

Figure 31 Retail 90 Design (n=114)

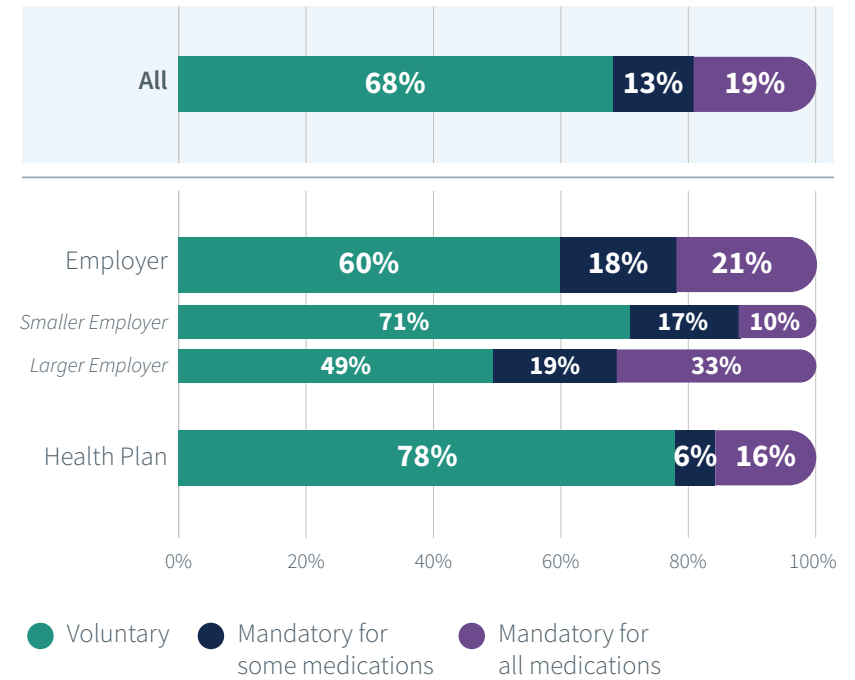


Not shown: 2% of respondents were not sure what design was used for this channel.

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Health plans were more likely than others to allow voluntary use of these channels, while larger employers were more likely than others to make use of these channels mandatory for some or all medications. Compared to last year, more plans used mandatory for all medications arrangements for these channels, with increases a little over 5% overall in both channels.

Figure 32 Mail-Order Design (n=143)



Not shown: 1% of respondents were not sure what design was used for this channel.

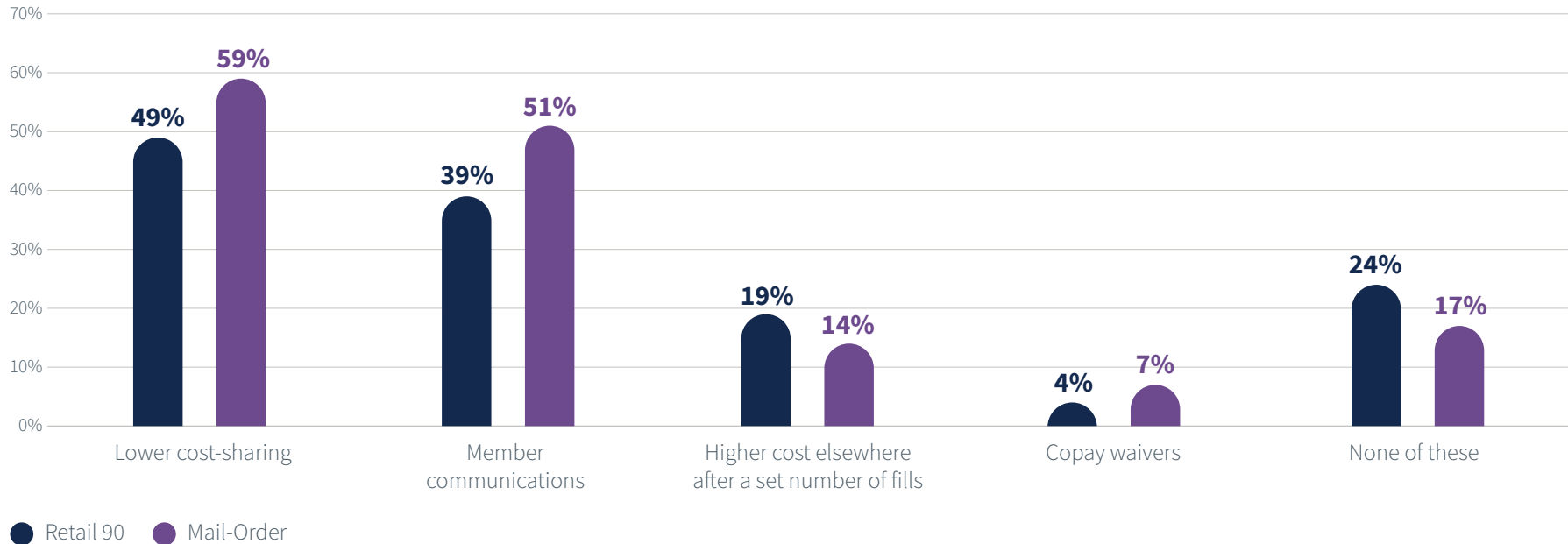
Pharmaceutical Strategies Group. 2023 Trends in Drug Benefit Design Report. Dallas, TX: PSG.

Strategies for Increasing Retail 90 and Mail-Order Utilization

When asked about strategies used to encourage utilization of retail 90 and mail-order channels, most respondents selected at least one strategy (see **Figure 33**). Lower cost sharing and member communications were the most commonly used strategies, and copay waivers were used the least. For the retail 90 channel, compared to last year, this year's results

showed decreased percentages using lower cost sharing and member communication strategies and a higher percentage using the strategy of instituting a higher cost elsewhere after a set number of fills. The mail-order channel did not demonstrate any notable year-over-year changes.

Figure 33 Strategies Used to Increase Retail 90 and Mail-Order Utilization (retail 90: n=84, mail-order: n=97)

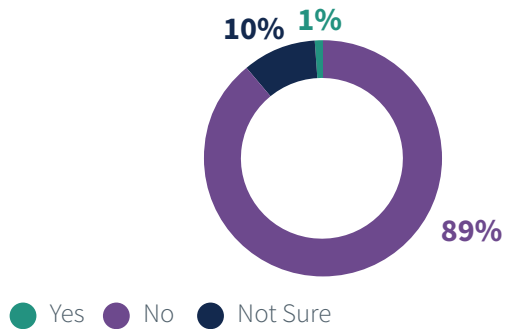


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Deductibles

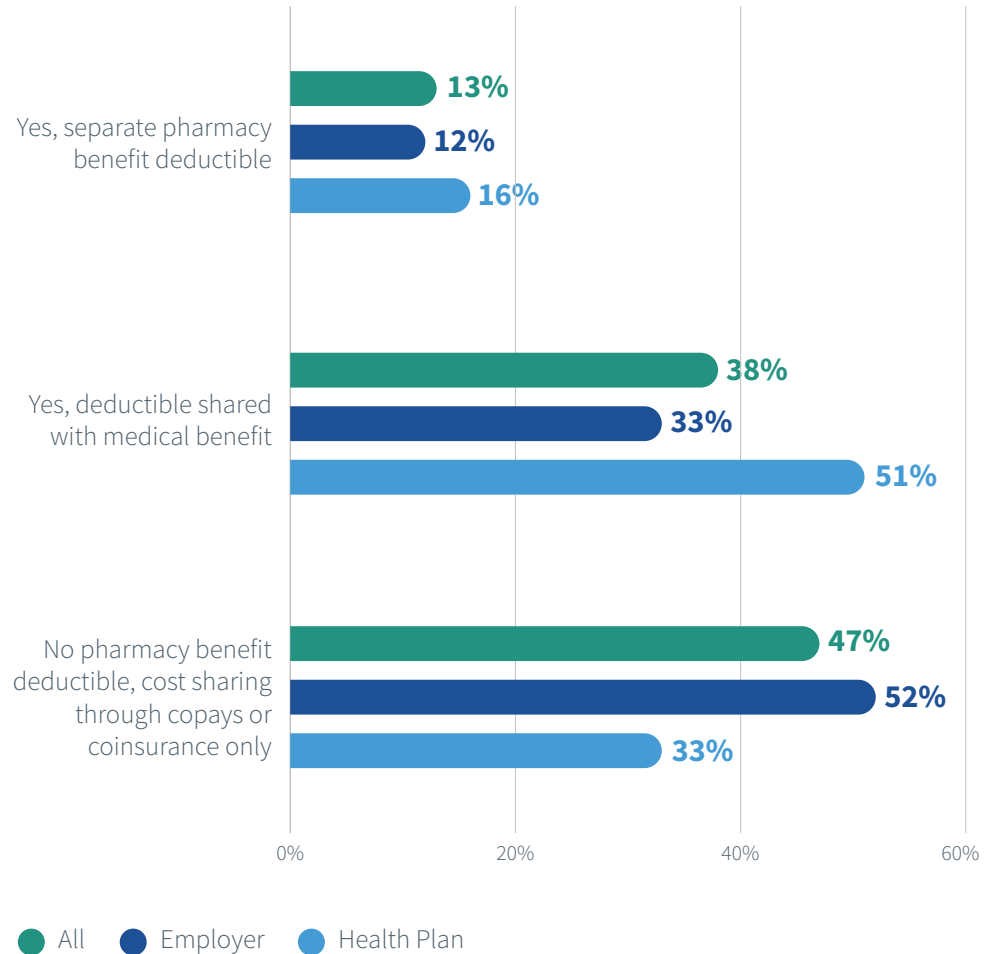
Another cost-sharing mechanism is a deductible, which requires the member to pay up to a specified amount prior to the plan covering any portion of their medication costs. Just over half of plans had a pharmacy benefit deductible, with a higher rate among health plans compared to employers (see **Figure 34**). This represents an increase compared to last year, when just 41% of plans reported using a pharmacy benefit deductible. Most plans with a pharmacy benefit deductible used a deductible shared with the medical benefit rather than a separate deductible. Among plans that did not use a pharmacy deductible, almost none were actively considering adding one in the next few years (see **Figure 35**).

Figure 35 Considering Adding a Pharmacy Benefit Deductible (n=70)



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Figure 34 Use of Deductible for Pharmacy Benefit (n=149)



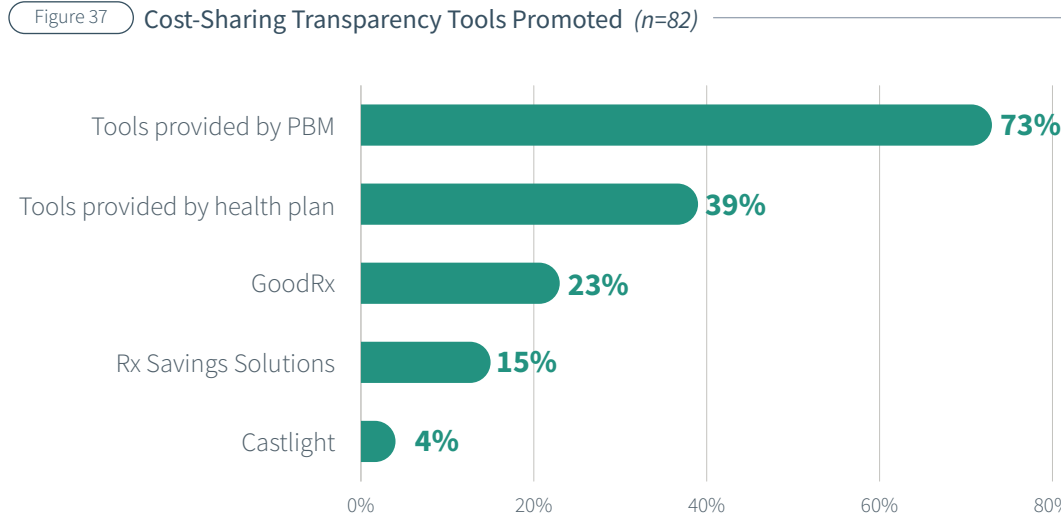
Not shown: 1% of respondents were not sure whether the plan had a pharmacy benefit deductible.

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Cost-Sharing Transparency Tool Promotion

Cost-sharing transparency tools can play an important role in helping members manage their cost sharing. In this year's survey, 63% of respondents reported they promote cost-sharing transparency tools, with no notable differences between employers and health plans or by size of employer. This year's result continues an upward trend in promotion of cost-sharing transparency tools (see **Figure 36**), likely driven by increases in the number of tools available and in education about these tools. Among those who indicated they promote cost-sharing transparency tools, 85% reported that the tools they use show the member their actual out of pocket costs based on their specific plan design.

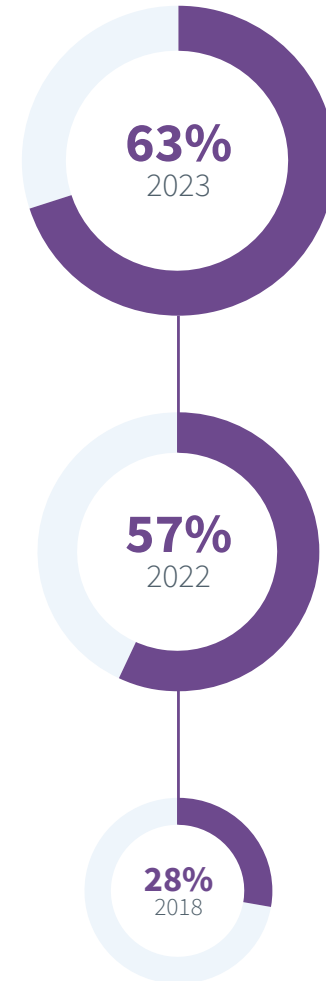
As shown in **Figure 37**, plans most commonly promoted cost-sharing transparency tools provided by their PBM or health plan, followed by GoodRx and Rx Savings Solutions.



Not shown: 4% selected other and filled in the names of other providers of cost-sharing transparency tools.

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Figure 36 Promotion of Cost-Sharing Transparency Tools (n=131)

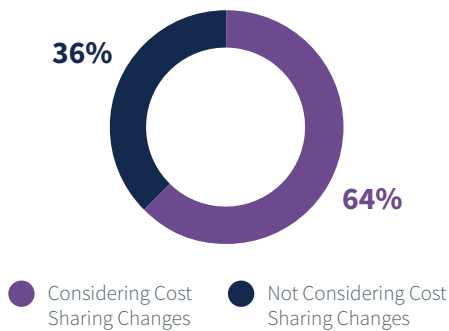


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Cost Sharing Changes

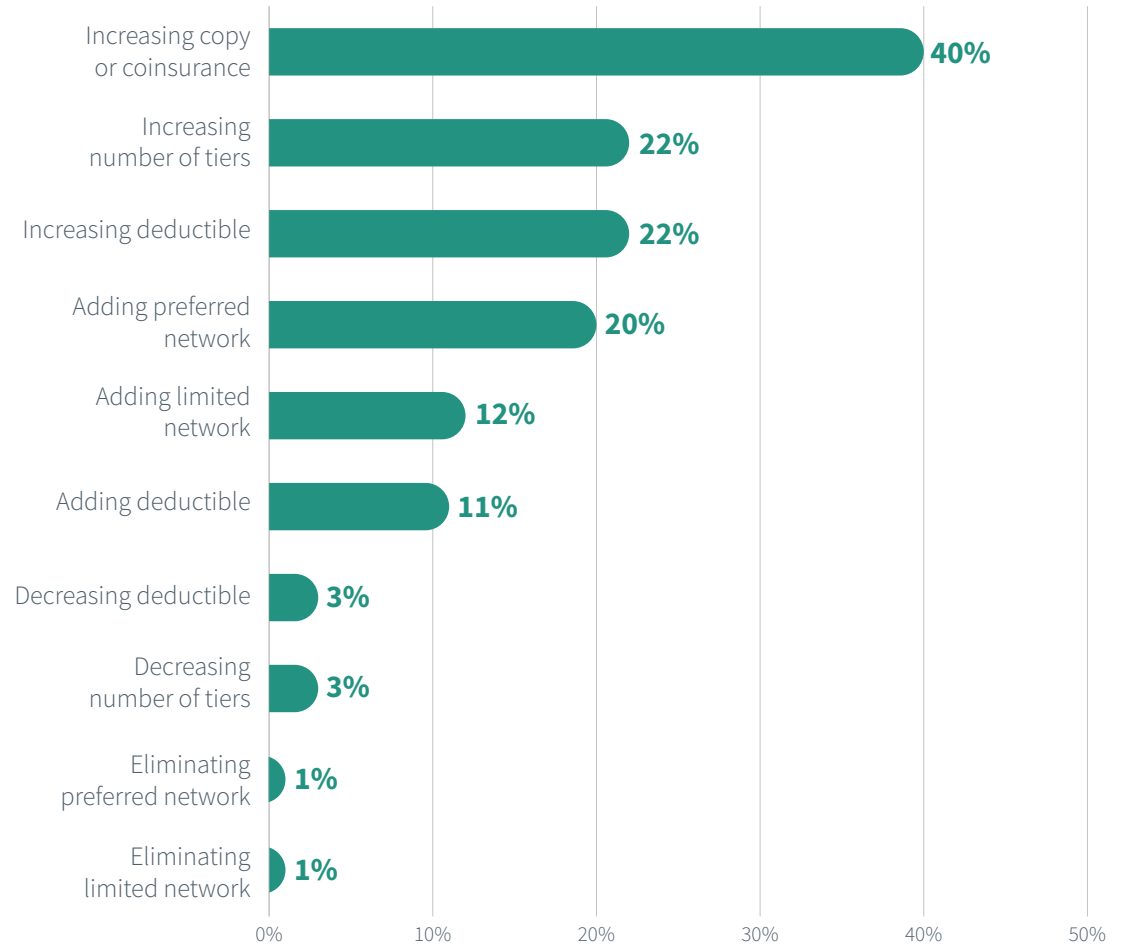
The majority of respondents were considering at least one change to their cost sharing arrangements (see **Figure 38**). As shown in **Figure 39**, the most commonly selected changes under consideration were increasing copay or coinsurance amounts, increasing the number of drug tiers, increasing the deductible, and adding a preferred network. Health plans were more likely than employers to be considering each of these most commonly selected changes. For example, 35% of health plans were considering increasing the deductible compared to just 17% of employers.

Figure 38 Considering Cost Sharing Changes (n=149)



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Figure 39 Cost Sharing Changes Under Consideration (n=149)



Not shown: 2% of respondents selected "other" and described changes not included on this list.

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Cost Sharing Decision Influences

Decisions about cost sharing structures and amounts can be complex, and respondents reported many sources that influence these decisions. As shown in **Table 2**, PBM or health plan recommendations was selected by the largest percentage of respondents, followed by claims history, corporate budgets, and consultant or broker recommendations.

Responses differed by respondent group. For example, employers were more likely than health plans to select consultant or broker recommendations, while health plans were more likely than employers to select member cost-sharing targets.

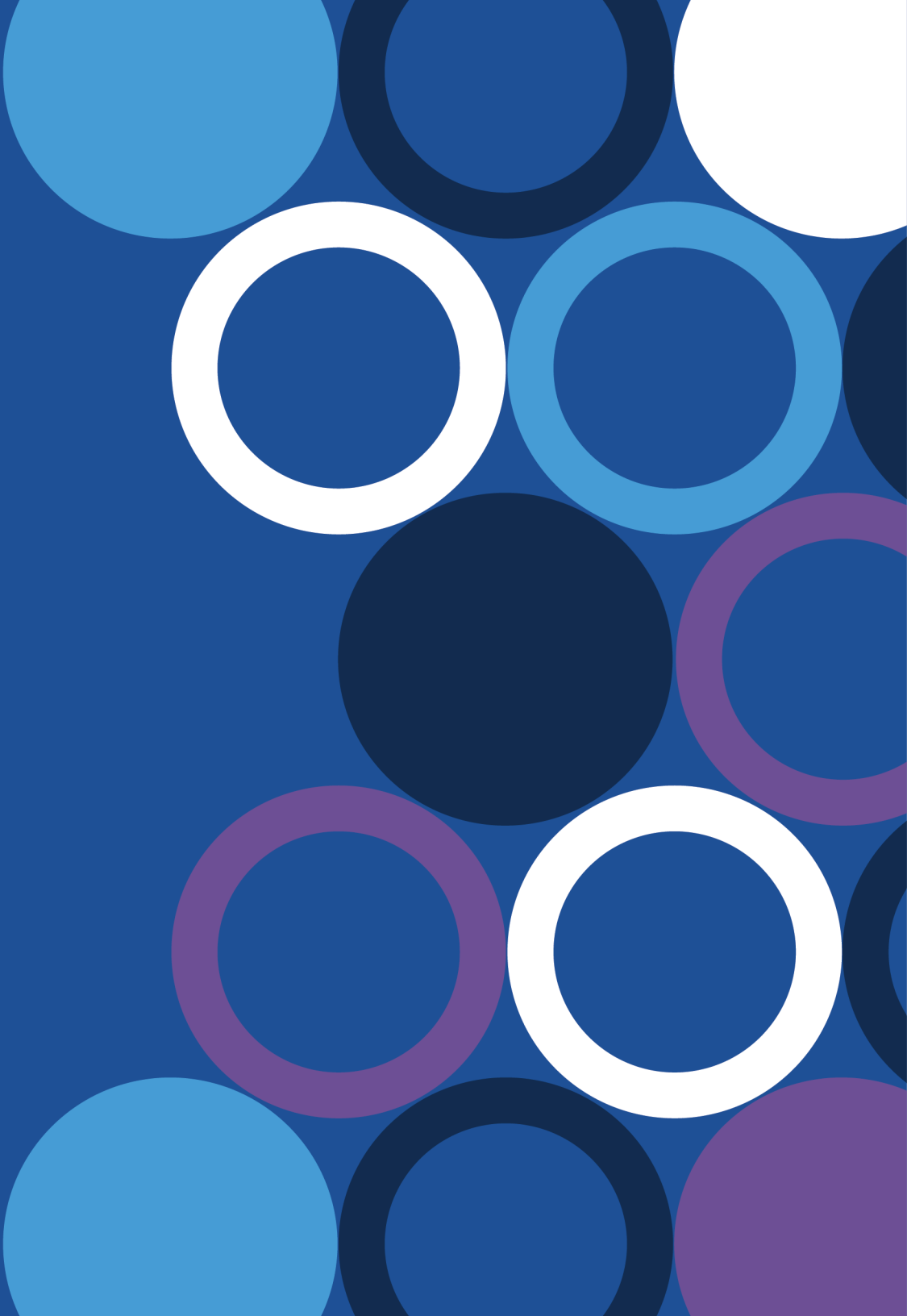
Table 2 Influences for Decisions about Cost Sharing (n=149)

Cost-Sharing Decision Influences	All	Employer	Health Plan
PBM or health plan recommendations	62%	58%	69%
Claims history	45%	43%	45%
Corporate budgets	44%	53%	35%
Consultant or broker recommendations	44%	51%	31%
Industry-specific benchmarks	42%	44%	39%
Corporate benefits objectives	42%	46%	37%
Corporate benefits philosophy	38%	42%	31%
Member cost-sharing targets	32%	26%	43%
Population health forecasts and strategies	22%	26%	20%

Not shown: 1% of respondents selected "other" and described a source of influence not included in this list.

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**Formularies and Utilization
Management Programs**

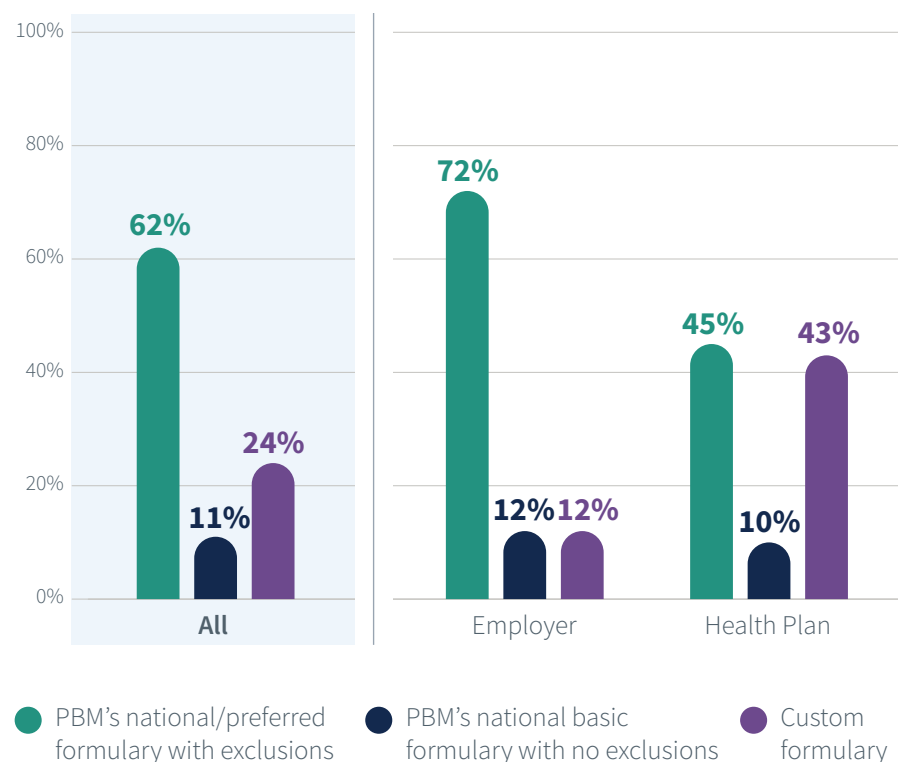


Types of Formularies

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 10 (*critical tool*), respondents' mean rating was 7.5 (employer: 7.3, health plan: 7.8), and 34% of respondents selected either 9 or 10.

Plans 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 40**, 73% of respondents used their PBM's national formulary with or without exclusions, while 24% used a custom formulary (up from 17% last year). 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. Within the employer group, smaller employers were more likely than larger employers to use their PBM's national formulary with exclusions (79% vs. 66%) and less likely to use a custom formulary (4% vs. 19%).

Figure 40 Type of Formulary Used (n=153)



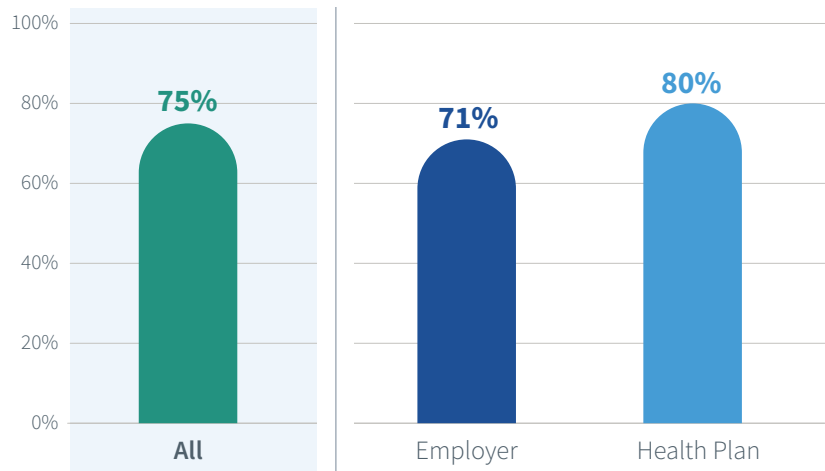
Not shown: 1% of respondents selected "other," and 3% were not sure what type of formulary the plan used.

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Formulary Exclusions: Use and Challenges

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 41**, among respondents who were aware of whether the plan had formulary exclusions for traditional (non-specialty) medications, 75% reported the plan had these exclusions, with a higher rate among health plan respondents compared to employer respondents. Within the employer group, larger employers were somewhat more likely than smaller employers to have formulary exclusions (74% vs. 67%). This year's results represent a slight decrease in the percentage of respondents reporting use of formulary exclusions (from 81% in 2022).

Figure 41 Use of Formulary Exclusions (n=129)



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Figure 42 Formulary Exclusion Challenges Ranking (n=95)

1	Member dissatisfaction
2	Clinical disruption
3	Appeals
4	Adherence
5	Physician complaints
6	Timing of new formulary decisions
7	Implementation issues

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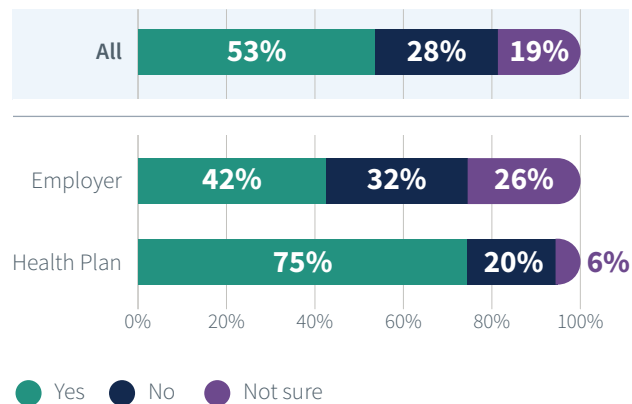
Although they can provide benefits, formulary exclusions also present challenges. When asked to rank challenges with formulary exclusions, respondents indicated that member dissatisfaction was the greatest challenge, followed by clinical disruption (see **Figure 42**).

Identifying and Reducing Wasteful Formulary Spend

When formularies include drugs that are therapeutically appropriate but cost substantially more for the same clinical benefit as therapeutic alternatives — what we call high-cost, low-value drugs — wasteful drug spend can occur. Examples of types of drugs that may be high-cost, low-value include me-too drugs (making minor modifications to create a “new” drug that does not add substantial clinical value), combination drugs (combining multiple active ingredients in a single drug, often at higher cost than when prescribed separately), prescription drugs where OTC alternatives are available, and brand name or higher cost generic drugs where lower cost generics are available.

As shown in **Figure 43**, 75% of health plans and 42% of employers reported they currently take steps to identify and reduce wasteful drug spend within the formulary. Within the employer group, larger employers were much more likely than smaller employers to be taking this action (54% vs. 30%). We asked those who were taking steps to identify and reduce wasteful drug spend within the formulary what those steps were, and their responses revealed 4 primary themes: blocks or exclusions, utilization management and other PBM programs, data monitoring and reviews, and reporting from their PBM (see **Table 3**). Emphasizing generics, fraud waste and abuse (FWA) programs, and education/communication were also mentioned by a few respondents each.

Figure 43 Takes Steps to Identify and Reduce Wasteful Spend in Formulary (n=152)



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Table 3 Steps Taken to Identify and Reduce Wasteful Spend in Formulary

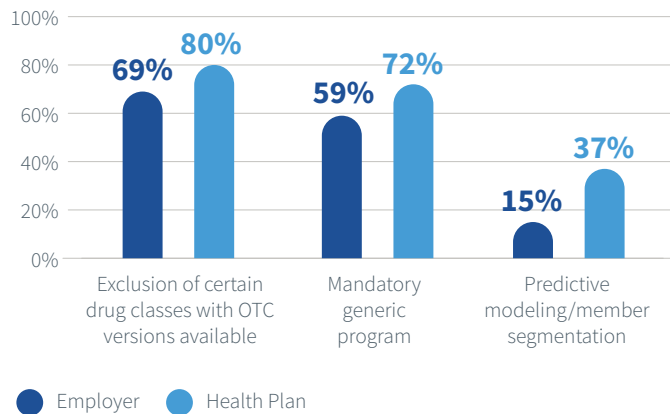
Theme	Example Comment
Blocks or Exclusions	<i>“Review new NDC numbers released through Medi-Span and block formulary drugs that are priced significantly higher than the market.”</i>
Utilization Management and Other PBM Programs	<i>“We have step therapy, prior authorization, or targeted generic step therapy on a range of wasteful, low-value medications. In addition, we use the PBM’s hyperinflation management list to keep from covering extremely high cost, inflated drugs that offer no real clinical value.”</i>
Data Monitoring and Reviews	<i>“Constant reviews of our usages and staying on top of new generics in market.”</i>
Reporting from PBM	<i>“PBM analysis of usage vs condition being treated.”</i>

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Trend and Utilization Program Use

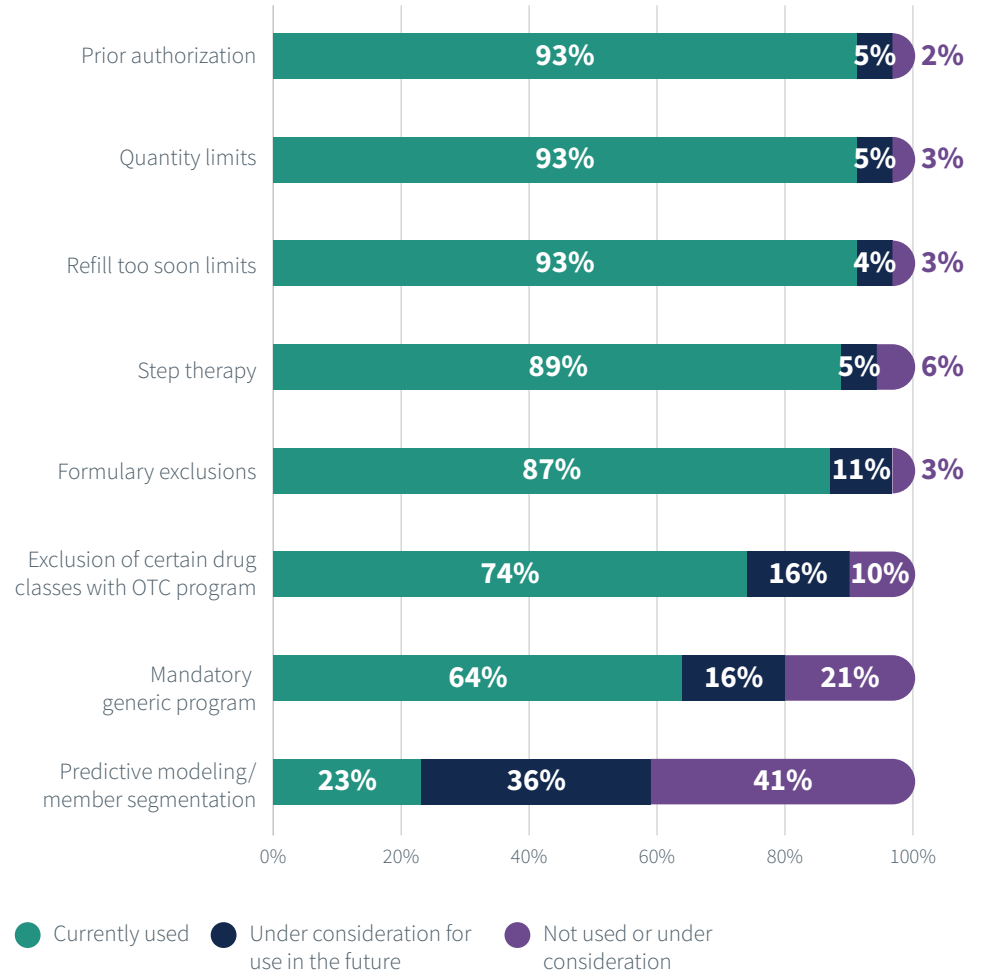
Plans can choose to use a variety of trend and utilization management programs. As shown in **Figure 44**, nearly all plans used prior authorization, quantity limits, and refill too soon limits. The vast majority also used step therapy and formulary exclusions. Health plans were more likely than employers to use several of the less ubiquitous programs (see **Figure 45**). Additionally, larger employers were more likely than smaller employers to use formulary exclusions (89% vs. 79%), a mandatory generic program (69% vs. 49%), and exclusion of certain drug classes with OTC versions available (76% vs. 63%).

Figure 45 Employer-Health Plan Differences in Trend and Utilization Program Use



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Figure 44 Trend and Utilization Program Use (n=152)

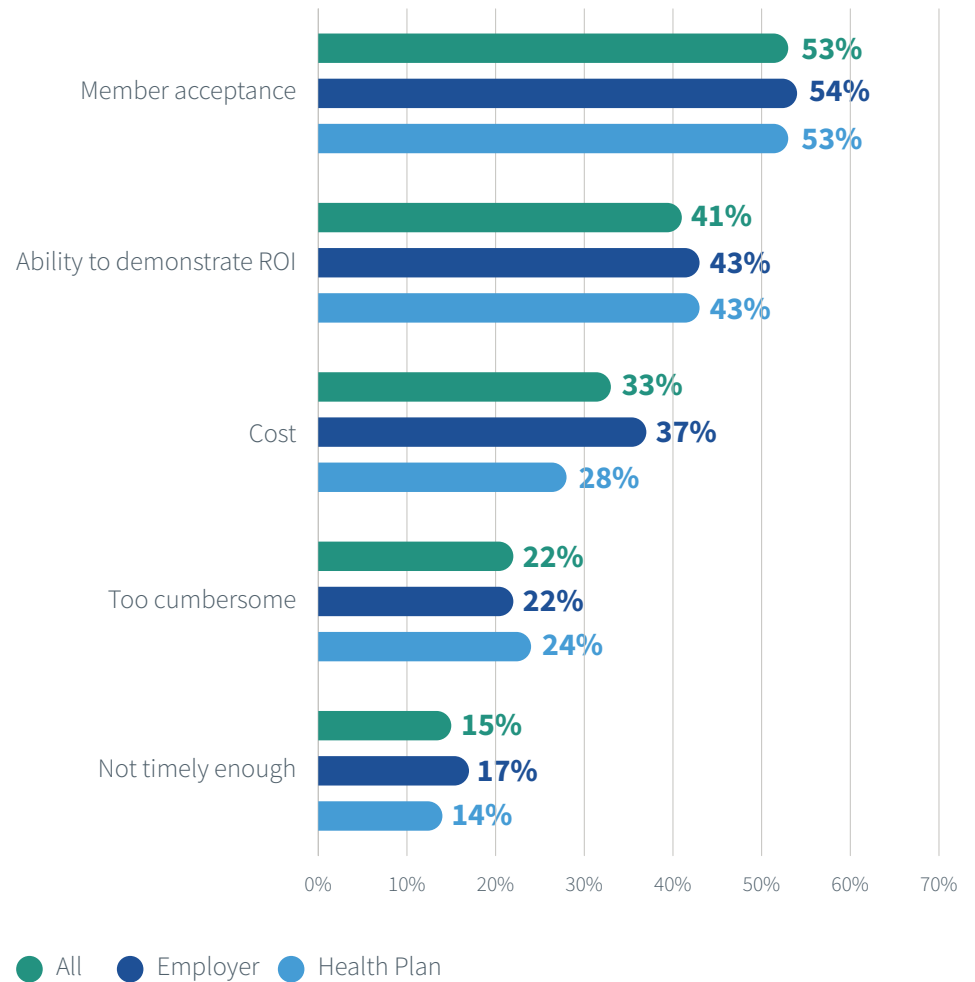


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Trend and Utilization Program Barriers

Although use of trend and utilization programs is high, plans still face obstacles in this area. Most respondents reported experiencing at least one barrier, and member acceptance was the most frequently cited barrier (see **Figure 46**). Compared to last year, greater percentages of respondents reported barriers of cost (33% vs. 22%) and cumbersomeness (22% vs. 9%). Employers were more likely than health plans to cite cost as a barrier, and within the employer group, larger employers were more likely than smaller employers to report this barrier (41% vs. 32%). Larger employers were also more likely than smaller employers to report lack of timeliness as a barrier (22% vs. 13%).

Figure 46 Trend and Utilization Program Barriers (n=152)



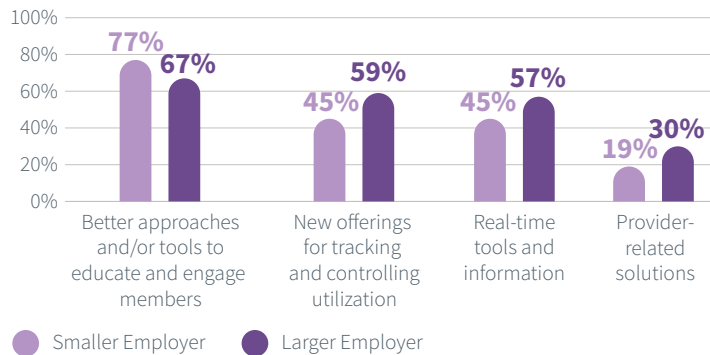
Not shown: 17% of respondents said they had no barriers, and 4% of respondents selected "other."

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Desires for Trend and Utilization Programs

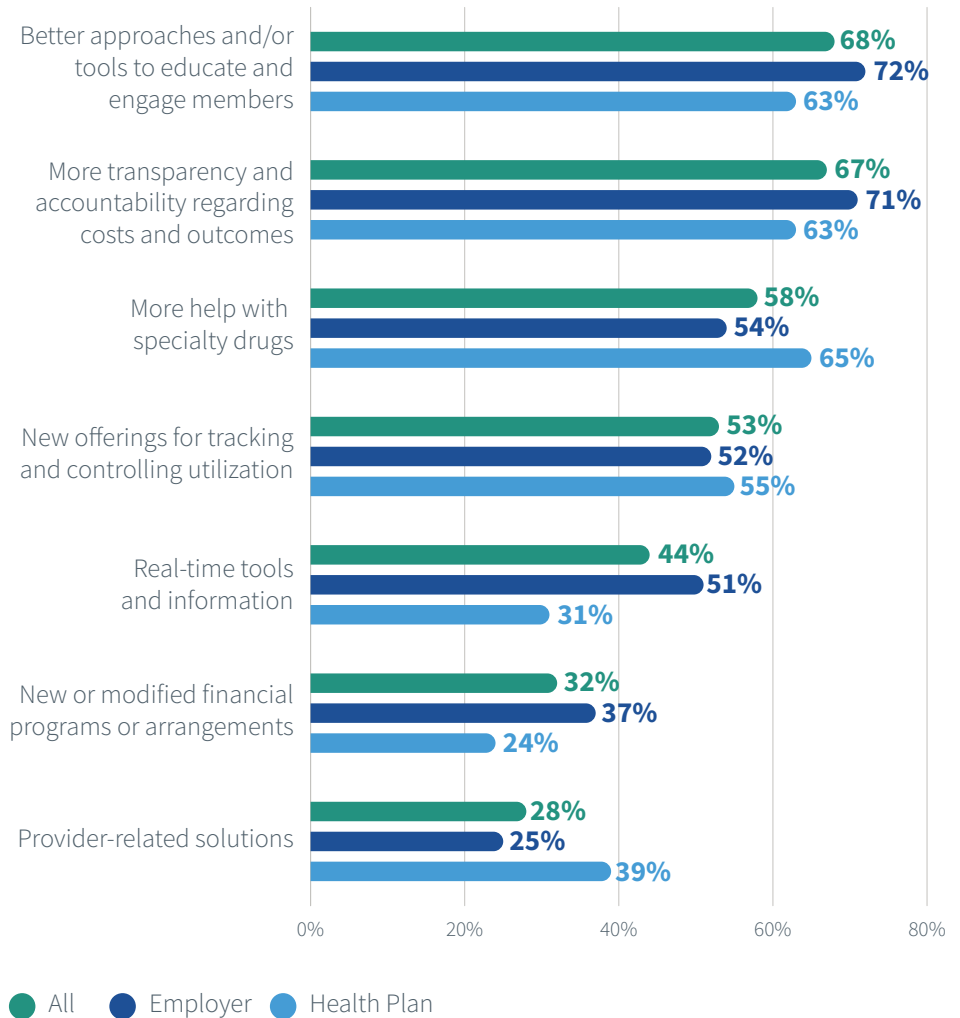
We also asked respondents what new trend and utilization programs or improvements or changes to current programs they would like to see (see **Figure 47**). About two-thirds of respondents wanted better approaches and/or tools to educate and engage members and more transparency and accountability regarding costs and outcomes. Over half wanted more help with specialty drugs and new offerings for tracking and controlling utilization. The percentages of respondents endorsing each item differed notably between employers and health plans. For example, health plans were more likely than employers to want more help with specialty drugs and provider-related solutions, while employers were more likely than health plans to want real-time tools and information and new or modified financial programs or arrangements. Smaller and larger employers also differed on several of these items (see **Figure 48**).

Figure 48 Employer Size Differences in Desired Improvements for Trend and Utilization Programs



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Figure 47 Desired Improvements for Trend and Utilization Programs (n=152)



Not shown: 4% of respondents said they weren't looking for any changes and 3% selected "other."

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Drug Access and Pricing

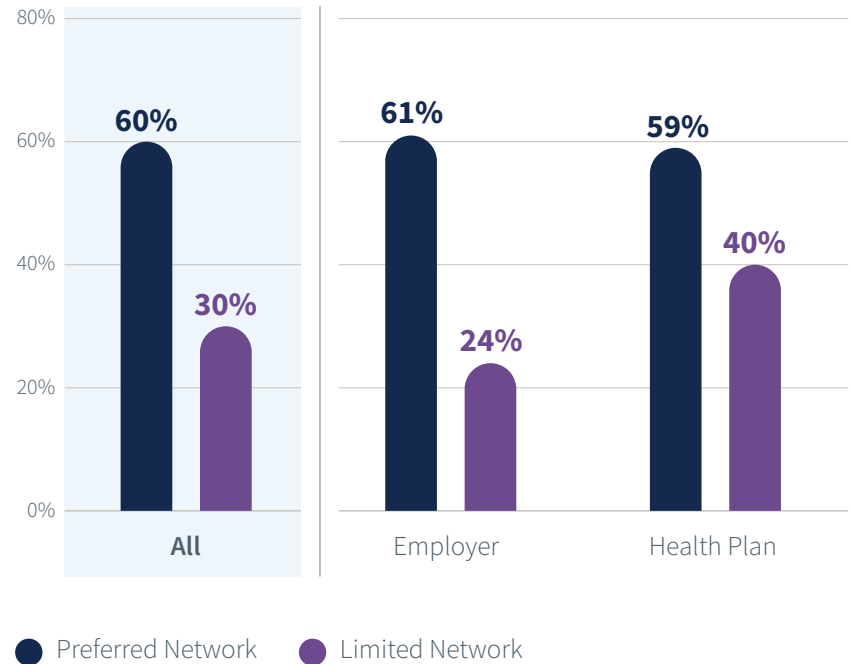


Pharmacy Network Designs

Deciding how drugs covered under the pharmacy benefit will be paid for and determining where members can access those drugs are complex aspects of drug benefit design. PBMs contract with retail pharmacies on behalf of plans, and those contracts have 2 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 49**, 60% of plans used a preferred network, and 30% used a limited network. Compared to last year, these results show a decline in use of preferred networks (from 68% in 2022) and an increase in use of limited networks (from 19% in 2022). Health plans were more likely than employers to use a limited network, and within the employer group, larger employers were more likely than smaller employers to use a limited network (31% vs. 17%).

Figure 49 Retail Network Design (n=153)

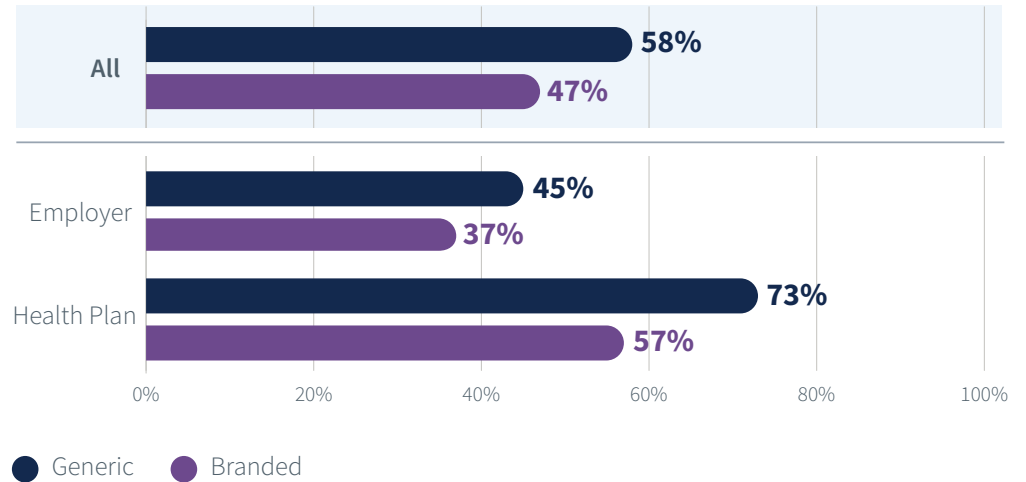


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Discounts

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. A little under two-thirds of plans had a guaranteed generic discount (see **Figure 50**), and the average discount off AWP ranged from 40% to 75% based on channel (see **Table 4**). The average discount amounts have continued to increase year over year, likely due to greater competitiveness in the market driving PBMs to offer greater discounts. For branded medications, just under half of plans had a guaranteed discount (see **Figure 50**), and the average discount off AWP ranged from 19% to 24% (see **Table 4**).

Figure 50 Have Guaranteed Discounts (generic: n=109, branded: n=108)



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Table 4 Average Discount Off AWP

	Retail 30	Retail 90	Mail Order
Generic	72%	75%	75%
Branded	19%	23%	24%

Note: Ns vary based on type and channel, ranging from 22 to 35.

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Maximum Allowable Cost Pricing

Another pricing metric is the Maximum Allowable Cost (MAC) price, the maximum payment amount for a given generic medication. As shown in **Table 5**, respondents' overall use of MAC pricing ranged from 24% for specialty generics to 57% for retail 30 generics, with substantial differences based on respondent group. Within the employer group, larger employers were more likely than smaller employers to use MAC pricing for retail 30 generics (62% vs. 53%).

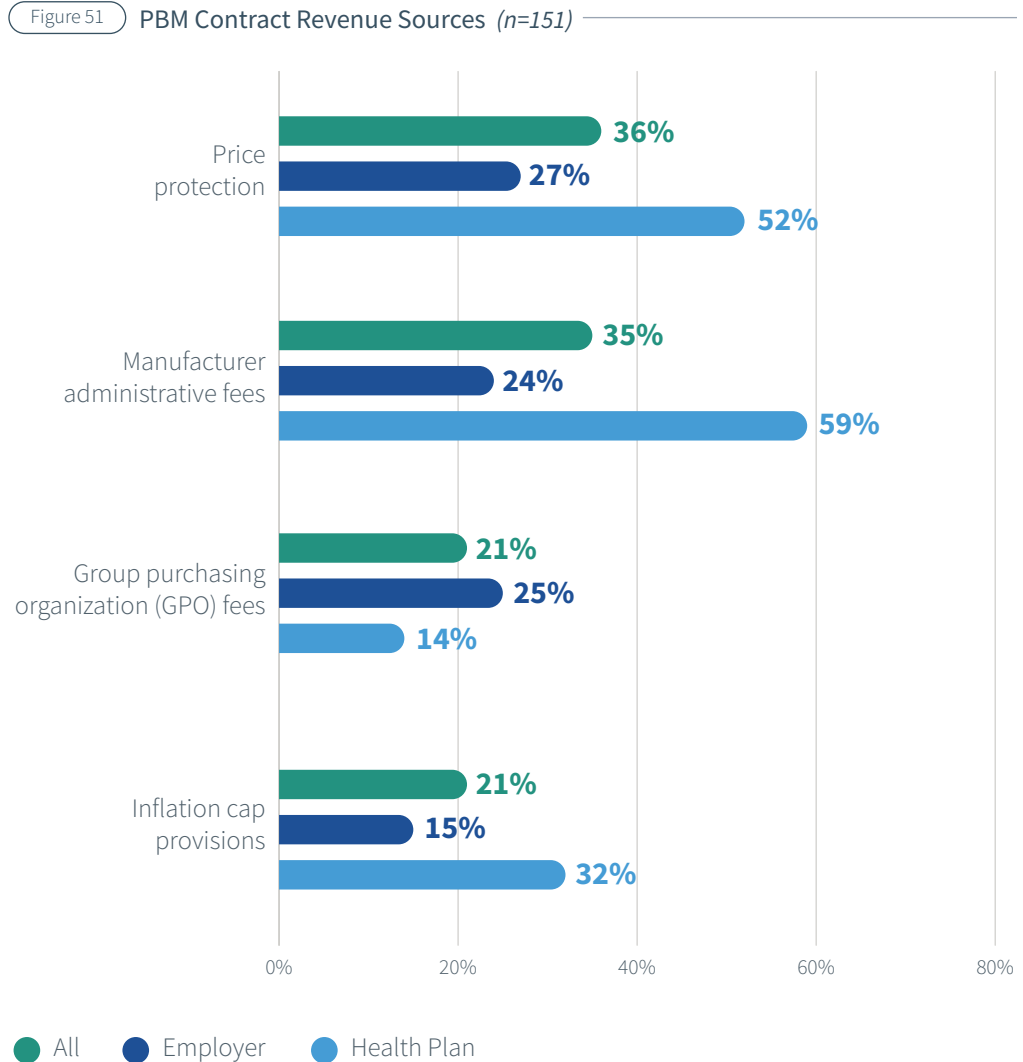
Table 5 Use of MAC Pricing (n=153)

	All	Employer	Health Plan
Retail 30 generics	57%	57%	63%
Retail 90 generics	53%	52%	61%
Mail-order generics	48%	47%	57%
Specialty generics	24%	17%	39%
Not sure	26%	27%	18%
None of these	11%	11%	10%

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Price Protection Provisions

Price protection provisions are sometimes included in PBM contracts to provide some cost stability by capping 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 51**, a minority of respondents reported that their PBM contract included these revenue sources. Employers were more likely than health plans to have contracts that included GPO fees, and health plans were more than employers to have contracts that included price protection, manufacturer administrative fees, and inflation cap provisions. Among those whose PBM contracts mentioned such provisions, 81% said the revenue gets passed back to the plan, and of those, 66% said an outside party validates the accuracy of the revenue passed back to the plan.

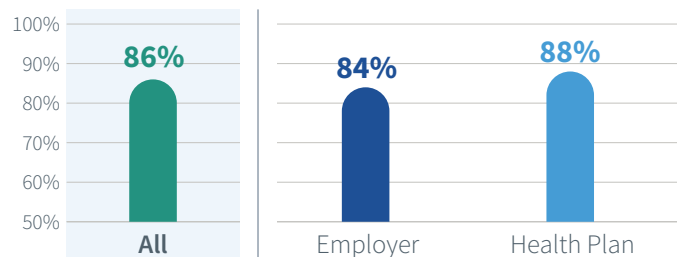


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Rebates

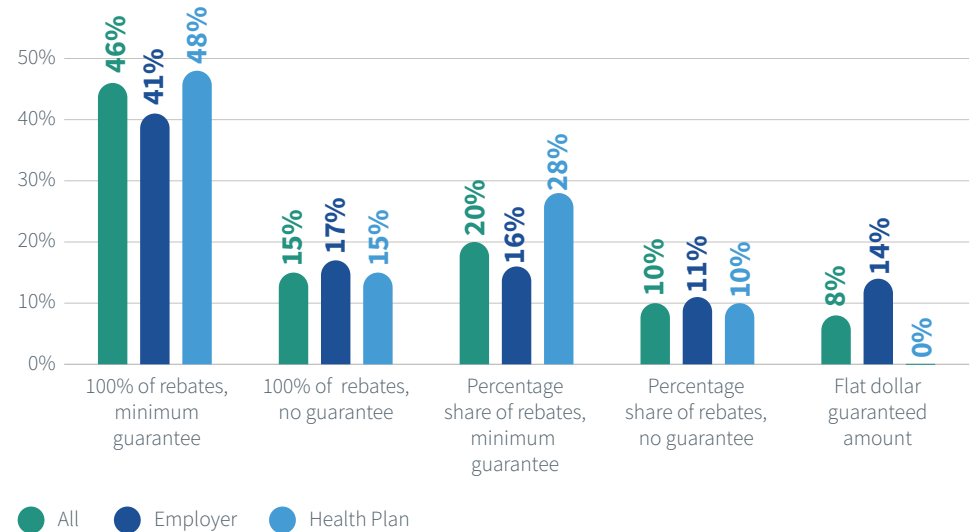
Rebates are typically negotiated as part of formulary contracting agreements, and a portion or all of the savings may be passed on to the plan. Rebate terms vary based on how the PBM contract is written. Contracts may guarantee a flat dollar amount or a percentage share of rebates, with or without minimum guarantees. The vast majority of respondents received rebates on traditional (non-specialty) drugs (see **Figure 52**). Within the employer group, larger employers were more likely than smaller employers to receive these rebates (93% vs. 74%). Across respondent groups, the most common rebate arrangement was 100% of rebates with a minimum guarantee (see **Figure 53**). As shown in **Figure 54**, smaller and larger 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 52 Receipt of Traditional (Non-Specialty) Drug Rebates (n=144)



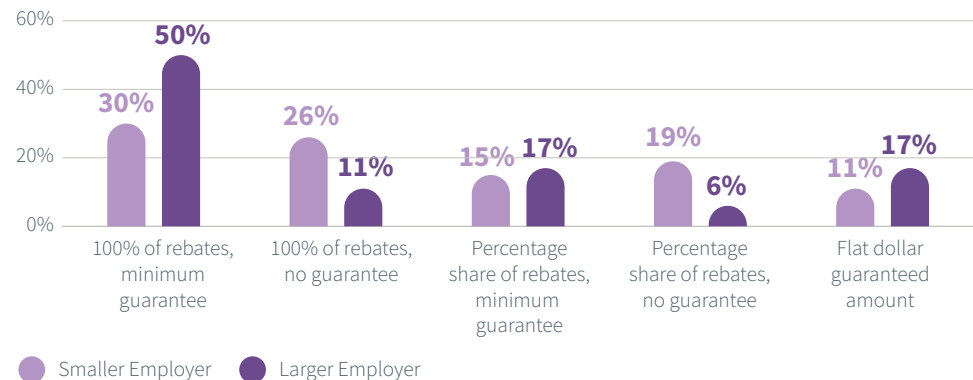
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Figure 53 Traditional (Non-Specialty) Drug Rebate Structure (n=110)



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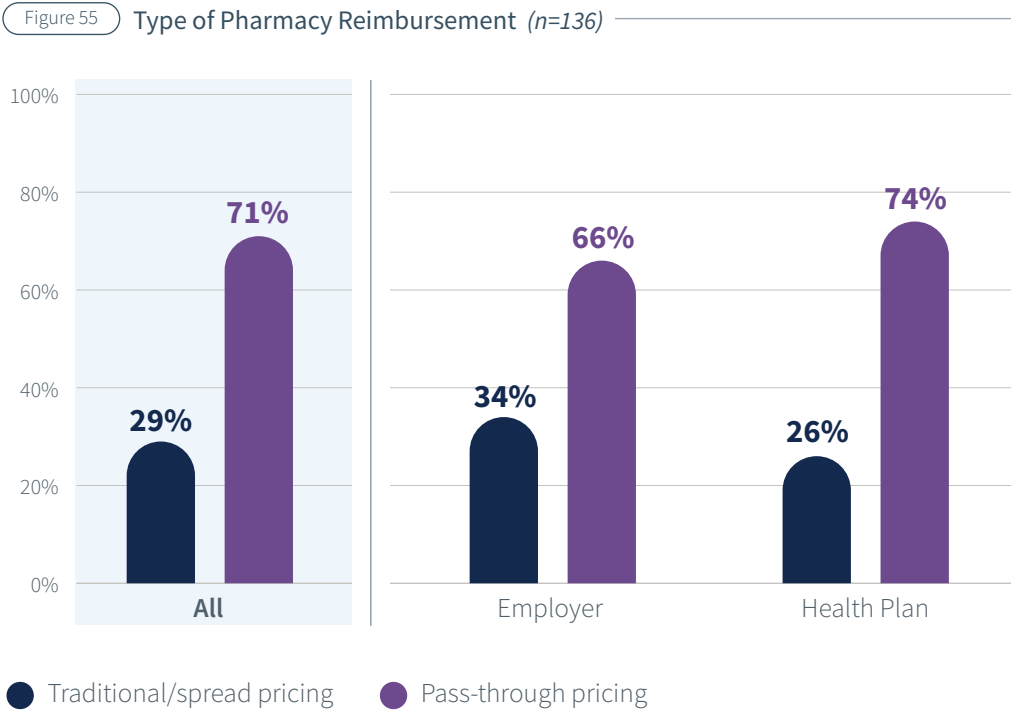
Figure 54 Rebate Structure by Employer Size (n=63)



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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 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 compensates the PBM. In pass-through pricing, the PBM provides all discounts, rebates, and other revenues to the plan and is compensated through administrative fees. As shown in **Figure 55**, 71% of plans used pass-through pricing, with a somewhat lower rate among employers compared to health plans. Within the employer group, smaller employers were more likely than larger employers to use pass-through pricing (71% vs. 61%).



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**Spotlight: Member-Related
Solutions and Other Current
Plan Considerations**

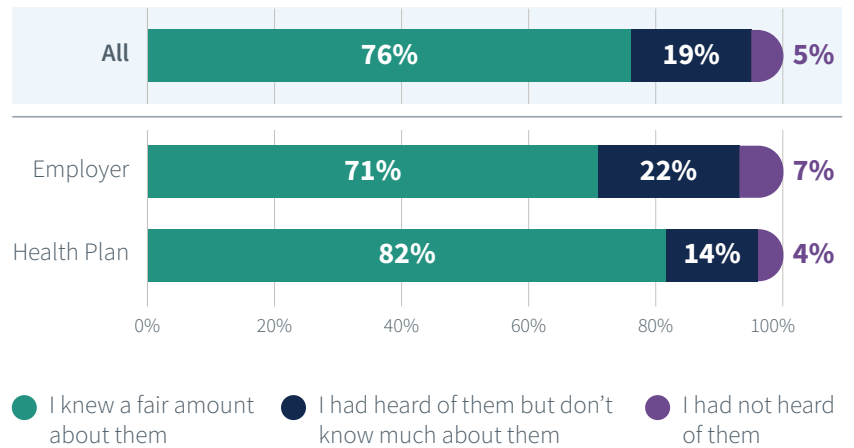


Copayment Assistance Programs: Awareness and Perceived Sustainability

Many pharmaceutical manufacturers offer copayment assistance programs, which help patients afford prescription drugs by covering some or all of their copay for specific higher cost medications. While these programs may help members afford expensive medications and stay adherent to therapy, stakeholders have concerns about potential impact to plans' formulary strategy and plans accessing dollars intended for patients.

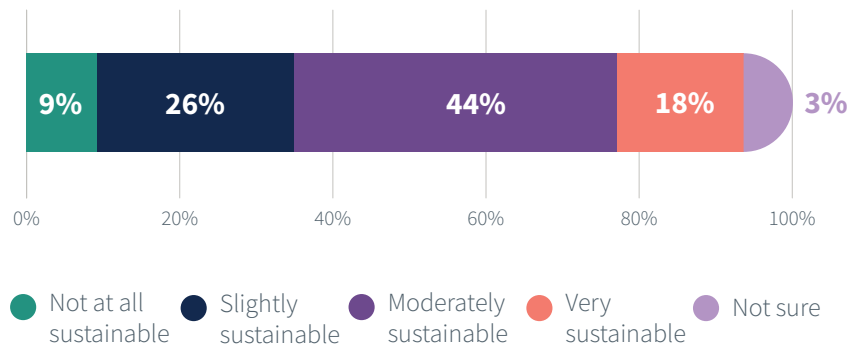
As shown in **Figure 56**, nearly all respondents had heard of copayment assistance programs, and most knew a lot about them. When asked how sustainable they believed these programs to be, respondents expressed just moderate confidence in the programs' sustainability: 35% believed copayment assistance programs are not at all or only slightly sustainable, and just 18% believed they are very sustainable (see **Figure 57**).

Figure 56 Awareness of Copayment Assistance Programs (n=149)



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Figure 57 Perceived Sustainability of Copayment Assistance Programs (n=140)

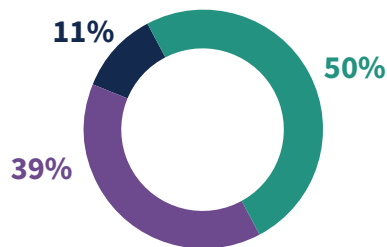


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Copayment Assistance Programs: Potential Reductions

We also asked respondents whether they had heard that pharmaceutical manufacturers may reduce their offerings of copayment assistance and manufacturer coupon programs. As shown in **Figure 58**, half of respondents had heard about this. We asked those who had heard about the potential reductions what concerns, if any, they had about these changes. As shown in **Table 6**, respondents' answers revealed 4 primary concern themes: member costs, plan costs, member non-adherence, and member dissatisfaction. Interestingly, a substantial portion of respondents indicated they had no concerns, and some explicitly stated their objections to these programs (see example in **Table 6**).

Figure 58 Have Plans Heard About Reductions in Copayment Assistance and Manufacturer Coupon Programs (n=141)



● Yes ● No ● Not Sure

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Table 6 Concerns About Potential Reductions in Copayment Assistance and Manufacturer Coupon Programs

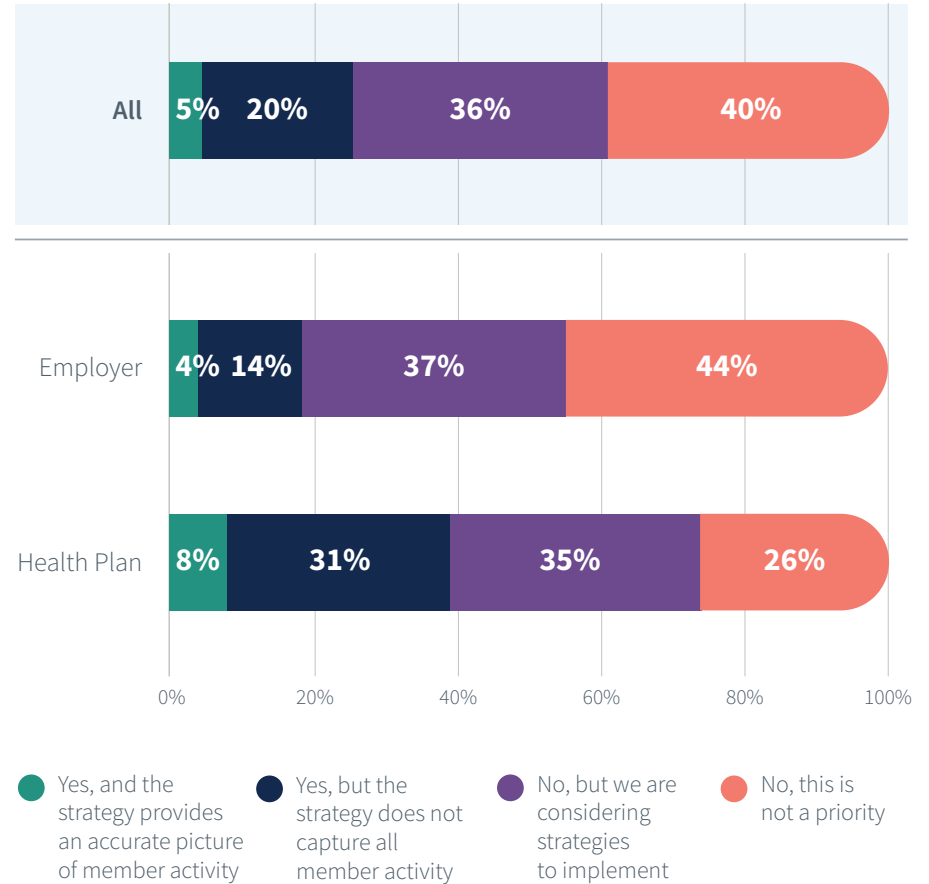
Theme	Example Comment
Member Costs	<i>"Members may now have a financial barrier to overcome that was not present when using the coupon."</i>
Plan Costs	<i>"These programs have become a large cost savings for our plans. If they are phased out, we will have to find new solutions."</i>
Member Non-Adherence	<i>"I have concerns that this would cause some employees to stop using these critical medications if they do not receive discounts from manufacturers."</i>
Member Dissatisfaction	<i>"Patients don't understand the intricacies of this type of program and will be upset when their copay goes back to its original amount."</i>
No Concerns	<i>"I hate these things. They push members to more expensive medications. They should be illegal and I'm glad to see them go."</i>

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Member Activity Outside the Pharmacy Benefit

Plan members increasingly have access to non-insurance payment options to obtain prescriptions (Amazon RxPass, discount cards, etc.). We asked respondents whether they have a strategy in place to capture and track member activity that occurs outside of the pharmacy benefit. As shown in **Figure 59**, just 25% of plans have such a strategy, and only 5% have a strategy that provides an accurate picture of member activity. Health plans were more likely than employers to have a strategy in this area, and within the employer group, larger employers were more likely than smaller employers to have a strategy (27% vs. 11%).

Figure 59 Does Plan Have Strategy for Tracking Member Activity Outside the Pharmacy Benefit (n=149)



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Consumer-Oriented Affordability Solutions

Consumer-oriented affordability solutions come from various stakeholders in the pharmacy industry, from pharmaceutical manufacturers to pharmacies to companies created explicitly for the purpose of addressing medication affordability. With a rapidly evolving landscape of consumer-oriented affordability solutions, plans have much to track and consider. As shown in **Table 7**, most respondents

were familiar with each of the solutions presented, but the majority were not currently implementing or considering implementing a strategy for them. However, there were a few exceptions to these overall trends: nearly a quarter of respondents were not aware of PBM prescription discount coupons and over half were either implementing or considering implementing a strategy for manufacturer-sponsored programs.

Table 7 Consumer-Oriented Affordability Solutions: Familiarity and Strategy (n=149)

Consumer-Oriented Affordability Solution	Currently implementing a strategy	Considering implementing a strategy	Familiar, but no strategy in place or under consideration	Not familiar
Digital/virtual pharmacy, also referred to as “online” or “mail-order” pharmacy (e.g., Mark Cuban’s Cost Plus Drugs, Amazon RxPass)	10%	13%	64%	14%
Third-party discount card, also referred to as “discount card” or “cash discount card” (e.g., GoodRx, SingleCare)	22%	9%	66%	2%
Manufacturer-sponsored programs (“manufacturer copay coupons” or “copayment assistance programs”)	41%	14%	42%	3%
PBM prescription discount coupons	14%	17%	46%	23%
Pharmacy-specific cash discount cards (e.g., Walgreens Prescription Savings Club, Optum Perks)	9%	12%	62%	16%

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Consumer-Oriented Affordability Solutions: Barriers

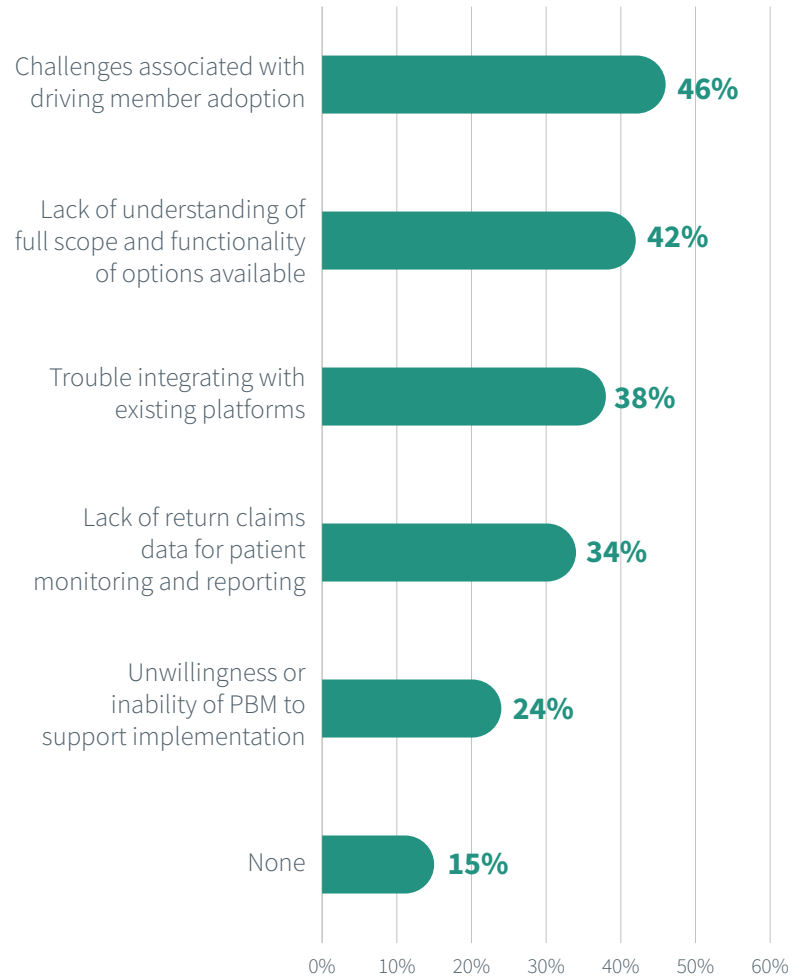
Although consumer-oriented affordability solutions can present opportunities, barriers may impede or prevent plans from incorporating these solutions into their benefit design. As shown in **Figure 60**, just 15% of respondents said they currently experience no barriers to incorporating these solutions into the benefit design, and the most common barriers were challenges associated with driving member adoption and lack of understanding of the full scope and functionality of options available. Experience of some of these barriers — e.g., unwillingness or inability of PBM to support implementation — varied notably by organization type (see **Table 8**).

Table 8 Consumer-Oriented Affordability Solutions: Barriers Differences by Organization Type

	Smaller Employer	Larger Employer	Health Plan
Challenges associated with driving member adoption	64%	47%	35%
Trouble integrating with existing platforms	31%	47%	39%
Unwillingness or inability of PBM to support implementation	16%	33%	26%

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Figure 60 Consumer-Oriented Affordability Solutions: Barriers (n=149)



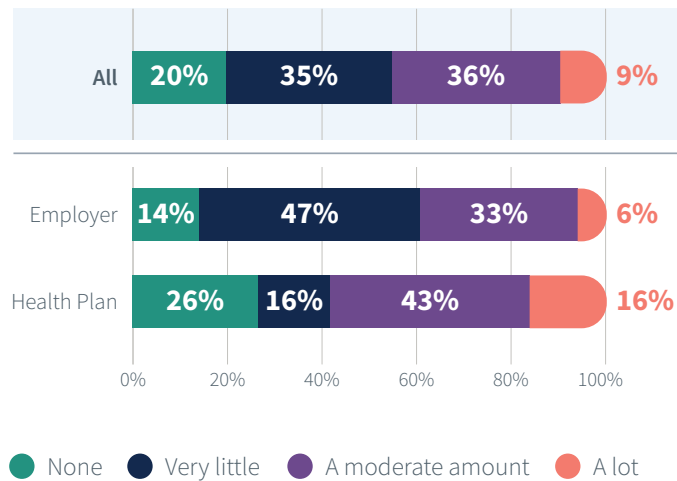
Not Shown: 5% of respondents reported experiencing other barriers, with no notable themes

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Social Determinants of Health

Social determinants of health (SDOH) are the conditions in which people are born, live, learn, work, play, and age that affect a wide range of health, functioning, and quality-of-life risks and outcomes.¹¹ When asked how much emphasis their organization currently puts on addressing SDOH to promote health equity among members, respondents gave mixed answers, with 45% saying they place a moderate amount or a lot of emphasis on this and 55% saying they place no emphasis or very little on it (see **Figure 61**).

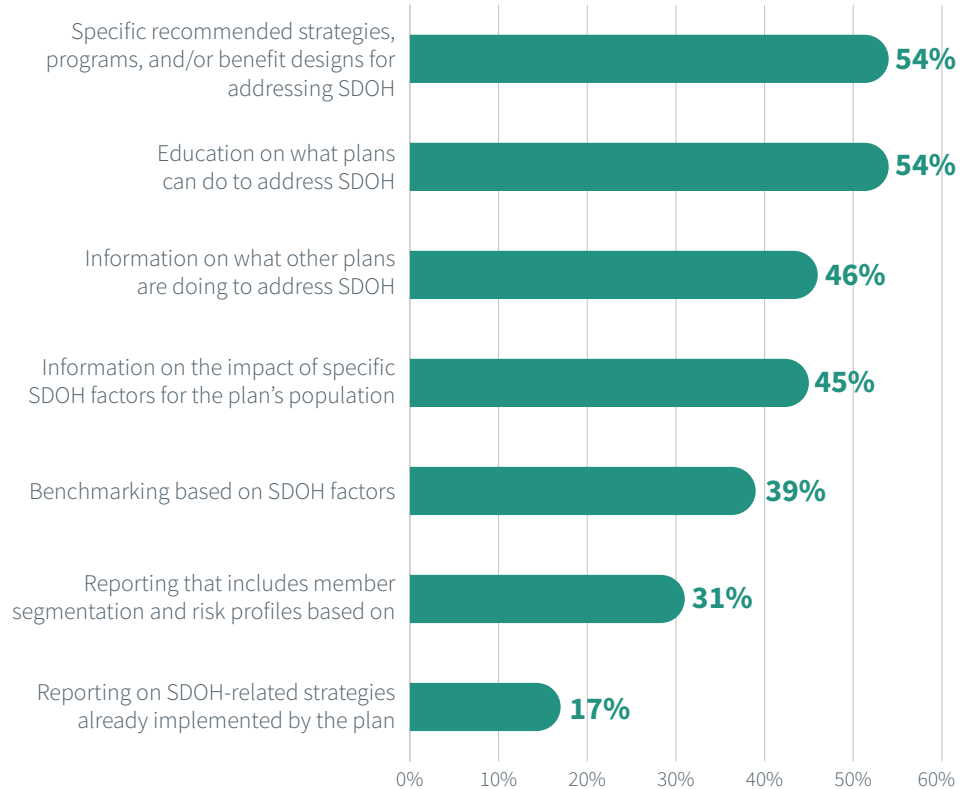
Figure 61 Amount of Emphasis Placed on Addressing SDOH to Promote Health Equity (n=149)



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¹¹ Healthy People 2030. Social Determinants of Health. <https://health.gov/healthypeople/priority-areas/social-determinants-health> Accessed April 26, 2023.

Figure 62 Current Organizations Needs Related to SDOH (n=149)



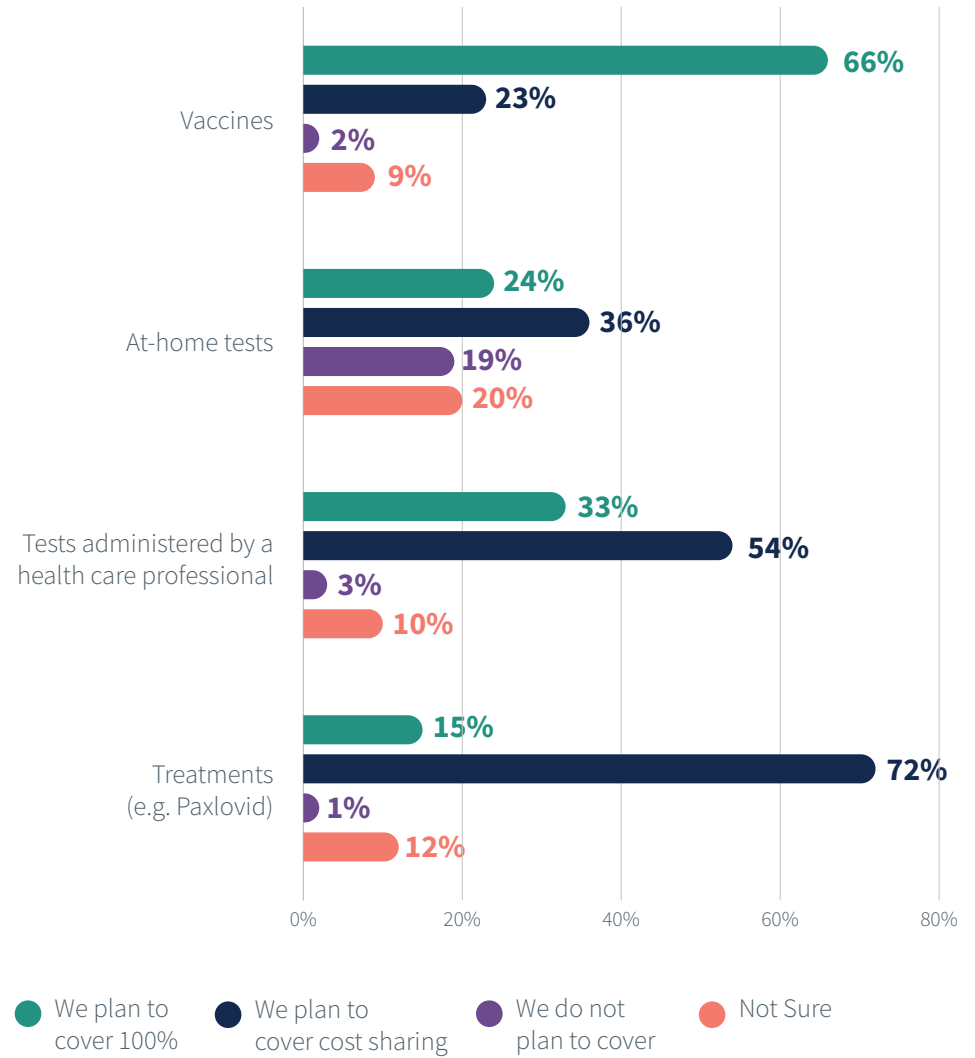
Pharmaceutical Strategies Group. 2023 Trends in Drug Benefit Design Report. Dallas, TX: PSG.

When asked to select their organization's top 3 needs right now when it comes to SDOH, respondents most frequently selected specific recommended strategies, programs, and/or benefit designs for addressing SDOH and education on what plans can do to address SDOH — over half of respondents put these needs in their top 3 (see **Figure 62**).

COVID-Related Coverage

As the COVID-19 pandemic transitions to endemic phase, plans have decisions to make regarding coverage of COVID-related vaccines, tests, and treatments. We asked respondents about their organization's plans for coverage of these COVID-related offerings when coverage is no longer required or the government no longer purchases them. As shown in **Figure 63**, most planned to cover vaccines 100% and to cover treatments with cost sharing. Plans for at-home tests and tests administered by a health care professional were more mixed: the vast majority intended to cover tests administered by professionals but were divided on whether they would require cost sharing, while nearly 40% were either not sure or were planning not to cover at-home tests. Employers and health plans did not differ notably in any area except for at-home tests, where health plans were more likely than employers to be unsure whether or how they would cover these tests (28% vs. 16%). Within the employer group, larger employers were more likely than smaller employers to be planning to cover vaccines 100% (78% vs. 58%).

Figure 63 Plans for Coverage of COVID-Related Vaccines, Tests, and Treatments (n=149)

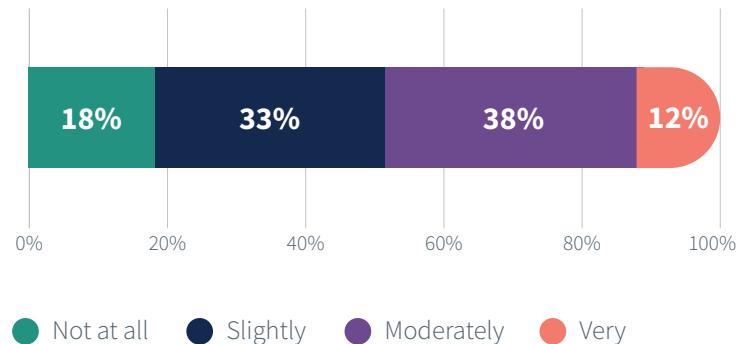


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Employer-Specific Considerations

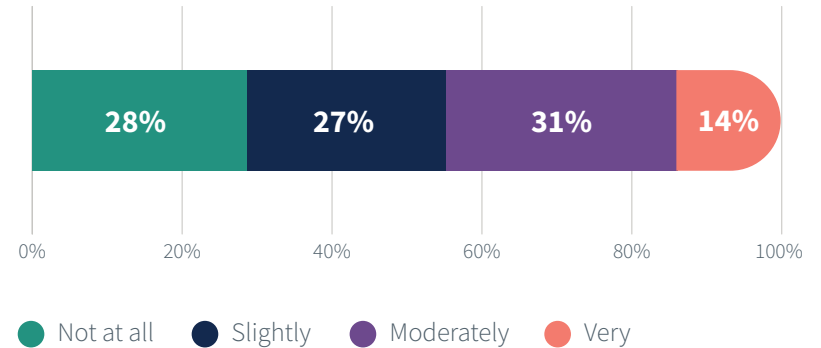
Employers face challenges in managing the pharmacy benefit and their benefit strategy more broadly amidst a large number of competing priorities. When asked the extent to which lack of time to be strategic about the pharmacy benefit was a concern for their organization, most respondents indicated they were slightly or moderately concerned about this (see **Figure 64**). Additionally, when asked what they anticipate for their organization's investment in benefits in the next 1 to 2 years, the vast majority anticipated either a slight increase (60%) or for the investment to stay the same (34%).

Figure 64 Employer Concern Regarding Lack of Time for Pharmacy Benefit Strategy (n=103)



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Figure 65 Employer Concern Regarding the Impact of State-Level Legislation on Pharmacy Programs (n=103)



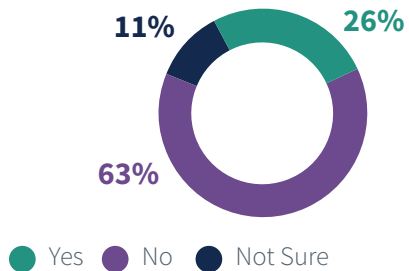
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Employers' pharmacy benefit strategy can also be impacted by state-level legislation (e.g., prohibitions on copay accumulators or spread pricing). We asked employers the extent to which they were concerned about the impact of state-level legislation on their pharmacy programs. As shown in **Figure 65**, respondents were mixed on this item, with 55% saying they were not at all or slightly concerned and 45% saying they were moderately or very concerned. Compared to smaller employers, larger employers were more likely to be at least moderately concerned about the impact of state-level legislation on their pharmacy programs (50% vs. 38%).

Health Plan-Specific Considerations

Health plans often have both fully-insured groups (where they are at risk for the drug spend) and employer self-funded groups (where they provide administrative services only), which presents unique opportunities and challenges. One potential challenge is competition with the health plan's PBM. When asked whether such competition was a concern, just over a quarter of health plan respondents said yes (see **Figure 66**). In an open-ended follow-up question, we asked those who cited competition with their PBM as a concern what strategies they use to reduce the risk of this happening and found that most of their focus was on provisions and language in the contract (e.g., "contract has most favored nation provisions" and "ensure transparency language on standalone contracts PBM is pursuing").

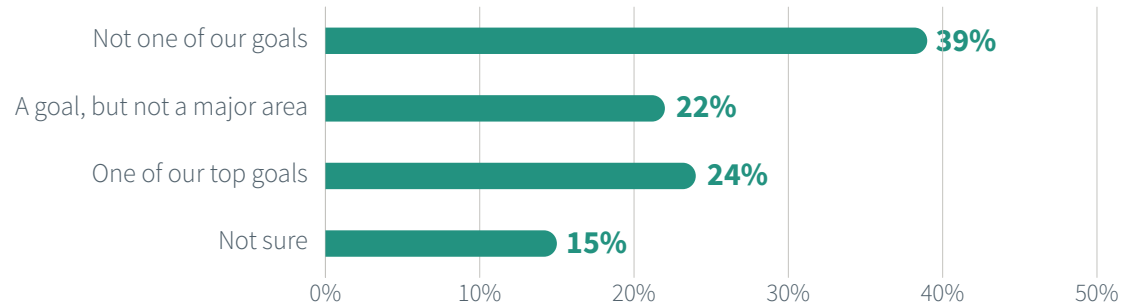
Figure 66 Is Competition with Their PBM a Concern for Health Plans (n=54)



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Recognizing that administrative services only (ASO) plans are an important part of some health plans' business, we asked health plan respondents the degree to which growth within pharmacy through ASO new business was a goal for their organization. As shown in **Figure 67**, nearly half reported this was either one of their top goals or a goal but not a major area of focus. In an open-ended follow-up question, we asked those who indicated growth within pharmacy through ASO new business was a goal what their organization was doing to achieve that goal and identified 4 themes: pricing strategies, sales and marketing, partnerships, and expanded offerings (see **Table 9**).

Figure 67 Growth Within Pharmacy Through ASO New Business as Goal for Health Plans (n=54)



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Table 9 Strategies for Achieving ASO New Business Goals

Theme	Example Comment
Pricing Strategies	"Maintain competitive pricing or AWP discounts and pass on savings or rebates to ASO groups."
Sales and Marketing	"We have access to Market Development folks as well as additional funding sources to work new business."
Partnerships	"We have developed associations with ASO organizations to offer our benefits with them."
Sales and Marketing	"Offering innovative pharmacy benefit programs."

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Methods and Respondent Profile



Methods

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

Methods

PSG developed and tested this comprehensive survey and then fielded the survey in February and March of 2023. Many items were retained from the prior year's survey, but some were removed to make space for new topics. 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 Drug Benefits. The most recent specialty report can be found on PSG's website: www.psgconsults.com/research.

The survey'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. All potential respondents completed screening questions before answering any survey questions and were disqualified if they indicated they did not represent an employer, health plan (or TPA or insurance company), or union/Taft-Hartley plan; who indicated they were not involved in making decisions for or managing the pharmacy benefit for their organization; or whose organization did not cover active employees under its pharmacy benefit. Because some respondents may be responsible for multiple plans, the survey asked respondents to answer questions about the largest plan (based on number of covered lives) that offered medical and pharmacy benefits. To express our appreciation for their time spent taking the survey, we offered respondents a small incentive in the form of a gift card or charitable donation. The survey collected responses from February 13, 2023, through March 10, 2023.

Data were stored in a secure, password-protected database and reviewed for low-quality responses prior to data analysis. Analyses were conducted:

- On the full sample
- By plan sponsor type (excluding unions, a group with too small of a sample size for meaningful analyses)
- By size of employer within the employer group (smaller employer: 5,000 or fewer lives; larger employer: more than 5,000 lives)

Respondents are included in the results for any question to which they provided a valid response. In most cases, responses of "don't know/not applicable" are not shown in the figures and tables but are noted underneath the relevant figure or table. Analyses were conducted using SPSS Statistics version 26 (IBM, Armonk, NY), Microsoft Excel, and the analysis tool embedded in the online survey platform (Alchemer, Louisville, CO). Percentages shown are rounded to the nearest whole number, so figure and table totals may not equal 100%.

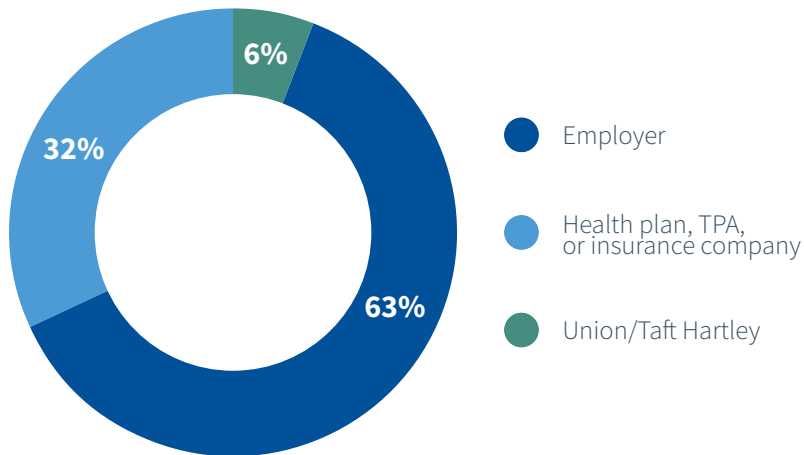
Report Sponsorship and Editorial Independence

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

Methods and Respondent Profile

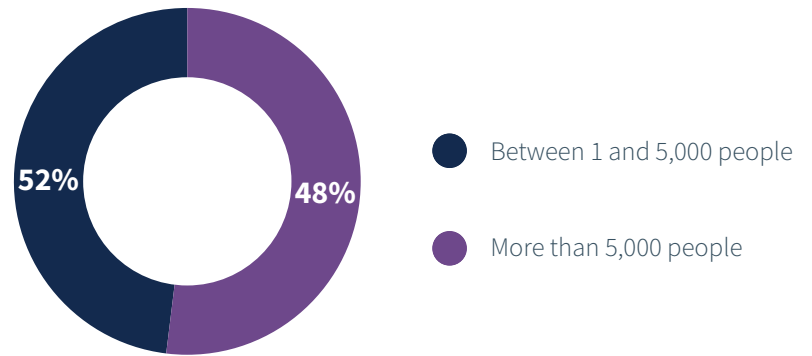
The survey sample included 180 benefits leaders representing employers, health plans, and unions/Taft-Hartley plans. As shown in **Figure 68**, employers made up the largest portion of the sample (63%), followed by health plans (32%). Within the employer group, the numbers of smaller and larger employers were nearly equal (see **Figure 69**). Of the plans represented in employers' survey answers, 47% were HDHPs. Plans were diverse in terms of where their largest number of eligible members reside (see **Figure 70**).

Figure 68 Respondent Type (n=180)



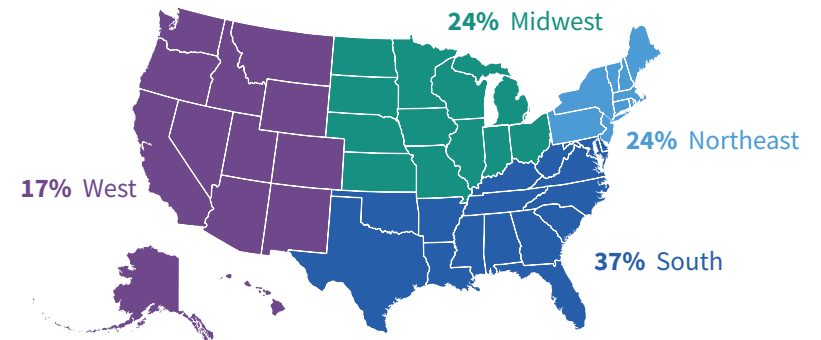
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Figure 69 Employer Size (n=113)



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Figure 70 Geographic Regions of Plans Represented in Survey (n=149)



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