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PHARMACY BENEFITS:

Pushing Towards Transparency and Savings

June 2024

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REIMAGINING EMPLOYER PHARMACY BENEFIT MANAGEMENT

Introduction

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Compounding Costs and Complexity in Pharmacy Benefits

The National Center for Health Statistics reported that physicians provided or prescribed 1 billion pharmaceutical drugs in 2019, with nearly 72% of visits involving drug therapy.[1] Close to half of Americans report using at least one prescription drug in the past 30 days, underscoring their prominence in modern medical care.[2] Overall pharmaceutical expenditures in the US reached $633.5 billion in 2022, and a RAND study found that US drug prices are 2.78 times higher than the OECD average.[3, 4] Furthermore, between 2022 and 2023, drug manufacturers increased the price of over 4,200 drugs, of which 46% were larger than the rate of inflation (Figure 1).[5] Both consumers and employers are affected by high spending and prices considering the significant majority of employers who provide health coverage include prescription drugs in that coverage.[6] In 2023, 28% of adults taking prescription drugs said it was difficult to afford the cost, and employer pharmacy benefit costs jumped 8.4% in the same year.[7, 8]

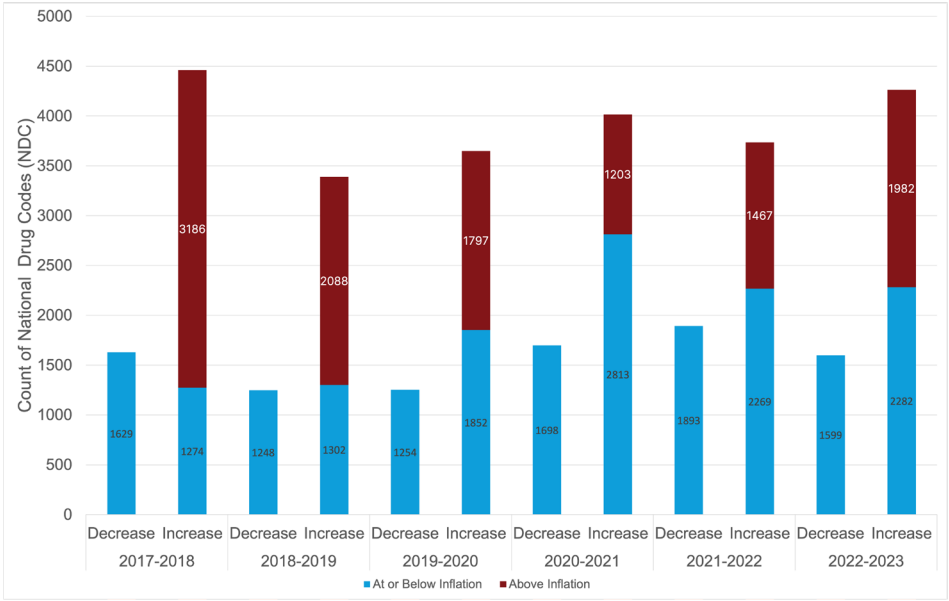

Figure 1. Total Number of Price Changes and Share of Increases that Exceed Inflation, 2017 to 2023. Adapted from the Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services.[9]

Employers seeking to address issues with cost, clinical appropriateness, and member experience associated with their pharmacy benefits are often challenged by the complex and extractive pharmacy ecosystem. Employers rely on multiple stakeholders to provide truthful and accurate information that will help them manage costs and ensure that their employees are ultimately moving towards better health outcomes. These stakeholders include pharmacy benefit managers (PBMs) who act as intermediaries, negotiating drug prices with manufacturers and managing formularies. The PBM industry has seen significant consolidation since the 2000s, with the top three PBMs claiming 79% market share as of

2022.[10] This lack of competition is one of several drivers disincentivizing transparency in the PBM industry. Complex pricing structures, confidential rebate arrangements, spread pricing practices, and other hallmarks of the traditional PBM industry create a further imbalance of information. Employers are subjected to asymmetric market information when contracting for the drugs that their employees need to live a healthier life, and PBMs are in the middle of a spider web of transactions that involve the drug manufacturer, brokers, distributors, and retailers– all of whom are adding to the cost of the prescription.

Challenges with Traditional PBMs

It is time for employers to think critically about how they have been purchasing and managing pharmacy benefits. Benefits leaders should ask if their PBM is really doing everything it can to help their company manage its pharmacy benefits costs and how they can support members with affordability and adherence. In an environment of exponentially rising and unsustainable costs, employers are increasingly aware of traditional players' shortfalls with controlling costs and improving health outcomes. While many employers are experiencing cost trend impacts driven by glucagon-like peptide-1 (GLP-1) drugs, they can expect to deal with additional rising spend and challenging clinical questions as expensive treatments like gene therapy and CAR-T cell therapy become more common.[11, 12, 13]

These shortfalls also impact members' clinical outcomes and out-of-pocket spend. Due to rebates and discounts negotiated between PBMs and drug manufacturers, PBMs may favor drugs with higher rebate offers or lower acquisition costs, regardless of their clinical efficacy or suitability for patients' needs. Furthermore, PBMs often negotiate pricing and rebate agreements with pharmaceutical manufacturers, wholesalers, and pharmacies, but the details of these arrangements are typically not transparent to patients or employers. As a result, members may not be aware of the actual prices and discounts available for their prescription drugs. Lack of price transparency can lead to members overpaying for medications and missing out on potential cost-saving opportunities, such as using generic or lower-cost alternatives.

While employers rely on their PBMs to find the most efficient ways to purchase pharmaceuticals for their employees, most of these same PBMs continue to extract undisclosed revenue from that very same system. ERISA plan sponsors have a fiduciary duty to act in the best interests of plan members. Within pharmacy benefits, these responsibilities include prudently selecting and monitoring service providers such as PBMs and ensuring that plan assets are used solely for the benefit of plan participants and are not subject to misuse or mismanagement which can occur when a PBM does not completely disclose all revenue they receive from the drugs procured on behalf of a plan sponsor.

Fulfillment of Fiduciary Duty

As a plan fiduciary, benefit leaders should examine their dependence on traditional PBMs in order to ensure that they are aligned with their self-insurance strategies. Recently, employers have pursued alternative strategies with PBMs in an effort to better manage their pharmaceutical expenses, including the use of pass-through or so-called "transparent contracts," preferred networks, and formulary management. However, these strategies have not produced the desired outcomes of better managed pharmacy costs or a better experience for members. A recent lawsuit has prompted many employers to fundamentally re-evaluate how they manage their pharmacy benefits.[14] By asking the right questions and challenging the status quo, plan sponsors will be able to clearly see there are viable alternative options that will allow them to be better stewards of their company's healthcare expenses.

Selecting partners whose incentives align with the employers' is a significant step in gaining more control over how pharmacy benefits are delivered, but it is not the last step. A full transformation also requires a new way of assessing the total impact of a PBM arrangement. The price of each drug purchased is only a part of the equation. The true

cost to the employer can be impacted by the nature of the financial relationship the PBM has with the manufacturer, which drugs they choose to include in their formulary, as well as their ability to manage the clinical effectiveness of the drugs. Taking all of those elements into consideration in a comprehensive manner as opposed to focusing on discounts will help employers more effectively compare the value of potential vendor partners.

Barriers to Change

In general, employee benefit leaders are not experts in pharmacy benefits or drug indications. They rely on their PBMs and consultants to provide expertise and guidance in designing and delivering pharmacy benefits to their employees. As noted above, the opacity and misaligned incentives in the market make their job extraordinarily difficult. Furthermore, any change made to pharmacy benefits has the potential to have a direct impact on patients who are taking drugs that are on existing formularies. Any time a change is made to a PBM, there is the possibility that the patient's current drug would not be on a new PBM's formulary. This risk of disruption can be a reason that employers might opt to not make a change to their PBM. One EHIR member described the challenges they experience when trying to make changes: "There's a huge moat around the pharmaceutical and pharmacy benefits industry, making disruption challenging. Even minor adjustments can have significant financial and clinical impacts." Employers and innovators in the pharmacy benefits space are carefully testing best practices to minimize disruption, and stakeholders should expect that different strategies may or may not be effective depending on their size, company culture, benefits ecosystem, and more. Another EHIR member described how they would approach this challenge: "When considering transitioning to a transparent PBM, employers worry about member disruption, but having talked to employer clients of transparent PBMs myself, this seems like a non-factor. As long as employers communicate appropriately and explain their philosophy behind the decision, members seem to understand."

Patient Engagement

There is an opportunity for employers to optimize not just plan-level medication procurement and access through their PBM, but also to enhance member-level medication utilization, member experience, and clinical outcomes. To support these aims, it is vital for employers to support plan members with chronic conditions after medications are procured by PBMs, prescribed by physicians, and dispensed by pharmacies. If a medication is not appropriate, is not working, is not being taken, or is causing harmful side effects, formulary status, rebates, and UM controls are irrelevant. In addition to clinical variation, the cost variation between similarly efficacious drugs, as well as between similarly situated pharmacies can drive significant differences in costs for the patient.[15] Patients need guidance to identify the right drug for their needs based on both costs and clinical outcomes.

Resources in this Report

This report presents our findings regarding current employer approaches to managing pharmacy spend, reducing the financial burden on members, and enabling improved health outcomes by demanding greater transparency from the industry and improved navigation. The members of our Employer Health Innovation Roundtable (EHIR) community are well-recognized as forward-thinking leaders in the employer health and wellness benefits space and have shared their experiences, concerns, and solutions via an extensive survey supplemented by interviews. Our members also often work towards their goals with vendor partners. Three leading vendors in this space–AffirmedRx, Navitus Health Solutions, and Rx Savings Solutions–partnered with EHIR to provide case studies and supplemental information on their program offerings to help enrich your understanding of key solutions and how employers have deployed them. We also provide a vendor landscape overview, identifying many of the leading providers of innovative solutions, as well as a set of questions to consider if you are planning to evaluate these vendors for your own company. This report should help employers identify potential vendor

partners who can address the unacceptable problems created by the traditional pharmaceutical benefits industry and manage their fiduciary exposure.

We hope the resources, ideas, and perspectives in this report will give you the confidence and tools to make substantive change in your pharmacy vendor ecosystem.

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1. CDC (2019)
2. CDC (2019)
3. AJHP (2023)
4. RAND (2024)
5. HHS (2023)
6. KFF (2023)
7. KFF (2023)
8. Mercer (2023)
9. HHS (2023)
10. Beckers Hospital Review (2023)
11. SHRM (2023)
12. UPenn (2023)
13. ASCO (2023)
14. Reuters (2024)
15. JAMA Network Open (2022)

A World 50 Group Community

EHIR INSIGHTS

Employer Health Innovation Roundtable (EHIR), a World 50 Group Community, is an action-oriented, independent group built by employers, for employers. EHIR was started nearly a decade ago out of a need for objective support in identifying and assessing emerging solutions to sift through the noise and stay ahead of the curve amid a rapidly changing competitive landscape. EHIR members are well-recognized as forward-thinking leaders in the employer health and wellness benefits space and have shared their experiences, concerns, and solutions for navigating the pharmacy benefits industry.

Employers Seek to Tackle Unsustainable and Opaque Practices in Pharmacy Benefits

EHIR Member Survey and Interview Findings

Background

EHIR surveyed 37 of our members, who are leaders in the employer health and benefits space, to understand their recent and forecasted pharmacy cost trend, cost containment strategies they are considering, and the priorities and pain points that drive their evolving pharmacy benefit design.

Cost Trend and Spend Categories

Currently, the significant majority (89%) of respondents use a traditional pharmacy benefits manager (PBM), while the remaining 11% use a transparent PBM. Traditional PBMs include longstanding players like Express Scripts, CVS Caremark, and OptumRx. Transparent PBMs are differentiated by their commitment to transparency in their pricing, contracting, and rebate practices, as well as overall performance reporting.

Half of respondents have seen their pharmacy cost trend increase more than 6% in the past two years, and 97% indicated that specialty drugs are among their top three cost drivers. Unsurprisingly, glucagon-like peptide-1 (GLP-1) drugs have surfaced as major cost drivers in recent years: 66% of respondents reported that GLP-1s indicated for treatment of diabetes were a top-three cost driver, and 50% reported the same for GLP-1s indicated for treatment of obesity.

Looking ahead, 46% of respondents expect their cost trend to increase more than 6% in 2025 and 2026. They also anticipate that specialty drugs will continue to drive significant spend in this timeframe: 89% predicted that they will be a top three cost driver (Figure 1). While cell and gene therapies were not yet in the top three spend categories for any of the respondents over the past two years, 17% project that they will move into the top three over the next two years. Luke Prettol, Principal Benefits Strategy Consultant at AT&T, described his framework around designing AT&T's cell and gene therapy program: "Firstly, we want to be sure we're getting the right patient to this therapy. That includes some pre-identification and partnering with the patient and their provider to make sure we get them on the right path. Secondly, we're essentially building Centers of Expertise to ensure we get patients to the provider that gives them the best chance of success. Getting the treatment right the first time is critical, as well as providing wraparound care. Thirdly, we're addressing the financial risk not only associated with the cost of the drug, but also the cost of administering the drug, which can be just as high."

Employers Building Momentum to Make Change

The persistent increase in pharmacy cost trend has proven unsustainable, yet many employers feel powerless to make a significant impact under the current pharmaceutical benefits paradigm. One EHIR member described these challenges: "While traditional PBMs claim to save you money, in reality they shift those 'savings' into another bucket and their revenue and profit margins continue to increase. PBMs are entitled to earn a profit, but right now it feels like they're taking advantage of employers. It feels like our hands are tied."

> **"It feels like our hands are tied."**
>
> - EHIR Benefits Leader on the current PBM environment

	Specialty drugs	Biosimilars	Generics	Cell and gene therapies	GLP-1s indicated for diabetes mellitus	GLP-1s indicated for obesity	Brand name non-specialty drugs (besides GLP-1s)	Other	Not sure
Past two years	97%	6%	0%	0%	66%	50%	6%	4%	0%
Next two years	89%	20%	0%	17%	54%	80%	6%	0%	3%

Figure 1. Top Three Drug Spend Categories, Past Two Years vs. Next Two Years; n = 36 for past trend and n = 35 for forecasted trend.

Luke Prettol at AT&T called out the unique challenges with managing pharmacy benefits and how these contrast with the relative flexibility and transparency of managing a self-funded medical plan: "Pharmacy is one of the fastest growing areas of spend in benefits, yet it's also the least clear and hardest area to set metrics for success. There are so many hidden and secretive components that make it hard to define what winning looks like and set goals to achieve that vision. This contrasts with the medical side, where we look at outcomes metrics and total cost of care. The cost side is also only part of the picture– we recognize that even issues such as adherence can be a challenge too."

With these dynamics in mind, it is not surprising that many respondents are considering making changes to their vendor ecosystem: for 2025 and 2026, 24% are considering changing their PBM, 19% are considering adding or changing another pharmacy vendor, and 8% are considering both. One EHIR member called out the impacts of making substantive change: "If I could make one change to the PBM industry, I would want every employer to move away from 'The Big Three.' We need to take away market share and transition to a transparent PBM paradigm where spread pricing doesn't exist anymore and employers know exactly what we're paying, just like we do with our ASO medical contracts. Promoting transparency and reducing the complexity of managing pharmacy benefits would promote more aligned incentives, and ultimately better serve the goal of getting members on the right drug at the right time."

Clinical Outcomes Outweigh Cost Sustainability in Pharmacy Benefit Strategy

Employers must balance numerous, and at times conflicting, values and objectives when building their pharmacy benefits strategy. While rising costs are top of mind for employers, surprisingly, the respondents did not rank cost sustainability as their most important objective. Rather, respondents ranked "clinical outcomes" as their most important objective, closely followed by "cost sustainability for the employer." The third most important objective was "employee experience." One EHIR member described balancing these objectives and how vendors should support them: "We're looking to transition from being drug-focused to member-focused, which would free us from needing to focus on things like maximizing rebates for a certain drug and instead focus on how to maximize the right care for the right patient. That said, we still need to be mindful of our pharmacy spending and the math needs to work. To help employers make changes to their pharmacy benefits management, innovators in the space need to explicitly call out metrics that differentiate them from traditional players and specific clinical programs or designs where other clients have seen success. Employers need to have clarity around the financial impact these innovators would have, otherwise it's really hard to make a change."

Negotiate new terms and rates (e.g. cost trend guarantee) with existing PBM partner	34%
Rely on PBM's traditional utilization management processes	23%
Reduce the number of drugs on formulary	14%
Implement a custom formulary	11%
Bring in an external vendor to manage UM for certain drug classes (e.g. GLP-1s for weight loss)	49%
Implement a transparent PBM model that includes a cost trend guarantee	34%
Implement a tool to support patient drug decisions based on cost or clinical differentiators (e.g. Rx Savings Solutions, etc.)	34%
Evaluate alternative payment models and/or outcomes-based contracting for high-cost Rx treatment regimens (e.g. cell and gene therapies)	23%
Implement an integrated savings program (e.g. GoodRx and MedImpact)	14%
Add a direct-to-consumer pharmacy (e.g. Mark Cuban Cost Plus) as an in-network option	11%
Other	11%
Not sure	3%
We aren't planning any Rx cost containment strategies for 2025-2026 currently	6%

Figure 2. Cost Containment Strategies Considered for 2025-2026, n =35.

Clinical outcomes ranked as the #1 most important objective when designing pharmacy benefits strategy (n = 35)

Cost Containment Strategies

Respondents are looking to vendor partners to help them contain costs for 2025 and 2026 and are considering a number of other strategies (Figure 2). Nearly half are considering bringing in an external vendor to handle utilization management (UM) for certain drug classes, most commonly those treating cardiometabolic conditions (which includes diabetes and obesity). A significant share are also considering implementing a transparent PBM model, as well as a patient decision support tool. Luke Prettol at AT&T described how his team is shifting their pharmacy strategy: "We want to go beyond price discussions and look at the quantity of drugs dispensed and the appropriateness of care, since that has a broader impact on outcomes and total cost of care." He went on to describe this shift in focus: "We're looking to shift from measuring value from a single drug to looking more holistically at care pathways for categories of conditions, which fits better with our medical strategy of looking at total cost of care and outcomes."

Overall, respondents repeatedly called out the need for greater transparency in the pharmacy benefits industry. An EHIR member described why they are pushing to make an impact: "Even as a relatively small employer, we want to be at the forefront of driving change in the PBM industry because our double-digit cost trend is unsustainable. Traditional PBMs don't provide enough transparency into the drivers behind that trend."

1. ACHP (2023)

AffirmedRx
PUBLIC BENEFIT CORPORATION

At AffirmedRx, PBC, we are a Public Benefit Corporation leading a transformation in the pharmacy benefit manager (PBM) industry with a model that emphasizes transparency and proactive patient support. As a pharmacist-led organization, our expertise is rooted in a deep understanding of healthcare from the ground up, ensuring that our strategies are aligned with practical, patient-centric outcomes. This leadership structure is crucial, as it means decisions are guided by those who understand patient care firsthand, not just corporate bottom lines. Our status as a Public Benefit Corporation legally commits us to upholding the public good versus focusing on shareholder profits. This foundation allows us to simplify the complexities of pharmacy benefits drastically, ensuring that employers and their employees can navigate their healthcare options with clarity and confidence, fostering a more sustainable and equitable healthcare system.

Content for this section provided by AffirmedRx, PBC.

Advancing Transparency: The Essential Shift in Pharmacy Benefit Management

By adopting a transparent approach to the PBM industry, AffirmedRx aims to dismantle the traditional complexities surrounding drug pricing and benefits administration. At AffirmedRx, transparency means clear, straightforward pricing without hidden fees or spread pricing.[1] We disclose all rebates and pass them directly back to our clients, ensuring they benefit fully from these savings. Additionally, we provide employers with comprehensive access to claims data and pricing information, enabling them to see exactly what they are paying for and why. This commitment not only aligns with our core values but also with the fiduciary responsibilities that employers uphold for their employees, fostering a trusting relationship where decisions are made with full visibility and accountability.

Financial Outcomes and ROI

We diverge from the traditional PBM model by not being driven primarily to maximize profits for our shareholders. Instead, we provide full disclosure by sharing comprehensive data with our clients, including detailed breakdowns of drug pricing, pharmacy claims, and rebates received. This enables our clients to achieve on average 20% savings on their pharmacy benefits spend.

Our clear pricing means that we itemize and explain each cost component without any hidden fees. This approach eliminates common industry practices such as spread pricing, where PBMs keep a difference between what they charge the plan and what they pay the pharmacies. Instead, we charge one straightforward administrative fee and pass through all other costs directly to our clients without markup. We also remove the complexities of vertical integration: we do not tell our employer clients what pharmacies they must use and when. Vertical integration only serves to add more profit for PBMs into the ecosystem, making drugs less affordable for employees on the plan.

Although percentages vary greatly and the contracts are shrouded in secrecy, some audits show that traditional PBMs are retaining spread at an alarming rate on brand drugs, generic drugs, and manufacturer rebates.[2] On a recently analyzed 30,000 life group using incumbent data supplied by a consultant, this spread equated to $2.66MM spread being retained by a traditional PBM, earning a revenue of up to $8.6MM by retaining both rebate revenue and pharmacy spread. AffirmedRx's only revenue, our admin fee, totaled $1.9MM for the same group. The savings AffirmedRx creates are a testament to the efficacy of our approach, offering a more sustainable model for managing healthcare benefits.

The Consolidated Appropriations Act (CAA) and Fiduciary Duty

The Consolidated Appropriations Act (CAA) has introduced stringent requirements for health plan transparency, underscoring the importance of fiduciary duty in the management of healthcare spending. Because the PBM industry has a reputation for being nefarious, prescription benefit plans are receiving the most scrutiny, which has created the most risk for plan sponsors. Our transparent model facilitates compliance with these new mandates, enabling employers to meet their fiduciary obligations with ease and confidence. By ensuring that employers can adhere to these regulatory requirements, we help safeguard them against potential legal and financial repercussions.[3]

The J&J Lawsuit: A Case Study in Transparency and Fiduciary Responsibility

A recent lawsuit involving Johnson & Johnson has brought to light the critical issues of transparency and fiduciary duty within the PBM industry.[4] This lawsuit highlighted how traditional PBM models, characterized by opaque pricing structures and potential conflicts of interest, can undermine the fiduciary responsibilities of benefit managers. Notably, the

lawsuit pointed to the partnership between a PBM and Mark Cuban's Cost-Plus Drug Company (MCCPDC) as an exemplary model of compliance and transparency. This partnership, which provides medications at a fixed markup, showcases how PBMs can operate in a manner that prioritizes patient access and affordability, thereby aligning with the principles of fiduciary responsibility.

Additionally, the lawsuit highlights two other main points.[5] First, a *prudent* fiduciary would receive all of their data to make appropriate purchasing decisions. When a plan sponsor does not get claim level rebate data, that puts plan sponsors at risk. It is not enough to say the PBM or consultant said the plan was getting a good deal – the fiduciary to the plan needs to see the data to make a *prudent* decision. This also matters when it comes to the formulary the plan allows the PBM to implement. If brands are preferred over generics, that will increase costs to the members at the pharmacy counter who have high deductible or co-insurance by driving to a higher cost medication. Rebates do not drive down costs for plan participants. Furthermore, if the PBM says the brand is cheaper than the generic, they should feel comfortable providing claims level data to prove it is not driving up costs for the entire plan.

Finally, the lawsuit underscores the potential for individual benefit leaders to be held personally responsible for failing to meet their fiduciary duties, not just the companies they represent. This development marks a significant shift in the accountability landscape, emphasizing the need for benefit managers to choose PBM partners and consultants that adhere to the highest standards of transparency and ethical practice.

This lawsuit is a roadmap for remaining "CAA-proof" and calls out the main ways employers can keep from having a similar lawsuit for their companies or themselves as fiduciaries:

1. Choose a transparent, pass-through PBM.
2. Choose a PBM that has no owned pharmacies or conflicts of interest.
3. Choose a PBM that has a lowest net cost formulary.
4. Choose a PBM and a consultant/broker that has the employers' best interest in mind and is not incentivized by higher cost prescription and formulary choices.

AffirmedRx fully recognizes and meets the objectives outlined above by addressing the critical need for transparency and accountability in pharmacy benefits management. First, we ensure that as a prudent fiduciary, every plan sponsor receives all necessary data to make informed purchasing decisions. This includes providing access to claim-level rebate data, thus ensuring that plan sponsors are not merely taking our word for it but can see the detailed data themselves and empowering them to make prudent decisions.

Additionally, our approach to formulary management prioritizes generics over brand-name drugs whenever possible and appropriate to keep costs lower for members, especially those with high deductibles or coinsurance. In cases where a brand-name drug is more cost-effective than a generic, we provide transparent, claims-level data to prove it, ensuring that our decisions are verifiable and do not compromise the quality of care.

Addressing Pharmacy Management Challenges

Historically, plan sponsors were advised that using a PBM-owned mail or specialty pharmacy was the most cost-effective option. However, emerging data challenge this notion. We streamline the process directly between us, the pharmacies, and our clients and we will never own pharmacies or fulfillment centers. We strictly operate on a transparent model where we earn a simple administrative fee per claim. This fee structure aligns our incentives directly with those of our clients, ensuring we prioritize their interests and cost efficiency.

Clinical Support for Patients

Our solution goes beyond financial benefits to offer comprehensive support for patients. We have developed an industry-leading proactive program that enhances medication adherence and reduces pharmacy-

level frustrations. By focusing on patient support, with clinically-sound solutions, we help individuals maintain their treatment regimens, which leads to better health outcomes.

Our technology platform monitors claim activity in real time, allowing us to identify and address prescription issues before they escalate, enabling us to coordinate with providers to explore cost-effective medication alternatives swiftly. Real-time clinical monitoring by our Patient Care Advocates (PCAs) to search for lower cost, therapeutically equivalent alternatives to drugs is a key component of our approach. AffirmedRx has consistently generated savings estimates in the range of $12 - $15 PMPM from generic/therapeutic substitution. Being proactive and reducing frustration makes the lives of providers, pharmacists, and our members easier. When a pharmacy claim is rejected for any reason, our dedicated team of PCAs quickly reviews the situation, decides on the best course of action, and intervenes to resolve the issue. This involves contacting members, prescribers, and pharmacies to suggest immediate corrective measures. Our PCAs also support patients in adhering to their medications, monitor for side effects or adverse reactions when starting new therapies, and assess the need for financial assistance. This comprehensive communication ensures that patients receive personalized care, making them feel valued and supported. Doctors also benefit from being kept informed about formulary issues that might impact their prescribing decisions, fostering a collaborative care environment. Pharmacists benefit because they have one less frustrated customer at their pharmacy counter.

Managing the Impact of High-Cost Drugs

The rising costs of specialty medications, including advanced cell and gene therapies, represent a formidable challenge for employers. Our transparent approach at AffirmedRx provides a strategic framework for effectively managing these expenses. Firstly, we utilize a meticulous formulary management system that prioritizes both efficacy and cost-effectiveness, ensuring access to the most beneficial and financially sustainable options. Secondly, while most cell and gene therapies are managed through the medical benefit today, we anticipate the potential for future treatments to be managed through the pharmacy benefit.

We are exploring the creation of a full carve-out solution for cell and gene therapies, where all risk – financial and clinical – is managed intentionally, providing employers access to pooled coverage, and employees access to high-quality facilities to administer these life-altering treatments. Thirdly, we engage in aggressive negotiation with manufacturers and leverage competitive bidding to obtain the best possible pricing. We offer robust analytics tools that allow employers to understand and forecast healthcare spending, making it easier to plan and allocate resources effectively. This comprehensive strategy ensures that employers can offer their employees access to groundbreaking treatments like cell and gene therapies without compromising their financial sustainability.

The Path Forward

The imperative for transparency and fiduciary responsibility in pharmacy benefits management has never been clearer. As the healthcare landscape continues to evolve, AffirmedRx remains committed to leading the charge toward a more transparent, equitable, and sustainable future. By transitioning to a transparent PBM partner, employers can ensure that they are not only meeting their regulatory and ethical obligations but also providing the best possible care for their employees.

1. AffirmedRx (2024)
2. Milliman (2018)
3. AffirmedRx: CAA Compliance
4. Bloomberg Law (2024)
5. WSJ (2024)

Revolutionizing Pharmacy Benefits Management for the Dallas Mavericks

Case Study

Client: Dallas Basketball Limited/Radical Ventures
Industry: Professional Sports
Total Membership: 1000 employees and dependents
Year Implemented: 2023

AffirmedRx partnered with Dallas Basketball Limited/Radical Ventures, also known as the Dallas Mavericks, to transition their pharmacy benefit management (PBM) system to a full pass-through, transparent model. The Mavericks aimed to streamline their plan participants' access to the Mark Cuban Cost Plus Drug Company (MCCPDC) for prescription fulfillment while ensuring minimal disruption to their population.

The Challenge

The Mavericks sought to transition to a transparent PBM model to improve cost effectiveness and accessibility for their plan participants. They aimed to leverage the MCCPDC, aligning with their mission to maximize benefits for both employees and the organization. Additionally, they wanted to alleviate administrative burdens for their benefit team by partnering with a trusted PBM provider. It was crucial for them to move away from their incumbent PBM, which did not have a relationship with MCCPDC, leaving Mavericks' members unable to utilize the benefits offered by Cuban's pharmacy.

The Solution

The Mavericks chose AffirmedRx as their solution provider due to our existing partnership with the MCCPDC. Traditionally, MCCPDC only offered direct-to-consumer medications, but this partnership extends their reach and impact. Partnering with a transparent pharmacy benefit manager (PBM) like AffirmedRx is crucial for MCCPDC because it ensures that the entire drug procurement and distribution process remains clear and understandable for consumers, eliminating hidden fees and inflated prices. Both companies share a commitment to social impact as Public Benefit Corporations, aligning with the Mavericks' values of integrity and community service. AffirmedRx's white-glove, proactive Patient Care Advocate (PCA) model was crucial for the Mavericks, ensuring a seamless transition to Cost Plus Drugs with dedicated on-site support and education for members. This model not only provides personalized assistance but also enhances the overall healthcare experience, ensuring that members fully understand and benefit from their new medication options. By collaborating, AffirmedRx and MCCPDC can provide more affordable, transparent, and socially responsible healthcare solutions.

Implementation and Launch

The implementation process began 90 days before the go-live date, involving extensive collaboration with the Mavericks to design a benefit plan that incentivized utilization of Cost-Plus Drugs. AffirmedRx conducted in-person educational meetings and webinars to inform employees about the new benefit and introduced them to their dedicated PCAs. Additionally, AffirmedRx provided comprehensive training for the Mavericks' benefit team to ensure smooth integration and ongoing support.

Outcomes Achieved

Within the first quarter post-implementation, 15.33% of all claims were filled through Cost Plus Drug pharmacies, marking a significant increase

from 0% at go-live. The transition resulted in an estimated 4.11% quarterly savings or $70.80 per claim transitioned. The benefit team reported reduced workload due to AffirmedRx's PCA support, who reviewed historical claims and identified members who would be impacted by the formulary transition. The PCAs proactively reached out to these members and their providers to facilitate a medication switch before it became an issue at the pharmacy level. Furthermore, member satisfaction surveys indicated a high level of appreciation for the proactive support provided by AffirmedRx. Regarding their experience with an AffirmedRx PCA, one team member commented, "I wanted to give a particular shoutout to Tasha yesterday, who spent the better part of the day getting everything exactly perfect for me related to my prescriptions and being super communicative and kind. It is rare that I encounter a service professional who makes a transaction feel pleasant like that!"

AffirmedRx recognizes that not all medications can be accessed through the MCCPDC. For the Dallas Mavericks, we developed a comprehensive strategy to manage these medications effectively. Our PCA model plays a pivotal role in this process.

Our PCAs work closely with healthcare providers to identify the medications that fall outside of MCCPDC's offerings. We then leverage our extensive network of trusted pharmacy partners to source these medications at the most competitive prices, ensuring that the Mavericks' members have access to the full spectrum of treatments they need. Our pharmacy network maximizes member choice and access at approximately 65,000 nationwide pharmacy locations. AffirmedRx places a significant emphasis on fostering positive pharmacy relations aimed at ensuring seamless interactions and collaborations with our network of pharmacies. Additionally, our PCAs provide personalized support and guidance to members, helping them navigate their medication options and understand any potential alternatives available through MCCPDC. When an alternative is not feasible, our PCAs assist with facilitating seamless transitions to other reputable suppliers, managing prior authorizations, and coordinating with insurance providers to minimize out-of-pocket costs.

By maintaining clear communication and offering dedicated on-site support, we ensure that all members receive timely access to their required medications. This holistic approach not only addresses gaps in access but also reinforces our commitment to transparency and patient-centric care, aligning with the Mavericks' values and enhancing the overall healthcare experience for their members.

ROI and Client Financial Savings

Through the first quarter of service provision, total costs before rebates decreased by 10.9%, and plan costs were down by 12.9%. These savings demonstrate the tangible financial benefits of transitioning to AffirmedRx's transparent PBM model and leveraging the Cost Plus Drug pharmacy network. The Mavericks experienced a positive return on investment (ROI) within the first quarter, with continued long-term savings anticipated.

Summary

AffirmedRx's partnership with the Dallas Mavericks exemplifies the success of transitioning to a transparent PBM model. By prioritizing member education, proactive support, and cost-effective solutions, AffirmedRx enabled the Mavericks to achieve significant savings while enhancing access to quality healthcare for their plan participants. This collaboration highlights the potential for innovative PBM solutions to drive positive outcomes for employers and employees alike, setting a new standard for pharmacy benefits management in the industry.

> Everything we pay for on a transactional basis, and they do what we tell them to do. That was an easy switch."
>
> *- Mark Cuban*

NAVITUS
HEALTH SOLUTIONS

Navitus Health Solutions, LLC, owned by SSM Health and Costco Wholesale Corporation, was founded as an alternative to spread-based PBM models to remove unnecessary cost from the drug supply chain and make medications more affordable. Now, more than 20 years later, the organization brings a range of pharmacy solutions to market through a portfolio of noted brands and partnerships including Navitus, EpiphanyRx, Lumicera Health Services, Archimedes, and CivicaScript. As an enterprise, we proudly serve over 14 million members through nearly 800 client relationships. Our PBM services are delivered through the Navitus and EpiphanyRx brands and continue to enable our clients to achieve desired health and financial outcomes.

Content for this section provided by Navitus Health Solutions.

NAVITUS
HEALTH SOLUTIONS

Providing PBM Clients Exceptional Clarity

Throughout the company's growth, Navitus has not wavered from its foundational principle of transparency and a commitment to a full pass-through PBM model. In practice, this means:

- We don't engage in spread pricing. Unlike traditional PBMs, we don't add cost to the system. We don't create or take margin from rebates and discounts we negotiate, pharmacy network contracts we manage, or inflated prices on drugs dispensed through our specialty pharmacy.
- 100% of all rebates and fees obtained are passed through to clients as received. We are audited annually to verify the pass through is correct and complete.
- Our clients have full access to their data – to the individual claim level.

This clarity means that our clients are empowered to understand the cost and value of their benefit and optimize it more fully as fiduciaries.

Our clients trust our approach because of the transparency at every step along the way – from our contracts and financial transactions to our business operations and outcomes. Our reporting technology enables a unique degree of visibility and fosters collaborative, consultative discussions to make informed decisions on behalf of members.

A Proven Model to Control Cost and Manage Trend

Our commercial clients include private and public sector employers, labor unions, and health systems. We enable our clients to access a full spectrum of benefit management services to deploy strategies aligned with their goals. By removing spread pricing, implementing utilization management controls, deploying lowest net cost formulary design, optimizing pharmacy network agreements, and providing personalized support for member clinical transitions, Navitus clients realize cost savings within the first year. Ongoing partnership and incremental actions lead to controlled trend over time (Figure 1).[1]

As reported in our 2022 drug trend report, despite notable increases in list drug prices and utilization compared to 2021, the average net cost per member per month (PMPM) trend for commercial clients was 2.6% for the measurement period.[2]

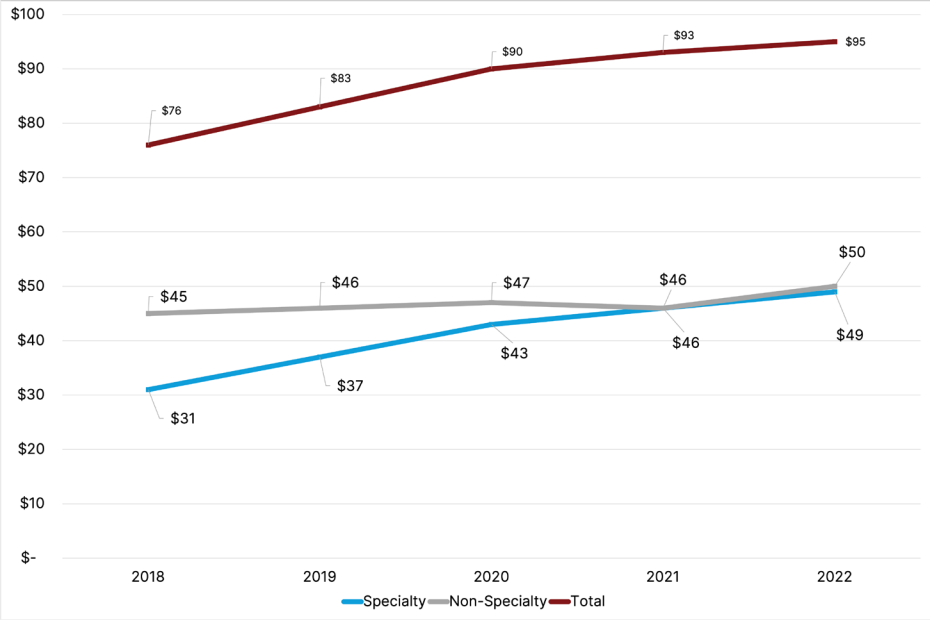

Figure 1. Commercial Book of Business Net Total Cost PMPM (2018-2022).

Enterprise Capabilities to Control Total Cost of Care

Medical specialty drugs represent approximately 40% of an employer plan sponsor's specialty drug spend.[3] Commonly injected or infused, medications in this category include those used to treat complex or rare conditions including cancer along with some of the highest cost orphan drugs and gene therapies. Despite their potential to significantly impact total cost of care, these drugs are often minimally managed and employer visibility is limited through the medical benefit.

Without rigorous management levers like those available for pharmacy, plan sponsors can be left paying for therapies that are inappropriate or excessive in cost. To complicate matters, sites of care can be highly variable in cost with little to no difference in clinical benefit, and the nature of reimbursement under the medical benefit creates greater potential for costly billing errors. In totality, these dynamics create significant pressure on an employer's benefit budgets and challenges their fiduciary accountability.

Our majority investment in Archimedes expands medical specialty management capabilities within the Navitus Health Solutions portfolio. With this, our clients can access data tools, monitoring, and retrospective outreach to the health plan to pursue various cost saving interventions. For example, Archimedes' retrospective review of medical claims has uncovered opportunities to lower medication cost through drug substitutions, site of care switches, or corrected billing. By engaging providers and, in turn, members, 1 in 5 engagements with Archimedes have resulted in medication cost improvement. This retrospective, voluntary intervention program delivers a 2:1 ROI for clients who have implemented it.[4] We estimate program ROI to be between 2:1 and 3:1 for employer plans that have also implemented access guidance services.[5]

Helping Members Access and Stay Adherent to Medication Therapy

Managing cost while also improving a patient's health and quality of life are guideposts for our enterprise pharmacy solutions. Our specialty pharmacy, Lumicera Health Services, deploys an actual acquisition cost-plus model rarely seen within the market. This provides life-changing savings to patients on specialty medications who otherwise may be forced to forego treatment.

The risk of that reality is all too common within our healthcare system. Prior to becoming one of our members, Eddie was forced to consider discontinuing treatment for metastatic cancer due to the high cost of the generic medication he accessed through a spread-based specialty pharmacy. When his benefits changed to the Navitus Health Solutions organization, Eddie transferred his prescription to Lumicera. The combination of a lowest net cost formulary approach, an acquisition cost-plus specialty pharmacy and a robust patient support model for managing complex conditions enabled Eddie to transition his therapy and reduce his out-of-pocket expense by nearly 95%. His plan realized similar savings on the paid amount.[6]

Patients like Eddie express strong satisfaction with Lumicera's high-touch patient care model, providing a stand-out net promoter score of 84 in our 2023 survey.[7] Each day, Lumicera clinicians uncover and seek to resolve questions about their patient's therapy. They help mitigate barriers to adherence, including helping more than 80% of Lumicera patients access copay assistance through enrollment and re-enrollment support.[8] In 2023, Lumicera clinicians helped secure average copay card savings of more than $500 for commercial patients.[9] This personalized support, in addition to digital patient engagement tools, contributes to therapy compliance rates greater than 90%.[10] Excellence in both clinical support and cost management produces positive outcomes for our patients and client partners.

As an enterprise, this is our "why".

We are committed to meaningful action that improves medication access and affordability. Aligned to this, we became a founding member of CivicaScript in 2022. As a public benefit company, CivicaScript develops quality specialty and non-specialty generic medicines with an express commitment to price transparency. CivicaScript products include a QR code on the prescription label that links to CivicaScript's maximum recommended price to the consumer. This unique feature provides a way for healthcare consumers to ensure the price they paid did not exceed CivicaScript's Maximum Retail Price (MaxRPTM) policy.

This is another avenue to create access to lower cost generic drugs. CivicaScript's first focus is to develop and manufacture six to 10 medicines for which there is not ample market competition to drive down price. This includes drug therapies for cancer. Their first product, abiraterone acetate 250mg, is the generic of Zytiga® and is used for combination treatment for a certain type of prostate cancer that has spread to other parts of the body. Lumicera is one of two dispensing pharmacies supporting the distribution of this low-cost product.

Summary

Over more than twenty years, Navitus Health Solutions has expanded our portfolio of pharmacy solutions to improve the health of those we serve. Our pharmacy benefit management services are delivered with a commitment to plan and drug cost data transparency to provide our clients the clarity to act with confidence. Our breadth of clinical management services helps clients tackle evolving challenges and support member access to the lowest cost, clinically appropriate medication therapies. By partnering together, we are committed to supporting our customers in achieving their benefit goals.

1. Navitus Health Solutions. 2023. Summarized data from published drug trend reports, 2018-2022.
2. Navitus Health Solutions Annual Drug Trend Report (2022, June)
3. Pharmaceutical Strategies Group. 2023 Artemetrx State of Specialty Spend and Trend Report. Dallas, TX: PSG.
4. Archimedes. 2023. Medical Management Book of Business Statistics. Unpublished internal company data.
5. Archimedes. 2023. Medical Management Book of Business Statistics. Unpublished internal company data.
6. Navitus Heath Solutions. 2023. Client-Specific Benefit Data Reporting. Unpublished internal company data.
7. Lumicera Health Services. 2023. Patient Satisfaction Survey. Unpublished internal company data.
8. Lumicera Health Services. 2023. Business Operations Reporting. Unpublished internal company data.
9. Lumicera Health Services. 2023. Business Operations Reporting. Unpublished internal company data.
10. Lumicera Health Services. 2023. Top 5 Disease State Adherence Rate Measurement. Unpublished internal company data.

Value-Driving Partnership: How a Global Employer has Realized Sustained Savings with Navitus

Case Study

NAVITUS HEALTH SOLUTIONS

Client industry: Industrial gas, Engineering
Estimated total members with benefits: 21,000
Product: Full-service pharmacy benefit management
Year implemented: Legacy company: 2015; Acquired company: 2020

Overview

Finding a partner for pharmacy benefit management (PBM) services that consistently delivers toward an organization's evolving needs can be challenging. The complexity of the industry and opaque models can cloud confidence, obscure a sense of alignment, and distort shared understanding. Moreover, employers seek to minimize disruption for members who are using their benefit and are stable on therapy. These factors create barriers to change for plan sponsors. Many choose to stay the course and hope for the best from spread-based models, rather than pursue an alternative.

Amid rising healthcare and pharmaceutical costs, the untapped savings potential of a transparent, pass-through PBM should compel a plan sponsor to explore this option. As a fiduciary, a plan sponsor is required to engage actively on behalf of plan participants and beneficiaries, providing benefits and paying reasonable expenses for plan administration. This requires consistent oversight, cost-level data visibility, and courage to challenge the status quo when a partner is not delivering to the fullest potential.

The Challenge

A large global employer within the industrial gases and engineering sector was at an inflection point during a post-merger integration. At that time, the legacy company had been a client of Navitus' for nearly five years. The acquired company's trust with their PBM vendor had eroded due to limited access to their data coupled with soaring drug cost and trend for their employee population. Doubtful that the vendor was providing them the full picture to optimize their benefits, they found their baseline costs to be 50% higher than those of our legacy client.[1] It was determined the company would change PBMs and implement with Navitus, expressing a desire for true partnership. They defined their decision parameters to include: 1) improved access to plan and drug cost data; 2) flexibility to support varied benefit set-ups; and 3) a willingness to partner closely with their benefits consultant. Like other employers, the organization was focused on providing an attractive benefit while keeping costs controlled and supporting the member transition experience.

A Market-Ready Solution

The organization found Navitus to be a market-ready solution. We are an established, full-service pharmacy benefit manager, serving the market for more than 20 years. Our model was developed to deliver transparency to acquisition cost. Our clinical management practices leverage sound formulary design and clinical edits to control waste and support member access to the lowest cost, clinically appropriate medication therapies.

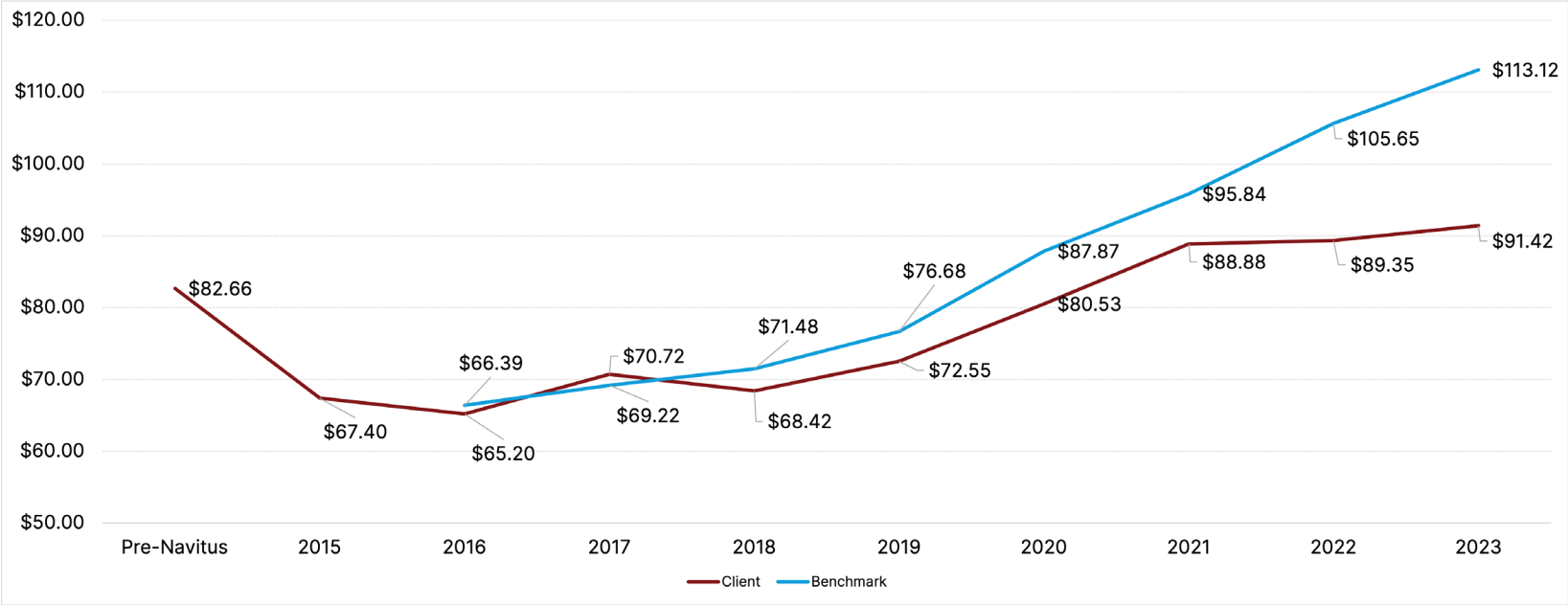

Figure 1. Client Net Total Cost PMPM (2015-2023). Summary of the net total cost PMPM for this client over time.

PMPM Savings Delivered by the Navitus Model

Data for the period of 2015-2023 reveals how the net cost per member per month (PMPM) trend over time has been well-maintained for our client across their tenure with our company (Figure 1).

When the legacy company first implemented with Navitus, the baseline net total cost PMPM from the prior PBM was $82.66. Within the first year, we achieved a cost reduction of nearly 18.5% through the application of our pass-through, lowest net cost formulary management model and copay assistance.[2] With Navitus' pass-through model, the client benefited from drug price decreases and rebate increases in real time, without having to wait for a market check. In addition, Navitus worked with our client to implement mandatory mail and opioid utilization programs including concurrent drug utilization in 2016-2019. During this time, net total cost PMPM trended under 4% compared to a benchmark of 5%.[3]

The acquired company was onboarded in 2020. Within the first year, that new segment realized a significant reduction in plan paid PMPM versus the prior PBM.

For the implementation, the client chose to install a three-month continuation of care strategy. This is often pursued by employers as a mechanism for facilitating clinical transitions when a new benefit is implemented. Pharmacy network decisions included Costco Pharmacy for mail order and Lumicera Health Services (a wholly owned subsidiary of Navitus) as preferred for specialty pharmacy.

Additionally, the client implemented Navitus' medically administered products (MAP) formulary. When pharmacy benefit controls are applied to medications otherwise processed under the medical benefit, notable savings result. This has reduced total cost of care for the client. 2023 data revealed that for every $1.00 PMPM increase in pharmacy spend on the

MAP formulary, the client realized medical savings of approximately $1.25 PMPM. For the 2023 calendar year, net benefit savings were estimated to be between $475,000-$500,000.[4]

Across the nine benefit years measured, net total cost PMPM trend averaged 4% versus a benchmark of nearly 8%.[5] This lower trend over time compounds the first year PMPM reductions realized when moving to Navitus. Together, this has generated significant savings for our client and continues to instill confidence in the value of the pharmacy benefit provided for their membership as a fiduciary.

Results like those highlighted are not anomalies. Consistently, our client has outperformed a variety of industry benchmarks related to their pharmacy benefit. Table 1 notes the following:

» Days' Supply Per Member Per Month (PMPM) is a measure of product in-hand. Working with Navitus to deploy clinically appropriate utilization management measures, the client outperformed the industry benchmark by 13% during the measurement period.[6]

» Per Employee Per Month (PEPM) Prescription (Rx) Cost is a recognized metric for setting benefit budgets. This measures drug cost and utilization. Even with an average member age 7% higher than benchmark, our client's PEPM Rx Cost was 16% below the reference during the measurement period.[7]

These metrics demonstrate ongoing effectiveness in deploying client-aligned benefit decisions that guide appropriate use and control costs. Calculated cost savings for days' supply per member per year during this measurement period was nearly $2.5M.[8]

Flexible Solutions for Emerging Needs

Partnership between Navitus and our client has continued to flourish, most recently with focus on emerging drug cost drivers. An industry report indicated a 2022 pharmacy trend in the employer market to be 14.4%, with glucagon-like peptide-1 (GLP-1) therapies driving a significant portion of this double-digit increase.[9] Like many employers, our client has contemplated the best path for managing increased utilization of GLP-1 therapies. The complexity of this category requires consideration of positive health outcomes over time compared to significant cost of coverage in the nearer term. If plan sponsors introduce utilization management measures, they may face limited rebate performance.

> For employers seeking to effectively control pharmacy cost, we would recommend Navitus, their lowest net cost philosophy and pass-through model, and their service model for supporting clinical management decisions."
>
> *- Client Representative: Director, Global Benefits*

Metric	Client Population	Industry Benchmark	Variance
Average Member Age	45.9	42.8	7%
Days' Supply PMPM	25.9	29.2	-13%
PEPM Rx Cost	$201.25	$233.92	-16%

Table 1. Navitus Client Data in Comparison to Industry Benchmarks (May 2021- April 2022)

Our client faced this trade off consideration when choosing to implement custom prior authorization rules for the 2023 benefit year. These rules were designed to control for appropriate use within this category and enable drug access for a subset of membership. By working with Navitus

partners, our client was empowered with their data. They referenced drug-level acquisition cost data, forecasted rebate value, and estimated member utilization to assess both cost and revenue impacts. In doing so, they were able to make an informed decision to proceed.

2023 plan data confirmed the approach controlled spend in the category to 7% of total plan paid dollars in comparison to an employer benchmark of nearly 13%.[10, 11] Moreover, utilization was less than 3% for the period 2023 vs. 2022, outperforming a benchmark of approximately 5%.[12] A client representative shared that the quality of clinical information provided, and subsequent program results, exceeded expectations. Coupled with easy-to-understand rebate-related reporting and timely rebate payments, Navitus enabled them to implement this benefit decision with confidence and monitor it against expectations.

Summary

For nearly a decade, a strong partnership has been fostered between Navitus and our referenced employer client. By establishing trust through complete data transparency, aligned goals and flexible benefit administration, ongoing savings and cost control for the plan has been achieved.

> Navitus is a true partner. They continue to distinguish themselves amongst their competitors. The accountability and way Navitus administers our prescription benefits plan has exceeded my expectations and supports our organization as fiduciaries of the benefits offered."
>
> *- Client Representative: Director, Global Benefits*

1. Client-provided data. 2024. Unpublished internal company data.
2. Navitus Health Solutions. 2024. Client-specific data reporting. Unpublished internal company data.
3. Navitus Health Solutions. 2024. Book of business data reporting for period 2016-2019. Unpublished internal company data.
4. Navitus Health Solutions. 2024. Client-specific program reporting. Unpublished internal company data.
5. Navitus Health Solutions. 2024. Commercial book of business benchmark. Unpublished internal company data.
6. Navitus Health Solutions. 2022. Combined client and client-provided industry data. Unpublished internal data.
7. Navitus Health Solutions. 2022. Combined client and client-provided industry data. Unpublished internal data
8. Navitus Health Solutions. 2024. Comparative cost savings of days' supply PMPY. Unpublished internal data.
9. Magellan Rx Management. 2023. Employer Market Insights Report™.
10. Navitus Health Solutions. 2023. Client clinical program performance reporting. Unpublished internal data
11. Navitus Health Solutions. 2023. Navitus commercial book of business reporting. Unpublished internal data
12. Navitus Health Solutions. 2023. Navitus commercial book of business and client clinical program performance reporting. Unpublished internal data

Rx Savings Solutions (RxSS) reduces prescription drug costs for employers, covered employees, and dependents through clinical technology, engagement marketing, member support, and concierge service. Since 2012, employers and health plan clients have controlled pharmacy spend by helping members find, change, and adhere to more affordable prescriptions with RxSS.

Content for this section provided by Rx Savings Solutions.

Rx Savings Solutions (RxSS) was founded on a belief that no one cares more about the cost of prescription drugs than the patients who need them. More than a decade ago, RxSS self-insured employer clients began to prove that helping members find affordable prescriptions is an effective, sustainable way to reduce plan spend.

Solving for a Persistent Problem

Despite years of payers, patients, providers, and politicians calling for more prescription drug price transparency, a lack thereof contributes to the status quo of annual increases in drug spend.

Between 2017 to 2022, payer net spending increased from $461 billion to $603 billion, a compounded annual growth rate of 4.5%.[1] Patient out-of-pocket (OOP) costs rose by $2.1 billion in 2022 alone, their second peak in five years.[2] Eight in 10 adults say prescription costs are unreasonable; one in five have not filled a prescription due to cost.[3]

Recent years have brought federal price transparency regulations on health systems, insurers, and plan sponsors; real-time benefit check provider interfaces; transparent pharmacy benefit managers (PBMs); along with various price lookup and other member-facing tools offered by traditional PBMs.

These developments, made in the spirit of transparency, have not slowed the growth in drug spending. Nor have they significantly changed long-existing norms: Patients trust what providers prescribe, yet 79% of providers do not know how much a drug they call into a pharmacy will cost the patient, let alone the payer.[4]

RxSS has shown that meaningful pharmacy cost reduction can be achieved when the individual, insured patient has full visibility into the costs and clinical effectiveness of every medication and fulfillment option within their pharmacy benefit (and outside of it). RxSS provides that transparency for more than 18 million members covered by client health plans and employers, including 50 of the Fortune 500.[5]

- Since 2012, RxSS has **saved employers and their plan members combined more than $393 million** by identifying lower-cost clinical and fulfillment alternatives, notifying members, and removing barriers to behavior change (i.e., changing from a legacy prescription to one with a lower cost for the member or plan).[6]
- Across **2.6 million conversions** from legacy prescriptions to doctor-approved, lower-cost alternatives, the average savings is **$138.84 per behavior change.** Average plan and member share of total savings breaks down to 70% and 30%, respectively.[7]
- In 2023, RxSS employer clients **reduced pharmacy plan spend by 32.5% when members switched to lower-cost prescriptions,** avoiding $252 million in pharmacy costs they would have incurred had RxSS not been implemented.
- In the same year, members who converted to a lower-cost prescription **reduced their pharmacy costs by 55%.**[8]

Making Transparency Actionable

Plenty of clinical, cost, and coverage information is available for today's healthcare consumer to inform discussions with providers about prescription decisions. However, most patients do not have the time or wherewithal to compile data from multiple disparate sources for easy, accurate comparison. RxSS consolidates it into one place.

Technology – RxSS layers over an employer's existing pharmacy benefit, plan design, formulary, and network, regardless of PBM and rebate

strategies in place. The RxSS technology "engine" ingests prescription claims along with eligibility, plan design, formulary, and accumulator files. A patented algorithm maps each claim against more than 50,000 drugs and dosages that have been identified and peer-reviewed by the RxSS Pharmacy & Therapeutics Committee. Savings opportunities are identified by the algorithm according to all plan variables in a member's unique benefit profile.[9]

- Out of the 8,226 different drugs identified across all clients' claims in 2023, 80% of drugs have an alternative mapped by the RxSS suggestion engine, and 90% of analyzed claims are for products with a suggestion.
- Based on claims analysis of all clients' total drug spend in 2023, the RxSS engine contains suggestable **alternatives for 93% of that spend.**[10]

Member Engagement and Experience – In the member portal and mobile app, members can view savings opportunities and check the cost and available alternatives for any drug. RxSS notifies the member via email, direct mail, or SMS when a lower-cost prescription is identified. RxSS determines how, when, and why notifications are sent based on available data and system-based logic. Inputs include value and type of savings opportunity, optional employer incentives, available member contact information, and communication preferences. Notifications can also appear within other healthcare point solutions in an employer's benefits ecosystem via RxSS API connections.

Ongoing, multi-channel communication and enhanced targeting drives consistent engagement results across diverse employer plan designs, industries, and member populations. RxSS qualifies a member as engaged if they exhibit at least one of five trackable, documented behaviors.[11]

Within the RxSS employer book of business:

- Members with pharmacy claims have a **28% engagement rate.**
- **49% of engaged members** switch to a lower-cost medication.
- Employers that follow the RxSS engagement strategy see **14% higher engagement** for members with pharmacy claims than employers that do not follow the RxSS recommendation.[12]

Importantly, RxSS data indicates that members engage for relatively small savings opportunities, many of which are equal to or less than fixed copays:

- **69% of all conversions** to RxSS-suggested prescriptions occur for OOP savings of **$20 or less per fill.**
- On average, more than **one-third of plan savings** have been generated by members acting on suggestions that save them **$10 or less per fill.**[13]

Concierge Service and Last-mile Support – Members can discuss suggested alternatives with their provider or engage the RxSS concierge service team to avoid time-consuming obstacles like repeated calls to busy provider practices and pharmacies. RxSS pharmacy technicians facilitate the prescription switch and follow up on the member's behalf. The same dedicated team provides live, one-on-one support to help members convert on opportunities they might otherwise miss.

- Members spend an average of **49.5 seconds** to initiate concierge service.[14]
- Prescribers **approve 88% of all prescription change requests** submitted by RxSS on a member's behalf.[15]
- Concierge cases are **completed in 5.7 days,** the average duration from initial prescriber outreach to fulfillment.[16]

Evolving with the Market and the Member

» When an RxSS member switches to a lower-cost alternative, they stay on it an average of 9 months. The duration reflects customary changes in drug costs, coverage, and formularies year to year but also RxSS's ability to identify and present new savings opportunities as well as expand the engagement platform's sophistication. In fact, 70% of total client and member pharmacy savings realized in 2023 came from new and recurring behavior changes initiated in 2023.[17]

» The solution automatically adapts to market developments planned and unplanned, such as the wave of Humira® biosimilars and the recent surge in claims for diabetes and weight-loss drugs. Specialty and other high-cost drugs project to be 56% of total drug spend by 2027.[18] The RxSS engine solves for specialty spend the same way it does for traditional drugs. Clinical alternative suggestions exist for 90% of clients' specialty pharmacy claims and 89% of spend.[19] In 2023, across the RxSS book of business, 61% of new and recurring specialty behavior changes and 94% of savings on specialty were due to clinical switches—change in drug formulation (e.g., capsule to tablet), generic clones, brand-to-generic substitution, or an alternative drug to treat the same indication.[20]

» As of 2022, six in 10 insured Americans purchased at least one prescription outside their pharmacy benefit.[21] Non-insurance "cash" pay and discount card pricing can now be presented to members when employers opt in to the RxSS discount card integration, providing members with deeper transparency into costs with and without insurance. When members choose to purchase at a non-insurance or discount card price, employers incur zero plan cost but still receive reported data as if the claim were adjudicated through the pharmacy benefit.

For employers, the current pharmacy landscape contains a mix of necessary evolution and extraordinary opportunity for positive impact. Transparency remains the catalyst for meaningful change to the status quo. RxSS partners with clients to find new ways to equip those in the best position to drive change—the roughly 50% of Americans who get health insurance through their employer.[22]

1. IQVIA (2023)
2. IQVIA (2023)
3. KKF (2023)
4. JAMA Network Open (2021)
5. RxSS client demographics (April 2024)
6. RxSS internal data; combined plan and member savings through 4/29/2024 for self-insured employer and public sector clients (May 2024)
7. RxSS internal data; combined plan and member savings and average savings per behavior change through 4/29/2024 for self-insured employers and public sector clients (May 2, 2024)
8. RxSS internal data; cost avoidance 1/1/2023-12/31/2023, using cost of original parent drug vs. cost of child drug after behavior change to calculate plan and member spend had RxSS not been in place, self-insured employers and public sector clients (May 2024)
9. RxSS clinical suggestion database (April 2024)
10. RxSS internal data; analyzed claims 1/1/2023-12/31/2023 (May 2024)
11. Tracked behaviors: 1) account activation, 2) behavior change within 6 months of receiving RxSS direct mail, 3) price lookup via drug search API, 4) interaction with RxSS pharmacy support team resulting in contact prescriber request, and/or 5) prescription switched within 60 days of prescriber contacted through Direct to Prescriber program.
12. RxSS internal data; average engagement rate for eligible members with claims through 12/31/2023 for self-insured employers and public sector clients who followed RxSS marketing plan (May 2024)
13. RxSS internal data; behavior change based on member savings thresholds, RxSS book of business (May 2023)
14. RxSS internal data; contact prescriber time to complete request, average for past four quarters (April 2024)
15. RxSS internal data; contact prescriber success rate (March 2023-March 2024)
16. RxSS internal data; contact prescriber average time to completion (March 2023-March 2024)
17. RxSS internal data; savings recency, RxSS book of business (May 2024)
18. IQUVIA (2023)
19. RxSS clinical suggestion database (September 2023)
20. RxSS internal data; savings by suggestion type when the parent drug has a specialty indication, RxSS book of business 1/1/2023-12/31/2023 (May 2024)
21. Prescryptive (2022)
22. KKF (2022), Employer distributions, 2022

U-Haul Goes All in to Put the Brakes on Pharmacy Spend

Case Study

Client: U-Haul
Industry: Truck, trailer, storage rental, and moving supplies
Population: 22,000 covered team members (employees) and dependents
Year Implemented: 2020
Offerings: RxSS portal (clinical suggestion engine, member engagement and concierge service), RxSS mobile app, AdminRx

The U-Haul tradition of offering strong benefits has helped make the company an employer of choice. Its benefits program reflects the DIY spirit that is synonymous with the U-Haul brand and the industry it created.

In the same way U-Haul offers everything needed for a successful move, U-Haul team members have robust resources available for improving health and wellness. Like U-Haul Company's customers, team members (employees) are spread across two countries, with about 19,000 of their 22,000 covered members located somewhere other than U-Haul headquarters in Phoenix, Arizona.

In 2019, the company looked to address high-cost medical and pharmacy claims, particularly from employees with chronic conditions. U-Haul Company's benefits leaders believed transparency into prescription prices and clinical alternatives could help their covered members find and adhere to the most affordable options for treating those conditions, which would translate to lower plan spend and reinforce its commitment to team member health and wellness.

U-Haul Company's benefits leaders chose to implement Rx Savings Solutions (RxSS) because they saw the potential for sustained success with a member-focused approach. Rather than shift costs or scale back coverage, U-Haul could help the two key stakeholders — team members and the plan — get more value from the existing pharmacy benefit year over year. It also meant no disruption to benefits, or changes to the plan design or pharmacy benefit manager (PBM).

Driving Engagement and Results

U-Haul elected to launch "off-cycle" in March so awareness and engagement could build months before open enrollment, when benefits and point solution communications compete for members' attention. The decision was the first of several that reflect support for the RxSS program at the highest levels.

RxSS and U-Haul partnered to overcome two inherent engagement challenges during launch and in the years since:

1. A high proportion of non-desk team members in a geographically dispersed population
2. Email addresses available for about half of primary covered members

U-Haul Company's "all-in" approach began at launch from the highest levels. Borrowing from RxSS launch best practices, the CEO of U-Haul sent an announcement email to all benefits-eligible team members to introduce the RxSS benefit. The internal announcement was followed by a four-touch email RxSS launch campaign. By April, 60 days post-launch, 11% of eligible primary members had activated RxSS accounts, which is slightly higher than the average for the RxSS employer book of business at the same milestone.[1]

In the months post-launch, U-Haul and RxSS deployed additional engagement tactics to grow registration and team member education,

including targeted direct mail savings notifications to reach non-desk employees, prescription delivery campaigns, educational videos featuring the U-Haul CEO, and pharmacist-led chronic condition-based webinars about diabetes and cardiovascular health to reach team members in those specific target populations. However, the most significant strategy shift occurred at the next open enrollment.

U-Haul executive leadership required team members to activate their RxSS accounts as a step in the benefits enrollment process. Since then, the primary member registration rate has averaged around 95%, including more than 98% of team members on maintenance medications, who have the most repeated impact on spend (Figure 1).[2]

> The direction from our CEO and leadership team was: It's an amazing tool, we make it available to team members, it can save them money—how can we get more of them to use it?"
>
> *- Becca Gibson, Wellness Program Manager, U-Haul*

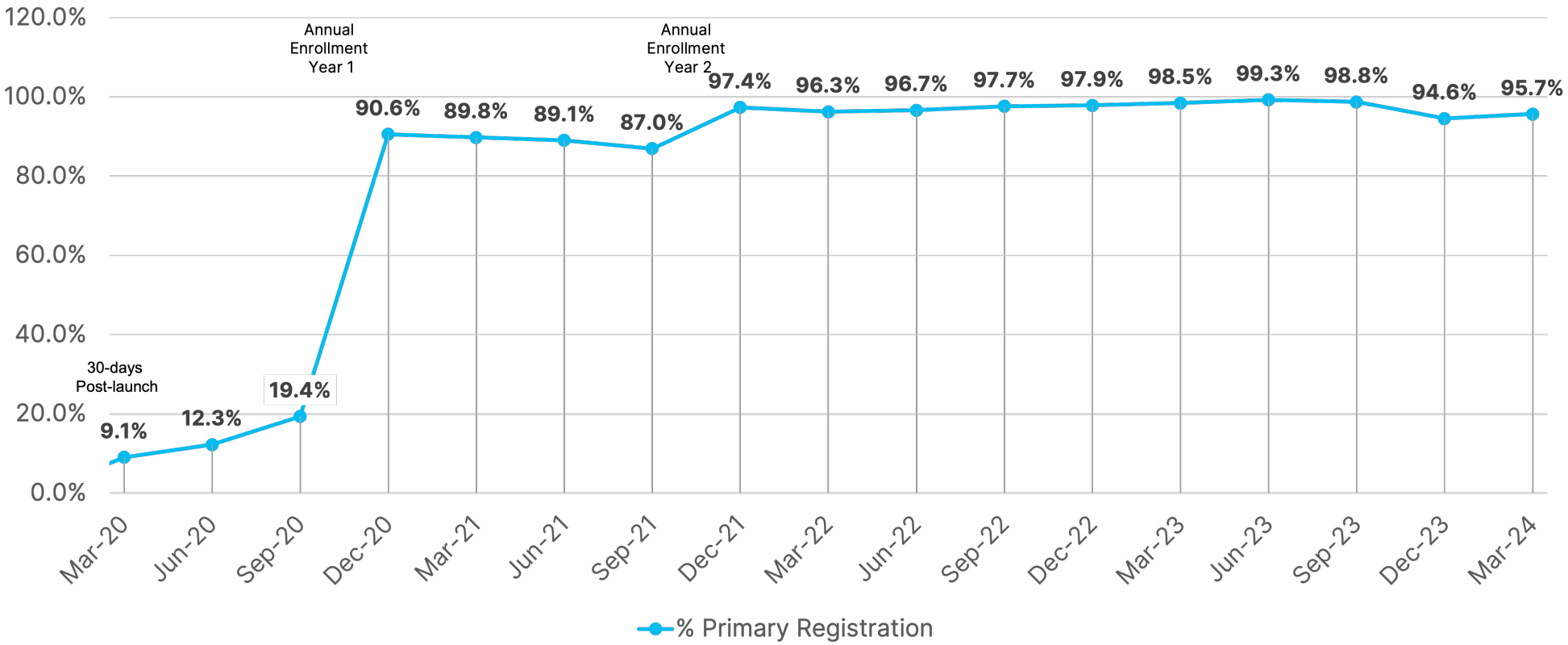

Figure 1. Primary Members with Activated RxSS Accounts. Registration rates under 100% are expected due to the U-Haul 1-month benefits enrollment grace period for employees onboarded throughout any plan year.

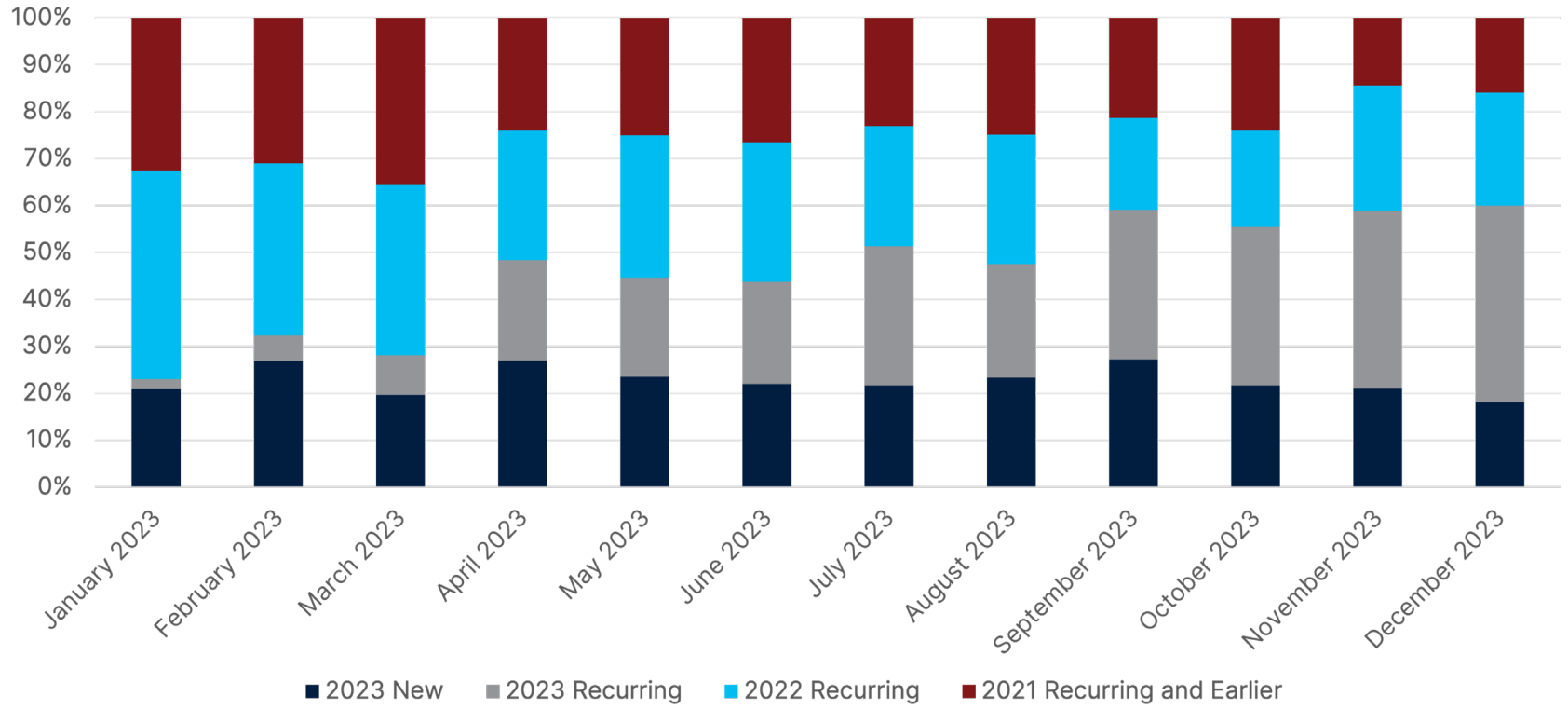

Figure 2. New and recurring savings by year as a percent of total savings realized in 2023 based on the first fill date.

Success Metrics

Covered member and plan savings continue to climb thanks to a steady volume of new conversions ("behavior changes") to lower-cost prescriptions and recurring fills of the new prescription. Ongoing engagement and evolving strategies to reach members help capture new savings. In 2023, nearly half (47%) of total savings were generated from behavior changes that originated in 2023 (Figure 2).[3] Recurring fills of the lower-cost prescription are key to sustaining savings, demonstrating that RxSS is effective in engaging members to make new switches and members who switch are staying on the lower-cost prescriptions. The average length of recurring behavior changes for U-Haul members is 11 months.[4]

Multiple additional factors contribute to U-Haul Company's escalating success:

- In 2021, the RxSS clinical savings engine contained approximately 30,000 possible lower-cost alternatives. By 2023, the RxSS Pharmacy & Therapeutics Committee, comprised of clinical and specialty pharmacists, had curated nearly 20,000 more.
- Due to ongoing internal promotion, including an instructional video posted on the U-Haul internal wellness portal, awareness and familiarity with the RxSS member portal and mobile app spread throughout more of the U-Haul population. Today, more than one in four registered U-Haul members use the mobile app, a rate 18% higher than the average seen from the RxSS employer client population.[5]

» U-Haul and RxSS continually evolve engagement strategies and refine the messaging, targeting logic, and timing according to individual member habits and savings opportunities to reach key sub-groups within the member population. Examples include:

- **Non-Desk Employees:** Members who have not taken action on email notifications, but have multiple savings opportunities reaching a specific dollar threshold, receive a detailed Personalized Savings Report (PSR) in the mail. In 2023, the direct mail channel, which includes PSRs as a sub-category, had a 35.3% behavior change rate for U-Haul members not engaged with email.[6]
- **Members with Chronic Conditions:** Members whose claims indicate certain chronic conditions are targeted for condition-based engagement campaigns, delivered with specific messaging utilizing email, direct mail, or telephone outreach depending on the member's communication preferences and historic engagement metrics. In 2023, email savings notifications, which include condition-based campaigns as a sub-category, averaged a 39% open rate and a 5% click rate—twice that of the RxSS book of business average (which includes health plans).[7]

As demonstrated by these examples, RxSS engagement marketing continually strives to make every communication more educational and relevant to each target population segment and streamline the conversion path to lower-cost prescription options.

> The majority of our high-cost claims are due to two or three chronic conditions (diabetes and cardiovascular). RxSS has really helped our team members find those lower-cost options and get us the savings and adherence we needed."
>
> *- Becca Gibson, Wellness Program Manager, U-Haul*

Four years post-launch, the average savings per fill when a U-Haul member switches prescriptions is $112.53. U-Haul realizes the most benefit with plan vs. member savings favoring U-Haul 80% to 20%, which is 10% more in U-Haul's favor than average for RxSS employer clients.[8] In the four years since the program started:

» Members saved more than $720,000, reducing their spend an impressive 48% compared to what they would have spent on the same prescriptions had RxSS not been in place.[9]
» Proving that when members save, the plan saves, U-Haul has amassed more than $3.3 million in cumulative plan savings resulting from members switching to lower-cost prescriptions–a 39% reduction in total lifetime plan spend.[10]
» U-Haul Company's lifetime ROI has grown to 4.6:1 based on combined plan and member savings and continues on an upward trajectory.[11]

U-Haul Company's relationship with RxSS exemplifies their DIY approach to employee benefits, empowering their team members to take control of their health and their healthcare costs. This has proven to be the right approach for U-Haul to move employee healthcare forward.

> Our teams do a fantastic job of collaborating on new ways to drive more awareness and engagement. RxSS understands our unique population and always brings fresh ideas to the table and supports our own initiatives however they can."
>
> *- Becca Gibson, Wellness Program Manager, U-Haul*

1. RxSS internal data; U-Haul vs. RxSS self-insured employer book of business, registration rate for eligible primary members 60 days post-launch (April 2024)
2. RxSS internal data; historical trend for primary members and primary members on maintenance medications with activated RxSS accounts (April 2024)
3. RxSS internal data; U-Haul savings recency trend by first fill date, last calendar year (April 2024)
4. RxSS internal data; U-Haul savings recency and average length of behavior change (April 2024)
5. RxSS internal data; mobile app users, U-Haul vs. RxSS self-insured employer book of business (~173 client groups) (April 2024)
6. RxSS internal data; U-Haul direct mail effectiveness, send date 1/1/2023-12/31/2023 (April 2024)
7. RxSS internal data; U-Haul savings notifications results, send date 1/1/2023-12/31/2023 (April 2024)
8. RxSS internal data; U-Haul average savings per behavior change, through 3/31/2024 (April 2024)
9. RxSS internal data; member cost avoidance 3/1/2020-3/2/2024, using cost of original parent drug vs. cost of child drug after behavior change to calculate plan and member spend had RxSS not been in place, self-insured employers and public sector clients (April 2024)
10. RxSS internal data; U-Haul cost avoidance 3/1/2020-3/2/2024, using cost of original parent drug vs. cost of child drug after behavior change to calculate plan and member spend had RxSS not been in place, self-insured employers and public sector clients (April 2024)
11. RxSS internal data; U-Haul lifetime ROI through 3/31/2024 (April 2024)

EHR

A World 50 Group Community

SOLUTION EVALUATION GUIDE

SOLUTION EVALUATION GUIDE

The following resources will be helpful to employers when evaluating vendors in the pharmacy benefits space. The chart below (Figure 1) provides an overview of indicative vendor solutions. Employers have a variety of solutions available to them: some are intended to fully replace a traditional pharmacy benefits manager (PBM), while others work in concert with a PBM.

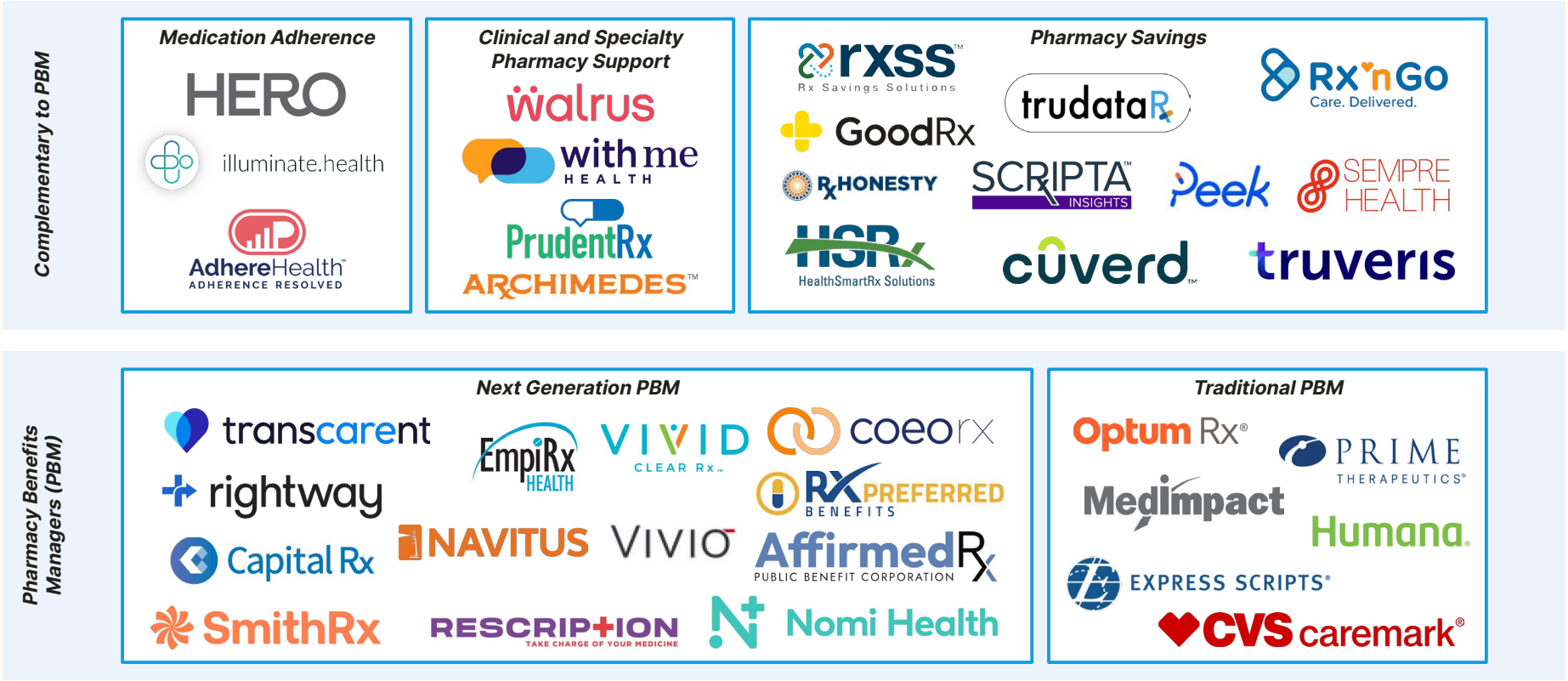

Figure 1. Pharmacy Benefits Landscape Overview. This graphic is intended to provide an indicative, but not comprehensive, view of the pharmacy benefits employer solution market. For convenience, the solutions have been sub-categorized based on their primary focus; however, the sub-categories may not be mutually exclusive.

Sample RFI/RFP Questions

This list includes questions relevant to PBMs and other organizations that support pharmacy benefits, so we invite you to select the questions that apply to the vendor type you are evaluating. This list should not be considered a comprehensive list of all questions an RFP should include. Rather, these are additional questions that can be included to elicit differences between solutions that may be less visible in typical RFP questionnaires, supporting you in finding the partner that is most aligned with the interests and needs of your organization.

Business Model Alignment & Transparency

1. How do you drive towards the lowest net cost of care for pharmacy and medical/healthcare spend? How do you promote competition within the market vs. pushing towards exclusivity?
2. Disclose all sources of revenue for your overall book of business.
3. Do you have any ownership ties or financial relationships that could influence your recommendations or decisions? Do you prefer a specialty pharmacy, mail order pharmacy, or other assets under common ownership?
4. Which of these sources will you rely on for profitability for this contract?
5. Which measures do you have in place to avoid conflicts of interest?
6. Disclose any financial arrangements you may have with the consultant/broker managing or evaluating this RFP.
7. What is your organization doing to reduce the Gross to Net gap in brand name medications?
    a. Do you pass through 100% of client-derived manufacturer value?
    b. How do you drive towards the lowest net cost?
    c. Do you contract for fees and administrative payments from manufacturers? Are those passed through to clients?
8. How does your organization contract for manufacturer derived revenue? Do you use rebate aggregators, GPOs, contract directly or use an alternative approach? If you use a GPO, describe how your GPO derives its revenues.

Questions to Consider When Selecting a Consultant

Since higher rebates and discounts do not always translate to lower spend, it is important for employers to select a consultant who evaluates PBMs based on lowest net cost in spend and not just rebate guarantees and average wholesale price (AWP) discount guarantees.

1. Is your consultant able to reallocate in their modeling?
    a. For example, if you are pursuing a biosimilar strategy, can the consultant's spreadsheet take into consideration the value of a lower cost biosimilar vs. a loss in rebates on a higher cost drug?
    b. Is this a primary modeling step or done situationally?
2. How does your consultant score the financial spreadsheet?
    a. Is the primary scoring based on rebates and discounts, or is equal weight given to lowest net cost and additional guarantees for management to the lowest net cost?
    b. Does this methodology align with your goals as a plan sponsor?
3. Would you consider a guarantee on managing to the lowest cost drug as equally or more important as a rebate or discount guarantee? How does your consultant evaluate these types of guarantees?

9. Do you include any dollars from Copay Assistance Programs in the calculation and/or reconciliation of rebates?
10. Do you own, or are you affiliated with, any entity from which you are receiving manufacturer-derived revenue?
11. What are your internal policies for maintaining ethical standards and transparency?

Pricing

12. Describe your pricing model. How does it align with member and client goals?

13. Do you offer a fully-transparent/pass-through pricing model?
    a. How do you define "pass through"? Is this a pass through of contracted pharmacy network rates, or a full pass through of rebates, or both? If you offer a pass through of pharmacy network rates, how can you provide auditability?
    b. Confirm that you have no traditional pricing which incorporates spreading of rebates and/or pharmacy pricing.
14. Can you provide examples of billing statements or invoices for current clients to illustrate transparency in pricing?
15. Do you contractually guarantee one MAC list at the client level to meet the financial guarantees, or do you manage multiple MAC lists?
16. Will you allow audits of your 835 file which includes all financial fields?
17. How do you ensure that any plan strategies recommended do not result in increased overall plan cost?

Clinical Engagement

18. Describe how you identify and steer members to lower cost medications.
19. What are the types of member interventions that you offer? E.g. alternative drugs, alternative fulfillment, alternative dosage, etc.
20. Do you promote the use of generic and preferred medications? Are you able to provide brand drug to brand drug interchanges and not just brand to generic? What about brand over generic strategies?
21. What percentage of your recommendations are clinical (alternate therapy, etc.) vs fulfillment-related (pharmacy shopping, retail to mail, etc.)?
22. Describe how you assess whether a drug will be effective for the patient.
23. In what situations do you interact with the patient and their doctor to influence drug choice? Is that at point of prescribing or retrospective?
24. How do you engage patients when you determine that a patient is not on the most appropriate drug for their clinical situation?
25. How do you coordinate patients with health conditions that cross both medical and pharmacy?
26. How do you assess when to dispense, when to stop and when to switch a drug?
27. What is your success rate for member interventions and how do you measure it?
28. Is your organization able to quantify the impact of your solution on adherence and health outcomes? If yes, please describe your process and most recent results.

Savings Guarantees and ROI

29. How do you measure ROI? Please provide the methodology used and any measurable results from actual client experience that can be tied to your ROI calculation.
30. How do you calculate your savings methodology? Are these savings guaranteed? Does your savings methodology/ROI calculation project expected savings or reflect only savings that have already been realized?
31. Describe how formulary changes impact your savings calculation.
32. What savings does your organization take credit for? What savings does your organization not take credit for?
33. Will you provide regular reporting on engagement and outcomes to validate your clinical engagement and savings guarantees?
34. Do you guarantee the differentiators in your PBM model? If so, is that a dollar-for-dollar guarantee or a percentage of the quoted admin fee?
35. Provide any contract caveats or limitations for savings guarantees.

Member Experience

36. Describe your member experience, including how members can access your solution and how savings suggestions are presented to members.
37. Describe your experience in identifying, engaging, and assisting members with providing member pharmacy cost transparency services.
38. How do you define and measure member engagement?
39. How do you drive towards proactive member engagement?
40. Please describe your best practices approach for identifying, educating, and incentivizing members to select lower cost options for prescription drugs.

41. Do your engagement opportunities specifically include lower cost or therapeutic alternatives? What percent are identified? What percent switch? How do you encourage members to move to the lowest cost alternative?
42. Do you include retail/mail cost savings suggestions that are agnostic to a specific retail chain and/or mail order facility?
43. Are health/clinical opportunities identified for the member in addition to cost savings opportunities?
44. How does your marketing outreach adapt to member preference and their engagement profile? Please provide examples of a successful engagement strategy/campaign used by clients. Include a brief background on the client(s), goal of the strategy/campaign, and results attributed to the strategy/campaign.
45. Do you measure member satisfaction and if so, how?
46. Will you guarantee member satisfaction service level agreements?
47. Describe the process for a member if a new prescription is recommended. How do you support members who want to act on a recommendation?
48. Are you able to request approval from prescribing physicians on the member's behalf? If yes, what percentage of requests are approved by the prescribing physician?
49. Can members look up pricing and view potentially lower cost alternatives for any medication, even those they are not currently taking?
50. Do you provide tools that help members manage their medications? If so, please describe.

Specialty Rx

51. In what ways do you manage or control costs of specialty medications? How are specialty medications handled and presented? Do you support generic alternatives for specialty medications?
52. Do you support patient assistance or copay maximizer solutions? If so, please describe the program and its cost. Will you guarantee any performance around this program?
    a. What are the member requirements for these programs?
    b. Are members required to use a specific pharmacy? (please list pharmacies)
    c. Will you allow this solution to be carved out to another vendor as part of your proposal?
53. How does your management of specialty medications drive towards lowest net cost?
54. Do you encourage Biosimilars? If so, how? Please provide examples.
55. How do you manage site of care steerage for specialty medications?
56. Can you incorporate data sources beyond pharmacy to create a more holistic picture of the patient in order to manage their overall health and healthcare costs more effectively? If yes, please describe.
57. Why is your specialty management approach better than a potential carve-out specialty management solution?

Product & Program Innovation

58. Looking ahead at your product roadmap, what 2-3 significant features/ products/ programs would you highlight that will become available and are likely to have a significant positive impact on patient experience or costs?
59. What are some of the key areas of the current healthcare ecosystem that your organization is trying to solve for over the next 2-5 years?
60. Provide two examples of innovation that you have implemented to improve the pharmacy program for clients of similar size to our organization.

Client Management

61. What level of reporting and data insights do you provide your clients? Are these self-serve or ad hoc reports?
62. Please provide sample reporting that clients receive and the cadence for each report. Please confirm for each report that this format will be followed and provided.
63. Do you measure client satisfaction? If so, how?
64. Will you provide service level agreements around client satisfaction?
65. Describe how your client management model will best align and meet the goals of the client?

66. Can and will you provide real-time reporting of adjudicated claims?
67. Are you able to identify fraud, waste, and abuse? If yes, please describe.
68. Will we have access to all data related to our account, including pharmacy claims and pricing data?
69. What are the terms and conditions surrounding data ownership?
70. Can we perform independent audits on the data provided?
71. What technology do you use to ensure transparency and efficiency in processing prescriptions and claims?

Formulary

72. Is the formulary created to drive to the lowest net cost? Provide detail.
73. Describe your formulary management (P&T) process along with the clinical and financial evaluation of adding medications to formulary.
    a. If a generic medication is available at the same or lower net cost, do you remove the brand from formulary?
    b. If yes, provide 3-5 recent examples of implementing this strategy.
    c. Is your P&T committee open for the employer or pharmacy consultant to view?
74. Describe the available options within benefits setup, formulary, and clinical programs that give plan sponsors flexibility.
75. Is there a cost for customization with the formulary or utilization management criteria? If so, how do you collaborate with the client to analyze and make a fully informed decision around customization?
76. Will you allow for independent oversight/control of the formulary?
77. How do you handle formulary changes? Describe how you manage formulary changes to minimize member disruption.
78. Do you offer non-insurance, cash, and/or discount card options to members? If yes, please describe.

Compliance

79. How does your organization ensure compliance with the Consolidated Appropriations Act (CAA)?
80. Can you provide examples of your compliance reports or documentation related to the CAA provisions?
81. How does your P&T committee operate in compliance with the CAA, particularly regarding formulary development and management?

Contract & Requirements

82. Confirm that your contract allows the client to carve out the following:
    a. Clinical management, i.e. Utilization Management or Rx Navigation Services
    b. Specialty drugs management, patient management and/or drug fulfillment
    c. Formulary management
    d. Specialty copay maximizer programs
    e. Prior Authorization and Step Therapy
83. How would contract provisions change if a client intends to actively manage which medications flow through Rx benefit versus medical plan?

Implementation

84. Do you measure implementation satisfaction? If so, how? Will you guarantee an SLA around implementation satisfaction?
85. Describe how you would enhance the employee experience for a smooth transition to your solution.
86. How does your implementation process make it an easy transition for the plan sponsor and benefit team?

Benefits & Clinical Program Flexibility

87. Do you have any limitations on the benefit structure or clinical programs which can be added to the pharmacy benefit?
88. Describe your ability to integrate with third-party solutions. Identify any requirements or limitations.
89. Do you offer SSO and/or API functionality? If so, please describe.

ABOUT THE RESEARCH

About the Research

This report was developed by the EHIR Advisory Services team with contributions from Natasha Coult and Sally Welborn. It includes data derived from a survey of EHIR members who are decision-makers in health and wellbeing benefits for large organizations. The survey was conducted in March and April of 2024, and responses were gathered from 37 unique EHIR member companies. Organization sizes range from 2,500 to over 400,000 employees, and EHIR member organizations span all major industries. A list of EHIR members can be found at https://www.ehir.com/ehir-cohorts. Survey respondents were asked to indicate the type of PBM contract they have (direct or via a coalition) and their PBM vendor(s). The survey questions also asked about trends respondents have observed in recent years and what they expect for the next two plan years. The survey findings were supplemented with interviews with responding EHIR members and desktop research.

About EHIR

Employer Health Innovation Roundtable (EHIR), a World 50 Group community, is an action-oriented, independent group built by employers, for employers. EHIR was started nearly a decade ago out of a need for objective support in identifying and assessing emerging solutions to sift through the noise and stay ahead of the curve amid a rapidly changing competitive landscape. EHIR provides a streamlined and efficient innovation intake and evaluation process along with valuable insights to the world's leading employers.

About Our Research Partners

The following organizations supported this project, including review of research questions and providing case studies and supplemental information on their program offerings. Their contribution sections are clearly indicated. The Research Partners did not influence the survey responses or interviews with EHIR members or the general content or interpretations in this report, which are the independent product of EHIR.

AffirmedRx, PBC

AffirmedRx, PBC is a pharmacy benefit manager that partners with self-funded employers to deliver patient-centric pharmacy benefits with a mission to improve health care outcomes by bringing clarity, integrity and trust to pharmacy benefit management. As a public-benefit corporation, its social mission of improving public health is just as important as the bottom line.

Navitus Health Solutions

Navitus Health Solutions, LLC, owned by SSM Health and Costco Wholesale Corporation, was founded as an alternative to spread-based PBMs. The business model is uniquely one where Navitus does not benefit when medication prices increase. Navitus is purpose-driven to remove unnecessary cost from the drug supply chain to further affordability, access, and outcomes for the people served.

For over 20 years, the organization has evolved and now brings to market a range of pharmacy solutions through a portfolio of noted brands and partnerships including Navitus, EpiphanyRx, Lumicera Health Services, Archimedes, and CivicaScript. As an enterprise, Navitus Health Solutions proudly serves more than 14 million members through nearly 800 client relationships. These include private and public sector employers, labor unions, health systems and health plans in both commercial and regulated markets. To learn more about Navitus Health Solutions, visit www.navitus.com.

Rx Savings Solutions

Rx Savings Solutions (RxSS), part of McKesson Corporation, reduces prescription drug costs for plan sponsors, covered members, and dependents through a combination of patented clinical technology, engagement marketing, and concierge member support. Founded in 2012 on a belief that no one cares more about the cost of prescription drugs than the patients who need them, the RxSS consumer-centric approach provides transparency and personalized recommendations for lowering prescription costs and dedicated pharmacy experts to help navigate the process with providers and pharmacies.

Currently 18 million members of self-insured employers, and commercial, Medicare, and ASO health plan groups find lower-cost drug therapies or fulfillment options through the RxSS member portal, mobile app, care management interface and discount card integrations. RxSS and our clients have proven that helping members find affordable prescriptions is an effective, sustainable way to reduce plan spend. For more information, visit rxss.com/who-we-help.