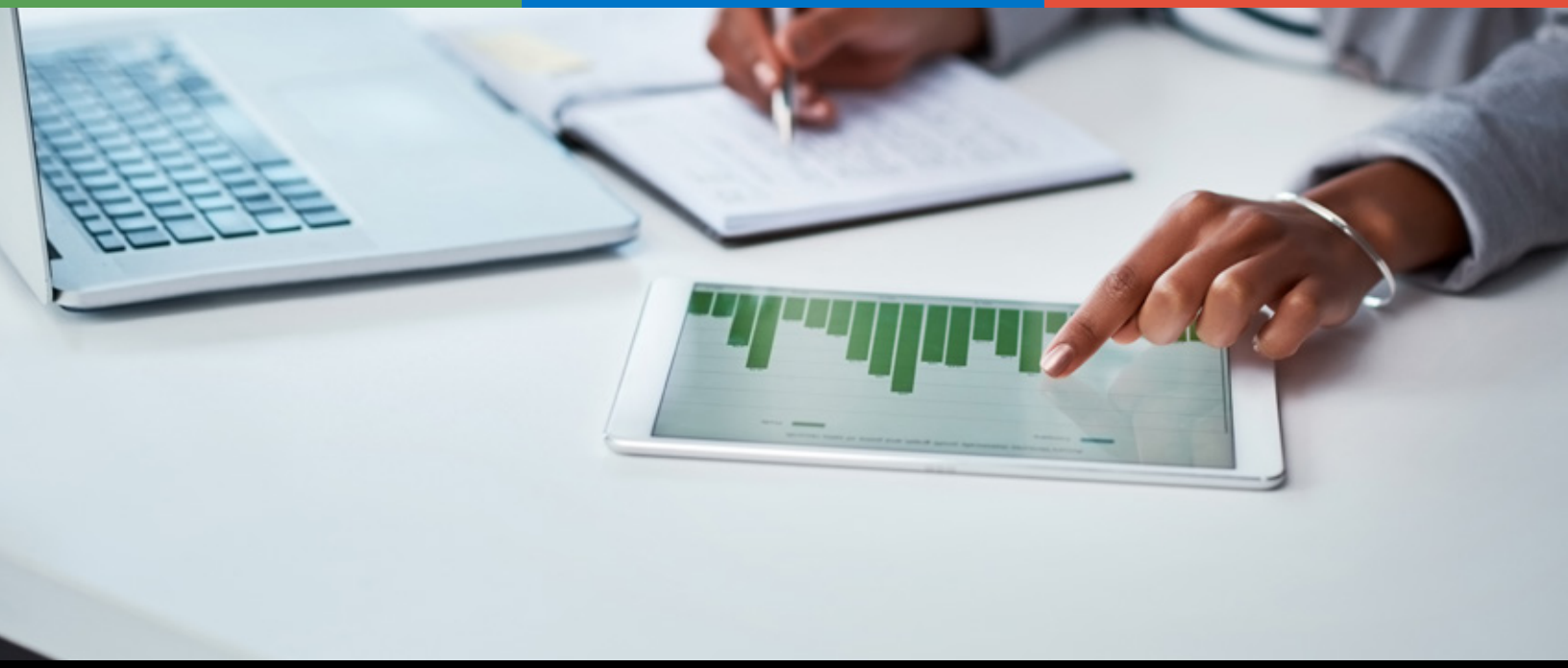
National Alliance
of Healthcare Purchaser Coalitions
Driving Innovation, Health and Value

PURCHASERS GUIDE TO PBM QUALITY 2019

- Comparative Information on PBMs
- Special Reports on Cutting Edge Practices
- Action Steps You Can Take Now



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

Cigna
CVS Health
OPTUM
MAXORplus
EXPRESS SCRIPTS
PERFORMRx

As a national consulting firm, we are barraged by new product innovations and vendors in the pharmacy space. Add that dynamic to the constantly evolving pharmacy market that we live in, and we do not go one week without breaking drug, legislative or benefit news. Our industry needs the invaluable, unbiased and objective expertise the National Alliance provides. Their PBM quality report is an excellent resource for consultants and plan sponsors to reference as they make vendor and benefit selections throughout the year.

Michael Zucarelli, National Pharmacy Practice Leader
CBIZ Benefits & Insurance Services, Inc.

Most of the information available to employers about the best practices in pharmacy benefit management come from the PBMs themselves. This PBM assessment is a source of information we can trust. I use the assessment to educate myself about the factors to consider in selecting a PBM partner; and I use it to develop the questions I will ask when we put our plan out to bid. It's the most valuable tool I've found.

Janet McNichol, Human Resources Director
American Speech-Language-Hearing Association

As the nation's largest accreditor of PBMs and pharmacies, URAC is uniquely positioned to work with PBMs to deliver the highest value possible from the remarkable medicines available today. As a physician, I can tell you that it should be considered 'best practice' for employers to use this report to compare the performance of all PBMs and customize your benefits and practices for maximum value for our families, companies, and employees.

Shawn Griffin, MD, CEO
URAC

The National Alliance of Healthcare Purchaser Coalitions' PBM Quality Assessment reinforces the important foundational role of standardized performance measurement in the evaluation of the health of purchasers' employee populations. As the premier developer of meaningful, consensus-based medication use measures, PQA applauds the National Alliance for its progressive approach to support purchasers in their PBM management strategies toward this end.

Laura Cranston, RPh, CEO
Pharmacy Quality Alliance

Dear Reader:

We're delighted to share with you our 2019 Purchasers Guide to PBM Quality. This 2019 Report includes a variety of PBMs, with large and small, "carve-out" and "carve-in" organizations demonstrating their commitment to transparency by answering questions on their policies and programs for the report.

In response to recent headlines and purchaser interest, we're featuring a special section on PBM Business Practices, including financial transparency and contracting options. However, we'll take this opportunity to point out that there are other aspects of transparency, and that by sharing their policies, programs, and results, our participating PBMs are already demonstrating a degree of transparency with our coalitions and their members.

Throughout the Guide you'll find articles from experts at our participating PBMs. Use these articles to educate yourself regarding best practices that purchasers should be looking for from their current or prospective vendors. Once again we include a short number of Action Steps, which highlight four emerging areas where PBMs can improve to be used in your discussions with current and prospective vendors. If purchasers align to drive improvement in these simple areas, we can move the market toward better transparency and value.

An important note: you, as the purchaser, bear considerable responsibility in the quality of services your PBMs deliver to you and your members.

1. Examine your benefit design to be sure it aligns with your company's goals and your members' best interest, such as supporting genetic testing when appropriate for precision medicine.
2. Require your vendors to share relevant information with the PBM, and for the PBM to reciprocate. Pharmacy data intersects with Medical, Behavioral Health, Wellness, and other vendors serving you and your members. It's important that everyone have all the available information.
3. Use this Guide to help you manage performance in your current vendors, and in future vendor selection. Invite our partner PBMs to participate in your RFPs. **Encourage/insist that your PBMs participate in the next Assessment!**

PBMs are under considerable scrutiny today, but the organizations in the 2019 Purchasers Guide to PBM Quality have demonstrated a willingness to open their actions to your scrutiny. Use it to guide discussions with your current or prospective PBM and you'll emerge better informed than ever before!

John Miller
Mike Thompson
Foong-Khwan Siew

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 COMPARATIVE INFORMATION

 SPECIAL REPORTS

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SPECIAL REPORTS

Participating PBMs

Cigna Pharmacy Management® is a Pharmacy Benefits Manager within a health services company. Our goal is to leverage holistic customer insights and integrated analytics to deliver a more personalized and connected customer experience and, ultimately, better outcomes and lower total medical costs.

Cigna Pharmacy Management is a business division of Cigna Health and Life Insurance Company that provides pharmacy benefit management services.

FOR MORE INFORMATION, please contact Kevin Buron at **kevin.buron@cigna.com** or 651-295-2078.

CVS Caremark provides a full range of pharmacy benefit management ("PBM") solutions to clients including employers, insurance companies, unions, government employee groups, health plans, Medicare Part D plans, Managed Medicaid plans, plans offered on the public and private exchanges, throughout the United States. Our innovative tools and strategies, as well as quality client service, can help improve clinical outcomes for members, while assisting clients with managing pharmacy and overall health care costs. Our goal is to produce results for our clients and their plan members, leveraging our expertise in PBM services, including: plan design and administration, formulary management, Medicare Part D services, mail order, specialty pharmacy and infusion services, retail pharmacy network management, prescription management systems, clinical services, disease management, and medical spend management.

FOR MORE INFORMATION, please contact Christopher Wilson at Christopher.**wilson4@cvshealth.com** or 201-602-8895.

Express Scripts is a healthcare opportunity company. Our services are designed to unlock new value in pharmacy, medical, and beyond—and create better health for all. We provide a full range of integrated pharmacy and medical benefit management services that guide patients and plans toward better health by prioritizing care and increasing savings. Services include home delivery pharmacy care, specialty pharmacy care and benefit management, benefit design consultation, drug utilization review, formulary management, and medical and drug data analysis. We drive down the cost of care for employer-funded, Medicare, Medicaid, and Public Exchange plans, and create the headroom needed to keep your members' cost-share low, access broad, and do more for those who are challenged by high out-of-pocket costs.

FOR MORE INFORMATION, please contact Vince Zwilling at **vjzwilling@express-scripts.com** or 314-684-6033.

MaxorPlus is a market-leading Pharmacy Benefit Manager that is pioneering the use of analytics and technology to identify intervention opportunities to engage members in new ways. The company's engagement platform, combined with a suite of clinical solutions, guides members through targeted journeys designed to address wasteful spending and sub-optimal clinical results. Performance of these programs is backed with a financial guarantee, creating a PBM solution that is member-focused, aligned with the interests of clients, and grounded in a foundation of service excellence. Maxor's PBM platform is complemented by Maxor Pharmacy Management & Consulting Services, a provider of outpatient pharmacy management solutions, and Maxor Specialty, a clinically-driven specialty pharmacy focused on rare and orphan diseases.

FOR MORE INFORMATION, please contact Eric Wan, Chief Commercial Officer by e-mail at **ewan@maxor.com** and/or by phone at (651) 235-4699.

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

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

FOR MORE INFORMATION, visit **www.optum.com/optumrx** or contact Don Houchin, Senior Vice President at OptumRx, **Don.Houchin@optum.com**

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

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

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

FOR MORE INFORMATION, please contact Nicholas Dinsmore at 215-863-5874 or **ndinsmore@performrx.com**.

Using the Guide

This guide is best used as a conversation manual.

Remember your last meeting with a PBM? Typically, the PBM comes prepared with reports and advice, while the client acts as a passive audience. Using this guide, you can take an active role in the meeting, and find out more about the PBM's philosophy and practices. In using the guide to steer the conversation, think of the graphs not as "scores," but as context.

Ask your PBM:

- **Why is your score so low?** There may be good reason, and you may be able to help improve the score!
- **How did you score so high?**
- **How does this performance impact your customers?**
- This year, we supply specific discussion suggestions in **five emerging areas**. Make sure you ask your PBM what they're doing in these areas!

Think about your goals:

- Are you looking for a PBM to **manage utilization** to keep pharmaceutical spend low, or do you want to **increase medication** utilization to drive down medical expenses for the long term?
- Are you looking for a **flexible PBM**? For example: Can they help with on-site pharmacy? Will they allow you to customize your formulary, prior authorizations, or other categories? Or maybe your needs are simple, and you're just looking for an **"off-the-shelf"** solution.
- Are you looking for **innovative contracting approaches**? This guide includes a focus on innovative PBM contracting practices, such as transparent contracts, open auditing, outcomes-based contracting (see page 8–9). If these approaches are of interest, be sure to ask your PBM which they offer. On the other hand, you may not be worried about cutting-edge arrangements.

Finally, ask yourself whether you are willing to implement benefit designs, such as linking co-pay to medication adherence, participation in disease management programs, or using higher value providers, to better manage both Pharmacy and Medical spend.

Standardization and Satisfaction

A word on standardized measures

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

www.pqaalliance.org

About satisfaction

To gain an objective view on plan sponsor views on their PBMs performance, we recommend the Pharmacy Benefit Management Institute (PBMI). For more than 20 years PBMI has been researching and reporting on PBM customer satisfaction. The 2019 PBM Customer Satisfaction Report is available for purchase in electronic format. This year's report includes detailed profiles for 11 PBMs and represents the views of hundreds of employers, union/Taft-Hartley groups, and health plans who cover more than 80 million lives.

www.pbmi.com

SPECIAL REPORT

TREND-SETTING BUSINESS PRACTICES: AND THE PBM RESPONSE

In 2019, PBM business practices have been the center of attention. This year, we highlight five of areas of interest to purchasers.

TRANSPARENCY

Price Transparency

Much of the current controversy in PBM practices has revolved around price transparency. **In a recent National Alliance survey, 80% of purchasers are considering a fully transparent PBM option as a strategy to combat the rising cost of drugs.** The definition of "transparent" is confusing in the PBM world. We asked about transparency in two ways: with regard to rebates only, and to all types of PBM revenue; including spread pricing, and all types of guarantees and rebates.

Expectation:	PBMs Meeting the Expectation
Able to report on how many clients receive 100% rebates as passthrough	3
Able to report on how many clients receive 100% All PBM revenue (from spread, all types of guarantees and rebates) as passthrough	3

Audits

Audits can be a powerful tool in ensure that contractual terms are being met, and that the PBM and purchaser's interests are aligned. We asked the PBMs about the depth of the audits they allow.

Expectation	PBMs Meeting the Expectation
Access to all claims over the life of the contract	1
Open book access to pharmacy network contracts and payments	1
Open book access to pharmaceutical industry contracts and payments	1
Maximum Allowable Cost (MAC) list for generics for review against paid claims	4

CONTRACTING OPTIONS

Outcomes-based Contracting

An outcomes-based contract would shift rebate/reward away from market share of medication, to outcomes in patients. **Our recent survey of 80 purchasers showed that 50% of purchasers either had in place, or were considering implementing outcomes-based contracting.**

Expectation	PBMs Meeting the Expectation
Do you have outcomes-based contracts in place?	4
Do you have reportable patient outcomes?	2
Do you have reportable financial guarantees?	0

Direct Contracting

Aggressive purchasers have begun to express interest in establishing contracts directly with entities beyond PBMs. These contracts could still require PBM engagement for access and management purposes. We asked about whether the PBM could support purchasers in contracting with Specialty Pharmacies; and with Drug Manufacturers. Keep in mind that this concept is very new. **In our survey, 38% of purchasers either had in place, or were considering implementing direct contracting with pharmacies, while only 15% either had in place, or were considering contracting directly with manufacturers.**

Direct Contracting with Manufacturers

Expectation	PBMs Meeting the Expectation
Are you able to support for select clients, for specific manufacturers?	3

Contracting with Specialty Pharmacies:

Expectation	PBMs Meeting the Expectation
Can you integrate claims data, accumulator files, deductibles, etc., for purposes of consolidated reporting?	2
Can customer care can make warm transfers for participants to the outside specialty pharmacy care teams?	4
Can the client can include the specialty pharmacy customer phone number on the ID card?	3

This information is derived from the 2019 National Alliance PBM Assessment.

Business Practices

- Third party accreditations and level of access for third-party audit
- Client support: data analysis and reporting; benefit coordination and collaboration

Why do we ask?

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

Overview of Business Practices

Third Party Accreditations (URAC)

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

Client Support:
Data Analyses and Reporting; Beneficiary Communication and Outreach support; Coordination and Collaboration

- Employer reporting: type, frequency
- Beneficiary communication and outreach
- Specialty drug reporting
- On-site pharmacy support
- Support direct contracting with specialty pharmacies and/or manufacturer
- Program(s) to counteract manufacturer co-pay assistance tactics

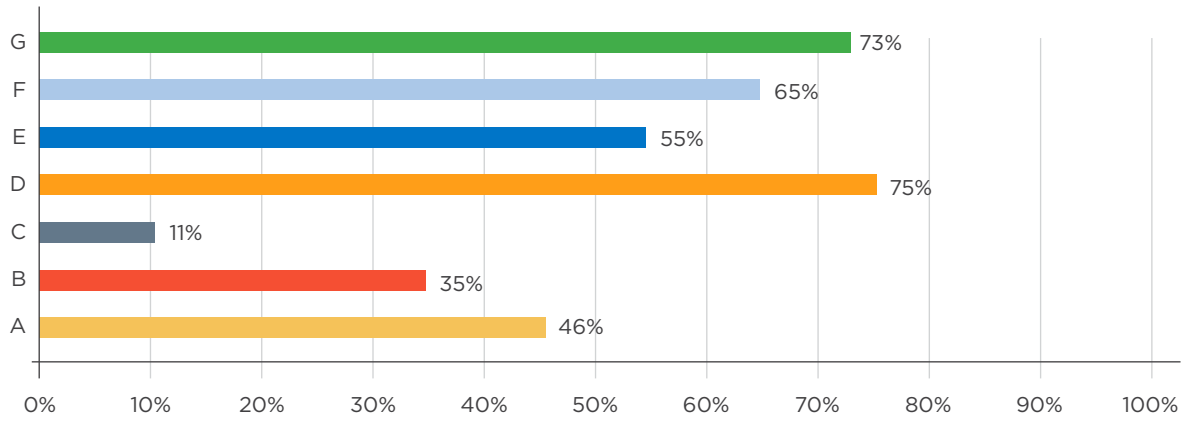
Business Practices Including Transparency

This section looks at outcomes-based contracting with manufacturers, level of transparency (audits, rebates) and client and member interest (fiduciary, price protection, revenue pass-through and non-medical switching).

Scoring differences were based on:

- Information on outcomes-based contracts and price-protection guarantees
- Depth and breadth of access on audits
- Willingness to act as fiduciary on variety of activities
- Information on percent of clients receiving 100% pass-through of rebates and/or 100% PBM revenue from spread, all types of guarantees and rebates

BUSINESS PRACTICES INCLUDING LEVEL OF TRANSPARENCY



Pharmaceutical Management

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

Why do we ask?

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

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

This section measures PBM performance in this important function.

Overview of Pharmaceutical Management

Specialty Pharmaceuticals Management

- Management strategies and results, sites of care, and flexibility
- Adherence Monitoring and Closing gaps
- Transparency
- Hepatitis C completion rate
- Use of biosimilars

Efficiency

- Management strategies and generic dispensing rates
- Overuse of antibiotics of concern

Program Organization

- Value-based formulary
- Value-based insurance design implementation
- Ability to customize

Quality, Safety and Adherence: Outpatient

- Adherence monitoring and closing gaps
- Addressing primary non-adherence
- Drug conflicts and opioid misuse
- Assessment of pharmacies in network and quality incentive programs

Pharmaceutical Support: Cardiovascular Disease, Diabetes, Behavioral Health

- Monitoring adherence and closing gaps
- Adherence results and appropriate management of cholesterol
- Policies on access to substance use medications
- Monitoring appropriateness of antidepressant and pain medication prescribing practices of practitioners.

Pharmaceutical Support: Tobacco and Obesity

- Coverage and access to medications
- Eligibility criteria for obesity

Specialty Pharmaceutical Management

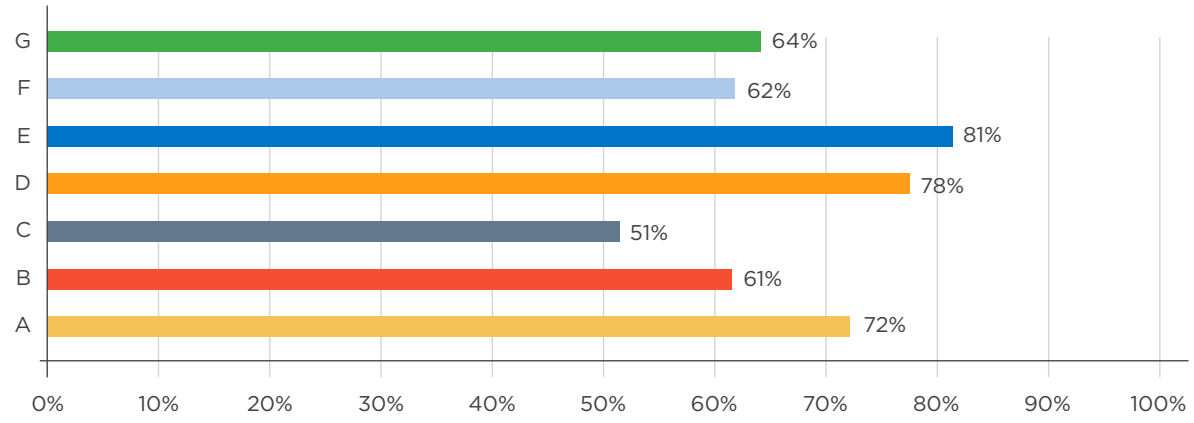
This section looks at access criteria, utilization strategies, and patient safety and adherence for these very expensive drugs. Some observations on PBM management strategies for this year's report:

- In 2019, all reporting PBMs have adherence monitoring programs and ensure that entities dispensing specialty medications have external third party accreditation
- As in 2019, the PBMs are slow to push for biosimilar uptake. Zarxio is the only biosimilar that is generally preferred versus original (Neupogen)
- In 2019, we see that PBMS are starting to use third-party drug value evaluations such as ICER to negotiate with manufacturers; however, none use calculations such as $/Quality Adjusted Life Years to exclude medications

Scoring Differences were based on:

- Level of hepatitis C medication completion rates
- Adherence rates measured as Proportion of Days Covered for RA, MS and HIV medications
- Flexibility and client support (customization of preferred drug list, ensuring coverage of genetic testing if testing is required to access medication)

SPECIALTY PHARMACEUTICAL MANAGEMENT



ACTION STEP

BIOSIMILARS

Action Step: Ask your PBM where biosimilars are positioned, and whether they are making efforts to increase uptake. There are four biosimilars on the US market at the time of this writing. As with last year's report, the main biosimilar for cancer tends to be positioned favorably on PBM formularies. However, other biosimilars are gaining formulary preference. Additionally, five of the six PBMs are contacting physicians about switching to biosimilars for newly prescribed patients.

Why is it important? As the biosimilar market expands, biosimilars have the potential to drive competition, and lower costs significantly. Progress is being made in increasing biosimilars market share, but unless PBMs and purchasers continue to promote emerging biosimilars, manufacturers will discontinue research and development of this important alternative.

SPECIAL REPORT

HEPATITIS CURE VALUE PROGRAM®

Express Scripts

A breakthrough therapy for hepatitis C has given hope to millions of Americans with the most common form of this life-threatening disease — but until Express Scripts launched the Hepatitis Cure Value Program® (HCV) in 2015, the cost of these medications was unsustainable. Unable to afford treatment for all who needed it, many plan sponsors withheld coverage for all but the sickest patients.

The HCV program pairs formulary and utilization management with exclusive distribution from Accredo® specialty pharmacy to best control costs and ensure optimal health outcomes. Since its debut, the program has successfully lowered the cost of curative hepatitis C treatments by nearly 50% and has created an unprecedented solution that expands access to an affordable hepatitis C cure. Patients receive better care when they fill their prescriptions through Accredo, including the support of specialist pharmacists via our Hepatitis C Therapeutic Resource CenterSM.

The HCV Program offers point-of-sale discounts on Viekira Pak, Viekira XR, and Harvoni prescriptions filled through the Accredo pharmacy. Under the HCV Program, patients obtain their medication exclusively from Accredo, Express Scripts' specialty pharmacy, an approach that delivers higher quality care to patients and greater value to payers. Express Scripts' research shows the percentage of hepatitis C patients who stop therapy is reduced by half when patients fill their prescriptions at Accredo.

Once enrolled in the HCV Program, members who are new to therapy will be instructed to obtain their first and subsequent fills of Harvoni or Viekira through Accredo. We have notified physicians of the requirement to fill at Accredo to ensure initial prescriptions are directed appropriately. Members who are on an existing hepatitis C therapy may continue their course of treatment through their current pharmacy.

Setting the Standard for Hepatitis C Care

Accredo's unique clinical approach helps ensure appropriate, cost-effective use of medications and better treatment outcomes compared with other specialty pharmacies. Accredo offers:

- **Patient Support** — Accredo's Hepatitis Therapeutic Resource CenterSM offers a team of specialized clinicians who possess unparalleled knowledge and understanding of the unique challenges of this condition and the drugs used to treat it. Accredo also offers online and technology resources for patients, including educational tools and a hepatitis C mobile app that educates patients about the risks of nonadherence and helps them stay on track with a customizable treatment schedule, medication reminders, a viral load graph, and other resources.
- **Proactive Intervention** — Our state-of-the-art predictive model for hepatitis C helps identify which patients are more likely to have a lapse in therapy. Our trained clinicians, possessing in-depth knowledge of side effects and risks, can provide extra support to help these patients effectively manage their treatment.

Hepatitis C can be a difficult condition for patients to manage, particularly during the course of treatment — and when patients stop their hepatitis C therapy, they must restart treatment from the beginning, potentially wasting tens of thousands of dollars in pharmacy spend. Because our specialized clinicians work with hepatitis C patients every day, they are able to provide individualized, high-touch care that helps patients remain adherent, achieve healthier outcomes, and reduce unnecessary healthcare spending

About Express Scripts

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

For more information contact: Jen Awsumb, Sr. Director Express Scripts Supply Chain, **jaawsumb@express-scripts.com**.

SPECIAL REPORT

LEVERAGING THE UNIQUE POSITION OF PHARMACY BENEFIT MANAGERS TO MANAGE MULTIPLE SCLEROSIS

PerformRx

- Falling in the parking lot while out alone with your 3-year-old son.
- Lying awake at 3 a.m. with tingling in your leg that won't subside.
- Getting to the grocery store and forgetting everything you needed to buy.

These everyday tasks are only a few of the challenges that a patient with multiple sclerosis (MS) experiences on a daily basis. In a world with a countless number of struggles, timely access to appropriate treatment options should not be an added burden for patients with MS.

The average annual cost for treatment in the 1990s when disease-modifying therapies (DMTs) were created was $8,000 to $12,000.7 Since then, the estimated annual average cost of treatment for DMTs has increased to more than $60,000 with a continued inflation rate significantly higher than the inflation rate of other prescription drugs.

In response, PerformRx has designed and implemented an MS medication adherence program dedicated to optimizing the benefit of high-cost medications for PerformRx clients and improving overall quality of life for their members by achieving optimal medication adherence. Our team helps patients adhere to medication regimens by providing support and eliminating barriers inevitably present when trying to manage MS.

Here's an example of the unique advantage a PBM has. During a routine adherence outreach, we discovered that a patient had not picked up her Copaxone® injections from her pharmacy that month because she was temporarily residing in a community group home where she was not allowed to store personal medication in the single community refrigerator. Although embarrassed, this patient trusted her PerformRx team enough to confide in them, and our team worked quickly to collaborate with her pharmacy and neurologist to arrange for her to get a disposable cooler with dry ice until she was able to get into her new apartment.

Evaluation of pharmacy and medical claims indicates that simple steps taken by PerformRx's clinical team improve communication and streamline patients' access, positively impacting patients' adherence to DMTs and their overall clinical outcomes. The percent of patients adherent to therapy has increased from 78.6% before program launch to 94.4% one year after implementation. This improvement also resulted in improved overall clinical outcomes. Early observations indicate that there has been an 11.9% reduction in the number of preventable events (complications, readmissions, admissions, emergency department visits, and other ancillary services) related to MS and a 35.8% reduction in health care costs associated with preventable events.

MS will present a patient with innumerable obstacles over time and, inevitably, physical disabilities. For many patients, the act of waking up and going through a daily routine is challenging. The goals of our program are to limit the number of additional, preventable stressors put on client members and ensure timely access to appropriate, effective treatment options while optimizing MS specialty drug costs. Being attentive to patients' needs and providing individualized care has allowed us to improve adherence to DMTs, reduce the number of unnecessary and costly medical events, and increase overall quality of life for our patients.

For more information, contact Nick Dinsmore at ndinsmore@performrx.com

About PerformRx

PerformRx is dedicated to innovative clinical programs, boutique services and holistic solutions. We have provided best-in-class PBM services since 1999.

For more information, please contact Nicholas Dinsmore at 215-863-5874 or **ndinsmore@performrx.com.**

Rx Management in Chronic Condition Management

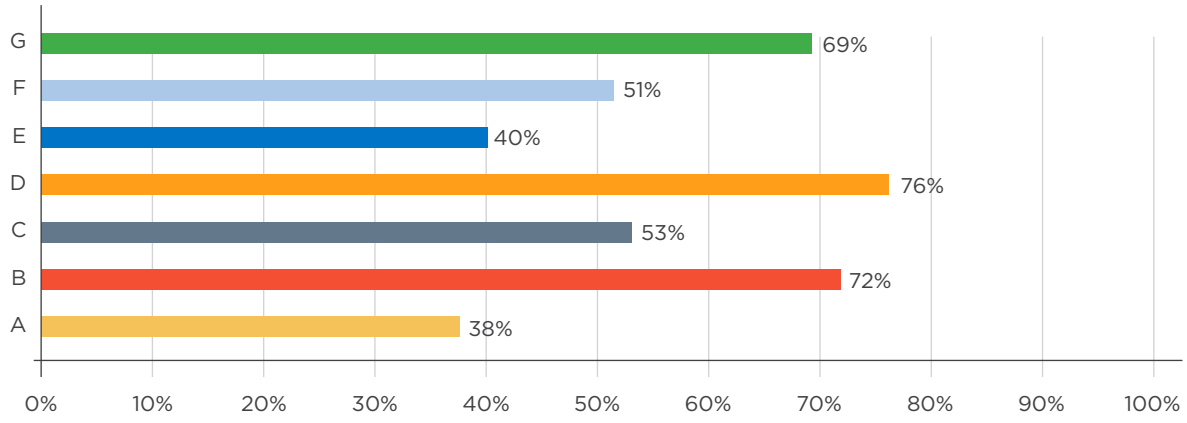
This section examines the PBMs ability to support patients with chronic disease or behavioral health (BH) issues, including adherence monitoring and coverage of BH/substance use medications and monitoring for appropriate prescribing among clinicians

- All monitor adherence to BH medications but not substance use medications
- Most have removed barriers to access substance use disorder medications for members diagnosed with condition

Scoring differences were based on:

- Appropriate treatment of cholesterol (use of statin) in patients with diabetes
- Adherence rates measured as Proportion of Days Covered for statins, hypertension and diabetes medications (Note that adherence rates will be higher for those who send out refills and automatic refill programs may also lead to waste)
- Monitoring appropriateness of prescribing for antidepressant, pain and sleep medications among clinicians

RX MANAGEMENT IN CHRONIC CONDITION MANAGEMENT



ACTION STEP

SUBSTANCE ABUSE TREATMENT

Action Step: The opioid epidemic has led to overdose being the leading cause of accidental death in the US. It is important that individuals suffering from this, or other forms of substance abuse, access treatment and follow their treatment regimen. Ask your PBM whether they are monitoring for compliance with substance use medications.

Why is it Important? According to a National Alliance Mental Health Action Brief, "Not complying with mental health medication therapy can lead to serious consequences such as relapse, hospitalization, incarceration, suicide, and poor quality of life." Purchasers should be sure their PBM is doing all it can to help patients comply with the treatment regimen.

https://connect.nationalalliancehealth.org/HigherLogic/System/DownloadDocumentFile.ashx?DocumentFileKey=6c65b6b7-632a-e164-931f-038587ba395f&forceDialog=0

SPECIAL REPORT

TRANSFORM DIABETES CARE EXPANDS TO IMPROVE HEALTH FOR PLAN MEMBERS WITH PREDIABETES, HYPERTENSION

CVS Health

The high prevalence of diabetes — it affects one in 11 Americans — and the cost burden it places on our nation's healthcare system are common knowledge. What may not be as well known is how complex it can be for patients to effectively manage the condition.

Transform Diabetes Care®, by CVS Health, helps reduce the complexity of self-management and improve health outcomes for members with diabetes, and prevent the onset for those at risk. It combines local points-of-care, remote biometric monitoring, and interventions led by health care professionals to help members comply with their prescribed therapy. Since its launch, it has demonstrated positive clinical outcomes:

- 1.2 percentage point HbA1C improvement achieved at 6 months and sustained at 12 months*
- More than 50% of members with uncontrolled diabetes were moved to controlled status*
- 31% connected meter enrollment among all eligible members with diabetes

Addressing More Areas of Care

Prevention programs that help consumers make appropriate lifestyle changes, can help reduce the risk of developing diabetes across a patient population by about 58% over three years.

The expanded Transform Diabetes Care program also helps members at risk of developing type 2 diabetes.

Diabetes Prevention Module:

Our proprietary analytic engine can analyze pharmacy and medical data to help identify those who may be at risk for type 2 diabetes. We can then enroll them in our prevention program, where they will receive:

- A connected digital scale
- An app-based, Centers for Disease Control and Prevention approved, 12-month diabetes prevention curriculum supported by daily action plans and weekly challenges
- Expert-led health coaching with registered nurses, dietitians, exercise physiologists and behavioral therapists
- The ability to meet with MinuteClinic® practitioners who utilize screenings, education, and targeted physical exams, as needed, to help prevent the onset of complications

Transform Care Diabetes Prevention Program goal is for 50% of enrolled members to lose at least 5% of their starting weight.

Hypertension Module:

Hypertension is the most prevalent comorbidity occurring twice as frequently in patients with diabetes compared with those who do not have diabetes. So Transform Diabetes Care now offers a hypertension model to help those with diabetes who also have hypertension. Once our proprietary analytic engine identifies members with hypertension, we can enroll them in the program and provide:

- A connected blood pressure cuff
- An app-based hypertension management program supported by education, digital coaching, action plans and weekly challenges
- Expert-led health coaching with registered nurses, dietitians, exercise physiologists and behavioral therapists
- Two annual metabolic visits at MinuteClinic with no out-of-pocket cost to members

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The program goal is an average reduction in systolic blood pressure of 9 mmHg in a given population for patients with blood pressure greater than 130/80, and of 12 mmHg for those with greater than 140/90.

With the expansion of the Transform Diabetes Care program, we can help more members reduce the risk of developing diabetes and help those already diagnosed with diabetes and/or hypertension better manage their condition.

About CVS Health

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

For more information, contact Christopher Wilson at 201-602-8895 or **christopher.wilson4@cvshealth.com**.

* Among members with uncontrolled diabetes (HbA1C ≥ 7) engaged with a connected glucometer (testing ≥ 5x/month over three months prior to 6- and 12-month evaluations). Average HbA1C improvement measured at 6 months and 12 months following meter activation.

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

AN INTEGRATED APPROACH TO DISEASE MANAGEMENT

Cigna

Research and experience show that behavioral health is a key factor to managing total person care. Medical and behavioral conditions have high rates of co-occurrence, particularly with chronic medical conditions such as diabetes which also require regular medication. When medical, behavioral, and pharmacy benefits are integrated, we have more access to important customer data, and more opportunities to maximize our many customer touchpoints, across all benefits. This means customers are more apt to participate in their health and wellness management.

As an example of integration in action, let's take Cigna customer "David" (age 47), who had high blood pressure and diabetes. Unengaged and unmotivated, David ignored calls and emails from Cigna about his health. However, he did place a call to the Cigna Pharmacy service center to discuss his blood pressure medicine options based on his formulary. Due to our integrated platforms, David was flagged for clinical interactions and was connected to a Cigna health coach. The coach, using a behavioral assessment, detected stress and anxiety related to his condition and made a connection to the Cigna Behavioral Health (CBH) team. CBH assisted with locating an in-network therapist, and David got 5 free visits. He also accessed the online stress program, and had the opportunity to speak directly with a coach. Taking these steps, he was better able to care for himself, better manage his stress, eat and sleep better, and get motivated to exercise, all of which helped both his emotional and physical wellbeing.

This integrated approach goes a long way when it comes to achieving positive health outcomes in the long term, and also leads to more savings; three years of integrating medical and pharmacy benefits save clients on average mid to upper $70 per member per year (or PMPY). Adding behavioral health benefits to the analysis builds on that plus some, driving an average $193 PMPY additional savings.

The savings are even higher when looking at customers who have a chronic condition like diabetes ($5,900 PMPY), or are taking a specialty medication ($9,792 PMPY). The basis for these cost savings is that these customers participate more in important programs sponsored by their employer; 22% engage more deeply in condition, behavioral and specialty drug coaching when clients choose Cigna for medical, pharmacy and comprehensive behavioral benefits.

Our integrated solutions deliver results for engaged customers with diabetes: 6% higher rates of preventative care, leading to better health outcomes; 18% reduction in out-of-network claims, making healthcare more affordable, and 24% fewer customers exceeding $100K in medical expense. Our integrated solutions also deliver results for engaged customers taking a specialty medication: 15% fewer in-patient admissions, and 25% lower in-patient costs.

We know, and we can now prove that when companies combine Cigna medical, behavioral, and pharmacy benefits, they drive better health outcomes in the short and long term, and better cost savings. Body and mind. At Cigna, we understand that the health system can't fully work for our clients and their employees until it supports both – together as one complete picture of health.

About Cigna

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

For more information, Contact Kevin Buron at **Kevin.Buron@cigna.com**

Rx Management
for Tobacco Cessation and Weight/Obesity Management

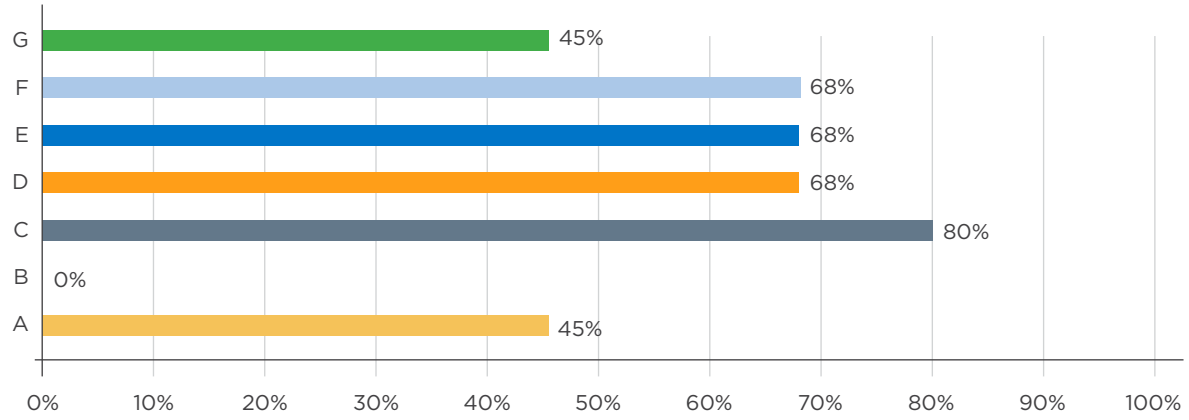
This section measures how the PBM supports prescription coverage of obesity and tobacco medications

Scoring differences in this section were based on:

- Activities to reduce barriers for access to medications to treat tobacco cessation and weight management
- Whether PBM provided guidance on eligibility criteria for covering medications for weight loss

Are PBMs advising clients that all tobacco cessation medications need to be covered with no out of pocket for members?

RX MANAGEMENT FOR TOBACCO CESSATION AND WEIGHT MANAGEMENT



ACTION STEP

OBESITY MANAGEMENT

Action Step: Check to see that your health plan and PBM are coordinating their efforts around obesity. Plans should be sharing their data with PBMs, and vice versa. Talk with your PBM about the impact of lifting restrictions on anti-obesity medications for patients who meet prescribing and prior authorization standards.

Why It's Important? Failure to manage obesity can lead to diabetes, hypertension, and a host of other medical comorbidities. A recent Action Brief from the Greater Philadelphia Business Coalition on Health points out that research shows those who couple lifestyle therapy with a pharmacotherapy weight loss program lose between 3% and 9% more on average than those strictly focused on a lifestyle plan.

https://www.gpbch.org/?selected=article_detail&id=103&resultpage=1

Efficiency (Generic) & Appropriateness Drug Use

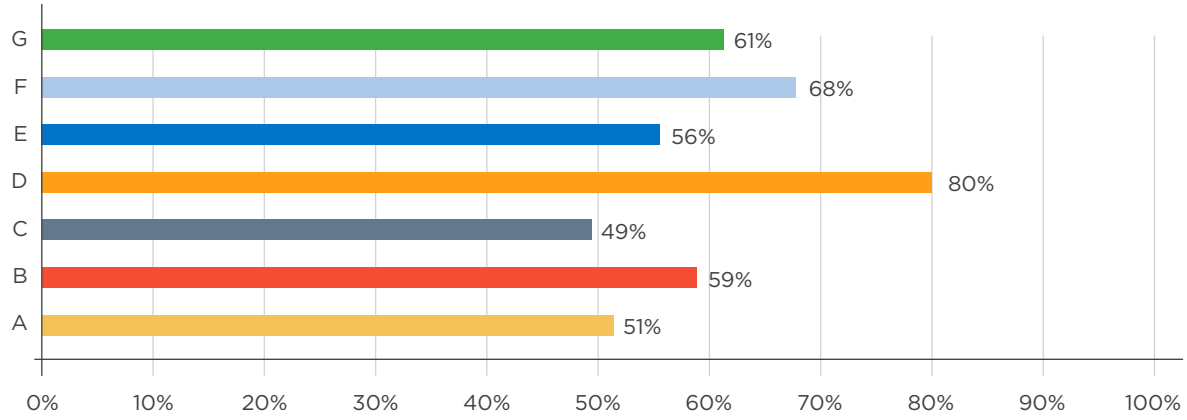
This section assesses the breadth and types of strategies PBMs use to assure appropriate, cost-effective utilization, including removal of low-value medications from formulary

All respondents have generic dispensing rate of over 86%

Scoring differences were based on:

- Formulary positioning of the nine medications shown to be of low value
- Addressing overuse of antibiotics of concern
- Programs in place to assure stabilization of medication regimens prior to filling drugs via mail service or extended retail

EFFICIENCY & APPROPRIATENESS



ACTION STEP

LOW-VALUE DRUGS

Action Step: Ask your PBM to provide you with formulary status, and ask for a comparison of spend net of rebate versus higher value alternatives, and if there are any associated fees, for these drugs identified as low-value. Some of the drugs are branded (in capitals) and others are expensive generic medications: DEXILANT; DUEXIS; ABSORICA; SOLODYN; JUBLIA; Esomeprazole Magnesium; Mometasone Furoate nasal spray; Metformin HCl ER MOD; Metformin HCl ER OSM

Why It's Important? A recent study by the Pacific Business Group on Health, reported by the Commonwealth Fund says, "Large self-insured employers and other plan sponsors can save 3–24% of outpatient pharmacy costs managed by PBMs by removing high-priced drugs with low or no added clinical value from their formularies. These savings are compelling, given the relatively low administrative barrier to implementation." These nine drugs represented 21% of the potential savings.

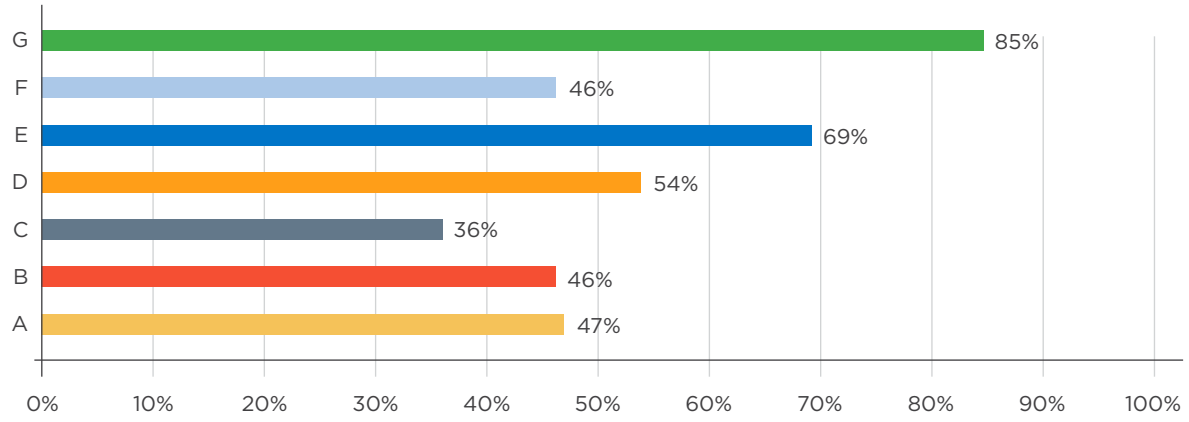
Rx Program Organization

This section assesses the PBMs ability to provide a value-based formulary, implementation of value-based insurance design with client, presence and information on preventive preferred drug list for high deductible health plans (HDHPs), and the PBM's flexibility.

Scoring differences are based on:

- The option of a value-based formulary that is based on evidence and not based on contracts with manufacturers
- The ability to provide an example of a value-based benefit design with at least one employer
- Flexibility in allowing employers to customize certain functions
- Presence and detail of a preventive preferred drug list for HDHPs

PROGRAM ORGANIZATION



Outpatient Quality, Safety and Adherence

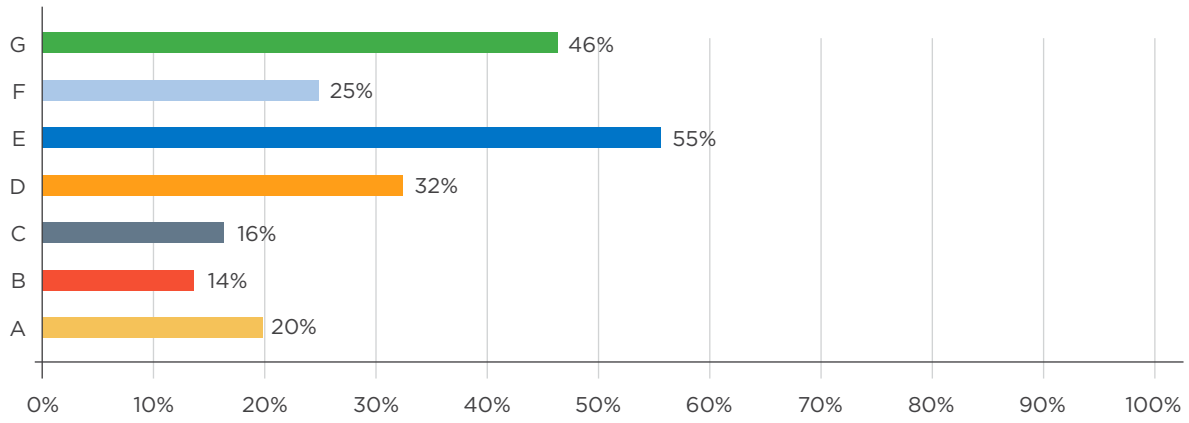
This section examines the PBMs programs for monitoring and managing patients on respiratory medications. It also looks at how the PBM tracks and manages drug conflicts, and potential opioid misuse and management of retail pharmacies

- No respondent requires retail pharmacies to monitor/track primary non-fulfillment

Scoring differences were based on:

- Ability to report and address drug-drug conflicts and opioid misuse
- Performance and reporting on optimal control of members with asthma
- Adherence rate measured as Proportion of Days Covered for long-acting inhaled bronchodilator agents in COPD patients
- Management of network pharmacies and presence of quality incentive programs

OUTPATIENT QUALITY, SAFETY AND ADHERENCE



Consumer Engagement

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

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

Why do we ask?

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

Overview of Consumer Engagement

Racial, Cultural and Language Competency

- Member demographics & sources of information
- Provider demographics
- Using the information
- Health literacy

Alignment of Benefit Design/Incentives

- Reducing barriers for chronic disease
- Reducing barriers for acute care

Price Transparency and Member Experience

- Cost calculators
- Patient-centered care/care coordination

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

Member Support & Programs, Tobacco and Obesity

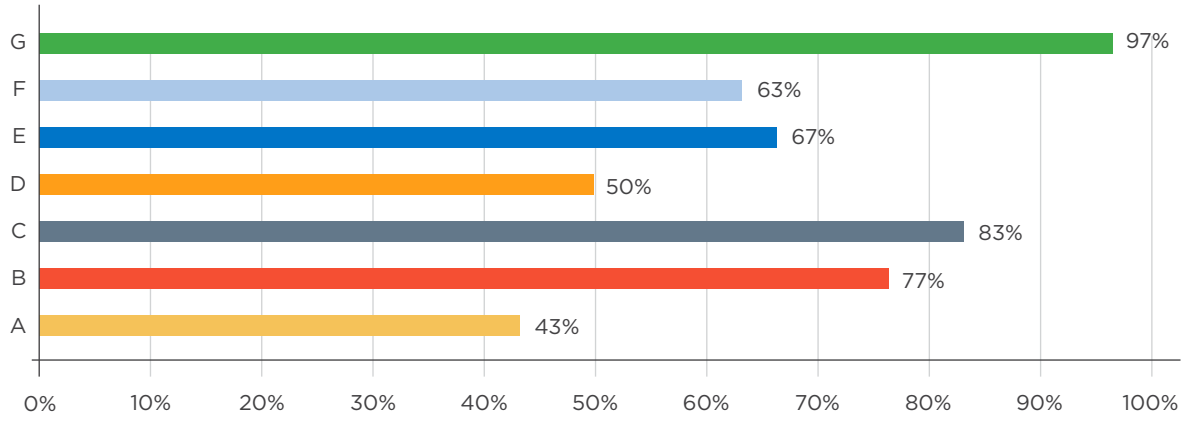
Price Transparency & Member Experience

This section measures the scope of the cost calculator and if members use the calculator

Scoring differences in this section were based on:

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

PRICE TRANSPARENCY AND MEMBER EXPERIENCE



SPECIAL REPORT

PRECHECK MYSCRIPT®

OptumRx

A genuinely empowered physician and by extension patient has access to all of the critical information they need to make an informed decision. But the patient experience — including what drugs are covered, and what price they will pay — will depend on multiple, interlocking variables: their benefit plan, the plan's pharmacy network, and any discounts their plan has negotiated with the pharmacy.

These variables are often invisible to both doctors and patients. So doctors might have no idea whether a particular drug is covered by the patient's benefit plan, or that it might require special utilization management permissions. Patients may not know if the prescription they have will be accepted when they get to the pharmacy, or how much it will cost.

PreCheck MyScript® from OptumRx removes invisibility from the process. This innovative tool offers physicians real-time information about available drug options, compares the exact out-of-pocket costs of each drug based specifically on the patient's benefit plan and flags whether a pre-authorization is needed. Because PreCheck MyScript is embedded directly into a physician's existing workflow, there is no need to adopt new technology.

This gives physicians a chance to discuss all medication alternatives with the patient face-to-face and file the pre-authorization online before the patient leaves the office to head to the pharmacy.

Initial results show using PreCheck MyScript has led physicians to choose a different, oftentimes lower-cost drug, about 20% of the time when a better alternative was offered. This means fewer surprises for consumers at the pharmacy and lower overall health care costs. In fact, it's saving about $135 per patient on each prescription filled when an alternative is selected.

The better the patient care, the better the outcomes — for everyone.

About OptumRx

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

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

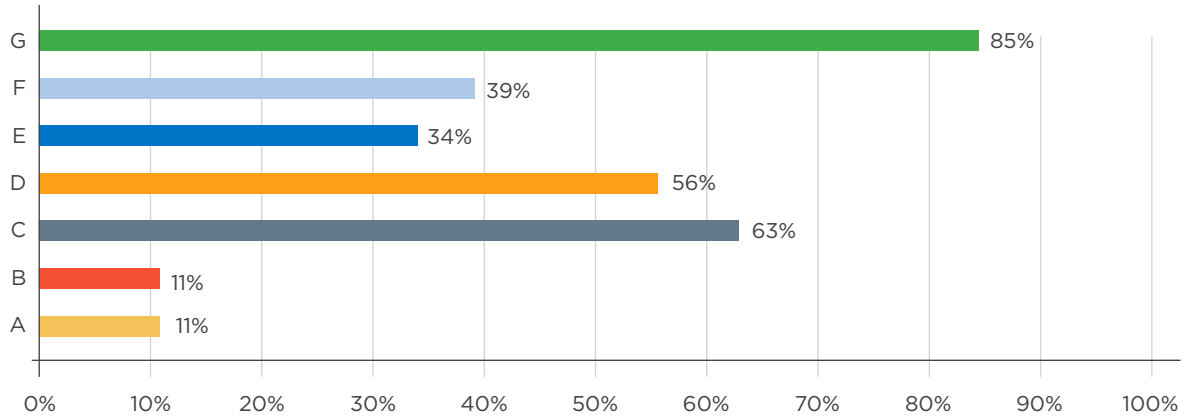
Racial, Cultural and Language Competency

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

Scoring differences in this section were based on:

- Capturing demographic information on new and existing members and using information to support member's language and/or cultural needs as well as supporting those with health literacy limitations
- Activities in place to support members with limited English and/or health literacy
- Activities that ensure delivery of culturally sensitive/appropriate care
- Evaluation of the impact of language and/or literacy activities

RACIAL, CULTURAL AND LANGUAGE COMPETENCY



SUMMARY OF ACTION STEPS

- Ask your PBM where **biosimilars** are positioned, and whether they are making efforts to increase uptake.

- Ask your PBM whether they are monitoring for compliance with **substance use medications.**

- Check to see that your health plan and PBM are coordinating their efforts around **obesity,** and talk with your PBM about the impact of lifting restrictions on **anti-obesity medications** for patients who meet prescribing and prior authorization standards.

- Ask your PBM about their policies regarding **low-value drugs.**

Caveats of the PBM Assessment

As with any performance assessment there are possible limitations/considerations in using the results:

1. **The advantage of experience**
   Over years, PBMs gain familiarity with the tool, and have the opportunity to refine their responses. Therefore, you could expect PBMs that have been with us for a few years to have slightly better scores.

2. **Data barriers**
   To achieve "apples to apples" comparisons, we require use of third-party specifications, which some PBMs are not prepared to incorporate. As they use these standardized measures, their scores could improve. More on this below.

3. **Business strategy decisions**
   The PBM may simply not include some elements in their business plan. PBMs can't work on all elements of the Assessment at one time, and some areas may not be high on their current priority list. And it could be that their customers haven't asked for some features. ***PBMs are not likely to expand their functions, and improve performance, until you ask them to!***

4. **Satisfaction**
   This tool does not assess satisfaction. Only experience can tell whether your representatives will be amenable, responsive, and competent.

National Alliance of Healthcare Purchaser Coalitions
Driving Innovation, Health and Value

The National Alliance of Healthcare Purchaser Coalitions is the only nonprofit, purchaser-led organization with a national and regional structure dedicated to driving health and healthcare value across the country. Our members represent more than 12,000 employers/purchasers and 45 million Americans, spending over $300 billion annually on healthcare. Purchasers range from small and mid-sized to very large organizations, representing private and public sector, nonprofit, and union/Taft-Hartley groups.

nationalalliancehealth.org/home

eValue8 HEALTHCARE

THE INFORMATION IN THIS REPORT IS DRAWN FROM A SUBSET OF EVALUE8, an evidence-based tool of the National Alliance of Healthcare Purchaser Coalitions. eValue8 was created by business coalitions and employers like US Bank, Ford Motor Company, General Motors and Marriott International to define, measure and evaluate health plan performance. eValue8 asks health plans probing questions about how they manage critical processes that control costs, reduce and eliminate waste, ensure patient safety, close gaps in care and improve health and health care. Plans and purchasers receive objective scores enabling comparison of plans against regional and national benchmarks and a roadmap for improvement. As a result of face-to-face discussion of findings and roadmap, plans learn what they need to do to align their strategies with purchaser expectations to maximize the value of the health care investment and, ultimately, improve health and quality of care. eValue8 is a transformational resource to help National Alliance member coalitions lead in improving health and value of health care services in their communities by advancing value-based purchasing.

nationalalliancehealth.org/www/initiatives/initiatives-market-assessments/evalue8

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