Pharmacy Benefit Management Institute®

TRENDS IN DRUG BENEFIT DESIGN

2018

Takeda

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Takeda Pharmaceuticals U.S.A., Inc.

SPONSOR LETTER:
TO OUR INDUSTRY COLLEAGUES

Takeda is pleased to sponsor the 2018 *Trends in Drug Benefit Design* report. This is the eighteenth consecutive year that Takeda has partnered with the Pharmacy Benefit Management Institute (PBMI) to bring independent, unbiased drug benefit management insights that industry stakeholders need and want. Readers of this report are diverse – they include employers, health plans, benefit consultants and brokers, financial analysts, state and local government staff, pharmaceutical manufacturers, and pharmacy providers.

We are proud to stand with PBMI to offer this resource. The report is updated annually to reflect marketplace trends and reader interests. This year, the report put special focus on high-deductible health plans and other cost-sharing designs that are being used frequently to manage prescription drug trend but may increase out-of-pocket costs for patients when they access needed medications.

The report clearly shows that plan sponsors continue to manage the pharmacy benefit carefully, and 62% develop the pharmacy benefit in concert with the medical benefit. These two intertwined and valued benefits help protect the health of the primary asset of American companies – their employees and their families.

Industry stakeholders will find valuable information on the latest trends in prescription benefit design, utilization management, rebate arrangements, pharmacy networks, and more. We hope that you will find this report to be a key resource, helping you meet the goals and objectives you have set for your organization to improve the quality of care you deliver.

Takeda is also pleased to support a downloadable online version of the report, which is available at www.pbmi.com.

Cordially,

Richard C. Ascroft, RPh, JD
Senior Vice President
Managed Markets and Government Affairs
Takeda Pharmaceuticals U.S.A., Inc.

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Acknowledgment

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About PBMI

The Pharmacy Benefit Management Institute (PBMI) provides independent research and education to help healthcare and benefits professionals work with pharmacy benefit managers to design drug benefit programs.

PBMI provides a forum for purchasers to exchange ideas and drive marketplace changes that improve pharmacy benefits and control costs.

Pharmacy Benefit Management Institute®

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Getting the Most Out of the Report

NEW QUESTION

New questions are denoted by the "New Question" banner.

REVISED QUESTION

Revised questions are denoted by the "Revised Question" banner.

The focus of this report is employer trends related to design and management of the overall drug benefit. Issues specific to specialty medications are explored in detail in a separate report — *Trends in Specialty Drug Benefits* — available from www.pbmi.com/SpecialtyReports. For your convenience, a summary of key findings is shown in the *Trends in Specialty Drug Benefits* section located on page 41 of this report.

Throughout the report, footnotes beginning with "Base" indicate the denominator group for the calculation of percentages and averages.

Figure and table totals may not equal 100% due to rounding.

Introduction

The Pharmacy Benefit Management Institute (PBMI) has produced this annual research report focused on highlighting employer-sponsored drug benefit design trends and strategies since 1995. The methods and questions have evolved considerably over the years, but the aim remains the same – to generate meaningful conversations and provide education on the use of best practices and innovation in drug benefit management. With this rich history in mind we are pleased to present the 2018 *Trends in Drug Benefit Design* report.

The 2018 *Trends in Drug Benefit Design* report focuses primarily on overall drug benefit design for the 2018 benefit year. Where appropriate, it also compares current year information to the prior year. Issues specific to specialty medications are explored in detail in a separate report – *Trends in Specialty Drug Benefits*. These reports, previous reports, as well as our other annual reports on drug benefit management-related topics, can be found at www.pbmi.com/PBMI-Reports.

In the last twenty-three years much has happened in drug benefit design. Not only are there many drugs that did not exist in 1995, but drug costs are of graver concern than ever for plan sponsors, consumers, and the nation. Cost sharing and formulary design have grown much more complex. In 1995, most plans had a two-tier flat copay design with the average retail copay differential less than $5 between generic and brand prescriptions ($5.74 and $9.69, respectively). Today very few employers have two-tiered benefit designs, with three, four, and five tiers becoming the norm. In 1995, 48% of employers excluded all oral contraceptives and 27%, all biotechnology drugs. Today, coverage of these two types of drugs is almost universal but exclusions within a class of drugs are very common.

What has not changed is the need for plan sponsors and pharmacy benefit managers (PBMs) to constantly look to trends and adjust plan design and clinical and trend utilization programs to meet current marketplace conditions. The need for meaningful conversations among all stakeholders – employers, PBMs, health plans, pharmaceutical manufacturers, pharmacies, and consumers – is greater than ever. Our hope is that this research will contribute to those conversations and help ensure continued access to safe, effective, and affordable medications.

Drug benefit design has changed a lot over the last two decades. New drugs, higher costs, and complexity are a greater concern to plan sponsors and consumers than ever before

EXECUTIVE SUMMARY

Findings from the 2018 *Trends in Drug Benefit Design* report emphasize the struggle faced by both plan sponsors and members in the face of drug costs. Managing drug trend remains the top priority for plans that often shift costs to members to keep overall benefit costs affordable. As more employers move to benefit designs containing deductibles and/or coinsurance, members are feeling more financial stress about higher, unpredictable out-of-pocket costs.

Plan sponsors and members both struggle in the face of high drug costs

Employers feel stress over drug costs but are not standing still

#1

Managing drug benefit trend **remains the top priority** for plans

83%

are self-funded and only **51%** have stop-loss insurance that includes prescription drugs

38%

reported four or more tiers, and **18%** have a separate tier for higher-cost generics

Use of traditional trend management tools holds steady:

94%	92%	91%	86%
Prior authorization	Quantity limits	Refill too soon limits	Step therapy

Deductibles becoming the new normal?

61% WITH HSA

A majority of employers offer a high-deductible health plan (HDHP)

18% WITH HRA

44%

have a pharmacy deductible, either alone or shared with medical

Offering HDHPs with good intentions

41% see them as an effective way to manage overall drug trend and save money

58% see them as an effective way to help consumers make better decisions

Consumer-driven benefit designs can create member cost uncertainty

Average deductible vs. wages

$1,740 SINGLE

$3,571 FAMILY

AVERAGE DEDUCTIBLE

VS.

MEDIAN WEEKLY INCOME

$881 SINGLE[1]

Nearly two weeks' pre-tax pay is needed to meet the deductible

$1,108 FAMILY[2]

More than three weeks' pre-tax pay is needed to meet deductible

$2,699 SINGLE VS. **$5,380** FAMILY

Just 37% of respondents have a maximum out-of-pocket (MOOP)

Flat dollar copays are used by about **60%** of plans

Member cost sharing: brand vs. generic drugs

$1,914

Average annual retail cost of brand drug = $5,800[3]
Average coinsurance of 33% = $1,914

VS.

$45

Average annual retail cost of generic drug = $280[4]
Average coinsurance of 16% = $45

Because most Americans who take prescription drugs take more than one, costs can start to add up.

Making this even more challenging: **57%** of adults in the U.S. have less than $1,000 in savings to cover health expenses, and nearly 25% have less than $100 saved. Only 43% have more than $1,000 saved for these costs.[5]

However, in 2017 about **85%** of people with commercial insurance paid less than $20 per month out-of-pocket for drug copays/coinsurance, and about half of these paid nothing since they filled no prescriptions.[6]

Employers are concerned for members

Top three challenges high-deductible health plans face

Medication is unaffordable before deductible is met

Members don't understand how deductibles work

Lack of member engagement/member consumerism

Although the use of trend and utilization programs are high, barriers still exist

44%

The most frequently cited barrier was member acceptance

Lower cost sharing is the most frequently used strategy

74%

make use of lower cost pharmacy channels voluntary ...

... and strategies to increase use are primarily through lower cost sharing and member communications

52% RETAIL 90	LOWER COST SHARING	**51%** MAIL ORDER
37%	MEMBER COMMUNICATIONS	**43%**

28%

Promote the use of cost-sharing transparency tools to help members manage cost sharing

Pricing more transparent or not?

The use of pass-through pricing has increased slightly from last year

59%
had pass-through pricing in 2017

63%
currently have pass-through pricing

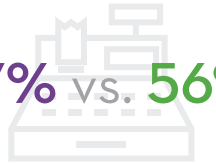
Most employers use MAC

27%
do not

Discounts for generics and brands

	RETAIL 30	RETAIL 90	MAIL ORDER
Average retail AWP discount for generics	56%	61%	63%
Average retail AWP discount for brands	20%	22%	25%

77% of plans have guaranteed discounts applied to generics



77% vs. **56%**

While 56% have guaranteed discounts applied to brands

Rebates can be important

83%
get rebates and of these, 58% get 100% of rebates

31%
have price protection provisions

Executive Summary Sources

1. Bureau of Labor Statistics. Usual Weekly Earnings of Wage and Salary Workers First Quarter 2018. April 13, 2018. Accessed May 29, 2018.
2. United States Census Bureau. Household Income 2016. September 2017. Accessed May 29, 2018.
3. Schondelmeyer SW, Purvis L. Trends in Retail Prices of Brand Name Prescription Drugs Widely Used by Older Americans, 2006 to 2015. AARP Public Policy Institute. December 2016. Accessed May 29, 2018. **Note that these prices are retail list price and exclude rebates.*
4. Schondelmeyer SW, Purvis L. Trends in Retail Prices of Generic Prescription Drugs Widely Used by Older Americans, 2006 to 2013. AARP Public Policy Institute. May 2015. Accessed May 29, 2018.
5. GoBankingRates.com. More than Half of Americans Have Less Than $1,000 in Savings in 2017. September 17, 2017. Accessed May 29, 2018.
6. Fein A. Exclusive Express Scripts Data: Most People Have Low Out-of-Pocket Prescription Costs. Drug Channels. February 15, 2018. Accessed February 15, 2018.

DESIGNING THE DRUG BENEFIT

Designing drug benefits that meet both the needs of the workforce and their families, and are affordable to both employee and employer, is challenging. Employers must consider many factors – budget, projected and past trend, the demographics and health status of their workforce, and corporate culture, among others. As the nation debates what to do about high drug costs and proposes changes that may affect future costs,[7] employers must manage these costs today.

Employers rely on their team of consultants, industry thought leaders, and vendors to provide expert advice and showcase best-in-class strategies to ensure that they design drug benefits that meet the dual goals of access and affordability.

Employers rely on consultants, industry thought leaders, and vendors to provide expert advice and strategies to design their drug benefits

Drug benefit design typically starts with a team of human resources and benefits professionals who are responsible for developing and managing employee benefits that make their organization an employer of choice as well as one that provides for the health needs of its workforce. As shown in Figure 1, the majority have considerable experience managing drug benefits. Nearly 40% have more than 10 years of experience with another 29% with 6–10 years of experience. However, most juggle drug benefit design and management with their other job responsibilities. As shown in Figure 2, 62% of respondents reported that 25% or less of their job was focused on designing and managing the drug benefit.

Although the process of designing and evaluating drug benefits differs by employer, the basic components include collaboration with key influencers and advisers, determination of benefit funding, and deciding whether to purchase stop-loss insurance.

Most employers rely on experts to help them design and purchase drug benefits. As shown in Figure 3, 83% use a benefit consultant. This percentage is higher than the 76% reporting the use of a benefit consultant in the 2017 report.[8] Use of benefit consultants is virtually identical for large and smaller employers (86% large; 81% smaller). Of those using a consultant, 66% use the same person to evaluate and design the medical benefit.

FIGURE 1. **Length of Time Managing Drug Benefit**

(n=273)

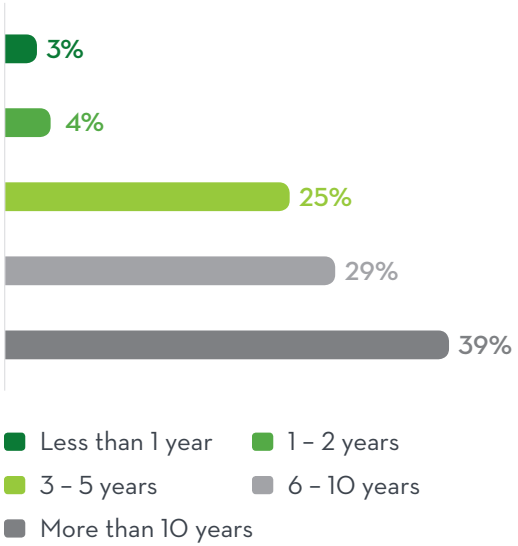


FIGURE 2. **Percentage of Job Focused on Drug Benefit**

(n=273)

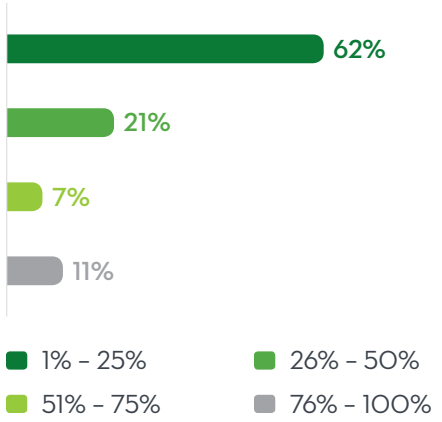
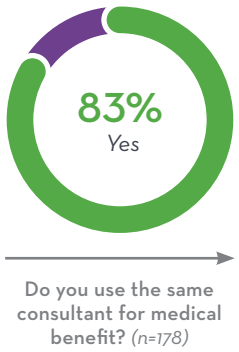
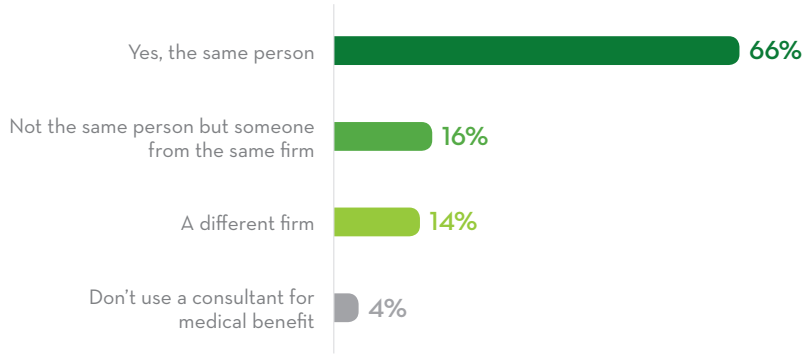


FIGURE 3. **Use of Benefit Consultant**

Base: Respondents who work directly for the employer. (n=215)





Here differences by employer size are more striking. Smaller employers are much more likely to use the same person to design both pharmacy and medical benefits (75%) than large employers (53%). These data can be found in the Appendix, Table 5.

As shown in Figure 4, 62% of employers reported that the drug benefit and medical benefit are designed in concert. Designing the drug and medical benefit together does not imply that the drug benefit is carved into the medical benefit plan. Rather, the designs on both benefits are done together but may ultimately fall under separate contracts and perhaps through different vendors. Given that smaller employers are more likely to use the same consultant to design both pharmacy and medical benefits, it is not surprising that they are also more likely to report designing both benefits together (66% compared to 56% of large employers; see Table 6 in the Appendix).

Employers may also choose to work with a coalition or other group purchasing organization. Coalitions and group purchasing organizations are entities that leverage group purchasing and contracting to obtain better pricing and terms than an individual member of the coalition/group might be able to secure on their own. They may be employer-led, consultant-led, or organized by common interest, industry, or geography.

As shown in Figure 5, 27% reported that they purchase their PBM services via one of these organizations. This is an increase from the 21% reporting use in 2017. No differences were seen by employer size.

Smaller employers are much more likely (75%) than large employers (53%) to use the same person to design both pharmacy and medical benefits

FIGURE 4. **How Benefits Are Designed**

Base: Respondents who work directly for the employer.

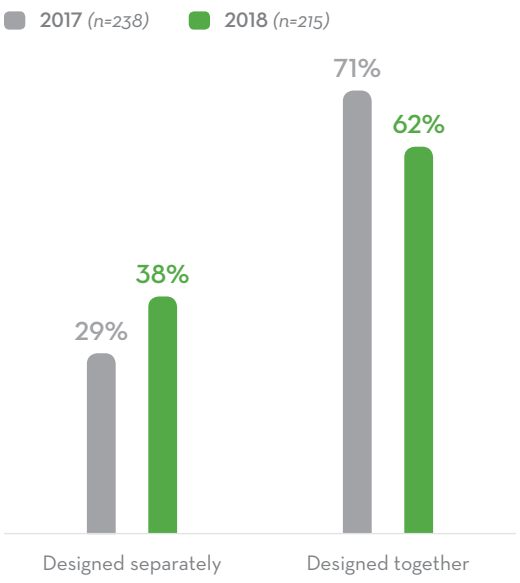
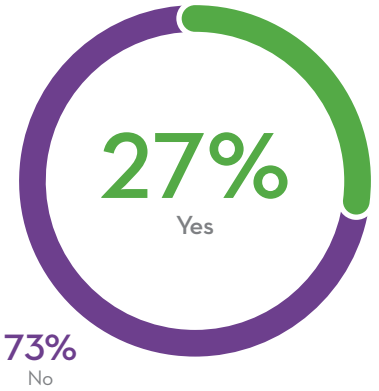


FIGURE 5. **Use of Coalition/Group Purchasing Organization for PBM Services**

Base: Respondents who work directly for the employer. (n=215)



As shown in Figure 6, consultants were rated as being the most influential in evaluating drug benefit design by 26% of respondents. We have seen a decline in the last few years of consultants being reported as most influential (36% in 2016, 30% in 2017, and 26% in 2018) but no discernible pattern in others that might be gaining influence. Figure 6A illustrates differences in the most influential group by employer size. Here you see that large employers more frequently reported consultants, their PBM, their health plan, and employee benefits committee as most influential when compared to smaller employers. Smaller employers were more likely to report brokers, senior management, and finance as influential.

One of the basic building blocks of drug benefit design is deciding whether, and how, to integrate drug benefits with the medical benefit. When the drug benefit is carved-in, the employer contracts directly with their health plan for both medical and drug benefit management and administration. The drug benefit may be administered directly by the health plan-owned PBM, or the health plan contracts with a PBM to handle the drug benefit administration. Conversely, when the drug benefit is carved-out, the employer contracts with the PBM to administer the drug benefit, either directly or via their health plan, but under a separate contract.

FIGURE 6. **Most Influential in Evaluating Drug Benefit Design***

**Results do not equal 100%. Remaining respondents indicated "Other" as most influential. (n=273)*

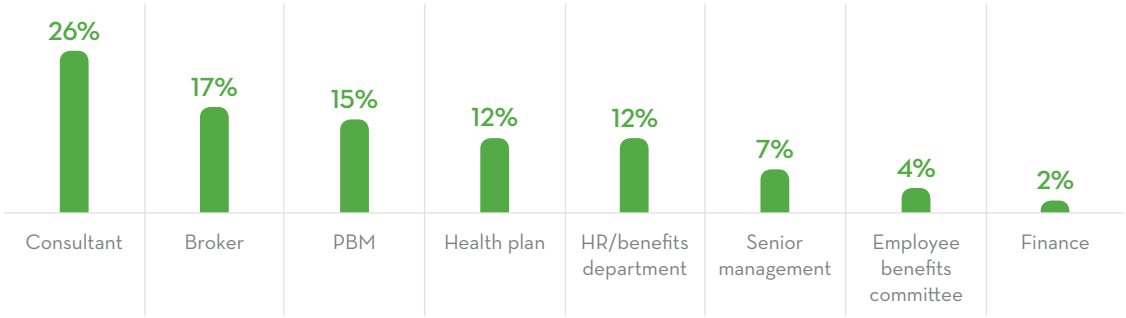
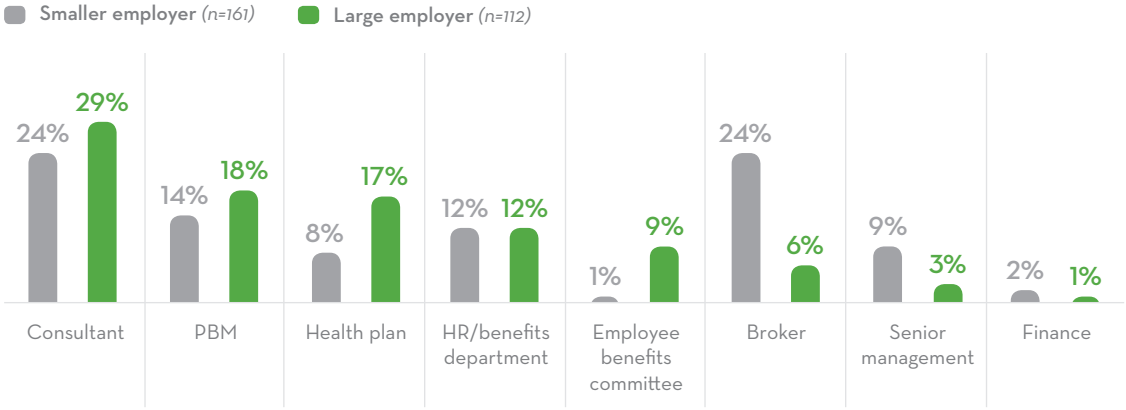


FIGURE 6A. **Most Influential in Evaluating Drug Benefit Design* — by Employer Size**

**Results do not equal 100%. Remaining respondents indicated "Other" as most influential.*



As shown in Figure 7, 63% carved-out the drug benefit. That is, the management of the drug benefit is separate from the management of the medical benefit, using two different entities or two separate contracts to administer the benefits. Irrespective of whether employers chose a carved-in or a carved-out drug benefit, one thing is clear – most respondents had no plans to change their carve-in or carve-out status.

The percentage of plans reporting that they carve-out drug benefits is considerably higher than last year when 46% reported a carved-out pharmacy benefit. However, we changed the wording of the question to more clearly define the difference between carved-out and carved-in. For this reason, this change should not be interpreted as a change in the marketplace but rather an improvement in the question design.

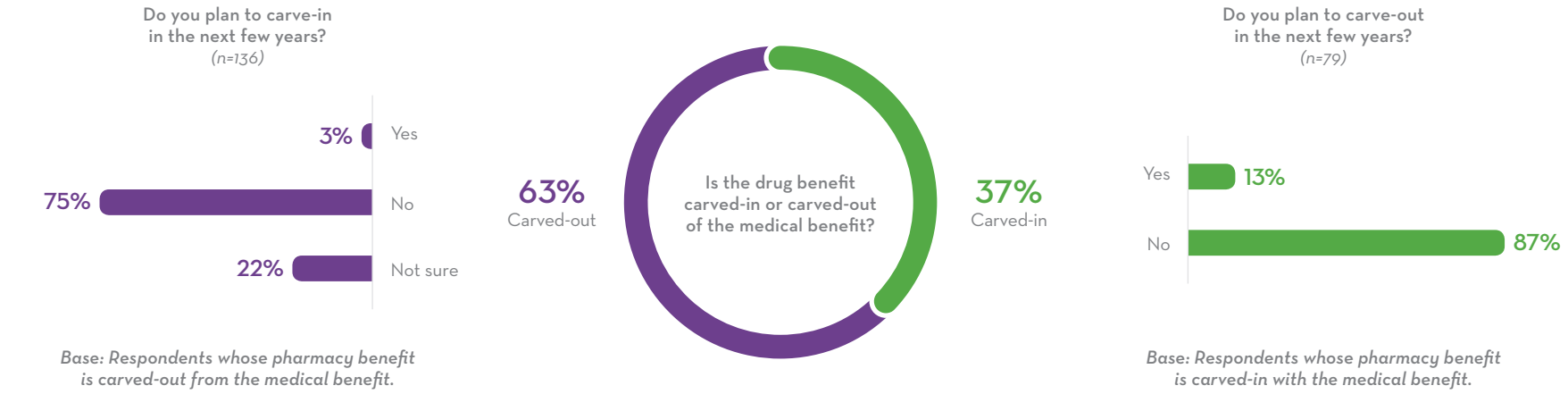
Large employers were more likely to carve-out pharmacy benefits than were smaller employers (74% and 56%, respectively). However, there were no differences by employer size in plans to make changes to what was currently in place.

Carved-out: Management of the drug benefit that is separate from the management of the medical benefit, using two different entities or two separate contracts to administer the benefit.

Carved-in: Management of the drug benefit that is included in the management of the medical benefit, using a single entity and contract to administer the benefit.

FIGURE 7. **Relationship with Medical Benefit**

Base: Respondents who work directly for the employer. (n=215)



Employers must also decide how to fund medical and pharmacy benefits. The clear majority of employers self-insure both pharmacy and medical benefits (83%; Figure 8). Self-insured plans take on more financial risk but may have lower overall costs when they manage benefits effectively.

One way to mitigate risk against financial loss due to one or more cases of catastrophic illness or unexpected large medical or drug claims costs is through stop-loss insurance. Stop-loss insurance for both pharmacy and medical claims was purchased by 51% of employers who self-insure, while 21% reported stop-loss insurance for medical only (Figure 9).

FIGURE 8. **How Benefits Are Funded**

Base: Respondents who work directly for the employer. (n=215)

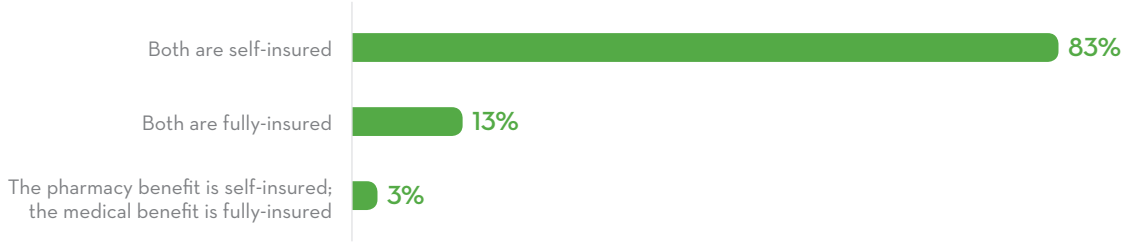
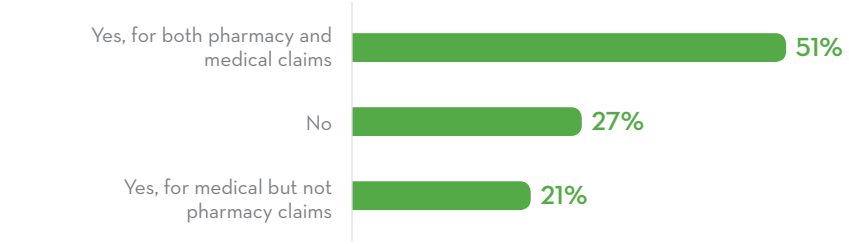


FIGURE 9. **Purchase of Stop-Loss Insurance**

Base: Respondents who work directly for the employer. (n=201)



BENEFIT DESIGN SPOTLIGHT

DRUG BENEFIT MANAGEMENT IN HIGH-DEDUCTIBLE HEALTH PLANS

The use of high-deductible health plans (HDHPs) has been on the rise. One survey of employers found that the prevalence of employers offering HDHPs with a health savings account (HSA) increased from 63% in 2016 to 66% in 2017.[9] However, in terms of enrollment, more members are covered by PPO health plans than HDHPs.

HDHPs are defined by the Internal Revenue Service (IRS) as plans with a deductible of at least $1,350 for an individual and $2,700 for a family.[10] The concept behind HDHPs, sometimes called consumer-driven health plans (CDHPs), is that by increasing member cost sharing, consumers are more likely to be engaged in their health. For employers, HDHPs offer a way to not only reduce their costs but also offer lower employee premiums for health benefits.

In the last few years we have noted the increase in employers putting benefit designs in place that include deductibles. In the 2017 *Trends in Drug Benefit Design* report, 56% of employers reported that their largest plan type included a deductible.[11] This is, however, a recent trend and is likely linked to the increased utilization of HDHPs.

HDHPs may be combined with either or both a health savings account (HSA) or a health reimbursement arrangement (HRA). A HSA is a personal savings vehicle that allows individuals enrolled in HDHPs to save for healthcare expenses not covered by their plan (including deductibles, copays, and coinsurance) using pre-tax dollars. The combination of HDHP and HSA or HRA is intended to provide financial protection against high healthcare costs while encouraging good consumer behaviors. HSAs are owned by the employee, and contributions to this account may be made by the employee, the employer or both.[12] HRAs, on the other hand, are owned by the employer but held in the employee's name, and contributions are made by the employer only.

The idea behind HDHPs is that they will decrease the use of low-value care and encourage consumers to actively consider both cost and quality when making healthcare decisions. The intended result is lower healthcare costs for both plan sponsors and consumers and increased member engagement.

However, the increased use of HDHPs has raised concerns including lack of affordability of needed care before the deductible is met, delaying or forgoing high-value treatment, and an increase in the proportion of household income dedicated to healthcare.[13]

The evidence on the impact of HDHPs is mixed. There is some evidence that healthcare spending is less for those enrolled in HDHPs[14] and that patients switch to lower-cost providers.[15] The intention that HDHPs will increase consumerism and engagement, however, has been less rosy. A recent study of consumer behaviors found that most Americans who are enrolled in HDHPs do not use information about price or quality of services, talk to providers about costs, or negotiate prices.[16] When prices are compared or discussions with providers occur, however, it is predominantly for prescription drugs. Of those in the study who had compared prices, 61% did so for prescription drugs, while two-thirds of those who had talked to providers about cost discussed prescription drugs.

Employers frequently offer more than one type of plan. As shown in Figure 10, 83% offered at least one preferred provider organization (PPO) plan, and 79% offered a HDHP either with a HSA or HRA. Large employers were more likely than smaller employers to offer HDHP plans with a HSA or HRA (Figure 10A). On average, PPO plans covered 60% of lives with very little difference by employer size.

NEW QUESTION

FIGURE 10. **Types of Plans Offered**

Multiple responses allowed. (n=273)

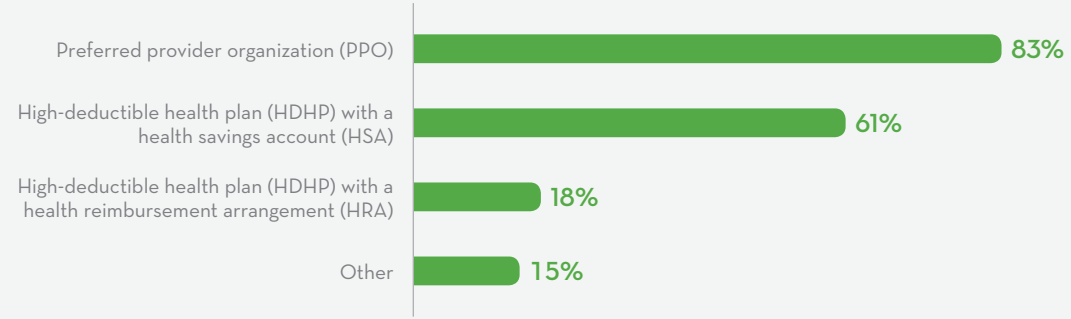
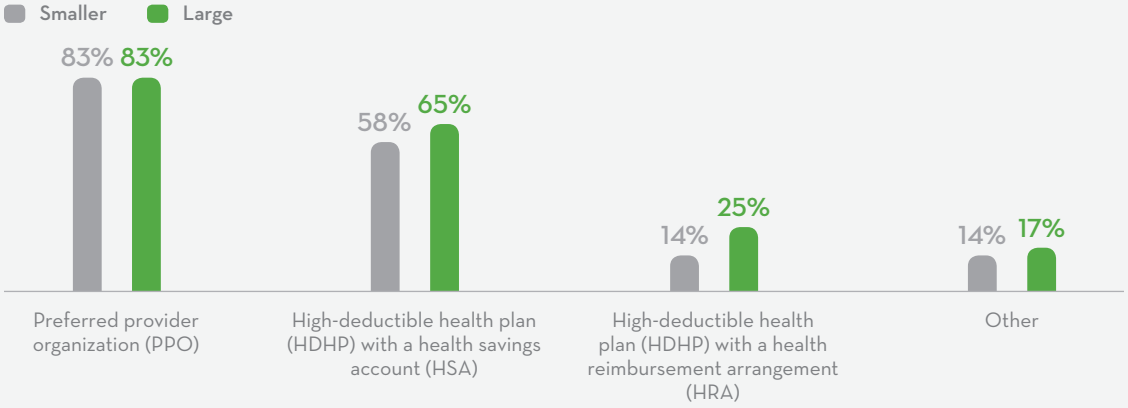


FIGURE 10A. **Types of Plans Offered – by Employer Size**

Multiple responses allowed. (n=273)

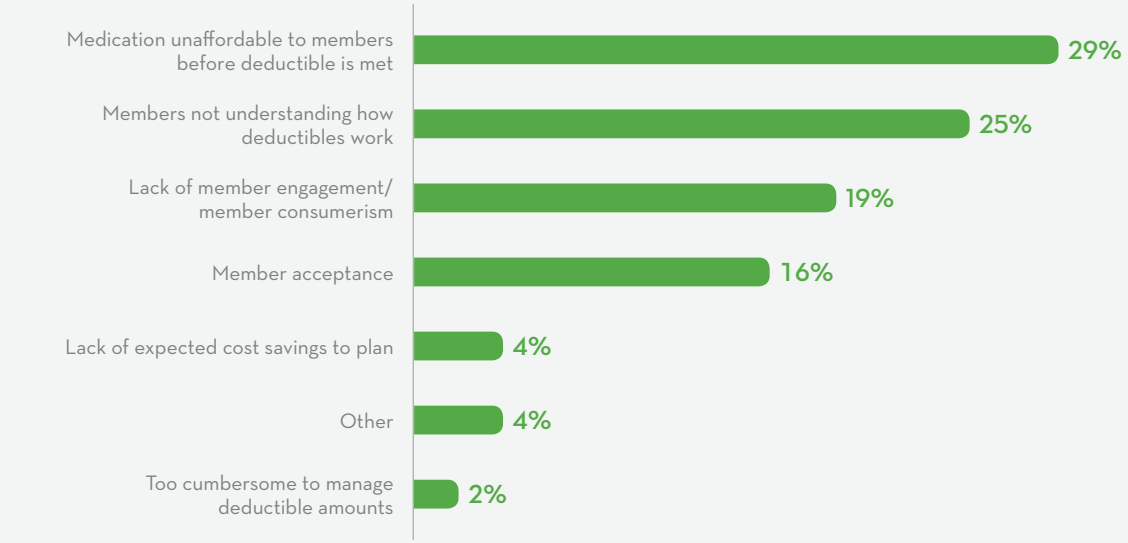


When employers were asked what they considered the number one challenge with HDHPs, the most frequent response was medications unaffordable to members before the deductible is met (29%; Figure 11). This is followed by members not understanding how deductibles work (25%) and lack of member engagement (19%).

NEW QUESTION

FIGURE 11. **Number One Challenge with High-Deductible Health Plans**

(n=273)



Unaffordable and Misunderstood

The top challenges with HDHPs are medications that are unaffordable to members before the deductible is met and that members do not understand how deductibles work

Respondents were also asked to rate how problematic these challenges were using a scale of 1 to 5 with 1 being "not a problem at all" and 5 being "a very big problem." As shown in Figure 12, medication affordability had an average rating of 4.1 and member understanding of how deductibles work was rated as 3.7.

HDHPs are sometimes touted as a way to manage overall costs. This may not translate to managing drug cost trend, however, as seen in Figure 13. Employer views were mixed, with 41% agreeing HDHPs are effective at managing overall drug trend, 33% being neutral, and 26% disagreeing. Views on HDHPs as an effective way to help members become better healthcare consumers were more positive, with 58% either agreeing or strongly agreeing.

NEW QUESTION

FIGURE 12. **Problems Related to High-Deductible Health Plans**

Scale is 1 ("not a problem") to 5 ("a very big problem"). N size varies by item.

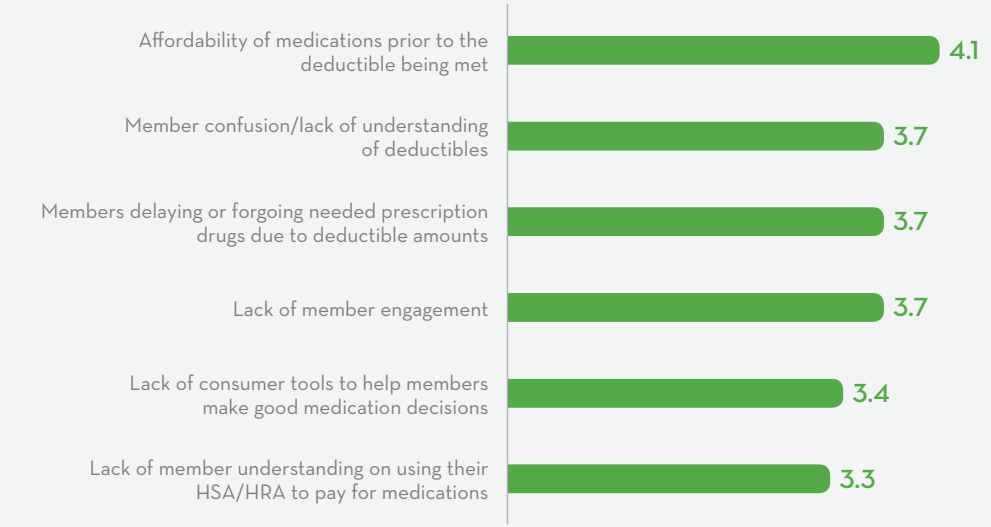
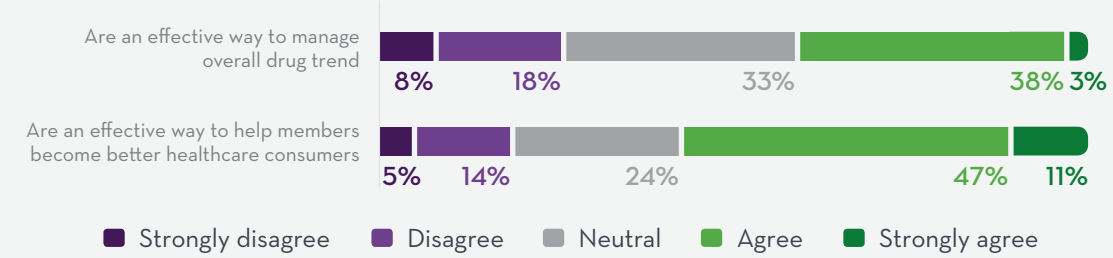


FIGURE 13. **Views on High-Deductible Health Plans**

(n=273)



We asked respondents to comment in their own words about the successes or challenges that their organization had experienced with HDHPs. A representative selection of responses is shown here.

> "At the right price point HDHPs are an effective way to help people understand their personal cost for healthcare and exposure to the true cost of prescription drugs"

Successes:

- "As long as the members are properly educated about what they are signing up for, there isn't much issue."
- "At the right price point they are an effective way to help people understand their personal cost for healthcare and exposure to the true cost of prescription drugs."
- "It is a great way to put the power back in the member's hand and let them take control of their financial present and future circumstances."
- "We have a huge overutilization issue with our PPO with medications (1.34 prescriptions PMPM) – HDHPs' population does not have this issue."
- "Employee awareness of medical and Rx costs has gone up!"
- "Employees have second thoughts about having a particular medical procedure and seek second opinion reviews. Also, employees look for generic drug options over more expensive brands. They are learning to be better healthcare consumers. Employees understand well how to use their HSA dollars to pay for these expenses."

Challenges:

- "Our population is generally fairly low-paid, which makes the 'sure thing' of a PPO attractive in its predictability."
- "Aligning Rx deductible contributions when patients utilize copay assistance cards at secondary claim adjudication. Money is applied to deductible that actually never is paid."
- "Biggest challenge is getting employees to even consider the option and 'do the math' and not overinsure themselves."
- "Challenges include lack of understanding by member and provider leading to prescription abandonment."
- "Delayed seeking necessary treatments."
- "Complaints about the costs of items before the deductibles are met. Everyone feels they deserve an exception."

COST SHARING

Cost sharing is the most visible part of the drug benefit for members and, for a small percentage of members, can represent a cost burden. It should be carefully considered by plan sponsors when developing drug benefit design. Member cost share, defined as out-of-pocket costs in addition to the amount members spend on their monthly premium, can come in a variety of forms – primarily copayments, coinsurance, deductibles, or some combination of these. Although member cost sharing gets quite a bit of press, most members pay relatively little out of pocket for drugs.[17] In 2017, about 85% of people with commercial insurance paid less than $20 per month out of pocket for drugs, and 50% had no out-of-pocket costs as they had no prescriptions filled.

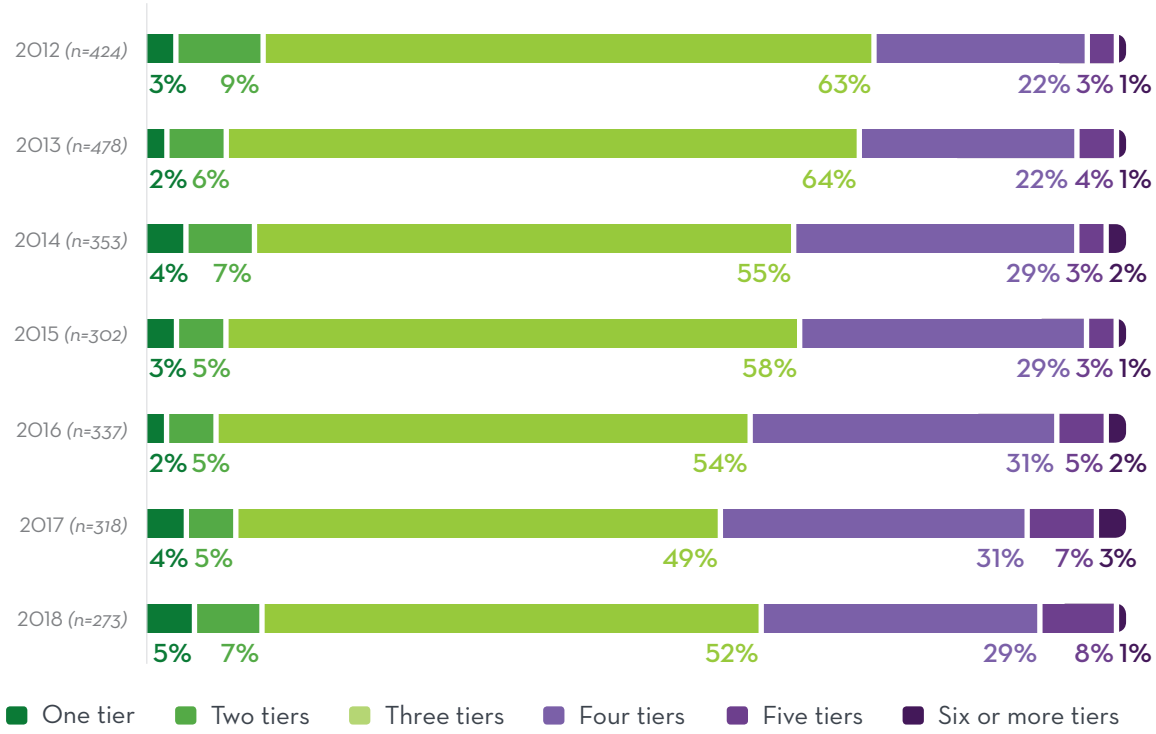
Although member cost sharing gets quite a bit of press, most members pay relatively little out of pocket for drugs

Employer-sponsored insurance plans typically require some form of cost sharing when members use their drug benefit. Cost sharing serves several purposes including defraying some of the costs for plan sponsors, keeping premiums affordable, reducing the use and costs of unnecessary drugs, and providing a financial incentive to choose a lower-cost place of service and lower-cost drugs when available.

Cost sharing is commonly based on the tier placement of a drug. Copayments are set dollar amounts for drugs based on their tier placement, while coinsurance requires the member to pay a percentage of the actual cost of the drug. Coinsurance amounts can exist with or without minimum and/or maximum out-of-pocket amounts per prescription. Additionally, some plans require members to meet a deductible amount prior to the plan covering any portion of medication costs.

As shown in Figure 14, the use of four or more tiers has grown over the last seven years. In 2012, only 26% of respondents reported four or more tiers for their plan. In 2018, 38% reported four or more tiers, a slight decline from 41% in 2017.

FIGURE 14. **Number of Tiers for Drugs Covered by the Plan**



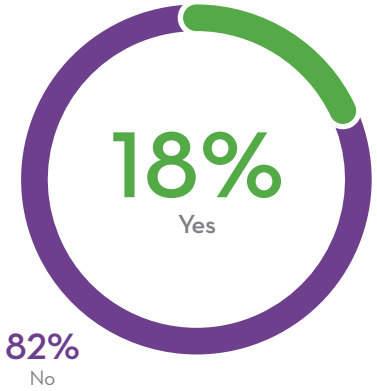
New for 2018, we asked whether the plan had a separate tier for higher-cost generic drugs. Generic drugs have been responsible for considerable savings to both plan sponsors and their members. However, some generic drugs have become extremely expensive in recent years,[18] and formulary position can be used by PBMs to negotiate better pricing for generics with therapeutic alternatives. In response, plan sponsors may consider moving certain generic drugs from what has typically been the lowest cost-sharing tier to a higher tier. As shown in Figure 15, 18% of plan sponsors reported they have a separate tier for higher-cost generics.

As we noted earlier in the Benefit Design Spotlight section (page 14) on high-deductible health plans, the use of deductibles has become much more common in the last several years. As shown in Figure 16, in 2018 27% of plans had a shared pharmacy and medical deductible, while 17% had a separate pharmacy deductible. In plans with a deductible that either includes or is specific to pharmacy only, the plan begins payment of their portion of drugs after the member has met the deductible amount. Among the 56% of plan sponsors who currently do not have a pharmacy deductible, only 10% are considering adding one (Figure 17).

NEW QUESTION

FIGURE 15. **Separate Tier for Higher-Cost Generics**

Base: Respondents with more than one tier. (n=260)



REVISED QUESTION

FIGURE 16. **Use of Deductible**

(n=273)

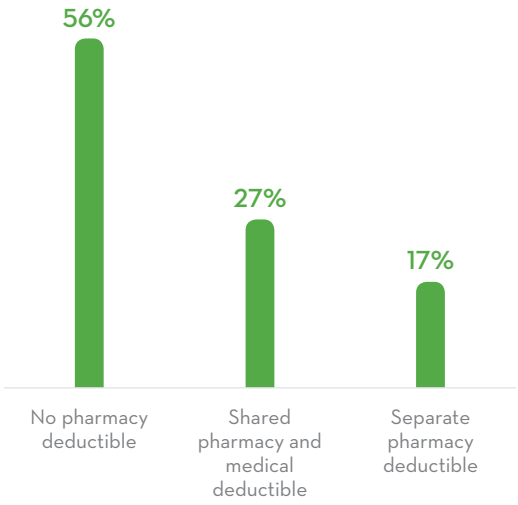
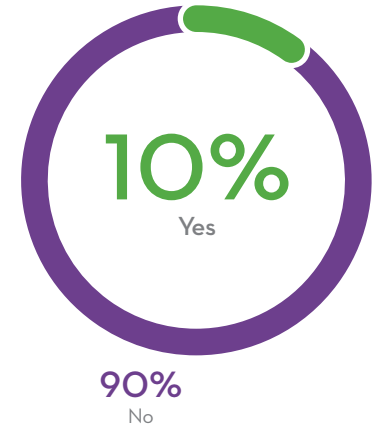


FIGURE 17. **Considering Adding a Pharmacy Deductible**

Base: Respondents without a pharmacy deductible. (n=118)



As shown in Table 1, for the minority of plans with a separate pharmacy deductible, deductible amounts averaged $408 for single coverage and $1,023 for a family. Average deductibles were higher for smaller employers than large employers ($514 single; $1,301 family for smaller employers vs. $263 single; $625 family for large employers). Please use caution when interpreting averages as sample sizes are fairly small.

When the deductible was shared by the medical and pharmacy benefit, deductible amounts averaged $1,740 for single coverage and $3,571 for family coverage (Table 2). However, the average shared deductible drops precipitously when looking at standard versus HDHPs. For HDHPs, average single coverage deductibles were $2,114, whereas for a standard deductible plan, the average single deductible was $644.

Maximum out-of-pocket (MOOP) limits protect members from very high out-of-pocket costs by placing a cap on the amount of cost sharing that a member is responsible for in a plan year. As shown in Figure 18, 37% of respondents reported the use of this protection. The use of MOOP limits for prescription drugs was similar in 2018 to that reported in 2017 (38%). The MOOP limits averaged $2,699 and $5,380 for single and family coverage, respectively.

TABLE 1. **Deductible Amounts, Pharmacy Only**

Pharmacy Only Deductible	n	Mean
Single coverage	40	$408
Family coverage	34	$1,023
Smaller Employer		
Single coverage	23	$514
Family coverage	20	$1,301
Large Employer		
Single coverage	17	$263
Family coverage	14	$625

FIGURE 18. **Use of Annual Out-of-Pocket Limits**

(n=261)

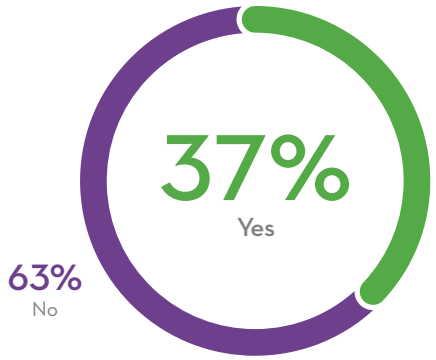


TABLE 2. **Deductible Amounts, Shared Medical and Pharmacy**

Combined Deductible	n	Mean
Single coverage	63	$1,740
Family coverage	63	$3,571
Smaller Employer		
Single coverage	36	$1,740
Family coverage	36	$3,524
Large Employer		
Single coverage	27	$1,741
Family coverage	27	$3,635
HDHP		
Single coverage	47	$2,114
Family coverage	47	$4,250
Standard		
Single coverage	16	$644
Family coverage	16	$1,578

As shown in Figure 19, cost-sharing structures were similar irrespective of pharmacy channel with more than half having a flat dollar amount.

Average copay, coinsurance, minimum, and maximum cost sharing amounts vary by tier and where prescriptions are filled. Data for three-tier designs are shown in Table 3 as this is the most common plan design. Details on four-tier and five-tier designs are shown in the Appendix as well as minimum and maximum amounts where applicable. In three-tier designs, average tier 1 flat dollar copays for a 30-day retail prescription were $12.21, up slightly from the average of $11.55 reported in 2017. Tier 3 copay amounts averaged $57.12, down by two dollars from 2017 ($59.14). Copay amounts for retail 90 and mail averaged around twice the retail 30 copayment, providing a savings to members of approximately one 30-day copay for every 90-day prescription filled.

For employers who reported having three-tier coinsurance designs, the percentage paid by the member is similar across all channels. The average coinsurance for tier 1 was 16%, up from the average of 14% reported in 2017. For tier 3 drugs coinsurance ranged from 33% to 36% depending on channel.

For employers with minimums and/or maximums for coinsurance, minimum/maximum amounts ranged from $7.69/$29.38 (tier 1, retail 30) to $83.89/$268.75 (tier 3, retail 90). These data and those for four-tier and five-tier designs can be found in the Appendix (Tables 7, 8, and 9).

FIGURE 19. **Cost-Sharing Structures for ...**

Base: Respondents who cover the dispensing channel.

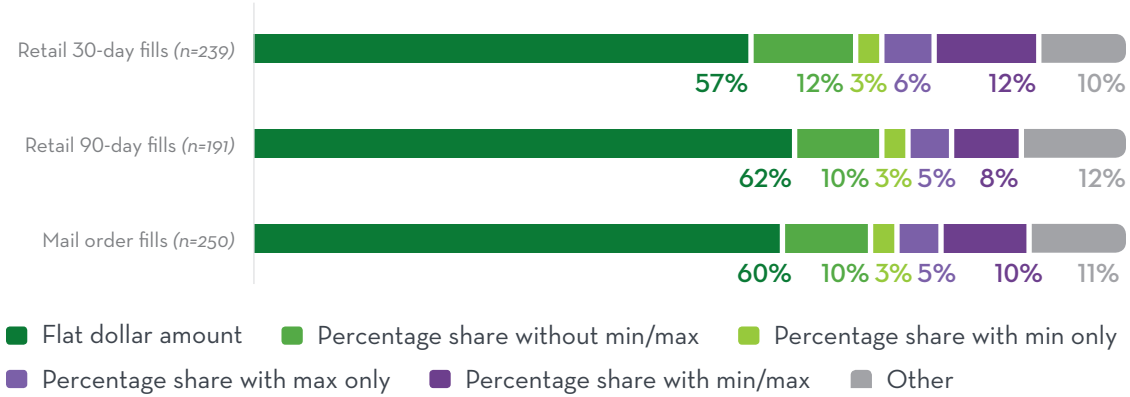


TABLE 3. **Average Cost Sharing for Three-Tier Copay and Coinsurance Designs**

Base: Respondents who cover the dispensing channel.

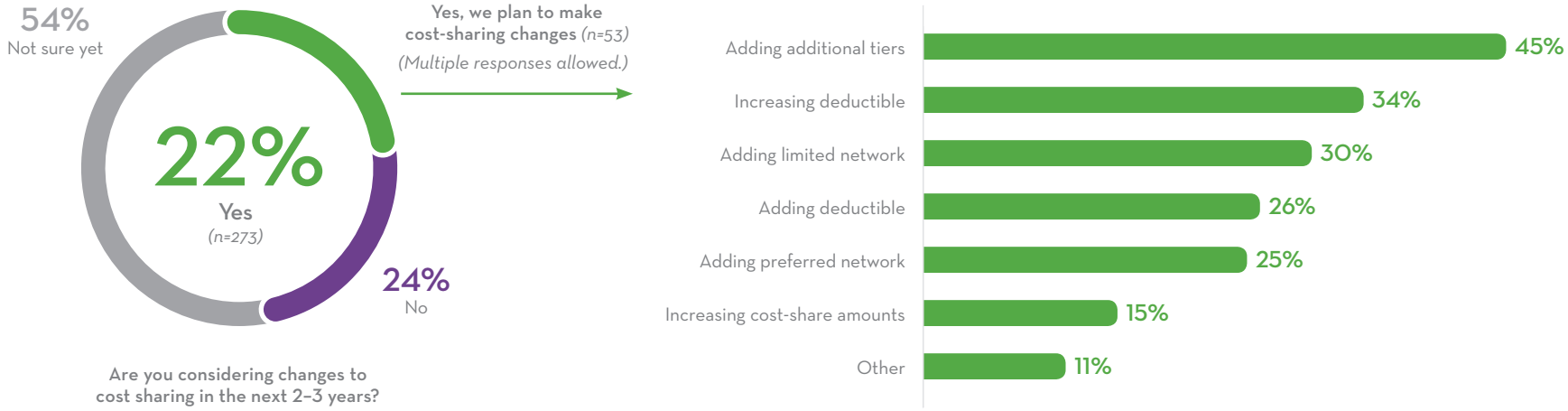
Flat Dollar Copay Designs				
	n	Tier 1	Tier 2	Tier 3
Retail 30	67	$12.21	$31.99	$57.12
Retail 90	51	$24.05	$65.44	$111.64
Mail	74	$20.39	$58.36	$104.19

Coinsurance Designs				
	n	Tier 1	Tier 2	Tier 3
Retail 30	38	16%	25%	33%
Retail 90	24	15%	24%	34%
Mail	34	14%	25%	36%

When asked whether they were considering changes to cost sharing in the next two to three years, 22% of respondents indicated that they were (Figure 20). This is considerably lower than the 33% reporting considering changes to cost sharing in 2017. More than half of respondents were not sure yet, and 24% were not considering making changes. Of those considering changes to cost-sharing, the most frequent change being considered was the addition of tiers (45%), followed by increasing deductible amounts (34%), and adding a limited network (30%).

When asked who/what influences how they make cost sharing decisions, employers most frequently cited consultant or broker recommendations (55%), followed by claims history and PBM or health plan recommendations (each 49%; see Figure 21 on next page).

FIGURE 20. **Cost-Sharing Changes**



Certain channels often have restrictions on where prescriptions can be filled (in the case of retail 90) or if use of that channel is mandatory. These are used in addition to network contracting to reduce overall costs by advantaging channels that offer lower drug costs and/or dispensing fees. As shown in Figure 22, 62% with a retail 90 benefit allow prescriptions to be filled in all retail network pharmacies while 38% restrict these fills to a limited or restricted network. These rates are essentially unchanged from last year (61% all pharmacies; 39% limited network).

Plan designs for retail 90 and mail order channels may require their use for some or all maintenance medications. As shown in Figure 23, the use of these channels was not required by 74% of respondents, with the remainder requiring the use of retail 90 or mail order channels for some or all maintenance medications.

FIGURE 21. **Influences for Cost-Sharing Decisions**

Multiple responses allowed. (n=273)

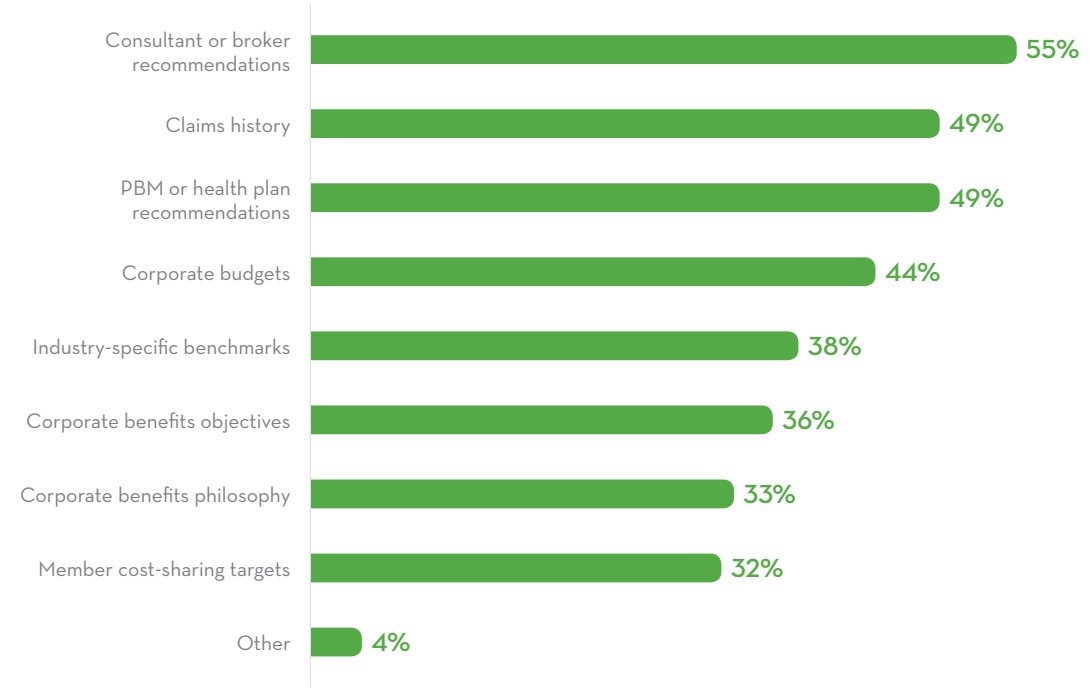


FIGURE 22. **Pharmacy Network Options for Retail 90-Day Fills**

Base: Respondents who cover retail 90-day fills. (n=191)

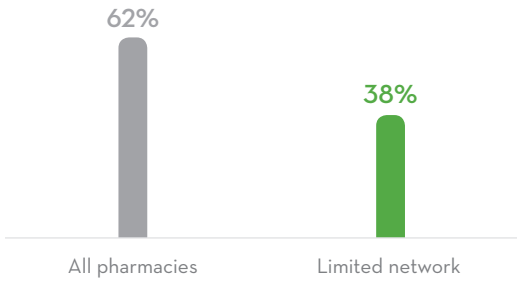
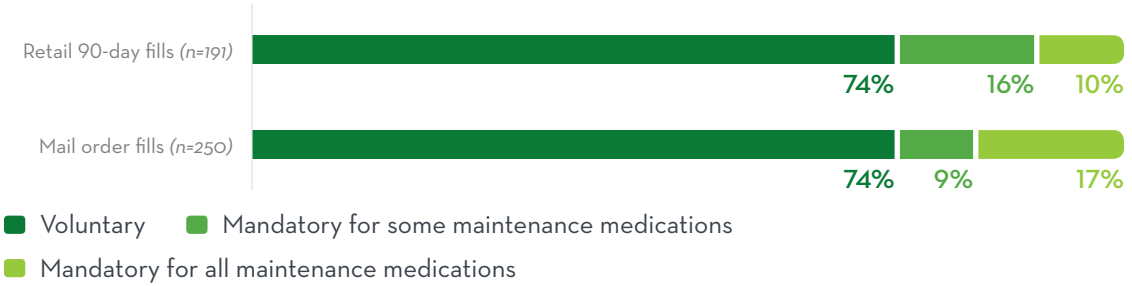


FIGURE 23. **Pharmacy Network Options for ...**

Base: Respondents who cover that dispensing channel.



Given the voluntary nature of channel use, it is not surprising that 77% of plan sponsors use one or more strategies to encourage the use of retail 90 and mail order. Lower cost sharing is the most frequently used strategy (52% for retail 90 and 51% for mail order; Figure 24), followed by member communications.

As shown in Figure 25, 28% of employers promoted the use of cost-sharing transparency tools to help members manage cost-sharing. Smaller employers more often reported the promotion of these tools (34% vs. 20% of large employers; Figure 25A). When asked which tools they promoted, responses included Blink Health, Castlight, GoodRx, My Blueprint, their PBM or health plan's tools, and tools provided by their consultant or broker, among others.

FIGURE 24. **Strategies Used to Increase Utilization**

Base: Respondents with voluntary design in that dispensing channel. Multiple responses allowed.

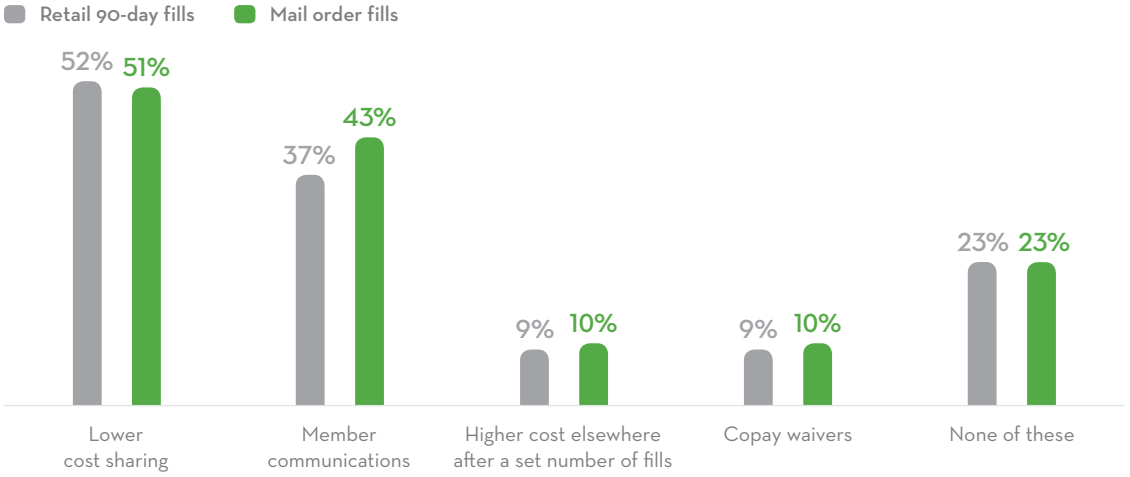


FIGURE 25. **Use of Cost-Sharing Transparency Tools**

(n=249)

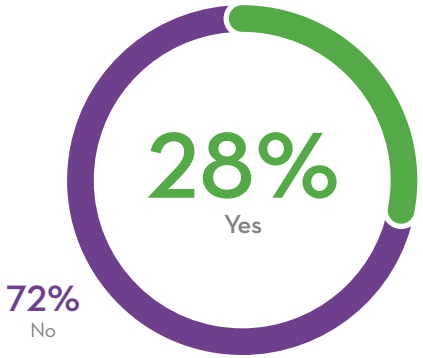
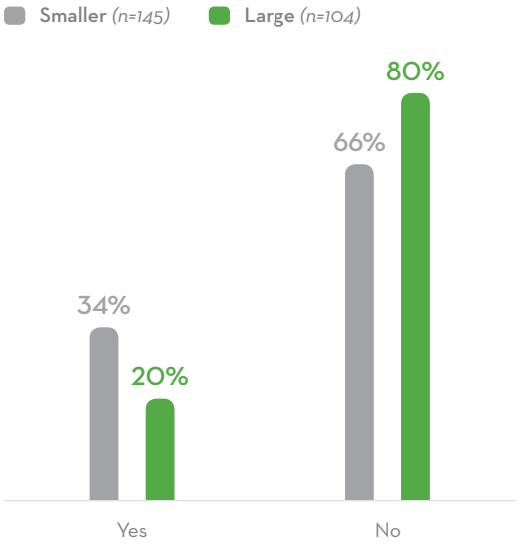


FIGURE 25A. **Use of Cost-Sharing Transparency Tools – by Employer Size**



CLINICAL AND TREND MANAGEMENT

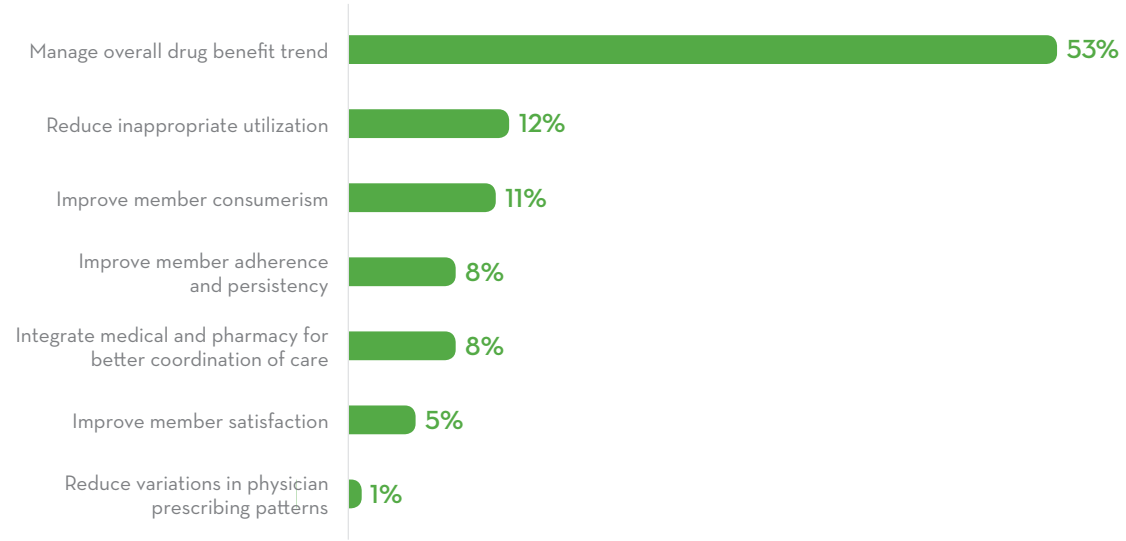
Clinical and trend management tools are common drug management strategies that focus on ensuring that clinically appropriate guidelines are followed, managing drug quantity limits and frequency of refills, and encouraging the use of lower-cost drugs through programs such as step therapy and prior authorization.

Additionally, many employers put patient clinical support and educational programs in place. These strategies focus more on improving overall health and ensuring the safe and effective use of drugs by members than on managing drug costs. Common programs include specialty care management, disease management, therapy adherence, and online tools and mobile applications that help members make informed benefit-related decisions.

The top trend management tools in use are prior authorization, quantity limits, refill too soon limits, and step therapy

Clinical and trend management strategies are driven by the primary goals for managing the drug benefit. The number one goal of respondents was to manage overall drug cost trend (53%; Figure 26). It is notable that the percentage of respondents who rated managing overall drug benefit trend as the number one goal declined from the 60% seen last year. This is likely due at least in part to the slowing of drug trend in recent years. In 2017 drug spending grew by only 1.5% for commercially insured plans, down from more than 10% in 2014.[19]

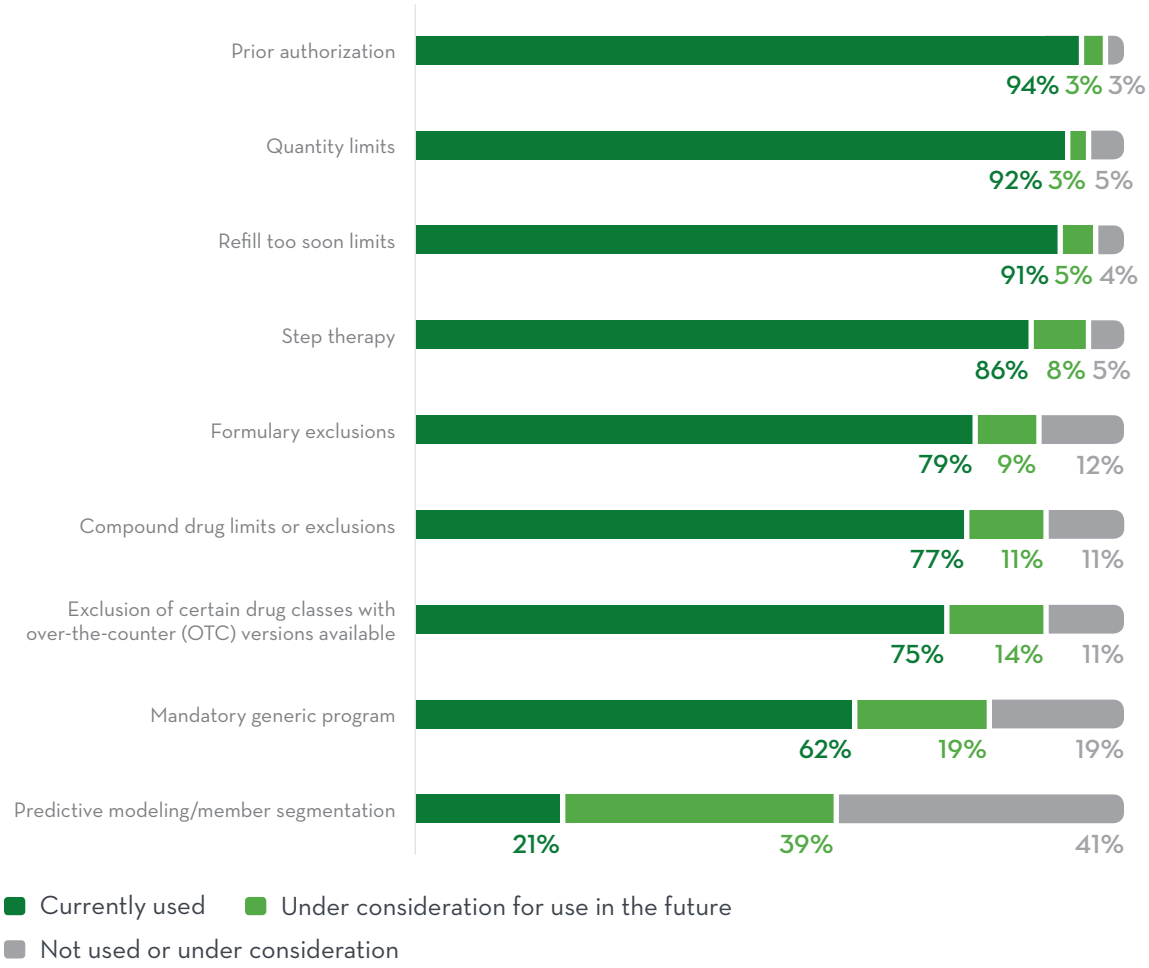
FIGURE 26. **Number One Goal for Management of Drug Benefit**
(n=273)



Trend management tools focus on cost savings by managing the utilization of medications and promoting the use of lower-cost drugs where available and appropriate. As shown in Figure 27, 94% of employers currently use prior authorization, 92% quantity limits, and 91% refill too soon/supply limits. The least frequently used tool was predictive modeling/member segmentation, used by only 21% of respondents but under consideration by 39%. Large employers were more likely to use each trend management tool than were smaller employers (data shown in Appendix, Figure 27A).

FIGURE 27. **Use of Trend Management Tools**

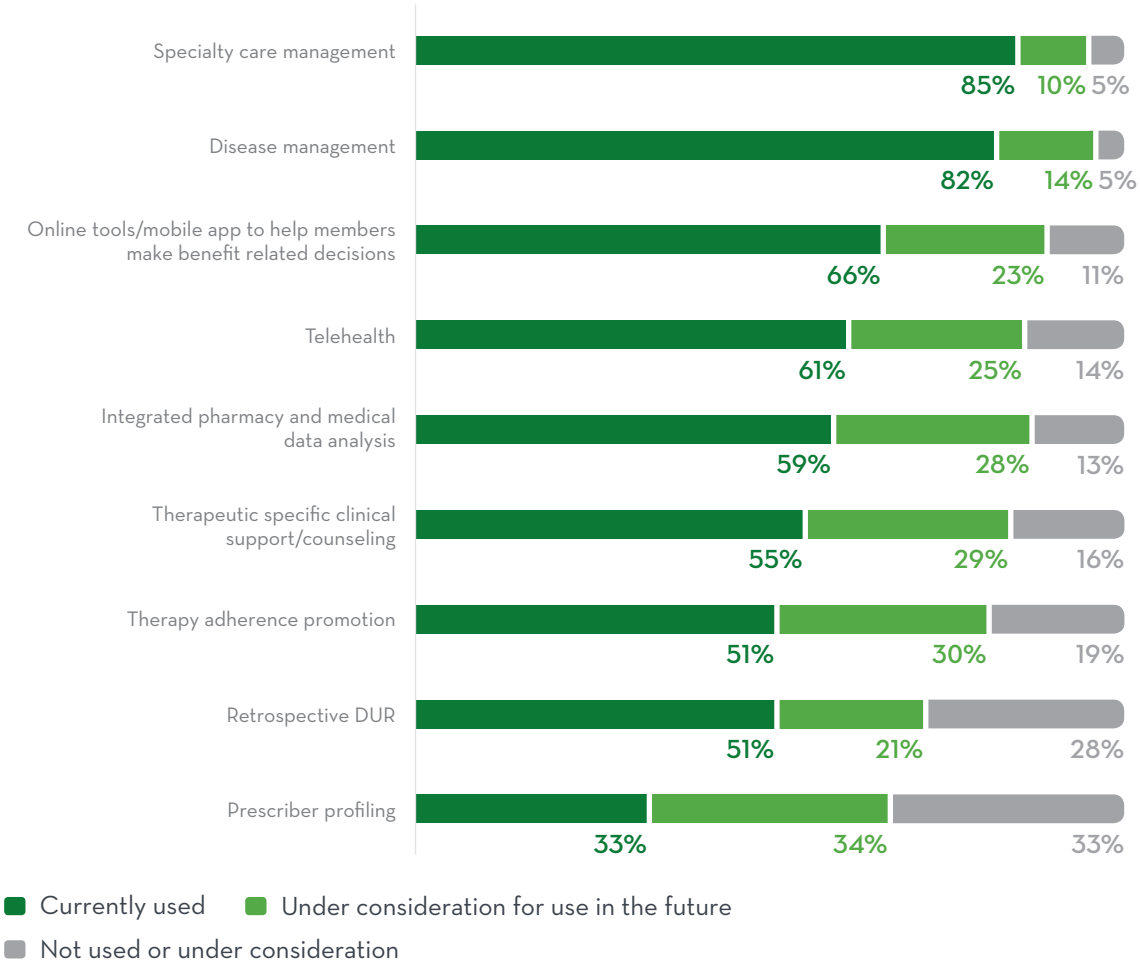
(n=273)



Clinical and educational programs typically focus on health and safety, with savings derived primarily from preventing potential negative health outcomes or events (such as nonadherence-related hospitalizations). Although clinical and educational programs are used less often than trend management tools, more than 50% of respondents reported the use of 8 of the 9 programs they were asked about (Figure 28). Like the pattern seen in use of trend management tools, large employers were more likely to report using each clinical and educational tool (data shown in Appendix, Figure 28A).

FIGURE 28. **Use of Clinical and Educational Tools**

(n=273)



Although the use of trend and utilization programs are high, barriers still exist. As shown in Figure 29, the most frequently cited barrier was member acceptance (44%). Member acceptance as a barrier has been declining in the last few years. In 2016 50% of respondents noted member acceptance as a barrier, dropping to 46% in 2017, and the current 44%.

We also asked about the use of controlled substance programs. As shown in Figure 30, 80% of respondents reported that they had such a program in place. The national focus on stemming the opioid crisis is reflected in the increased use of these programs, up from 76% in 2017 and 71% in 2016. Large employers were more likely to report having a controlled substance program (87%) than were smaller employers (75%).

FIGURE 29. **Barriers to Trend and Utilization Programs**

Multiple responses allowed. (n=273)

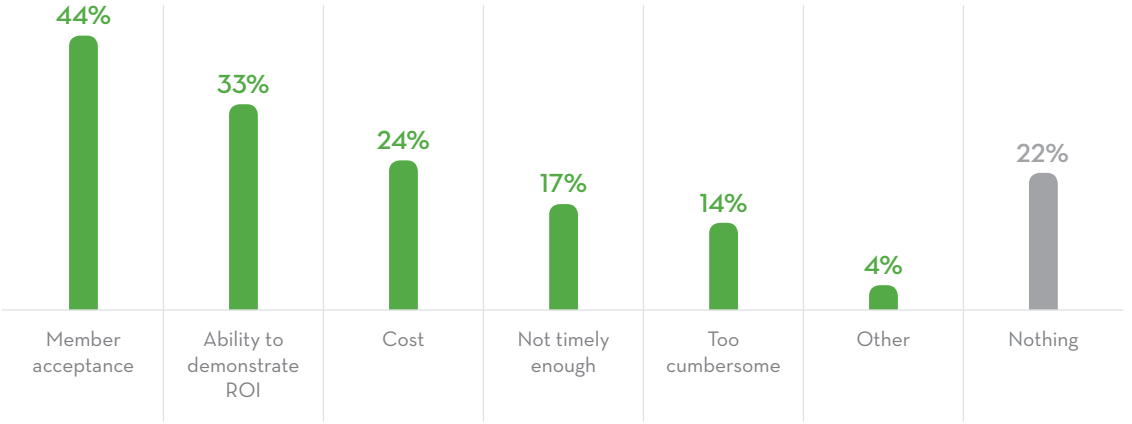
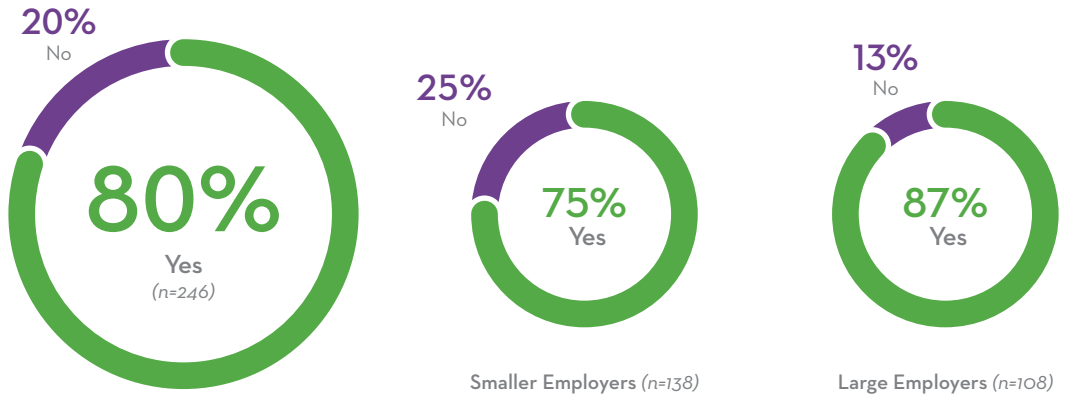


FIGURE 30. **Use of Controlled Substance Programs**



DRUG ACCESS AND PRICING

Some of the more complex yet critical parts of drug benefit design and management are determining where members can access drugs covered under the benefit and how these drugs are paid for. The most visible part to members in these areas is the retail network where prescription drugs are filled. Network design might allow them to go to any pharmacy, encourage using certain pharmacies through lower out-of-pocket costs, or mandate use of specific pharmacies.

Less visible to members but integral to the cost of prescription drugs is how they are priced, including discounts and rebates that can lower costs for plan sponsors.

Determining where members can access drugs covered under the benefit and how they are paid for is part of a complex process

Retail Networks

A key component of drug access is determining retail network design. PBMs contract with retail pharmacies on behalf of the clients that they serve and base contracts on two main components – design and discounts. Network design determines where members can fill prescriptions and at what level of cost sharing. Deeper discounts from the retail pharmacies included in network design are possible from preferred or limited network arrangements.

Drug reimbursement has two primary elements – drug ingredient cost and dispensing fees. However, these are not set amounts, but rather negotiated by PBMs or directly by the plan itself. Both the net cost of the drugs themselves and the fees charged by pharmacies to dispense them may be reduced in exchange for volume or other concessions.

The three primary types of pharmacy networks, in order of least to most restrictive, are open, preferred, and limited. Open networks typically include all major chain pharmacies and most independent pharmacies, placing almost no limits on where members can use their drug benefit to fill prescriptions. In a preferred network arrangement, members are encouraged, typically through lower cost sharing, to use a subset of participating pharmacies that are willing to reduce their reimbursement in exchange for the possibility of higher prescription volume. In preferred networks, members are usually not restricted to certain pharmacies but may pay more to use a nonpreferred pharmacy. The most restricted are limited networks, which require members to use specific participating pharmacies for benefit coverage. Although there is no single numeric definition of a limited network, a typical arrangement used by PBMI for survey purposes is to define it as a network from which at least one major pharmacy chain is eliminated.

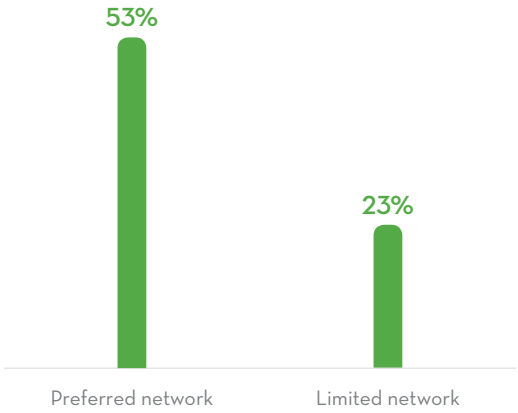
As shown in Figure 31, 53% reported use of a preferred network and 23% of a limited network, virtually unchanged from last year. On average, members who used a nonpreferred network pharmacy paid 38% more out-of-pocket than they would have had they used a preferred pharmacy, compared to 36% more reported in 2017

Pharmacy Reimbursement

PBM contracts may include either traditional markup (often called "spread" pricing) or pass-through pricing. In traditional/spread pricing PBMs pass along some of the savings negotiated to plan sponsors, retaining some of these savings in compensation for PBM services. The "spread" is the difference between the amount paid by the plan sponsor to the PBM and the amount the PBM pays the pharmacy. On the other hand, pass-through pricing passes all pharmacy pricing negotiated by the PBM on to the plan sponsor. That is there is no difference in the amount paid by the plan sponsor to the PBM and the amount paid by the PBM to the pharmacy.

REVISED QUESTION

FIGURE 31. **Retail Network Usage**
(n=273)



As shown in Figure 32, 37% of respondents indicated that they received traditional/spread pricing, and 63% reported pass-through pricing. The use of pass-through pricing has increased slightly from last year. Large employers were more likely to report pass-through pricing (71%) than were smaller employers (57%).

Discounts on drug ingredient costs are typically expressed as a percentage off the Average Wholesale Price (AWP), a list price benchmark for many drug transactions. As shown in Figure 33, 77% reported a guaranteed discount applied to all generic medications, and 56% reported a guaranteed discount applied to all brand medications. Guaranteed discounts are those that the PBM is contractually obligated to provide to the plan. Other discounts may also be offered but are not guaranteed.

As shown in Table 4 the average discount off AWP varied by channel. For generic drugs average AWP discounts ranged from 56% at retail 30 to 63% for mail order. Discounts on brand-name drugs were much lower with averages between 19% and 25% depending on channel.

Another pricing metric is the Maximum Allowable Cost (MAC) price. MAC prices represent the maximum payment amounts for generic medications. Because they provide consistent pricing for generic drugs of the same strength and dosage made by multiple manufacturers (e.g., multi-source generics), MAC prices offer an important source of discounts for plan sponsors. PBMs generally consider their MAC lists to be proprietary, and it is common for PBMs to use different MAC lists within their book of business. Like AWP, there is no standard definition for MAC.

FIGURE 32. **Type of Pharmacy Reimbursement**

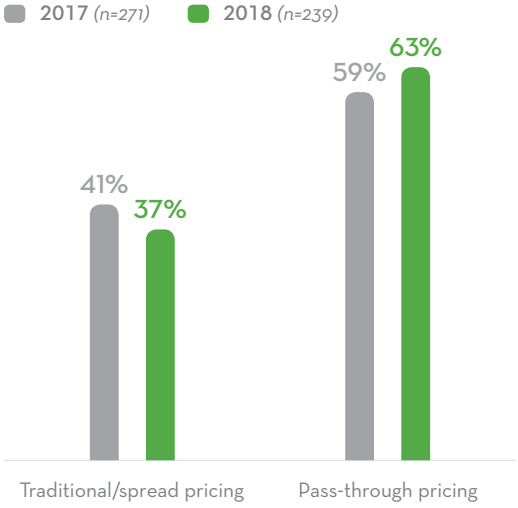


FIGURE 33. **Have Guaranteed Discounts**

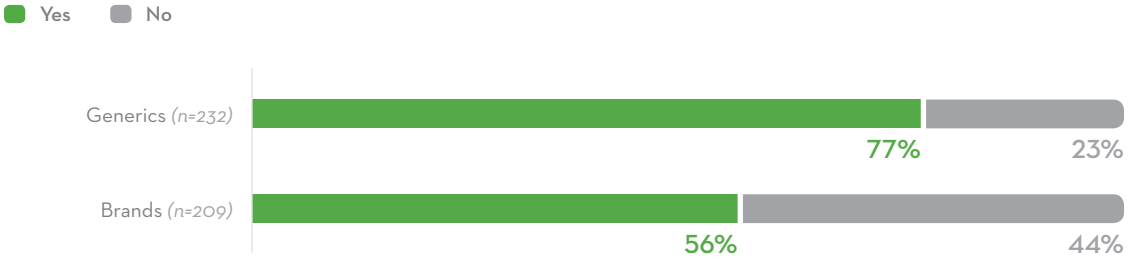


TABLE 4. **Average AWP Discount**

Base: Respondents with a guaranteed discount for the drug type. N varies by dispensing channel and drug type. N/A = not applicable.

	Retail 30	Retail 90	Mail Order	Specialty
Generics	56%	61%	63%	N/A
Brands	20%	22%	25%	19%

As shown in Figure 34, respondents most often reported the use of MAC pricing for retail 30 generics (61%), followed by mail order generics (54%) and retail 90 generics (43%). Large employers were more likely than smaller employers to report use of MAC pricing in each channel.

Rebates

Rebates are typically negotiated as part of formulary contracting agreements and, depending on the contract, sometimes a portion (traditional/spread) or all (pass-through) of the savings is passed on to the employer. Rebates and/or other negotiated price concessions from manufacturers are typically based on the predicted volume of drugs dispensed. Additionally, price reductions (discounts) may be negotiated for, including a single manufacturer's drug on the PBM's formulary and excluding competing drugs or by putting the drug on a lower cost-sharing tier. These arrangements essentially trade volume for price.

Rebate terms for employers vary based on how their PBM contract is written. Contracts may guarantee a flat dollar amount or a percentage share of rebates (with or without minimum guarantees), on a "per prescription," "per rebatable drug," or brand and generic utilization basis. Eighty-three percent of respondents reported that they received rebates on traditional (non-specialty) drugs (Figure 35). The most frequent arrangement was 100% of rebates being passed through to the employer, either with a minimum guarantee (31%) or with no guarantee (27%).

FIGURE 34. **Use of MAC Pricing**
(n=192)

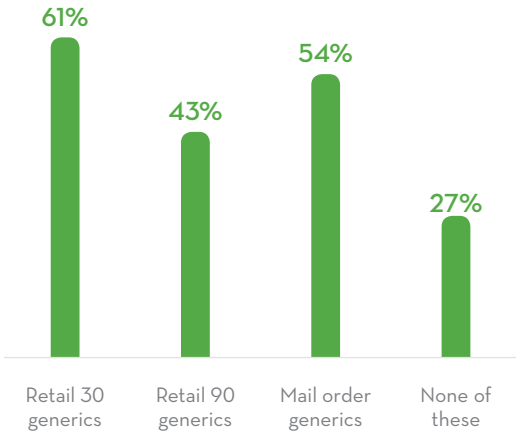
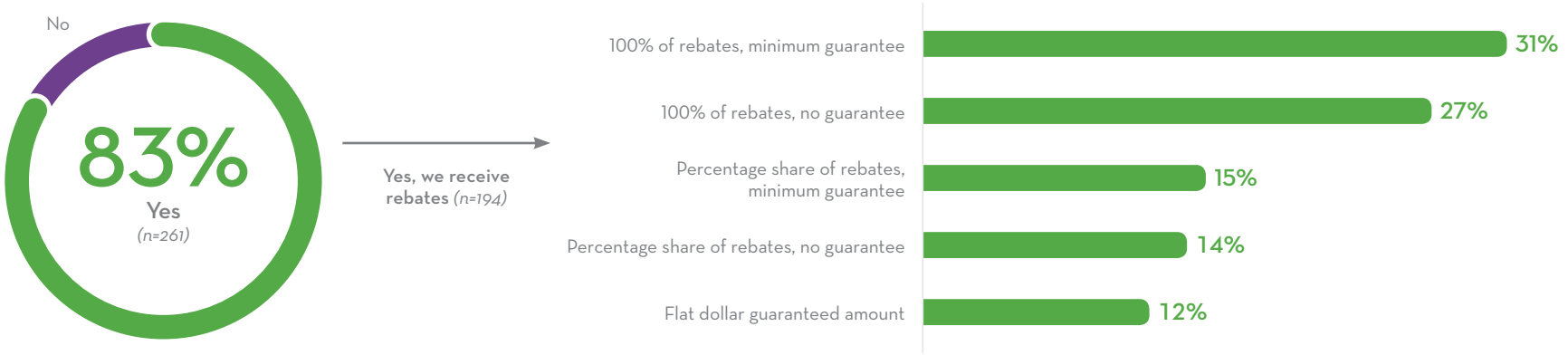


FIGURE 35. **Receipt of Traditional (Non-Specialty) Drug Rebates**



As shown in Figure 36, rebate arrangements were more common for large employers, with 87% reporting receiving rebates versus 80% of smaller employers. Differences by employer size were also seen when looking at receipt of 100% of rebates. Large employers were more likely to receive 100% of rebates with a minimum guarantee than were smaller employers (39% vs. 26%), whereas smaller employers were more likely to receive a flat dollar guaranteed amount (17% vs. 7%).

Price protection provisions are sometimes included in PBM contracts as a way to provide some cost stability by putting a ceiling or cap on the amount manufacturers can increase the cost of a medication during the life of the rebate contract with the PBM.

As shown in Figure 37, 31% of respondents reported that they had price protection or inflation cap provisions in their PBM contract. Large employers were more likely than smaller employers to have price protection provisions (38% vs. 26%, respectively).

Of those with such provisions, 98% reported that the revenue from them gets passed back to the plan. Nearly all (87%) respondents felt that their plan benefits from price protection provisions.

FIGURE 37. **Price Protection Provisions in PBM Contract**

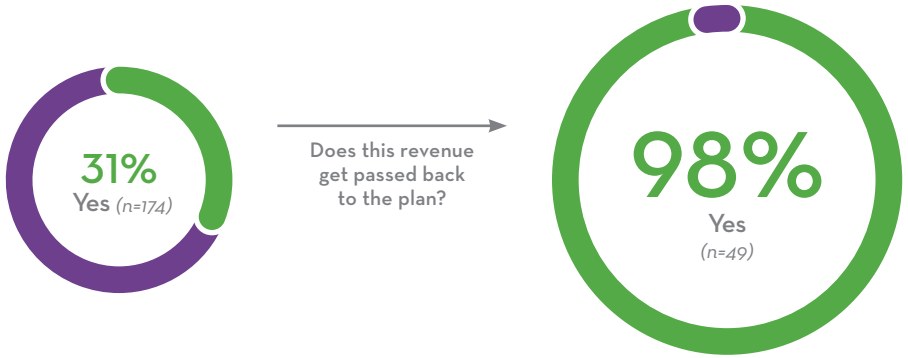
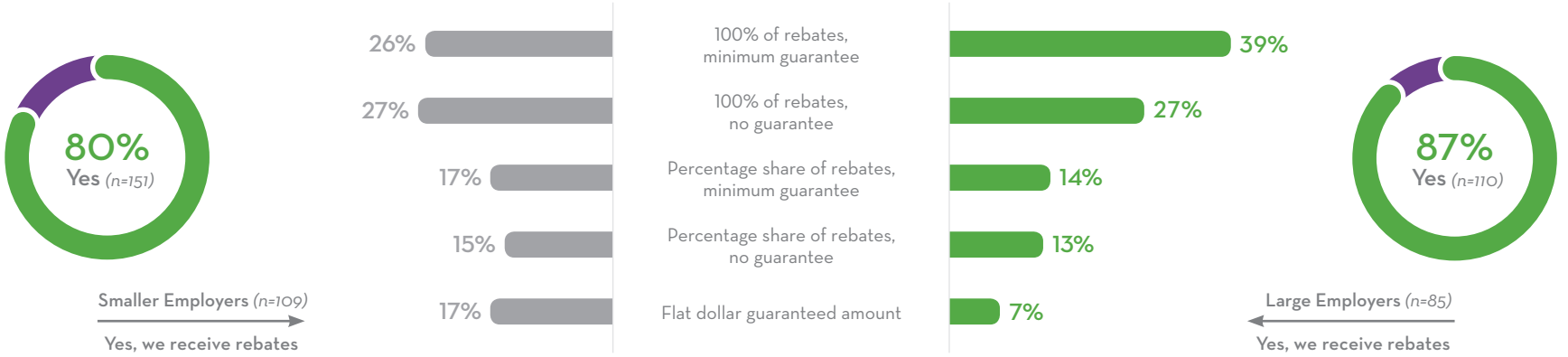


FIGURE 36. **Receipt of Traditional (Non-Specialty) Drug Rebates — by Employer Size**



When asked to describe in their own words how it benefits their plan, typical responses included:

- "Seeing the increase in some of the older drugs or the inflation on some generics, this protection has given us some protection, so we haven't had to absorb it all."
- "Provides a mechanism to predict future drug costs for certain drugs accurately."
- "By having the protection in place, it incentivizes the PBM to be able to better contract with manufacturers."

Formulary decisions are another important aspect of drug benefit management, from both a contracting perspective (i.e., rebates may influence or be influenced by formulary placement) and for member cost sharing. Plan sponsors can choose to use the PBM's standard national/preferred formulary, develop a custom formulary, or use some other formulary such as that developed by their health plan.

As shown in Figure 38, 70% used the PBM's national/preferred formulary while 27% had a custom formulary. A small percentage (3%) used formularies developed by their health plan or medical third-party administrator (TPA).

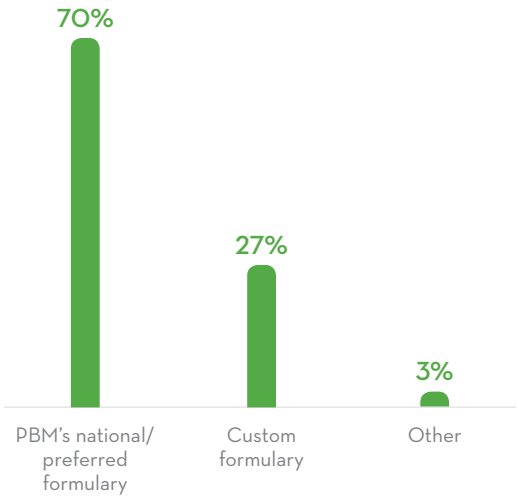
To provide some insight into the decision-making process to choose either the PBM's national/preferred formulary or to use a custom formulary, we asked an open-ended question on why they chose the formulary they did. Common responses from plan sponsors choosing the PBM's national/preferred formulary included:

- "We prefer to have a formulary that is consistent, and we can follow recommendations/changes of that formulary made by the PBM."
- "Recommendation by consultant."
- "It was the easiest choice and we feel very comfortable with their formulary development methodology."
- "We do not have the expertise to customize the formulary. That is one of the reasons we hire a PBM."

Among those choosing a custom formulary reasons included:

- "Better control of costs."
- "Greater flexibility & autonomy."
- "Flexibility combined with a focus on clinical outcomes/efficacy first and foremost."
- "Being a faith-based institution, some of the drugs on the standard formularies need to be included or excluded. The result is a custom formulary, although it's not very different."

FIGURE 38. **Type of Formulary Used**
(n=259)



We also asked respondents how important they thought the role of formulary was in managing drug cost trend. Using a scale of 1 to 5 where 1 meant formulary has no impact on managing traditional drug cost trend and 5 meant formulary plays a critical role in managing traditional drug cost trend, the largest percentage of respondents rated it a 4 out of a possible 5 in terms of importance (Figure 39).

Formulary exclusions are a tool frequently used to manage drug costs, provide leverage for price concessions or higher rebates, and support clinical decisions. In the traditional drug space, nearly all common medical conditions have multiple clinical options available.

As shown in Figure 40 (next page), 69% of respondents reported that their plan has traditional (non-specialty) drug formulary exclusions. Compounded medications were the most frequently reported as having exclusions (64%), followed by drugs used to treat sexual dysfunction (58%) and weight loss (48%).

Like many management strategies, formulary exclusions can create challenges. The challenge most often reported as number one was member dissatisfaction (76%; Figure 41).

FIGURE 39. **Role of Formulary on Managing Drug Cost Trend**

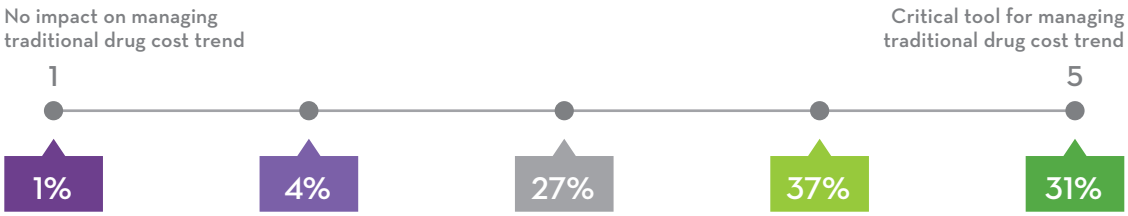


FIGURE 41. **Number One Challenge Associated with Formulary Exclusions**

Base: Respondents with formulary exclusions. (n=165)

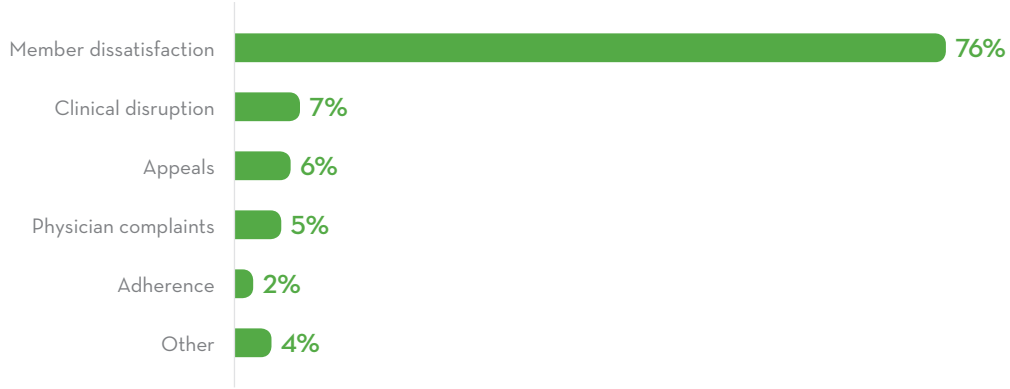
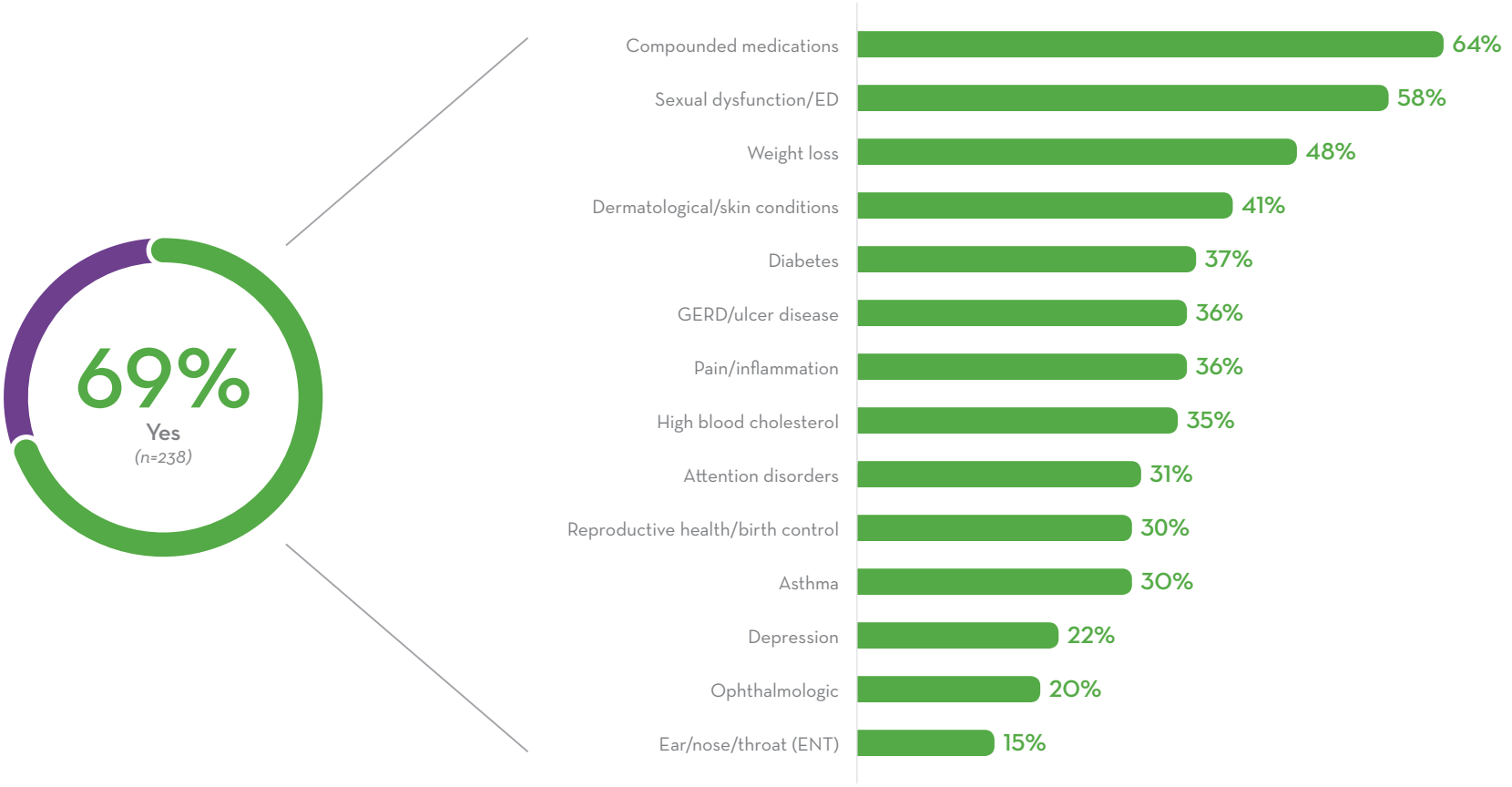


FIGURE 40. **Use of Formulary Exclusions**



5.1

The average number of therapeutic areas with traditional (non-specialty) drug formulary exclusions

Conclusions

Although drug benefit design is as complex as ever, employers have faced the challenge armed with both years of experience and trusted advisers. Nearly 40% of those responding to the survey this year had 10 or more years' experience managing the drug benefit, 83% use a consultant to assist in the design, and 27% are part of a coalition or group purchasing organization. Additionally, 62% of employers design medical and pharmacy benefits in concert – perhaps more important than ever considering how many drugs are covered by both medical and pharmacy benefits and sensitivity to the need for parity between benefits.

Trends we have noted in the last few years that continue include the use of HDHPs, deductibles, and coinsurance versus flat dollar copays for member cost-sharing. These create a level of financial uncertainty for many members, even if they themselves do not have high out-of-pocket costs. Plan sponsors have turned to these types of benefit designs to keep the cost of health coverage affordable for all their members, but plans have concerns about members being able to afford needed medications before deductibles are met and member understanding of how HDHPs work.

A trend to watch in the future is whether the percentage of plans carving-in drug benefits with medical benefits increases over the next few years as the number of PBMs independent of health plans declines.

The primary goal for managing the drug benefit remains managing trend. This is necessary as employers and other plan sponsors have real financial pressures to contend with. They understand that employees value health and drug benefits and want to be able to continue to offer them. However, the tradeoff is often that members are responsible for a larger share of costs.

10+ years

Nearly 40% of respondents to this year's survey have 10 or more years of experience managing the drug benefit

HIGHLIGHTS FROM THE PBMI 2018

TRENDS IN SPECIALTY DRUG BENEFITS REPORT

Advances in drug therapy allow patients with complex and rare diseases to manage their conditions with long-term chronic treatment. Plan sponsors recognize the value of these medications to their members and want to provide best-in-class drug benefits. However, the cost of these drugs continues to create grave concern for plan sponsors.

In recognition of the challenges faced by plan sponsors in managing specialty drug benefits, seven years ago PBMI began publishing a separate annual report that focuses solely on this topic. Here we present a few findings from the 2018 *Trends in Specialty Drug Benefits* report. We hope you will download or request a print copy of the report itself to learn more.

Download your free report at www.pbmi.com/SpecialtyReports

Critical Concern – The Cost of Specialty Drugs

Specialty drug costs have been the top concern every year since the inception of this report, and this year is no exception.

61%

of respondents list management of specialty drug costs as their number one priority.

Large costs for small populations …

It is estimated that specialty medications will account for **HALF** of total U.S. drug spend by 2020 even though only 1% to 2% of Americans use specialty drugs.

… with no end in sight

Specialty drug spending under the medical benefit has increased **55%** since 2011, and double-digit average specialty trend under the pharmacy benefit has been the norm since 2007.

Employers Caught in the Middle

87%

of workers report health and drug benefits as extremely or very important. Employers know that drug benefits are important to recruit and retain key talent and that healthy employees are more productive.

$52,486
AVERAGE TREATMENT

The average annual cost of treatment with a single specialty drug was $52,486 in 2015.[i]

VS.

$48,665
MEDIAN WAGE

Median wage in 2016 was $48,665,[ii] and median household income in 2016 was $57,617.[iii]

The average cost of healthcare in 2017 for a family of four was $26,944. **57%** is paid by the employer.

Tough Choices: Tactics to Manage Specialty Trend

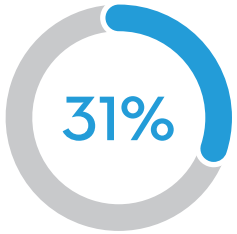
Balancing premiums with member out-of-pocket costs

33%

The prevalence of high-deductible health plans continues to increase, rising from 28% in 2016 to 33% in 2017.

Balancing member access with network management

of respondents reported that their contract requires the use of a designated specialty pharmacy.



Significantly fewer reported different cost-sharing designs by site of care.

59% of employers used prior authorization to encourage use of lower-cost sites of service.

44% have reduced cost-sharing amounts at preferred sites of service.

Sharing costs and managing trend

Cost-sharing and trend management are two of the most common specialty benefit plan design strategies.

56% of respondents in 2017 reported a separate cost-sharing tier for specialty drugs under the pharmacy benefit compared to 52% in 2016.

And excluding some drugs altogether

58%

of respondents reported using formulary exclusions for specialty drugs.

62%

of all employers agree that formulary exclusions are an effective way to manage specialty trend.

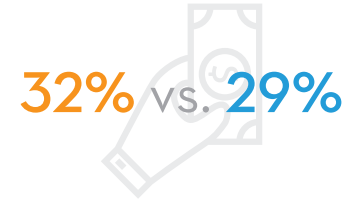
41%
#1 CHALLENGE

Member dissatisfaction is the top challenge associated with formulary exclusions, followed by clinical disruption.

24%
#2 CHALLENGE

The use of coinsurance has risen significantly

Under the pharmacy benefit, the use of coinsurance for specialty medications, either alone or with minimum/maximum amounts, increased from 52% of employers in 2016 to 58% in 2017.



The average coinsurance under the medical benefit is higher than under the pharmacy benefit.

And copayment assistance programs typically don't count toward patient deductibles or maximum out-of-pocket amounts

When copayment assistance programs are used, less than half of respondents reported that the amount is credited as if the member paid with their own money.

Opinions on the success of respondents' strategy to use copay accumulators varied widely. Some of the verbatim quotes included:

"Our Rx out-of-pocket (OOP) is so low and I don't think that it is fair to the company to have to cover Rx's at 100% when the actual OOP hasn't been met. It's also not fair to the employees that are paying the full co-pay amount and had to hit the annual maximum just because they don't have a copay card."

"It is wrong and I believe it is a fiduciary lapse on the part of the PBM to apply money to the plan participant's deductible, copay and coinsurance using some other source of money."

"Most members pay nothing for specialty drugs. With no actual out-of-pocket cost it is very difficult to steer toward more affordable options."

Orphan Drugs: Providing Hope ... Creating Concerns

Rare diseases are not so rare

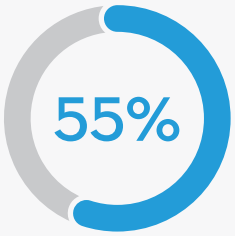
They affect nearly **30 MILLION** Americans – compare this to the 14.5 million with a history of cancer and the 1.5 million who have a stroke or heart attack annually.

Of the new drugs approved in 2016, **41%** were orphan drugs used to treat a rare disease or condition.

Only **5%** of rare diseases have treatments available.

When they are available they tend to be very expensive – with average annual drug costs per patient of **$140,000**.

Drug cost is a primary concern to employers



With the high price tags associated with many orphan drugs, it is unsurprising that over half (55%) of respondents rated drug costs as their top concern.

71% do not feel the current prices of orphan drugs are sustainable.

But other concerns abound:

- "Lack of information on efficacy."
- "How much we don't know about them and what's out there that could at some point devastate our healthcare cost budget."
- "Patient/provider demand – even though a drug may not be overwhelmingly effective, if it is the ONLY treatment option for that disease, patients and providers demand it and insist that the plan must cover it."
- "There is going to reach a point at which the market is not going to be able to support additional cost."

In response to concerns, employers have put programs in place to manage orphan drugs

82%

have prior authorization

62%

implemented clinical care management programs

59%

limit orphan specialty drugs to 30-day supply

53%

require use of specific specialty pharmacy

Key market trends for specialty drugs include:

A focus on orphan conditions

A rich drug development pipeline, especially in oncology

Increased focus on the value of expensive medication

Continued concerns about specialty drug prices

Sources

i. https://www.specialtypharmacytimes.com/news/specialty-drug-cost-increases-hit-record-high

ii. https://www.ssa.gov/oact/cola/AWI.html

iii. https://www.census.gov/content/dam/Census/library/publications/2017/acs/acsbr16-02.pdf

APPENDIX

PBMI, an independent education and research organization, has conducted research on drug benefit design for over 25 years. Recognizing the challenges faced by plan sponsors in designing the drug benefit, we have sought to provide an in-depth look at trends and best practices in our annual *Trends in Drug Benefit Design* report.

The aim of this work is to collect information on management priorities and strategies, cost sharing, clinical and trend management programs, and other strategies, as well as opinions about current and future developments affecting the ability of plan sponsors to manage drug benefits.

We are grateful for the participation of drug benefit leaders who provided not only question responses but also comments regarding the questions themselves.

PBMI has been conducting research on drug benefit design for nearly

25 years

Questionnaire Development

The development and analysis of surveys is both a science and an art. As emphasized in Stanley Payne's seminal work on survey question design, *The Art of Asking Questions* (Princeton: Princeton University Press, 1951), survey questions must be guided by the evidence of rigorous experiment, as well as by a combination of intuition and experience. Design of the drug benefit has become more complex since PBMI first started this report in 1995. Plan sponsors look for ways to manage drug costs while providing members affordable access to needed medications. Recognizing this, questions are added and modified each year to reflect current drug benefit management practices, opportunities, and concerns.

New questions are denoted in the report by the green "New Question" banner and modified questions are denoted by the purple "Revised Question" banner.

NEW QUESTION REVISED QUESTION

PBMI conducted its drug benefit survey of U.S. employers in February and March 2018. The 2018 survey was developed, tested, and fielded by PBMI research staff and will continue to be monitored and adjusted to account for new developments.

The comprehensive survey instrument collected information on drug benefit plan design for prescription drugs dispensed through retail, mail order, and specialty pharmacy distribution channels.

Respondents answered questions about:

- Drug benefit design decision-making, goals, and challenges
- Networks, contracts, and reimbursement strategies
- Member cost sharing
- Clinical and trend management strategies and tools
- Use of, and options on, high-deductible health plans
- Future considerations for drug benefit design

To minimize the possibility of biasing respondents' priorities and preferences, many questions used item randomization. For example, although "consultant" is the first item shown in the discussion of who is most influential in helping employers evaluate and design drug benefits because respondents mentioned it most often, it was not the first item (influencer) asked of every respondent. Instead, all influencer options were presented in a randomized order that was varied each time a respondent initiated the survey. This is important because studies have shown that respondents tend to favor responses at the beginning or middle of a list, leading to possible bias.

As in previous years, strategies specific to specialty medications were not explored in detail in this report. PBMI conducts the research and publishes a separate annual specialty drug management report, *Trends in Specialty Drug Benefits*. For the convenience of our readers, a summary of the findings from the 2018 *Trends in Specialty Drug Benefits* report is shown in the preceding section. The full report can be found on the PBMI website at www.pbmi.com/SpecialtyReports.

Research Sample

The survey respondents encompassed 273 benefit leaders representing an estimated 61.6 million covered lives. Respondents included employers, unions, or the person designated to provide responses on their behalf, such as their health plan representative.[20] All respondents offer prescription drug benefits for active employees. To qualify for the survey, respondents had to report being responsible for the organization's prescription drug benefit. Respondents reporting retiree only, workers' compensation, and publicly covered groups (i.e., Medicare, Medicaid) were excluded from this survey.

Analyses were conducted on the full sample and with the sample split by employer size. We defined smaller employers as having 5,000 or fewer lives and large employers as having more than 5,000 lives.

Because some respondents may be responsible for more than one plan, the survey asked respondents to answer questions about the largest plan, based on number of covered lives, that offered both medical and pharmacy benefits. Thus, the drug benefit design information included in this report represents the benefit plan for which the survey was completed, not necessarily all drug benefits covered by the employer for all plans offered.

As in prior years, respondents were offered a small incentive for completing the survey as an expression of our appreciation for their time.

Data Collection and Analysis

Data were collected into a secure, password-protected database and reviewed for quality and out-of-range responses. Respondents are included in the results for any question in which a valid response was provided.

Throughout the report, notes beginning with "Base" indicate the denominator group for the calculation of percentages and averages (e.g., respondents for whom a question is applicable). In most cases (unless specifically reported), responses of "do not know" or "not applicable" were excluded.

PBMI employed descriptive and inferential statistical analyses to derive the findings presented in this report. Not applicable (N/A) is notated where there are no or insufficient data to report. Anything referred to as statistically significant indicates a p value <0.05. Figure and table totals may not equal 100% due to rounding. Percentages shown in the text, figures, and tables have been rounded to the nearest whole number or nearest first decimal, as appropriate (e.g., 62.47% would appear as 62% in the text and figures and 62.5% in a table).

Descriptive and inferential statistical analysis were conducted using SPSS version 22 (IBM Corp. Released 2013. IBM SPSS Statistics for Windows, Version 22.0. Armonk, NY: IBM Corp.), and the analysis tool embedded in the online survey platform (Qualtrics, Provo, UT).

Report Sponsorship and Editorial Independence

PBMI gratefully acknowledges the support of Takeda Pharmaceuticals U.S.A., Inc. (TPUSA) for their sponsorship to cover costs incurred in the production of this report. Neither TPUSA, nor any other third party, has access to the sampling frame information (names, email addresses, etc.), individual responses, or raw data gathered. Additionally, TPUSA provided no input into the conclusions drawn from our analysis and presented in this final report. This policy protects the confidentiality of the survey respondents and ensures the independence and objectivity of this report.

Respondent Profile

All 273 respondents of this year's *Trends in Drug Benefit Design* report stated that they were responsible for managing the drug benefit for their organization. This group of primarily human resources (HR) professionals manages the challenging job of working through both the strategic considerations and budget implications of an ever-changing drug benefit landscape.

Survey respondents were diverse and are representative of key decision makers of employer drug benefits. More than three-quarters (76%) reported they worked directly for the employer who sponsored the drug benefit. The remaining 24% were employed by the employer's health plan (21%) or by a union, union health fund, broker, coalition or group purchasing organization, consulting company, or TPA.

These respondents have primary day-to-day responsibility for managing the drug benefit for the employer being represented. Fifteen percent of respondents were responsible for a drug benefit plan negotiated as part of a union or collective bargaining agreement.

As noted, some respondents may be responsible for more than one plan. When this was the case, the survey asked respondents to answer questions about the largest plan, based on number of covered lives, that offered both medical and pharmacy benefits. Of the plans represented in the survey, 62% covered active employees and their dependents only, and the remaining 38% covered both active employees and retirees.

Geographically, respondents represented employers across the U.S., with the largest percentage from the Midwest (33%), followed by the South (29%), the Northeast (19%), and the West (19%; Figure 42).

The specific industries represented ranged from education and health services (29%) to construction, information technology, and natural resources and mining (each 1%) as shown in Figure 43.

Respondent job titles were very similar to previous reports, with the most frequent titles being Pharmacy/Benefits Director (25%), Pharmacy/Benefits Manager (16%), and Vice President (14%).

FIGURE 42. **Geographic Region of Survey Respondents**
(n=273)

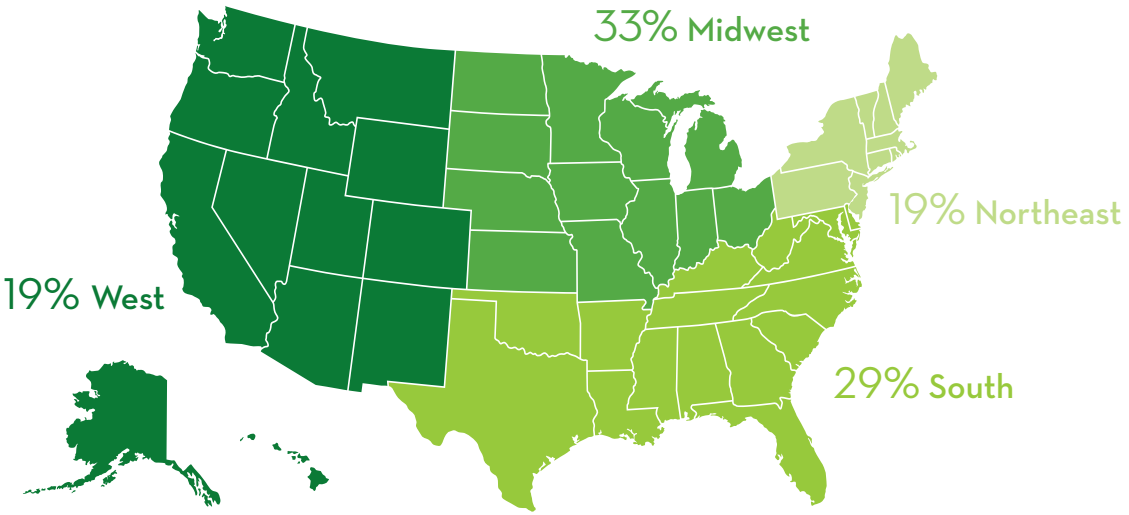


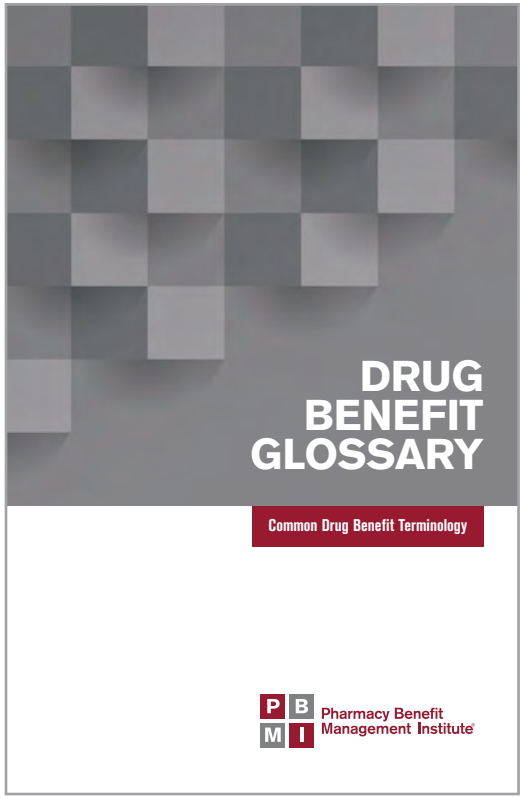
FIGURE 43. **Industry Type of Survey Respondents**
(n=272)

29%	18%	7%	7%	6%	4%
Education and health services	Manufacturing	Service-providing industries	Financial activities	Professional and business services	Public administration

2%	1%	1%	1%	25%
Leisure and hospitality	Construction	Information	Natural resources and mining	Other

Acronym Glossary

AWP	Average Wholesale Price
CDHP	Consumer-Driven Health Plan
DUR	Drug Utilization Review
ED	Erectile Dysfunction
ENT	Ear/Nose/Throat
GERD	Gastroesophageal Reflux Disease
HDHP	High-Deductible Health Plan
HR	Human Resources
HRA	Health Reimbursement Arrangement
HSA	Health Savings Account
IRS	Internal Revenue Service
MAC	Maximum Allowable Cost
MOOP	Maximum Out-of-Pocket
OTC	Over-the-Counter
PBM	Pharmacy Benefit Manager
PBMI	Pharmacy Benefit Management Institute
PMPM	Per Member Per Month
PPO	Preferred Provider Organization
ROI	Return on Investment
Rx	Prescription
TPA	Third-Party Administrator



For more drug benefit-related terms see the PBMI Drug Benefit Glossary which can be downloaded at no cost from https://www.pbmi.com/DrugBenefitGlossary.

Additional Data Tables and Charts

TABLE 5. **Use of Benefit Consultant – by Employer Size**

Base: Respondents who work directly for the employer and use a benefit consultant for their pharmacy benefit.

	N Count		Percent	
	Smaller	Large	Smaller	Large
Yes, the same person	77	40	75%	53%
Not the same person but someone from the same firm	12	17	12%	23%
A different firm	12	13	12%	17%
Don't use a consultant for medical benefit	2	5	2%	7%
Total	**103**	**75**	**100%**	**100%**

TABLE 6. **How Benefits Are Designed – by Employer Size**

Base: Respondents who work directly for the employer.

	N Count		Percent	
	Smaller	Large	Smaller	Large
Drug benefit and medical benefit designed separately	43	38	34%	44%
Drug benefit and medical benefit designed together	85	49	66%	56%
Total	**128**	**87**	**100%**	**100%**

TABLE 7. Average Cost Sharing for Four-Tier Copay and Coinsurance Designs

Base: Respondents who cover the dispensing channel.

Flat Dollar Copay Designs					
	n	Tier 1	Tier 2	Tier 3	Tier 4
Retail 30	43	$10.06	$29.44	$55.87	$117.86
Retail 90	34	$19.46	$62.42	$113.33	$210.56
Mail	44	$17.65	$55.28	$103.64	$158.70

Coinsurance Designs					
	n	Tier 1	Tier 2	Tier 3	Tier 4
Retail 30	16	15%	25%	33%	31%
Retail 90	10	15%	26%	33%	32%
Mail	12	16%	26%	34%	33%

TABLE 8. Average Cost Sharing for Five-Tier Copay Designs

Base: Respondents who cover the dispensing channel.

Flat Dollar Copay Designs						
	n	Tier 1	Tier 2	Tier 3	Tier 4	Tier 5
Retail 30	12	$8.92	$20.00	$41.67	$80.91	$167.78
Retail 90	14	$17.32	$41.43	$93.57	$170.38	$393.75
Mail	14	$17.68	$55.36	$101.07	$169.62	$410.63

TABLE 9. **Average Minimum and Maximum Amounts for Three-Tier and Four-Tier Designs**

Base: Respondents who cover the dispensing channel.

		Minimum Amount				Maximum Amount			
Retail 30	**n***	**Tier 1**	**Tier 2**	**Tier 3**	**Tier 4**	**Tier 1**	**Tier 2**	**Tier 3**	**Tier 4**
3-Tier Structure	18, 21	$7.69	$23.89	$52.50	-	$29.38	$66.67	$136.67	-
4-Tier Structure	10, 11	$10.00	$21.50	$38.50	$45.00	$29.20	$69.73	$112.55	$164.09
Retail 90									
3-Tier Structure	9, 12	$22.22	$46.67	$83.89	-	$60.92	$163.75	$268.75	-
4-Tier Structure	7, 7	$17.29	$42.43	$85.00	$6.00	$45.00	$106.00	$189.29	$226.25
Mail									
3-Tier Structure	15, 18	$16.97	$42.33	$86.15	-	$44.00	$117.50	$218.75	-
4-Tier Structure	8, 8	$16.38	$39.63	$81.88	$20.00	$40.00	$102.75	$182.81	$188.33

**n for minimum, maximum (varies since not every plan has a minimum and/or maximum)*

FIGURE 27A. **Use of Trend Management Tools — by Employer Size**

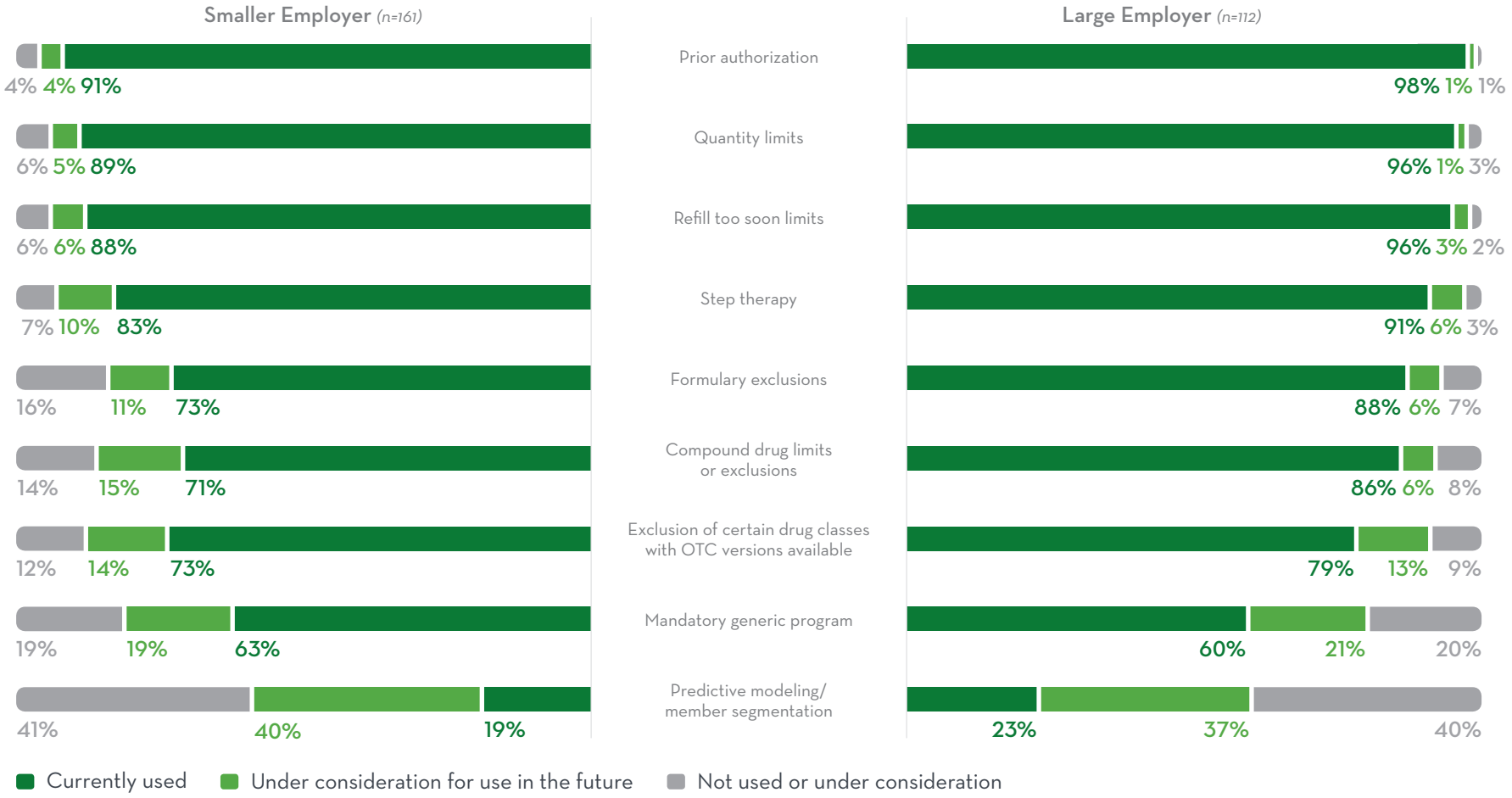
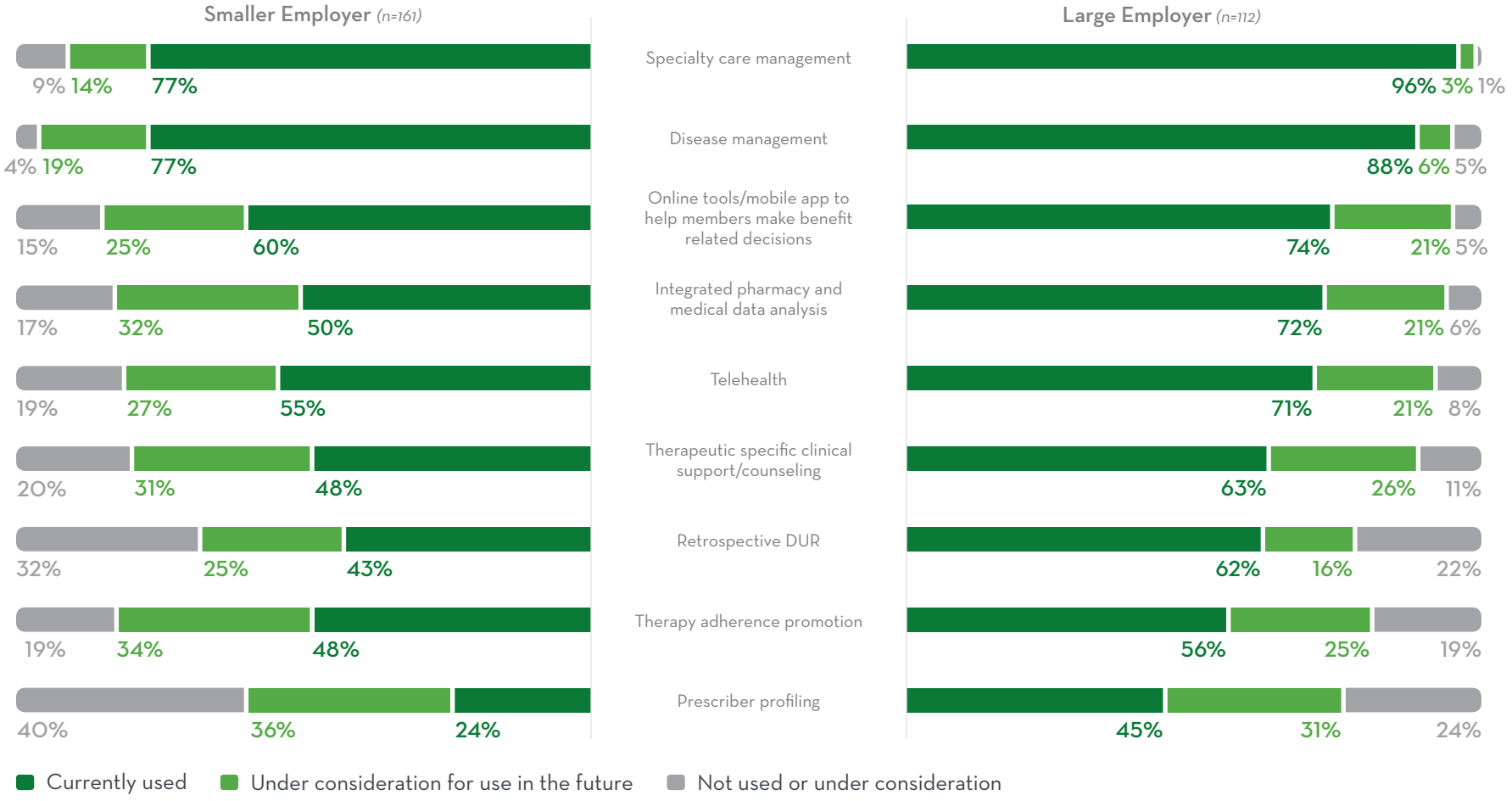


FIGURE 28A. **Use of Clinical and Educational Tools — by Employer Size**



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Appendix: Methodology & Respondent Profile

20. Of the 273 respondents, 58 (21%) were representatives directly employed by their health plan. Sensitivity analysis was conducted to compare responses by employers directly and health plan representatives. Where differences appear, they are either discussed directly or the base is limited to employers.

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