

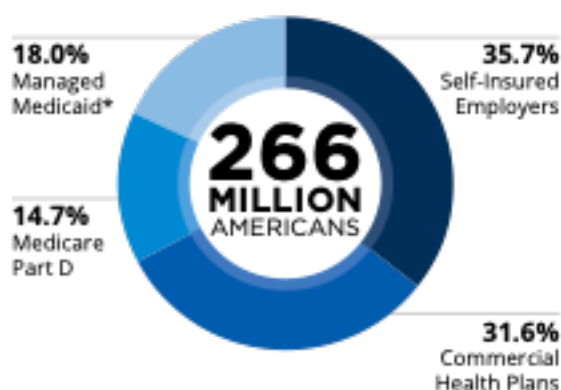
ABOUT PCMA

The Pharmaceutical Care Management Association (PCMA) is the national association representing America's pharmacy benefit managers (PBMs). PBMs administer prescription drug plans for more than 266 million Americans who have health coverage from a variety of sponsors. PCMA continues to lead the effort in promoting PBMs and the proven tools they utilize, which are recognized by consumers, employers, policymakers, and others as key drivers in lowering prescription drug costs, increasing access, and improving outcomes.



PBMs serve consumers across plan types

Americans With Drug Benefits Managed by PBMs, by Type of Coverage



* Excludes "Medicare/Medicaid Dual Eligibles" where drugs are covered by Medicare Part D



PBMs promote pharmacy access

PBMs work with health plans, employers, and government programs to ensure that their members and employees have access to necessary medications through a variety of pharmacies, including retail, community, mail order, and specialty pharmacies.



How PBMs reduce drug costs

- ✓ Encouraging the use of generics and affordable brand medications
- ✓ Reducing waste and increasing adherence to improve health outcomes
- ✓ Offering home delivery of medications and creating networks of affordable and high quality pharmacies
- ✓ Negotiating rebates from drug manufacturers and discounts from drugstores
- ✓ Managing high-cost specialty medications



PBM savings

PBMs are projected to save employers, unions, government programs and consumers an average of \$962 per person per year.



**\$962
PER PERSON
PER YEAR**

PCMA MEMBERS

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 CERPASSRx

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 envolve
Pharmacy Solutions

 EXPRESS SCRIPTS

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NEXT GENERATION PHARMACY BENEFIT

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Better. Smarter. Today.

TOP FEDERAL SOLUTIONS FOR HIGH DRUG COSTS IN 2021

1. **Make Medicare Part D more affordable.** The rebate rule, which limits Part D plans and pharmacy benefit managers from negotiating lower drug costs on behalf of Part D enrollees, should be repealed or rescinded. This rule needlessly raises Part D premiums by 25% and imposes nearly \$200 billion in costs on taxpayers.
2. **Eliminate anticompetitive “pay-for-delay” agreements.** Patent settlements, or “pay-for-delay” agreements, allow brand name drug and biologic patent holders to pay potential competitors to delay market entry or not produce a competing generic drug or biosimilar.
3. **End orphan drug exclusivity abuses.** Orphan exclusivity periods should apply only to those prescription drugs originally approved by the U.S. Food & Drug Administration (FDA) under an orphan indication and only for the orphan indication itself.
4. **Revise innovator biologic exclusivity to seven years.** Seven years (reduced from 12 years under current law) of market exclusivity would provide sufficient return for manufacturers while speeding competitor biosimilars to market to promote affordability and access.
5. **Allow for FDA accelerated approval of me-too brands.** Accelerated review is granted by the FDA to new drug applications that address “unmet need,” the criterion for which should be updated to account for the economic need for competition to lower prices.
6. **Promote uptake of biosimilars and interchangeables.** Policies should encourage market entry of biosimilars, rather than erect unnecessary barriers, including barriers to achieving interchangeability and therapeutic substitution. Uptake also can be supported by requiring use of a common billing code to pay for a reference biologic and its biosimilars.
7. **Promote broader adoption of value-based purchasing (VBP),** including by modernizing and better aligning the Stark Law and Anti-Kickback Statute to promote value-based care. While Centers for Medicare & Medicaid Services (CMS) took a necessary first step with respect to the treatment of VBP arrangements under Medicaid Best Price, there are additional improvements that would foster greater innovation and expansion in the use of VBP for prescription drugs.
8. **Explore additional ideas through the Center for Medicare & Medicaid Innovation to help every beneficiary affordably access needed prescription drugs.** Medicare Part D plans have been working with CMMI on innovative demonstration programs, including the new Part D Insulin Senior Savings Model. Other models similarly could be explored.
9. **Eliminate the tax deductibility of direct-to-consumer (DTC) prescription drug advertising.** While DTC drug ads may encourage some to seek care, they also may encourage costlier and unnecessary forms of care—with the result being higher health care costs for all.
10. **Ensure smooth implementation of real-time benefit tools (RTBTs) in Part D** and empower prescribers to inform patients of cost-effective, therapeutically equivalent medications by extending RTBT solutions to state Medicaid and Children’s Health Insurance Programs and Qualified Health Plan issuers on Federally-facilitated Exchanges.

11. **Promote wider adoption of electronic prescribing (eRx)**, including by requiring eRx for all prescriptions (not just controlled substances in Medicare), subject to limited exceptions to decrease fraud and diversion and increase patient access and safety.
12. **Allow select exclusions in protected classes.** The Medicare Payment Advisory Commission (MedPAC) recommends applying objective criteria to make select exclusions of protected classes (e.g., classes where CMS and MedPAC have identified the availability of many treatment options) to allow plan sponsors to more directly manage prescription drugs.
13. **Promote availability of biosimilars in protected classes** by ensuring Part D plans have the flexibility to cover the biosimilar or the innovator product – but not require coverage of both – where there is a biosimilar in the class.
14. **Modify the two drugs per-class requirement.** The current requirement that Part D plans cover two drugs per class is outmoded. Instead, modifying the requirement by requiring plans to ensure access to therapies based on conditions or disease states would reduce costs without sacrificing access to needed drugs.
15. **Encourage innovative Part D benefit design to lower costs and improve access to care** by allowing Part D plan sponsors to offer additional plans, including designs that offer enrollees more options to use money-saving and convenient home delivery.
16. **Repeal any willing pharmacy provisions.** Requirements that all pharmacies be included in Part D networks drives up costs and are unnecessary, given CMS network adequacy requirements. Congress should repeal the provision. As Congress considers such action, CMS could evaluate allowing plan sponsors the ability to offer a narrower network plan option.
17. **Give Part D plans meaningful access to Part A and B claims data.** To 4coordinate care and make the best coverage decisions for beneficiaries, Part D plans need to be able to use medical data as well as prescription data. Legislative changes allowing use of these data for this purpose also would advance indication-based formularies and decrease prescriber burden.
18. **Encourage the use of lower-cost drugs in Medicare Part D** by allowing CMS to modify cost sharing for Low-Income Subsidy beneficiaries to establish stronger incentives to select generic and low-cost brand drugs (e.g., zero-dollar copayments), with increasing levels of copayments for less cost-effective therapeutic options.
19. **Build on existing efforts to apply Part D PBM tools to Part B drugs.** Adding Part D PBM tools (e.g., value-based formularies, price concession negotiations with manufacturers, prior authorization, and care management) to Medicare fee-for-service and building on efforts in Medicare Advantage to allow step therapy for Part B drugs would make drugs more affordable on the medical side of the Medicare benefit.
20. **Eliminate the cap on the Medicaid Drug Rebate Program's inflationary penalty** to discourage drug manufacturers from excessively increasing list prices.
21. **Permit states the same tools available to employers and Medicare Part D plans to limit coverage of drugs for which there is inadequate evidence of clinical effectiveness or ample competition of therapeutic alternatives.** States should have the flexibility to adopt private-sector formulary management techniques, which drive value and lower costs, in their Medicaid programs.

PBM TOOLS SAVE IN SEVEN KEY WAYS, HERE'S HOW:



Negotiating Rebates from Drug Manufacturers

PBMs negotiate rebates from manufacturers of brand-name drugs that compete with therapeutically similar brands and generics. Manufacturers typically provide a rebate if their product is "preferred," which means it is assigned a copay lower than that of competing products.



Negotiating Discounts from Drugstores

Retail pharmacies provide discounts to be included in a health plan's pharmacy network. The more selective the network, the greater the discount, because each pharmacy will gain more business.



Offering More Affordable Pharmacy Channels

Mail-service and specialty pharmacy channels typically give health plan sponsors deeper discounts than do retail pharmacies. These channels also help encourage the use of preferred products for additional savings.



Encouraging Use of Generics and Affordable Brands

PBMs use several tools to encourage the use of generic drugs and preferred brands.

These include formularies and tiered cost sharing, prior authorization and step-therapy protocols, generic incentives, consumer education, and physician outreach.



Reduce Waste and Drug Interactions

PBMs use Drug Utilization Review and other utilization management programs to reduce over-utilization and waste, as well as reducing adverse drug events associated with polypharmacy.



Improving Adherence

PBMs implement medication adherence programs and care management programs to help patients with chronic disease stick to their prescription regimens. These programs improve clinical outcomes and reduce overall health care spending.

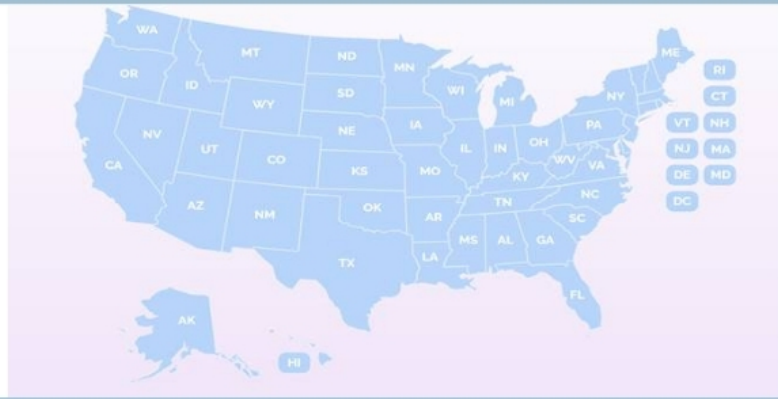


Managing High-Cost Specialty Medications

PBMs combine savings from all the above categories with the unique capabilities of specialty pharmacies in safely storing, handling, and delivering complex, often injectable, medications that cost thousands of dollars per dose and in providing effective patient education, monitoring, and support for those with complex conditions, such as hepatitis C, multiple sclerosis, and cancer.

See How Much PBM Tools Could Save Your State Over The Next 10 Years

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Learn More About The Value of PBMs

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