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Managing Editor
Leslie Small
lsmall@aishealth.com

Senior Reporter
Peter Johnson

Data Reporter
Jinghong Chen

Executive Editor
Jill Brown Kettler

Will 'Build Back Better' Spell Disaster for Pharma Innovation?

The House of Representatives on Nov. 19 passed Democrats' hard-fought, $1.7 trillion social spending bill, bringing it significantly closer to becoming law and ushering some of the most ambitious drug pricing reforms ever attempted.

With the fate of the Build Back Better Act now in the hands of the Senate, the debate over how its drug pricing provisions will impact innovation in the life sciences industry has never been hotter — especially now that the Congressional Budget Office (CBO) has weighed in.

To some industry observers, the bill's most controversial attempts to rein in drug prices — including allowing Medicare to negotiate the price of drugs with manufacturers and penalizing drugmakers if their list prices rise faster than inflation — are tantamount to sabotage of the pharmaceutical sector.

"Efforts to dismantle the pharmaceutical industry — one of the crown jewels of U.S. industry — moved another step closer to fruition," Numerof & Associates President Rita Numerof, Ph.D., writes in a statement emailed to AIS Health. "The consequences of this ill-considered plan to give HHS enormous, unchecked power to unilaterally reduce Medicare drug costs will have far-reaching and devastating ramifications: reduced investments in life-saving drug R&D, slower economic growth and reduced health care quality for U.S. patients, to name just a few."

continued on p. 5

Big Three PBMs' 3Q Results Make Up for Insurer Disappointments

The three largest PBMs — Cigna Corp.'s Express Scripts, UnitedHealth Group's OptumRx, and CVS Health Corp.'s Caremark — each posted strong results in the third quarter of 2021. Indeed, those PBMs were essential — in the eyes of Wall Street — to making up for the impact of COVID-19 on the profitability of their parent companies' health insurance subsidiaries.

Cigna Corp.'s Evernorth, the parent company of Express Scripts, took in $31.9 billion in pharmacy revenue for the first three quarters of 2021, up from $28.7 billion in the same period during 2020. Wall Street analysts were bullish on Evernorth and Express Scripts despite skepticism of Cigna's overall performance.

Cigna Chief Financial Officer Brian Evanko told investors during a Nov. 4 conference call that "adjusted pharmacy script volume increased 8% to 411 million scripts, and adjusted pre-tax earnings grew 7%…compared to third quarter 2020."

Evanko added that "for Evernorth, we continue to expect full-year 2021 adjusted earnings of at least $5.8 billion, representing growth of at least 8% over 2020."

The company won a major pharmacy contract award from the Dept. of Defense, expanding Express Scripts' contract to manage pharmacy benefits for TRICARE to include specialty pharmacy.

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"The new contract also allows for expansion of specialty and care coordination services through 2029," said Cigna CEO David Cordani during the call.

In a Nov. 4 note on the results, Citi equities analyst Ralph Giacobbe wrote that "Evernorth came in generally inline [with projections] with higher revenue but lower margin." Giacobbe praised the segment's "strong organic growth, which includes growth in both retail network and specialty pharmacy services," and noted that Evernorth "benefit[ed] from supply chain management and business growth, partially offset by strategic investments." He added that the Express Scripts merger still has unrealized benefits for Cigna.

"While we believe some discount to MCO peers is still warranted, over time we see that valuation gap narrowing given…ESRX [Express Scripts] synergies/cross-selling opportunities," Giacobbe wrote. That said, the Express Scripts "deal brings integration risk as well as uncertainty around client retention as well as general headline risk given the focus on drug pricing [in Washington, D.C.] and evolving PBM model."

Evercore ISI analysts Michael Newshel and Joe Amato wrote in a Nov. 4 preview of the call that "Evernorth earnings were in line with expectations," while noting that "3% top-line upside [was] offset by…lower margin, and YoY growth slowed to still-high 7% from elevated 13% in first half."

On Nov. 5, the day after the call, Jefferies analysts wrote that "Evernorth continues to outperform." They also pointed out that Express Scripts could yield synergies for Cigna's expanding relationship with telehealth provider MDLive.

SVB Leerink analyst Whit Mayo was also bullish on Evernorth, despite skepticism of Cigna overall, writing that "strong specialty growth and further evidence of positive inroads with Evernorth generally paint a better underlying picture beyond medical cost pressure."

OptumRx, the PBM division of UnitedHealth Group's health care services subsidiary Optum, took in $23.3 billion in revenue during the third quarter of 2021, up from $22 billion in the third quarter of 2020. For the first nine months of the year, OptumRx has taken in $67.4 billion, up from $65 billion during the same period last year. The PBM filled 344 billion quarterly adjusted scripts in the third quarter of 2021, up from 325 billion quarterly adjusted scripts in the third quarter of 2020. According to Oppenheimer equities analyst Michael Wiederhorn, the overall Optum segment beat the projected Wall Street consensus estimates for earnings.

During an Oct. 14 conference call with investors discussing the results, UnitedHealth Group Chief Financial Officer John Rex said that "OptumRx revenue and scripts grew 6% year over year and earnings, 5%. OptumRx has seen both strong customer retention levels and sales success for the largely completed '22 selling season and early activity for '23."

OptumRx Will Grow Outside Retail

In response to a question from CreditSuisse equities analyst A.J. Rice, OptumRx CEO Heather Cianfrocco said she expects OptumRx will see more growth from home delivery and specialty pharmacy than retail in 2022.

"Our home delivery, specialty, infusion, the multi-dose, as well as our direct-to-consumer community businesses, those will continue to grow in '22. We see those... outpacing growth of the rest of OptumRx pharmacy," Cianfrocco explained.

Rex also touted OptumRx's deal to provide pharmacy benefits to Point-32Health, a new integrated health

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system founded by Harvard Pilgrim Health Care and Tufts Health Plan. Rex said OptumRx "will provide integrated pharmacy benefit and specialty offerings" to "more than 2 million people" through the deal.

Giacobbe was bullish on the PBM's results in an Oct. 14 note, saying that Optum's results were "led by" OptumRx, among other segments — though he did call out the PBM's drop-off in margin compared to 2020. He also observed that "UNH is a diversified enterprise, which limits risk to any one segment, and [management] has executed well."

"The company's Optum business is a nice complement to its core managed care operations and continues to account for a large share of earnings," Wiederhorn wrote in an Oct. 14 note on the results. He also wrote that new OptumRx contract awards could generate considerable upside for the firm.

Caremark Sees More Claim Volume

CVS Health Corp.'s pharmacy services segment, which includes the Caremark PBM, took in $39 billion in revenue in the third quarter, up from $35 billion in 2020, for a growth rate of 9.3%. The segment earned $1.7 billion in operating income for the quarter, up 9.5% from the $1.6 billion in income reported during the same quarter last year. The segment processed 564.4 million pharmacy claims during the quarter, up 36.2 million from the same period last year.

According to a Nov. 4 press release discussing the results, growth was "primarily driven by improved purchasing economics which reflected increased contributions from the products and services of the Company's group purchasing organization and specialty pharmacy….These increases were partially offset by continued price compression."

The press release also explained that total pharmacy claims processed increased 6.9% on a 30-day equivalent basis for the third quarter of 2021, when compared to the prior year. That increase was primarily driven by net new business, COVID-19 vaccinations and increased new therapy prescriptions, which were adversely impacted by the COVID-19 pandemic during the third quarter. Excluding the impact of COVID-19 vaccinations, total pharmacy claims processed increased 5.3% on a 30-day equivalent basis for the third quarter of 2021 compared to the prior-year period.

CVS Performs Well in Selling Season

According to CEO Karen Lynch, who discussed the results on a Nov. 3 earnings call, CVS "added over 1.3 million new integrated pharmacy and medical members through the 2021 and 2022 selling season."

She added that "for the 2022 selling season, we achieved a 98% retention rate. We drove $10.4 billion of growth new business, resulting in $8.9 billion of net new business wins."

Chief Financial Officer Shawn Guertin added that "total pharmacy membership increased by 1.6 million lives sequentially, primarily reflecting growth in government programs." Guertin also credited the pharmacy services segment with driving the firm's overall profitability, saying pharmacy and retail stores offset COVID-19 costs in CVS's health benefits segment.

Newshel wrote in a Nov. 3 note that the pharmacy services segment outperformed his projections in both profitability and prescription volume.

by Peter Johnson

SCAN Health Opts to Invest in Medication Adherence Tool

SCAN Health Plan, a California-based Medicare Advantage insurer, is pushing further into the world of virtual drug management with an investment in Arine, a software vendor with a focus on artificial intelligence-backed medical management solutions.

On Oct. 19, SCAN Group, the carrier's parent company, announced it had taken a minority stake in the vendor, with whom it had a previously established client relationship. The investment in Arine, whose software platform relies on predictive analytics to drive medication adherence, gives SCAN the ability to target specific populations and tailor messages individually to members, including to traditionally underserved populations, according to Binoy Bhansali, corporate vice president of corporate development for SCAN Group.

Populations of Color Are Vulnerable

"We have a gap in adherence scores in certain populations," Bhansali tells AIS Health, a division of MMIT. He points to Black and Latinx communities as those that typically see lower adherence to medication regimens, which can produce poorer health outcomes and increase overall costs of care.

Estimates show that adherence rates to medications aimed at treating chronic disease are only about 50% across the larger population, and those rates may slip as members age. They tend to be lower among minority groups as well. Using the Arine platform allows SCAN to "engage our members in a different way," Bhansali says. That includes messaging and reminders that are "culturally appropriate" as a way to reduce the risk of

patients falling out of step with their plans of care.

Bhansali says that while it's too early to show definitive quality returns in the data, the indicators are promising. "Early metrics are pointing in the right direction," he says.

The potential to move the needle is huge. According to statistics from Arine, 20% of older adults are taking inappropriate medications, and medication non-adherence or misuse is responsible for one-third of emergency room visits among the elderly population. To combat the problem, Arine's software platform "analyzes social, clinical and behavioral data and develops personalized recommendations that enable clinicians to tailor care for patients and their care teams," according to a press release.

Plans Vie for Virtual Assets

The early quality returns and continued focus on member care are not the only reasons for SCAN's investment in Arine, Bhansali says. The tech vendor presented a compelling business case on its own.

Taking a minority stake gave SCAN "the financial opportunity for the investment to return money," he says.

That type of tech-based investing follows a wider industry trend, notes Ashraf Shehata, national sector leader for health care and life sciences at consultancy KPMG. Chronic care management and data-driven medication management have become "a major area of strategic investment," Shehata tells AIS Health.

Since the start of the COVID-19 pandemic, health plans have been part of "a very heavy investment cycle…to move toward the digital world," Shehata says.

The working relationship between SCAN and Arine, which moved from a strictly client-based structure to an ownership stake, marks something of a "try-before-you-buy kind of approach," Shehata adds.

For SCAN, the investment comes as the latest move in the organization's wider diversification strategy, according to Bhansali. In recent months, SCAN has invested in MedArrive, a partnership focused on in-home care, as well as Monogram Health, a tech-driven vendor that manages and coordinates care of chronic kidney disease. The series of investments fits a pattern of seeking to more directly impact at-risk patients, often those from marginalized groups.

"At a national level, there's a huge interest in health equity," Shehata says.

System Aims for Tailored Messages

The scientific community has long identified cultural and racial differences as a key factor in medication adherence rates. A 2019 study appearing in PloS One found that, even when controlling for socioeconomic factors such as income and education, "substantial racial disparities persisted."

Feeding its AI-driven platform with claims and documentation data, among other inputs, the Arine system delivers tailored messaging to patients that seeks to resonate culturally and linguistically. As the early indicators are showing, the patient-directed messaging can help ensure members are taking the correct medications and staying on them.

The direct financial stake in Arine is likely to provide SCAN the ability to drive, or at least influence, the continued development of the company's software offerings, which would have the added effect of bolstering the carrier's direct impact on its members. In other words, SCAN could "request some priority over the investment cycle," according to Shehata. "If your investment gives you the ability to focus on the needs of your organization, you can do it."

Contact Shehata via ashehata@kpmg.com and Bhansali via sorlando@scanhealthplan.com.

by Richard Scott

New FDA Appointee Is Likely to Emphasize Real-World Data

President Joe Biden recently nominated former FDA Commissioner Robert Califf, M.D., to run the agency once more, ending nearly a year of temporary leadership under Acting Commissioner Janet Woodcock, M.D. One insider says that Califf might look to reform and improve the accelerated approval pathway following the controversial Aduhelm (aducanumab) approval earlier this year.

Califf previously led the FDA during the Obama administration, running the agency for roughly the last two years of Obama's term. Califf advocates for using "real-world evidence" in addition to clinical trial data in medical approvals. Aduhelm, an Alzheimer's drug, was approved without such data, though studies of the drug relying on real-world evidence — which takes into account electronic medical record and insurance claims data — are underway. During Califf's initial tenure, Sarepta Therapeutics' eteplirsen, a muscular dystrophy drug, also earned accelerated approval despite a large outcry from medical researchers.

Critics Raise Ethics Concerns

After leaving government, Califf led Google parent company Alphabet Inc.'s medical division. Before serving in government, Califf administered

clinical trials on behalf of pharmaceutical manufacturers at Duke University. Because of that work, members of Congress including Sens. Bernie Sanders (I-Vt.) and Ed Markey (D-Mass.) expressed concerns during Califf's initial nomination review in 2015 that he might have conflicts of interest. Those criticisms have come up again — Califf received compensation from pharma companies as a board member in recent years — but Califf seems likely to be approved by the Senate through a bipartisan vote once again, despite the objections of Democratic Sens. Joe Manchin and Richard Blumenthal.

Speedy Approvals May Be Reformed

Kelly George, Ph.D., an associate principal at Avalere Health, tells AIS Health, a division of MMIT, that the accelerated approval process does meet an important need despite recent controversies.

As a physician, Califf "understands the concept of what it means to have patients with unmet medical needs," George explains. "What it means to wait to get all the data sets, means that there are patients that could potentially benefit [before approval], but can't because you're still waiting for 100% [of clinical trial] data. That's where the accelerated approval comes in — what are these types of drugs that are looking at really long timelines?"

"The point of accelerated approval is being able to potentially meet patient's needs while we're gathering more data," George continues. "If there's a suggestion of efficacy, there's a suggestion of a patient benefit, we'd rather have something on the market than nothing."

The accelerated approval process was designed in the 1990s, after largely LGBTQ+ activists, such as ACT UP, pushed the FDA to grant HIV/AIDS patients access to experimental therapies.

"The whole point is, we don't know a tremendous amount about [accelerated approval] drugs," George explains. "That doesn't necessarily mean they don't potentially have benefit. Aduhelm ended up in a rather controversial space."

Aduhelm did meet some clinical standards, George says, "but people are still parsing out what [Aduhelm] means for the patient in the end."

"There's certainly a number of conversations about improving the process," George adds. "Instead of products continuing to stay in the market until FDA does something, you could switch the burden and say the sponsor [company] automatically loses market access at a certain point, unless FDA does something. There's also a MEDPAC proposal where you have a different rebate and pricing system for products in that pathway."

Can Califf Move the Agency Forward?

"What Califf does in this space is he brings expertise in both real-world evidence and clinical trials…those are two fantastic ways to get data on a drug more quickly and efficiently," George continues. "You can do real-world evidence, once we have our feet on the ground in that space — presumably you can do it cheaper and quicker."

George believes that Califf's ability to "move the agency forward" in real-world evidence "is fantastic. The thing about real-world evidence, which may not be applicable to Califf, is it pulls the power away from sponsors and into…stakeholders' hands."

If a clinical trial is the only acceptable standard of evidence, "you went back and looked at the clinical trails that the sponsor ran. And that was it. The sponsor ran trials…they published what they wanted to publish."

George says that the real-world evidence trend allows "collaborations like ICER. They are getting together and saying, let's go look at drugs that have already been on the market for years, and do real-world evidence studies and see if those studies come up with the same types of efficacy as the clinical trials way back when. So that's no longer the sponsor controlling the data — that's the third party who [manages value or] pricing and [coverage] decisions based a whole new set of data."

Contact George via Isabella Paladino at Isabella.paladino@finnpartners.com.

by Peter Johnson

How Will Bill Affect Pharma?

continued from p. 1

The Pharmaceutical Research & Manufacturers of America took a similar position, with PhRMA President and CEO Stephen Ubl writing in a Nov. 19 statement that "the consequences of this heavy-handed drug pricing plan will make a broken insurance system worse and throw sand in the gears of medical progress. It will stifle continued innovation after a medicine is first approved, discourage the introduction of generics and biosimilar treatments and undermine the robust competition that has made the Medicare Part D program a success for millions of seniors."

In addition, "the bill doesn't address perverse incentives in the system that are leading to higher costs for patients," Ubl added. "This is a disappointing day for patients, and I hope the Senate will reject this flawed drug pricing plan and

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deliver the more balanced approach patients deserve."

The CBO estimated in its Nov. 18 report that the drug pricing reforms included in the Build Back Better Act will result in 10 fewer drugs entering the market over the next 30 years, out of an expected 1,300 new drugs. Regarding projected savings, the CBO estimated that over the next decade:

- ***Allowing Medicare to negotiate drug prices will save the federal government about $79 billion;***
- ***Requiring rebates if drug list prices aren't capped at inflation would save about $84 billion;***
- ***Repealing a never-implemented rule that would have restructured the Part D rebate system will save about $143 billion***; and
- ***Redesigning the Part D benefit — such that manufacturers and payers share a greater amount of costs in the catastrophic phase of coverage, and seniors' out-of-pocket costs are capped at $2,000 — would save approximately $1.5 billion.***

The $79 billion in savings predicted to result from allowing Medicare drug price negotiation is significantly less than the $456 billion that the CBO estimated the government would save if Congress passed H.R. 3, the Elijah E. Cummings Lower Drug Costs Now Act. As Democrats decided what drug pricing provisions to include in their social spending bill, H.R. 3 served as a starting point. The CBO had also estimated that the more-robust H.R. 3 would lead to 59 fewer drugs coming to market in the next three decades (compared to 10 fewer under the Build Back Better Act). Unlike in H.R. 3, the Build Back Better Act would limit Medicare negotiation to drugs with the highest gross spending in Medicare Part B and Part D that are also single-source therapies and have been on the market for nine years or more (for small-molecule drugs) and 13 years (for biologics). All insulin products would be targeted for negotiation, and therapies produced by small biotech companies would be exempted until 2028.

The Build Back Better Act also places stricter limits than H.R. 3 did regarding how frequently HHS will be allowed to engage in Medicare drug price negotiation. While H.R. 3 instructed HHS to negotiate for the prices of "at least 25" eligible drugs in the program's first year and "at least 50" annually after that, Democrats' revised drug pricing reforms will limit negotiation to "no more than 10" eligible drugs in the program's first year, rising to a maximum of 20 drugs over time.

Negotiated Prices Are Just for Medicare

In the version of the Build Back Better Act passed by the House, the price-negotiation provisions do not apply to the private sector, but the inflation cap on prices does, according to Loren Adler, associate director of the USC-Brookings Schaeffer Initiative for Health Policy. However, it's not clear what the Senate parliamentarian — who decides whether parts of legislation comply with budget reconciliation rules — will do about the inflation caps provision.

Even though the Build Back Better Act represents a scaled-back version of H.R. 3, it's not entirely unsurprising that PhRMA and other stakeholders are still crying foul over the potential impact of the legislation, Adler says. On the one hand, "I'm very confident that there is a substantial difference in the effects on new drug development from the full H.R. 3 proposal and this proposal," he tells AIS Health, a division of MMIT.

However, "I'm not sure that there's an exact dollar amount related to how vociferously PhRMA will claim that these provisions will destroy the industry and all innovation to mankind," he adds. "They're lobbyists; it's understandable. But there's no distinction drawn between relatively small reductions in revenue and huge reductions in revenue."

Will Bill Become a Slippery Slope?

Numerof, however, says it isn't enough that the Build Back Better Act will have a more muted effect on the industry than Democrats originally envisioned.

"Like much of the initially proposed 'Build Back Better' plan, the starting terms were too far reaching for them to have any chance of passage. In response, the terms of the current proposal are scaled back, but nonetheless create the infrastructure and establish the precedent for the radical changes it envisioned," she tells AIS Health. "In doing so, this legislation sets the stage for incremental but continuing government incursion into an industry that has defined extraordinary results....Government almost never gives power back, and in this instance we expect nothing more than a continuing slide from the industry's current heights."

Ultimately, the whole picture is complicated by the general lack of clarity into how the pharmaceutical industry's business model actually works, Adler argues. "We know there is some relationship between the expected market size for a drug or the expected revenues that they'll earn and whether the drug gets developed, but the magnitude of that relationship is highly uncertain."

Contact Numerof via Mallory McDonald at mallory.mcdonald@pinkston.co and Adler at ladler@brookings.edu. G

by Leslie Small

Contact sales@aishealth.com if you'd like to review our rates for group subscriptions.

News Briefs

✦ ***Cigna Corp.'s Express Scripts is offering its health plan and employer clients a "first-of-its-kind" option to cover over-the-counter COVID-19 tests.*** Starting Jan. 1, 2022, members of participating plans will be able to choose an applicable COVID-19 test kit at a participating in-network pharmacy and show their Express Scripts member ID card at checkout to process the kit through their pharmacy benefit. Plans that opt into the new solution can set a copay for the COVID tests either at a discounted rate or $0. "Our new COVID-19 test kit solution creates more affordable and easily accessible testing options, ultimately contributing to safer communities and less disruption in our daily lives," said Amy Bricker, president of Express Scripts.

✦ ***The latest version of the Build Back Better Act would lead to a 40% payment cut, on average, for Medicare providers that furnish the Part B drugs that are likely to be initially targeted for government price negotiation.*** That's according to a new analysis from Avalere Health, published on Nov. 18, which noted that the impact "is particularly pronounced in the physician setting for all specialties, which would see a 44.2% cut versus 36% in the hospital outpatient departments." Certain types of practices would also see larger pay cuts than others: Medical oncology, hematology/oncology, and rheumatology practices would experience reductions of 42.9%, 41.3%, and 48.5%, respectively, in add-on payments, according to the analysis.

✦ ***In a new study that examined data from 17 of the largest U.S. health plans, researchers found that insurers applied more stringent step therapy protocols than those outlined in clinical guidelines more than half (55.6%) of the time.*** "These findings raise questions about potentially overly restrictive step therapy protocols, as well as concerns that variability across health plans makes protocols onerous for patients and practitioners alike," researchers wrote in the study, which was published in the November issue of Health Affairs. The study authors also wrote that their findings "suggest the need for state and federal legislative initiatives to help ensure appropriate prescription drug use."

✦ ***Prime Therapeutics will now prefer Semglee, the first FDA-approved interchangeable biosimilar on the U.S. market, on its national formularies.*** With its interchangeable designation, Semglee (insulin glargine-yfgn) can be substituted for the reference brand product Lantus by pharmacists, dependent on state pharmacy laws. The move by the Blue Cross Blue Shield-plan owned PBM comes in the wake of Cigna Corp.-owned Express Scripts' decision in late October to prefer Semglee over Lantus on its largest formulary. "This formulary change reinforces Prime's commitment to increasing biosimilar adoption and also demonstrates that we are not beholden to rebates, as we're able to also prefer the lowest net cost therapy," Kelly Pokuta, vice president and chief trade relations officer at Prime, said in the PBM's Nov. 3 press release. On Oct. 15, the FDA approved its second interchangeable biosimilar: Cyltezo, which is the first interchangeable biosimilar version of autoimmune condition treatment Humira.

✦ ***Among the drugs with price increases in 2020 that had the most substantial effects on U.S. spending, the Institute for Clinical and Economic Review (ICER) determined that seven of 10 "lacked adequate new evidence to demonstrate a substantial clinical benefit that was not yet previously known."*** Even after pharmaceutical rebates and other concessions, those "unsupported price increases" cost the U.S. health care system an additional $1.67 billion beyond what would have been spent if their net prices had remained flat. ICER noted in its report that the estimated budget impact is larger than the $1.2 billion cost associated with the seven therapies highlighted in last year's report on unsupported drug price increases, but the organization said the main reason was "the $1.4 billion increase in spending due to unsupported net price increases for a single drug: adalimumab (Humira)."

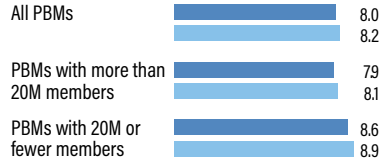
✦ ***Cigna named Christine Gilroy, M.D. as the new chief medical officer of its PBM Express Scripts.*** Gilroy, whose most recent role was associate chief medical officer at the startup insurer Bright Health Group, will be charged with "building and managing clinical care programs to increase quality, drive affordability and improve value," according to a Nov. 22 press release from Cigna. Gilroy will also "serve as a strategic adviser and close partner to Express Scripts clients, providing guidance on critical plan design decisions." Before her stint at Bright Health, Gilroy served as Colorado HealthOP's medical director and was the governor-appointed physician and chairperson at CoverColorado.

Smaller PBMs Beat Big Firms in Customer Satisfaction

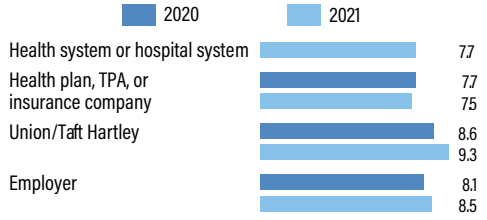
by Jinghong Chen

Plan sponsors' overall satisfaction with their PBMs increased from 8.0 on a 1-10 scale in 2020 to 8.2 in 2021, according to Pharmaceutical Strategies Group's 2021 Pharmacy Benefit Manager Customer Satisfaction Report. Based on surveys completed by 291 plan sponsors who provide pharmacy benefits to their employees, the report found that PBMs with 20 million or fewer members tend to have higher satisfaction ratings than larger PBMs. Average satisfaction was highest for PBMs' opioid management programs, while gene therapy financial protection programs rated the lowest and only 13% of the respondents used such programs. Among PBMs with more than 20 million members, MedImpact scored the highest overall satisfaction rate (8.5).

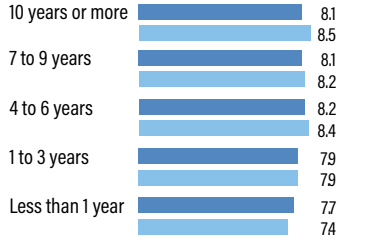
Mean Overall Satisfaction



Mean Overall Satisfaction by Plan Sponsor Type



Mean Overall Satisfaction by Time With PBM



Satisfaction With Utilization Management Programs

Utilization Management Programs	Clinical & Cost Managements Used			Mean Satisfaction				
	Use	Do Not Use	Not Aware if Offered	Program Delivery	Promised Savings	Clinical Outcomes	Member Experience	Program Reporting
Prior authorization	87.6%	9.3%	1.7%	8.1	7.9	8.0	7.7	7.7
Formulary exclusions	86.6%	10.3%	1.7%	8.0	7.8	7.9	7.6	7.7
Step therapy	84.5%	10.3%	3.8%	8.2	7.9	8.0	7.7	7.6
Opioid management programs	68.4%	18.6%	10.7%	8.4	8.1	8.2	8.2	7.9
Disease-specific programs	63.9%	25.1%	8.9%	8.1	7.8	7.9	7.8	7.7
Clinical savings guarantees	52.2%	24.4%	17.9%	8.2	8.1	8.2	8.2	8.1
Pharmacy trend guarantees	48.1%	24.1%	20.6%	8.3	8.1	8.2	8.2	8.2
Copay accumulator programs	40.6%	36.4%	20.3%	8.0	7.8	7.7	7.7	7.7
Copay maximizer programs	36.4%	41.6%	18.9%	8.2	8.0	8.0	8.0	8.0
Gene therapy financial protection programs	13.4%	44.0%	35.7%	7.9	8.1	8.2	8.1	8.3

Satisfaction With PBMs That Have More Than 20 Million Members

PBM	Mean Overall Satisfaction Rating	Mean Likelihood to Recommend	Mean Likelihood to Renew Contract Without Competitive RFP	% Who Report PBM is Aligned With Goals
Aetna	7.8	7.6	7.1	80.0%
CVS Health	8.1	8.0	6.8	82.1%
Express Scripts	8.1	8.0	7.3	88.3%
MedImpact	8.5	8.5	7.6	100.0%
OptumRx	8.1	8.1	7.6	81.4%
Prime Therapeutics	7.3	7.6	8.0	80.0%
All PBMs with more than 20M members	8.1	8.0	7.3	85.5%

Mean Satisfaction Rating by Specialty Management Function

	2020	2021
Financial reporting in the pharmacy benefit	8.0	8.3
Formulary management of specialty medications	8.1	8.2
Customer service for patients using specialty medications	8.1	8.2
Delivery of promised savings on specialty medications	7.7	8.2
Customer services for prescribers of specialty medications		8.2
Management of specialty medications in the medical benefit	7.6	8.1
Utilization management programs for specialty medications	7.8	8.1
Clinical patient management to improve outcomes		8.1
Drive lower drug pricing via rebate negotiation for specialty medications	7.5	8.0
Financial reporting in the medical benefit	7.6	7.9

NOTES: TPA refers to a third-party administrator. RFP refers to a competitive request for proposal.

SOURCE: "2021 Pharmacy Benefit Manager Customer Satisfaction Report," Pharmaceutical Strategies Group. Visit https://bit.ly/3FBH2YI.

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