RADAR on

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Business Strategies and Analysis for Health Plans, Employers, PBMs and Pharma Companies

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Senior Reporters
Judy Packer-Tursman
jptursman@aishealth.com
Leslie Small
lsmall@aishealth.com

Executive Editor
Jill Brown Kettler

Director, Data Solutions
Susan Namovicz-Peat

Costly New Nasal Spray for Depression Raises Payer Issues

Many clinicians have publicly expressed cautious optimism about the FDA's recent approval of a nasal spray for major depressive disorder in adults who have been resistant to multiple other treatments. But payer issues abound for Spravato (esketamine) — which its manufacturer says is set to become available starting March 18 — partly because the FDA is imposing strict parameters on its use due to safety concerns.

Esketamine is derived from ketamine, a general anesthetic first approved by the FDA in 1970. Similar to ketamine, Spravato is designated as a Schedule III controlled substance that may carry the risk of illicit use or diversion. Thus, the FDA said in approving Spravato on March 5 that the nasal spray cannot be taken at home. Instead, the patient must self-administer it under the supervision of a health care provider in a doctor's office or clinic certified by the drug's manufacturer — a controlled distribution model that will further add to the cost of an already expensive treatment, industry experts tell AIS Health.

"Our hope is we'll have hundreds of [Spravato-certified] centers open across the country in the first year," Kristina Chang, a spokesperson for Spravato's manufacturer, Johnson & Johnson's Janssen Pharmaceuticals, Inc., tells AIS Health. Depending on the site of administration, Spravato may fall under the medical benefit, pharmacy benefit or both, she says.

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As Insulin Prices Balloon, Insurers Try to Offer Some Relief

Amid increasing public scrutiny of rising insulin prices, some health insurers are taking matters into their own hands to help their diabetic members afford the lifesaving medications.

Between 2012 and 2016, there was a rapid increase in total health care spending on people with type 1 diabetes, "driven primarily by gross spending on insulin that doubled over the period" — even though insulin use rose only modestly, according to a Health Care Cost Institute report released in January.

Even more recently, Senate Finance Committee Chairman Chuck Grassley (R-Iowa) and Ranking Member Ron Wyden (D-Ore.) on Feb. 22 launched a bipartisan investigation into insulin prices by sending letters to leading insulin manufacturers Eli Lilly and Co., Novo Nordisk A/S and Sanofi S.A., seeking information regarding recent insulin price increases of up to 500% or more.

At Minnesota-based HealthPartners, the members who are hardest hit by rising insulin prices are those in high-deductible health plans (HDHPs), says Young Fried, vice president of pharmacy plan services at the not-for-profit integrated delivery system. Many of HealthPartners' group-plan members have HDHPs, which make

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enrollees responsible for a greater share of their health care costs before their coverage kicks in.

"Because we have such a high percentage of that benefit, we do get calls [and] concerns about, 'I didn't realize it was so expensive,'" she says. "We hear it from the members directly, and then we also hear it, because we're an integrated delivery network, from our providers."

In a recent conversation with a medication therapy management pharmacist, Fried adds, she learned that 60% of the pharmacist's diabetic referrals were for patients experiencing insulin affordability issues, rather than those who needed help adjusting their medication or dosage.

Though HealthPartners' commercial line of business is most affected, Fried says insulin affordability is also an issue for Medicare members who are in the Part D "doughnut hole," a gap between the initial coverage phase and the catastrophic phase when members are on the hook for a greater share of their drug costs.

At Pennsylvania-based Geisinger Health Plan — part of the Geisinger Health System — Medicare enrollees are the ones who have the most trouble paying for their insulin, according to Jamie Miller, the health plan's system director of managed care pharmacy.

Compounding the problem is the fact that Geisinger recently received a "Corrective Action Required" citation from CMS during a program audit, with the agency citing the health plan for not moving members' insulin from the Medicare Part D benefit to the Part B benefit when they're using an insulin pump, Miller says. CMS classifies insulin pumps as durable medical equipment, and thus they're required to be on the Part B benefit.

The steps Geisinger had to take to comply with that Medicare rule has "resulted in a financial hardship for our members," Miller says. She explains that insulin is on the brand preferred tier of the health plan's Medicare Part D formulary, requiring members to pay a $47 copay for a month's supply when in Medicare's initial coverage phase. But Miller says members whose insulin was moved to the Part B benefit found themselves having to pay 20% of the list price — much more than the $47 copay they were used to.

Overall, Geisinger saw its spending in the diabetes drug class rise 13.8% between 2017 and 2018, according to Miller. Spending on the top three drugs in the diabetes category — Novo Nordisk's Novolog Flexpen (insulin aspart injection), Sanofi's Lantus SoloStar (insulin glargine injection) and Novolog vials — rose 9%, 5.8% and 7.4%, respectively, year over year. Those trends make insulin costs an issue that affects all of Geisinger Health Plan's members, not just those who have diabetes.

"The higher the cost of drugs, the more the health plan has to pay toward those drugs, [and] ultimately it goes back to the member in increasing those premiums," Miller says.

Geisinger Mulls Formulary Tweak

As Geisinger works out what it wants its Medicare benefit to look like in 2020, Miller says one goal is to make insulin more affordable for its senior members.

"What I'm asking the team to do is find a way to basically make the cost of insulin the same on the Part B benefit as it would be on the Part D benefit," she says. While nothing has been solidified yet, HealthPartners is considering adding a sixth, "zero-dollar" tier to its Part D formulary where it would put insulin and select other drugs.

Beyond those potential formulary changes, there's not much Geisinger can do to help Medicare enrollees afford their insulin, Miller says, pointing out that government health plans don't

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allow the use of drug manufacturer coupons.

At HealthPartners, one tactic it deploys to ease the burden on members is a policy called "plan pay the difference," Fried says.

Many PBMs, she explains, have "member pay the difference" policies, in which patients who select a brand-name drug over a generic must pay a copay plus the cost difference between the two drugs. But with HealthPartners' policy, if the brand drug becomes cheaper than the generic with rebates, "we would actually have the member pay the generic copay instead of the brand, and then we would reimburse the pharmacy the brand cost, so that they're made whole as well," she says.

HealthPartners Offers Rx Shopping Tool

HealthPartners also offers plan members an app-based shopping tool, powered by the GoodRx platform, which allows them to see what their out-of-pocket cost for an insulin prescription would be at nearby pharmacies. The organization is working on offering a similar tool to providers.

Meanwhile, Pittsburgh-based Highmark Health offers insulin coverage at post-deductible copay levels for members with HDHPs, according to Corey DeLuca, Highmark's director of clinical pharmacy services.

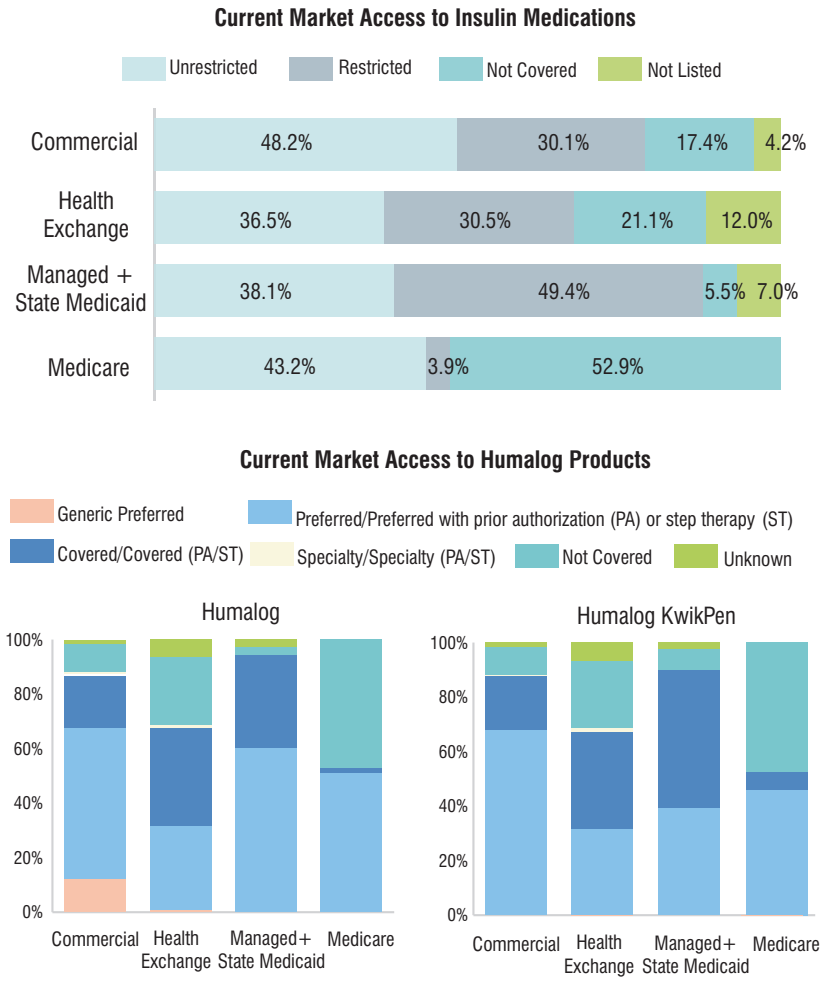
Insulin therapies also are available on Highmark's formularies without prior authorization, and it covers a variety of insulin products "on the most preferred brand formulary tiers" across its various business lines, DeLuca says.

For its part, Blue Cross and Blue Shield of North Carolina at the beginning of the year introduced a point-of-sale rebate program for insulin, which is available to members who have Affordable Care Act individual

Current Market Access to Insulin Medications

by Jinghong Chen

All insulin medications are covered under the pharmacy benefit. Almost half of lives under commercial formularies have coverage for insulin medications without utilization management restrictions, while more than 52% of Medicare beneficiaries lack access to at least one insulin drug. Meanwhile, amid ongoing debate about the high cost of insulin, Eli Lilly and Co. announced March 4 that it will introduce a lower-priced version of Humalog, called Insulin Lispro. This version will cost $137.35 for a single vial, which is 50% cheaper than the current Humalog list price. The graphics below show how insulin medications and two popular Humalog products are covered among commercial health plans, health exchange plans and Medicare and Medicaid programs.



NOTE: The numbers of total covered lives under commercial, health exchange, Medicaid and Medicare formularies are 108.5 million, 10.6 million, 63.1 million and 32.9 million, respectively.

SOURCE: Managed Markets Insight & Technology, LLC database as of March 2019.

and small-group plans. "The member fills their prescription at the pharmacy and receives the manufacturer rebate at point of sale (POS) by way of reduced drug cost. They do not have to wait for a reimbursement," explains a spokesperson for the Blues plan.

In the first couple of months of the program, members have saved nearly $200,000 on insulin, and an analysis from the Blues plan "shows that the members will have greater savings with our POS rebates than moving to generic insulin," the spokesperson said.

Lilly Debuts Cheaper Insulin Drug

In one potentially positive development, Eli Lilly on March 4 said it will introduce a version of Humalog (insulin lispro injection) in the U.S. with a list price that's 50% lower than the brand drug. The "authorized generic" — or generic drug manufactured by a brand company — will have a list price of $137.35 per vial.

For HealthPartners, the new version of Humalog could make a difference to the health plan's members, Fried says. "Especially those who have high-deductible plan benefits — as they're paying for everything up front — a lower generic cost means that they're going to see a lower price up front," she says. Thus, HealthPartners' preference is to allow the authorized generic version of Humalog when it comes out.

In a research note to investors based on a conversation with former CVS Health Corp. executive Jim Maritan, Credit Suisse analyst A.J. Rice noted that "for a government sponsored plan, using the authorized generic may be the better option, but a commercial health plan might still be better off using the higher priced option and [taking] advantage of the rebates."

"Our expert also notes that every state has different generic substitution rules and says it remains to be seen how that impacts the adoption of the AG [authorized generic]," he added.

Though it is technically a biologic, insulin historically has been regulated as though it were a small-molecule drug under the Federal Food, Drug and Cosmetic Act. Because of that regulatory quirk, the Eli Lilly drug Basaglar, approved in 2015, is referred to as a "follow-on" insulin product for Lantus, rather than a biosimilar.

However, starting in March 2020, insulin will be licensed as a biologic under the Public Health Service Act — effectively opening up a pathway for biosimilar competition, the FDA announced last December.

Fried says she's encouraged by that move, but says she worries the original manufacturers would increase rebates to "lock out" competitors. "That's a tactic that drugmakers are doing a lot more, and it puts pressure on all the PBMs, all the plans to consider not putting that biosimilar in place."

Contact Fried via Patricia Lund at patricia.a.lund@healthpartners.com, Miller via Mark Gilger at mcgilger@thehealthplan.com and DeLuca via Leilyn Perri at leilyn.perri@highmarkhealth.org. ✧

by Leslie Small

Magellan's PBM Could Be Attractive Acquisition Target

After weathering a rocky 2018 and facing public pressure from a hedge fund, Magellan Health Inc. appears more and more likely to end up on the selling block. If the company does opt for a sale, some industry experts say, its PBM could be one of the most attractive assets to potential buyers.

Though Magellan's insurance business contains Medicaid managed care contracts and radiology and behavioral health assets, "we would think most larger MCOs already have these capabilities in house and it's not clear if buyer interest would be high for this side of the business other than for the Managed Medicaid book," Jefferies analyst David Styblo wrote in a Feb. 20 research note.

But the PBM Magellan Rx "doesn't seem as integrated and could be sold as standalone," which "could be interesting for companies wanting to enhance their medical pharmacy and clinical management capabilities," he added.

PBMs Can Be a Savvy Buy

In general, "there's always an opportunity for good-quality PBM assets" to be purchased in the managed care space, says Ashraf Shehata, a principal in KPMG's health care life sciences advisory practice and Global Healthcare Center of Excellence.

"When we're starting to see issues like PBM transparency make their way through CMS, when we're starting to see more and more of the total cost, out-of-pocket spend for the PBM dollar become a bigger part of the restructuring of health policies, and then when we also start to see the pharmacy benefit move more toward a hybrid of online mail order plus potentially retail, it's hard to see a future for health care without the PBM being front and center to this consumer strategy," Shehata adds.

Magellan's PBM, though, has had its issues. The company said in its fourth-quarter and full-year 2018 earnings report that Magellan Rx's profits decreased from $139.9 million in 2017 to $104.4 million in 2018. That was "primarily due to the loss of

specialty carve-out business during the first half of 2018 as well as $7 million of unfavorable non-recurring items in the fourth quarter related to inventory, rebate receivables, and prior year customer settlements," according to Magellan's earnings release.

On a more positive note, CEO Barry Smith mentioned during Magellan's earnings call that the company's PBM had a 100% retention rate in its specialty carve-out business during the fourth quarter and picked up a Fortune 100 employer account.

Pricing Pressure May Continue

Looking ahead, "for the PBM business, the pricing pressure in the 2020 selling season for health plans in particular does not look poised to abate," Leerink analyst Ana Gupte advised investors. In fact, based on Leerink's own analysis and "early feedback" by Smith, Cigna Corp. (with its newly acquired PBM Express Scripts) and UnitedHealth Group's OptumRx "appear willing to price competitively" to make up for the loss of their contracts with Anthem, Inc. and Cigna Corp., respectively, she wrote.

Shehata, though, argues that the PBM industry has always been a "tale of three cities," comprising the largest entities, middle-tier players mostly owned by health plans, and small independent PBMs that have built their business models around rebate transparency and customer service.

"I definitely think that third-tier segment isn't necessarily going to go away," he says. However, there is an opportunity for an organization that wants to act as an "aggregator" of smaller PBMs by buying up several of them, putting them on a common platform and making improvements to their rebating and pricing tools. "If somebody were willing to do that, there could be kind of a bigger back-end valuation," Shehata says.

As for Magellan's fourth-quarter performance, it reported a $1.16 earnings-per-share (EPS) loss, which Gupte pointed out missed expectations by $2.25. Magellan has now had a "big EPS miss" in all four quarters of 2018, she added.

On Feb. 22, the hedge fund Starboard Value — which owns approximately 9.8% of Magellan shares — sent an open letter to the company's shareholders suggesting new candidates for its board of directors and urging Magellan management to explore selling all or part of the company.

Gupte suggested that Anthem and UnitedHealth are the most likely strategic buyers, "in light of their synergies with Medicaid in [Magellan's] Complete Care [segment], and the PBM across IngenioRx and Optum Rx."

Read Magellan's earnings release at https://bit.ly/2NMnMhr and the Starboard letter at https://bit.ly/2BOa5Kd. Contact Shehata via William Borden at wborden@kpmg.com. ✧

by Leslie Small

Civica Rx Aims to Provide 14 Drugs in Short Supply in '19

Since its launch in 2018 *(HPW 7/13/18, p. 4)*, Civica Rx, the new not-for-profit generic drug and pharmaceutical company run by health systems and hospitals, tells AIS Health it has made solid progress in its ongoing effort to address persistent shortages of certain drugs administered within their four walls. While its first medications have not yet been delivered, the company asserts this will occur later this year by using a multi-faceted approach to manufacturing.

Meanwhile, participation is growing in the provider-led enterprise, Civica spokesperson Debbi Ford said in a March 12 email. Civica's membership now consists of more than 800 hospitals across the U.S., she said, and "We are in talks with additional health systems at this time."

Spearheaded by Utah-based Intermountain Healthcare, the company was founded by seven hospital systems and three philanthropic members: 10 governing organizations in all that comprise Civica's board of directors. In recent months, nearly 20 more health systems have joined Civica as founding and partnering members, Ford said.

Scarce Drugs Are On the Way

According to Ford, Civica's initial focus remains unchanged. The company first aims to provide 14 vital drugs, "mostly sterile injectables such as anesthesia medications, antibiotics, and pain medications and expects to deliver these products this year," she says.

"We have enlisted the support of a Drug Selection Advisory Committee, which includes health system pharmacy experts, to prioritize the medicines we make and the order in which we make them," she added. "So far, the Committee's input has reflected incredible alignment on the most urgent medication needs."

Pressed on Civica's timeline and more specifics, Ford responded, "For timing on when we plan to deliver our first medications, our answer still stands for 'this year.'" She said the company is "not narrowing down the timeframe at this point."

Ford explained that for many generic injectable drugs undergoing a shortage, there often are one or two viable generic drug manufacturers that capture most of the market. Howev-

er, she said, there are multiple other generic drug manufacturers that have an FDA-approved Abbreviated New Drug Application (ANDA) and have "capable manufacturing facilities and capacity to produce the drug undergoing shortages, yet are dormant due to business and/or other reasons."

Ford said that any disruption in the supply chain for a drug that has only one or two manufacturers "almost immediately leads to a drug shortage, which is difficult to recover from because no other manufacturer can readily produce the required inventory."

Civica Outlines Its Response

Civica is taking a three-pronged approach to its manufacturing strategy. This involves:

✦ ***Work with several manufacturers,*** "including the dormant manufacturers who have the U.S. FDA approval, capable manufacturing facilities and capacity to produce Civica-labeled generic drugs, allowing manufacturers to re-enter the market," Ford said. Civica "will build safety stock to create a buffer in the event of a future disruption within the supply chain and work with these manufacturers to invest in their suppliers, facilities, capacities, processes and people."

✦ ***The development and/or purchase of ANDAs for generic drugs and work with contract manufacturing organizations to produce Civica products.*** "Owning an [ANDA] increases Civica's ability to assure availability and affordability for our members," she said.

✦ ***The purchase and/or building of Civica manufacturing facilities using Civica's ANDAs.*** "This approach continues to increase control, add redundancy, increases competition and allows Civica to provide the lowest cost product at a sustainable price," she said.

Large-scale participation in Civica's initiative could have a significant impact, says Bill Oldham, chairman and chief financial officer of AscellaHealth, a Berwyn, Pa.-based PBM. He notes that many of AscellaHealth's hospital clients are facing drug shortages, and some in the National Capital Region are considering partnering with Civica, among other options.

Will the cost of drugs go down because of Civica's efforts? Probably not, Oldham says. Will drug costs go up? Maybe. In any event, "there will be a new game in town," he says. "Whether it will have an enormous impact or not is anyone's guess."

Should Civica Enter Specialty Industry?

Oldham suggests that Civica may look beyond the headlines of meeting its own pharmaceutical needs and try to venture into specialty medications, "where the money is. They could potentially buy up specialty pharmacies as part of the deal, which could impact the spend."

But he cites "an enormous regulatory hurdle even for manufacturing a few drugs," and predicts Civica is "going to want to stick with generics because the cost and the risk are less."

"At the end of the day, you have to manage that supply and regulatory risk against the demand that's out there," he says. "The proof in the pudding is when they have to switch from one [generic] to another generic…in terms of spreading risk and cost."

"They have a good idea, a good opportunity," Oldham says. "Whether it becomes a profitable business remains to be seen."

Contact Ford at debbi.ford@civicarx.org and Oldham via Nicole Dufour at ndufour@cpronline.com. ✧

by Judy Packer-Tursman

Spravato Raises Cost Concerns

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Then there is the cost for the new specialty drug. Typically, the cost of generics for antidepressants such as Eli Lilly & Co.'s Prozac (fluoxetine) or Pfizer's Zoloft (sertraline Hcl) is "really inexpensive, less than $50 a month," notes Dea Belazi, Pharm.D., president and CEO of AscellaHealth, a Berwyn, Pa.-based PBM. By comparison, the cost would mushroom into thousands of dollars monthly for Spravato.

Given the "significant cost dynamic" of Spravato, payers will use due diligence, wanting pre-authorization and assurance that the patient has tried multiple traditional therapies first, Belazi says. "It's not a cakewalk. There are some challenges with [Spravato's] use." He estimates administration costs of at least $100 to $200 per session which, at two sessions weekly, "adds up pretty quickly." Moreover, he says, payers will have to work with the psychiatric community on proper coding, assuming certified administration centers are accessible to their patients.

Payers May Balk at High Cost

Janssen's nasal spray can work faster than other treatment options, with some antidepressants requiring four to six weeks of use to become effective, Belazi notes. "Some psychotherapists I've talked to see esketamine as a bridge while antidepressants kick in," he says. However, "because of the price point, I'd guess 99% of payers will limit this to a treatment-resistant population."

The bottom line is, "there's a significant cost implication here for the payers," Belazi says, "and most payers will want to calculate what the patient population could look like to estimate costs. The data aren't very clear on that….At the end of the day, it's a debilitating disease. But if it's high

cost, you'd likely be looking at other options."

The FDA approved Spravato's use, in conjunction with an oral antidepressant, to treat depression in certain adults who have not responded to at least two other therapies.

Still, there are cautions associated with it. Spravato's labeling contains a boxed warning that patients are at risk for "sedation and difficulty with attention, judgment and thinking (dissociation), abuse and misuse, and suicidal thoughts and behaviors" after the drug is administered. Among its most common side effects, increased blood pressure was identified in clinical trials.

FDA Requires REMS for Spray

Because of these risks, the FDA will limit availability under a Risk Evaluation and Mitigation Strategy (REMS). This means the drug must be administered in a "certified medical office" where providers can monitor patients, the agency said. Given the risk of sedation and dissociation, patients must be monitored by a health care provider for at least two hours after receiving their Spravato dose, among other precautions.

Janssen, Spravato's manufacturer, says it is working with sites to prepare for the REMS, but Belazi thinks access could be problematic: "The challenge with this that I see, because of the way it's being administered, is how will the patient get it?"

Mesfin Tegenu, R.Ph., president of PerformRx, LLC, a Philadelphia-based PBM subsidiary of the AmeriHealth Caritas Family of Companies, notes the FDA is requiring a REMS program to help track Spravato's long-term safety and effectiveness. "It has a different mechanism of action compared to currently marketed products which can only be proven superior once we have more real-life data," he says.

Tegenu predicts that "coverage policies will very likely be very conservative, utilizing product labeling, all available literature and REMS program requirements as a guide," citing concerns with the product's long-term safety as well as its diversion risks.

"With an estimated $47,000 a year per treatment, it is reasonable to expect manufacturers to establish outcomes based ROI [return on investment] for this medication," he says, adding that Spravato will be considered a specialty drug. PerformRx manages both pharmacy- and medical-covered specialty drugs under its specialty drug management program, he says.

Cost Depends on Treatment Duration

Janssen's Chang, when asked about Spravato's cost, says, "The thing to remember is there's no [specified] duration of treatment in the label — nothing saying six months or 12 months. It's at the discretion of the provider."

According to Janssen, the wholesale acquisition cost (WAC) of Spravato is $590 to $885 per treatment session. "The cost of therapy varies based on the dose used per session and how many sessions take place, both of which can differ patient to patient."

During the induction phase of therapy, which lasts for one month, patients are treated twice a week with either 56 mg or 84 mg dosing, so the WAC for the one-month induction phase ranges from $4,720 to $6,785, the manufacturer says. "Patients who have responded to therapy in the induction phase move on to the maintenance phase [in which] patients are treated with either the 56 mg dose or 84 mg dose either weekly or every two weeks, so the WAC for a month of maintenance therapy will range from $2,360 to 3,540." This WAC does not include any administration and observation costs, the company notes.

Janssen asserts that Spravato's WAC is consistent with other specialty mental health drugs, "and is not reflective of mandatory discounts or negotiated rebates that may be paid to government and commercial insurers."

Point of Care Reimbursement Will Vary

The manufacturer explains that payers will determine coverage policies for medical, pharmacy or both for Spravato, noting "commercial payers have signaled a focus on medical coverage." Treatment centers may seek reimbursement in different ways:

✦ ***Hospitals, integrated delivery networks and some outpatient clinics*** "will likely purchase the product and seek reimbursement for both product and administration/monitoring under the medical benefit," Janssen says.

✦ ***At a community mental health center,*** "the co-located pharmacy and mental health are often separate legal entities," Janssen says. "Both [settings] will need to certify in the REMS. Healthcare professionals will write a prescription to the pharmacy [which] will seek reimbursement under the pharmacy benefit. The healthcare professional will separately bill for administration and monitoring under the medical benefit."

The manufacturer further notes that Spravato, as a self-administered drug, is by definition a Medicare Part D product under CMS rules.

Read about the FDA's approval of Spravato at https://bit.ly/2EGkhF0. Contact Belazi via Nicole Dufour at ndufour@cpronline.com, Tegenu at mtegenu@performrx.com and Chang at kchang12@its.jnj.com. ✧

by Judy Packer-Tursman

News Briefs

✦ ***Trying to accelerate adoption of point-of-sale drug discounts, UnitedHealth Group's OptumRx and UnitedHealthcare said March 12 they are expanding their consumer POS prescription drug discount programs to apply to all new employer-sponsored plans.*** For new business proposals beginning January 2020, the companies said they "will only support new employer clients that incorporate [POS] discounts to consumers as part of their plan design." The expansion builds on their existing POS discount programs, announced a year ago and effective Jan. 1, 2019, which are expected to serve 9 million-plus consumers this year. "Just two months into the year, the existing program has already lowered prescription drug costs for consumers by an average of $130 per eligible prescription," the UHG subsidiaries said. Read more at https://bit.ly/2Hx8sEw.

✦ ***Drugmakers alone set and increase prices for their products, and they alone have the ability to reduce their prices, America's Health Insurance Plans recently told Congress.*** AHIP, in written testimony submitted March 7 for the House Ways and Means health subcommittee's hearing on promoting competition to lower Medicare drug prices, outlines its support "for recent improvements to the Medicare Part D prescription drug program and enhanced private sector negotiation tools in Medicare." The trade group also cites concerns with CMS's proposed rule on drug rebates that "would raise premiums on America's seniors by 25 percent, increase taxpayer costs by nearly $200 billion, and give away tens of billions of dollars to Big Pharma — while doing nothing to address the core problem of high drug prices in this country." View AHIP's statement at https://bit.ly/2TA54Qj.

✦ ***Net spending on prescription drugs increased from $205.7 billion in 2012 to $341 billion in 2016,*** according to a new report from Pew Charitable Trusts. The report also found that total health insurance premiums allocated to health plans' pharmacy benefit increased from 12.8% in 2012 to 16.5% in 2016, and that manufacturer rebates grew from $39.7 billion in 2012 to $89.5 billion in 2016. Further, a survey of health plan and PBM personnel included in the study found that PBMs passed through 78% of manufacturer rebates to health plans in 2012 and 91% in 2016. Read more at https://bit.ly/2SQg5I8.

✦ ***While 80% of the American public sees profits made by pharmaceutical companies as a major factor contributing to the price of prescription drugs, 63% say PBMs are a major factor,*** according to the latest Kaiser Family Foundation Health Tracking Poll. In addition, the majority of the public is in favor of most current policy options aimed at helping keep the cost of prescription drugs down, including allowing Medicare plans to put more restrictions on the use of certain drugs, making it easier for generic drugs to come to market and allowing Americans to buy drugs imported from Canada. Learn more at https://bit.ly/2H5ZDkN.

✦ ***More than 70% of value-based arrangements (VBAs) implemented between drug manufacturers and payers from 2014 to 2017 were not publicly disclosed,*** according to a study from the *American Journal of Managed Care.* In addition, VBA implementation is "relatively low," the study said, with manufacturers and payers reporting that approximately 33% and 60% of early dialogues translate into signed VBA contracts, respectively. Access the abstract at https://bit.ly/2VWOA1f.

✦ ***As the Trump administration considers finalizing a proposed rule that would restrict the use of drug manufacturer rebates paid to PBMs, antitrust litigation from the 1990s should serve as a "cautionary tale," according to a new report.*** The report, authored by attorneys from Foley Hoag LLC, notes that before the lawsuit in question "most manufacturers offered upfront discounts on their products in exchange for greater volume — much like the type of upfront pricing now set forth in the Proposed Rule as a 'solution' to rising drug prices." But litigation filed by hundreds of retail drugstore pharmacies successfully challenged that paradigm on antitrust grounds, ultimately leading manufacturers to shift to the system in place today in which they apply retrospective rebates based on a PBM's or payer's ability to affect market share. The attorneys argue that without congressional action, "manufacturers would likely be unwilling or unable to offer the same level of price concessions through an upfront discounting system." See https://bit.ly/2TCtPey.