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Laura Joszt, MA

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Peter Wehrwein
pwehrwein@mjhlifesciences.com

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wmulderry@mjhlifesciences.com

Senior National Accounts Manager
William Meyers
wmeyers@mjhlifesciences.com

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Kyle Foster
kfoster@mjhlifesciences.com

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PBMs are more important than ever

The pharmacy benefit management (PBM) industry has emerged as one of the most important, interesting and perhaps controversial sectors of American healthcare. As we discuss in this issue's cover story, PBMs have risen to prominence partly as a result of the growing number and the greater expense of pharmaceuticals. It was only a decade ago that the Sovaldi (sofosbuvir), a hepatitis C antiviral drug, caused an uproar because of its $1,000-a-pill price. Now, for many conditions, a drug that price would ruffle nary a feather. Spending on specialty drugs — expensive drugs for relatively uncommon conditions — accounts for approximately half of all the spending on drugs combined. The stakes of managing the use, delivery and cost of pharmaceuticals have gotten so much higher. The PBMs are smack-dab in the middle of all this action.

As we outline in our story, the industry has become increasingly consolidated with three large PBMs managing roughly 80% of the prescriptions. The large PBMs are also part of a trend toward vertical integration in healthcare. The Federal Trade Commission has launched an inquiry into the industry because of that concentration and any anticompetitive features it might have. The industry's defenders say it requires and rewards scale and is a counterweight to the pricing power of the drugmakers. Its critics — which include some new, smaller companies promising transparency and lower costs, and business groups devoted to healthcare purchasing — say the large PBMs use rebates and other tactics to extract an undue amount of profit from the complicated U.S. drug supply chain.

The arguments can get heated and the rhetoric, slashing. MJH owns and runs the Pharmacy Benefit Management Institute®. As we have done with the story in this issue, our goal is not to take sides or settle scores but to examine issues, share ideas and create a forum for the exchange of analysis, opinion and education about the industry.

The provenance of the "may you live in interesting times" adage is uncertain. And some people use it ironically. Regardless, whatever else might be said about the PBM industry, it is amid some interesting (to put it mildly) times. We are excited to be part of them and to help others to understand and navigate one of the most complex, turbulent corners of the healthcare world. ■

Mike Hennessy Jr.
President and CEO
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Mission *Managed Healthcare Executive*® provides healthcare executives at health plans and provider organizations with analysis, insights and strategies to pursue value-driven solutions.

A conversation with Greg Baker, RPh, CEO of AffirmedRx

On lessons learned, a 'broken' PBM industry and creating a better formulary

Greg Baker, RPh, is CEO of AffirmedRx, a recently established pharmacy benefit management (PBM) company and a new addition to the Managed Healthcare Executive *editorial advisory board. Baker describes his early career, shares some of his critical opinions about the PBM industry and how, in his view, his company is offering a better alternative.*

Peter Wehrwein, managing editor of Managed Healthcare Executive*, conducted this interview.*

This transcript has been edited for clarity and length.

You worked for Walgreens for 13 years early in your career. What about those years have shaped your view of pharmacy and your career path?

Several things came out of my [time at] Walgreens that continue to benefit me greatly. First, Walgreens is a process-oriented place. When you think about how to properly run a company at scale, Walgreens does an amazing job of that. They need to make sure they standardize a lot of processes. You have to communicate well to your staff. You have to train your staff well. Those are things, just from a general business acumen standpoint, I continue to use in pretty much every job I've ever had.

I'm a pharmacist by training, [which gave me the opportunity] to be really close with the patients and to … understand what happens when prescriptions get rejected. They have to try to figure out what to do in this crazy world of pharmacy benefits. "I can't pick up my prescription. Why is that? What's happening?" We've really tried to figure out how to build a PBM [pharmacy benefit management] product that's different, that helps the person standing at the pharmacy counter but also makes the pharmacist's job easier.

Lastly, especially during my time at Walgreens back in the 2000s, we were able to do some pretty innovative things. I live in Louisville, Kentucky, and people in Kentucky fill a lot of prescriptions, so we were always very successful and they let us do some interesting things. We started partnering with community health departments to do things like bone density screenings, cholesterol screenings [and] smoking cessation programs. We trained all our pharmacists in smoking cessation. That really gave me this other interesting view: It's not just about the pill, it's all the ancillary things — the testing, the provider visits, the lifestyle changes, the ability to afford medications. Those are things I think about every day, even here at AffirmedRx, which is a very different company than what a community pharmacy typically is.

Then you worked for about seven years at Premise Health. What was that job was like?

Premise is a very interesting business model. When I was there, we would work with the Microsofts, Walt Disney companies, the BMWs of the world — the really large, jumbo self-funded employers that have a lot of employees in one

geographic location. We would put the pharmacy in that location to service those employees and dependents.

The really defining difference about Premise is how they got paid. At Premise, we would pass through the cost of the drugs. So, here's what we bought the drug for, pass it through — no markup. The company never made any money on the drugs. We were really a service-oriented model, to get better adherence, better patient outcomes by providing a high level of concierge pharmacy services for these people. [Premise] got paid by taking salary and benefits as a bucket of money, and then they put a management fee and then a G&A (general and administrative) fee on top of that, so it was very transparent.

We've tried to build a PBM that only makes money in a very transparent fashion, that's not aligned to the cost of the drug, and trying to then line things up in a way that makes more sense from a healthcare standpoint versus a financial standpoint.

Do you think it'd be fair to describe you as a PBM industry critic?

I like that. We are in a lot of meetings [where], about two-thirds of the way through, you see people start thinking, "What does this guy do?" And we're like, "Oh, we are a PBM, too. I've just spent a lot of time telling you why the industry is broken, but that's why we're also trying to do things differently."

Could you identify an event or a period where the industry became, in your view, broken?

I think PBMs started losing their way around 2008 to 2009, when they decided they were going to own their own fulfillment channels, mail-order businesses and specialty pharmacies, and then they could decide what they pay themselves.

In my opinion, the wheels fell off the bus and it got totally out of control in 2017 into 2018. Two specific events occurred at that point in time: That's when the PBMs really started experimenting with, and then fully implementing, this concept of an exclusionary formulary. That was all for their own financial best interest. They would go to AbbVie, which makes Humira [adalimumab], and Amgen, which makes Enbrel [etanercept], and say, "Both of you guys are not on formulary anymore; it's one or [the other]. And whoever gets on, my formulary gets access to 100 million lives, so how much do you want to pay up to get that access?"

The second extension of that is when Express Scripts started Ascent, which is their GPO [group purchasing organizations] in Switzerland, so then all those rebatable dollars in the contracts between the PBMs and the manufacturer got totally hidden in these GPOs. There's also Zinc by CVS and Emisar by UnitedHealthcare — now we've got $250 billion a year that the manufacturers are paying into these GPOs.

Things got really bad. That's when we started getting extra frustrated and said, "There has to be a better way to do this."

Would you take the position that these GPOs that are headquartered overseas should be banned? Should that be part of the legislation that is being discussed in Congress?

It's going to be hard to legislate our way out of that, because these are incredibly sophisticated, complex organizations.... Everybody likes to bash on pharma a little bit because of their patent thickets, so they can extend the life of their patents and sell more of their drugs without a generic. Well, the PBMs have picked up that same business model, in my opinion, and they've started the GPOs for rebates. They sell drugs to their own mail-order pharmacy and define their own profits. All these new corporate layers that they're building into the system to opaque things create more pools of profit for themselves, always at the detriment of their clients. When Congress tries to say, "Hey, PBM, you can only do this thing." Well, under that same corporate umbrella, there's four other companies that have started to work their way around that legislation. So, it's going to be really hard for us to get to the point where we can legislate a better product.

Tell us a little bit about AffirmedRx and how you hope to succeed.

We said we could sit on the sidelines and complain about it, or we can try to build a product that we think makes sense. And does the market really want that change that it's been asking for?

We put ourselves together as a public benefit corporation, not as a C corporation, publicly traded company where the board members and officers of the company have a legal and fiduciary responsibility to drive maximum shareholder value. When we think about why people say the healthcare system is broken today, [it's] because it's profiting too much off its clients. It's doing exactly what it's

been created to do. We did not want to be in that same situation. As a public benefit corporation, I'm an officer of the company and a board member; my job is not to solely maximize shareholder value. My job is to do as much good for as many people as possible. At a foundational level, we can make different decisions. That's how healthcare should be done.

PBMs make a percentage of their profit based off revenue. If you're going to make [a] 10% profit margin, do you approve a $50 drug or a $5,000 drug? Part of the reason why formularies are created to try to favor brand drugs and higher-priced drugs over generics is because they're making a percentage. We changed that and said, "We're only going to get paid a dollar amount per net pay claim. Whenever a claim hits our system, we get paid a dollar amount." Whether it's a $50 drug or a $5,000 drug, I get paid the same either way. It's pulling conflict out of the system. We make better decisions in our clients' best interest.

Technology really matters, which nobody really talks about in the PBM industry. Just about the entire established industry, the big three and a lot of the other PBMs that are out there, they all still work on DOS-based systems. Nobody seems to question them on that. We use a cloud-based, Windows-driven system where we can create and drive rules and efficiency and do things with a click of a button versus having to have somebody code the entire DOS language. It's much more flexible and seamless, [which is] why our cost can be significantly lower.

We have a unique role called a patient care advocate. We have made the commitment that every time any claim rejects in the system, there's a person on our site who looks at that rejected claim — because we caused the reject, right? So instead of having a patient show up at the pharmacy counter and find out their drug didn't get covered, we move it over to this queue where this rule says, "This claim rejected." Then we can call the doctor and say, "Hey, doc. Here's what you need to do," and "Hey, pharmacist, here's what's going to happen," and "Hey, patient, here's what we've done to help you out." We take care of all that work for them and make sure these people are dedicated to each client.

You said the part of the problem with the PBM industry, in your opinion, is exclusionary formularies. But you have a formulary and don't cover all drugs, so how is it different than what other PBMs do?

Not every PBM creates its own formulary. A lot of formularies are rented from somebody else, so understanding who owns what and how the formulary is created really matters.

We spent almost a year as a clinical team and through P&T [pharmacy and therapeutics] committee building out our formulary. We have one example where we have a brand drug on formulary, and it's Lantus [insulin glargine injection]. Novo Nordisk took the price of Lantus down 73% late last year, and it's cheaper than the other authorized biologics in that class. It's the lowest cost when we can get, it's not a formulary rebate decision. We don't have brand-name Adderall [amphetamine/dextroamphetamine] or] brand-name Advair [fluticasone propionate/salmeterol]. We don't have Humira over biosimilars.

What's also different about us is we give all the data to the client — here's what you pay, here's the decisions we made, here's what we get back in rebates. All the data are there so they can see exactly everything we can see. The traditional PBMs don't show those data.

We believe the market needs to start saying that there's no other procurement process where we don't get this level of data and we stay with a vendor. Yet, for some reason, we continue to do it in the PBM industry.
If they're actually saving us all the money, then why can't they show us all the data to prove it? And if they're not, there are companies like AffirmedRx that will show you all the data and prove where those savings go — and the fact that we're not making money on you. It'll be interesting to see how that plays out. ■

Sanjula Jain urges taking a comprehensive approach to the alarming increase in cancer cases among younger populations

In this "Tuning In to the C-Suite" podcast, editor Briana Contreras spoke with Sanjula Jain, Ph.D., the chief research officer at Trilliant Health, about the shift in cancer incidence to younger people.

To read the full article, scan the QR code.