Florida Alliance
Summer Education Series

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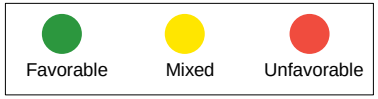
Industry Trends: Overview

Several key factors across the Rx distribution channel are impacting the macro landscape in which PBMs operate

PBM Market trends		
Trend	**Impact on PBMs**	**Summary of trend and impact on PBMs**
1 **Vertical integration**		► Five of the largest PBMs are vertically integrated with health insurance and specialty pharmacies ► In addition to helping to manage drug spend, vertical integration will encourage integrated insurers to discount their in-house PBM services to win the combined business, forcing remaining stand-alone PBM to lower prices
2 PBM Legislations — **Scrutiny around rebates**		► The share of commercial rebates that plan sponsors receive has increased as PBMs increasingly pass through the majority of these funds ► PBMs are responding to marketplace demands by reducing their reliance on profits from rebates and offering more transparent models that feature lower or no rebates
PBM Legislations — **Payer and government pressures**		► Spread pricing has become highly controversial in Managed Medicaid programs and is now prohibited in the Medicaid market in several states ► Network spreads gained by PBMs are expected to decline as payers become savvier at negotiating effective contracts with their PBMs
3 **Specialty drug dispensing**		► Growth in specialty drug spending is sharply outpacing that of traditional drug spending ► The concentration of specialty and mail dispensing revenues results largely from strategies used by payers and manufacturers to narrow specialty drug channels ► PBMs now earn >50% of their profits from specialty drug dispensing activities

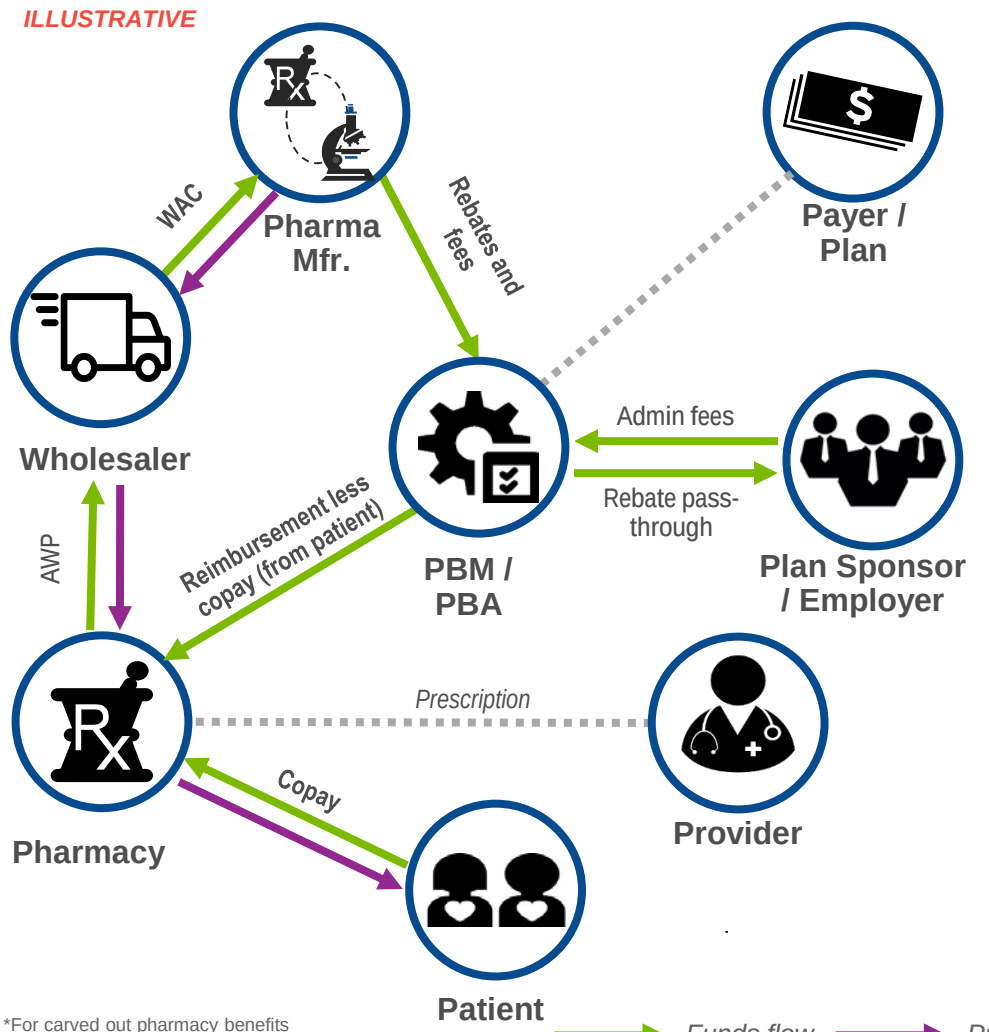


Source: Drug Channels, Analyst Reports, EY-Parthenon Analysis

PBM Overview: The "Traditional" Pharma Value Chain

The current economic model is complex; multiple points for product and funds transfer to ultimately deliver therapies to patients

Mapping the Pharmacy Value Chain*



How do they engage?	Stakeholder	Key Revenue Streams
	Pharma Manufacturer	► Wholesaler / distributor purchase of drug (at WAC price)
	Wholesaler	► Drug purchase from manufacturer (at AWP price)
	Pharmacy	► Reimbursement and dispensing fees ► Co-pay from patient (per prescription)
	PBM	► Administrative fees collected from payers / plan sponsors ► Percentage of mfr. rebates ► Pricing spread, co-pay clawbacks
	Payer / Health Plan	► Fees for benefits management ► Portion of rebates from manufacturers passed through PBMs
	Plan Sponsor / Employer	► Employee contributions ► Rebates from manufacturers passed through PBMs

*For carved out pharmacy benefits

Source: EY-Parthenon Analysis

Funds flow *Product flow*

PBM Overview: Types of PBMs

The pharmacy benefits management landscape can be segmented into four main categories; fundamental capabilities are largely consistent across entities

Spectrum of Pharmacy Benefits Stakeholders

	Traditional PBM	Pass-through PBM	Technology Platforms & Next Generation PBM Models	Aggregators / Coalitions
Definition	► Third-party administrator of prescription drug programs for health plans and employers ► Employer receives a portion of rebates and discounts negotiated by the PBM ► Revenue streams are often opaque and not fully disclosed	► Third-party administrator of prescription drug programs for health plans and employers ► Employer pays the contracted discounted pharmacy prices and dispensing fees that the PBM has negotiated ► Revenue based on per claim / PMPM administrative fee	► Technology and data-driven start-up companies focused on streamlining PBM processes (claims adjudication, data reporting, etc.) ► Leverage advanced analytics and machine learning to provide differentiated offering ► Revenue based on per claim / PMPM administrative fee	► TPAs that aggregate buying power of small and midsize employers to negotiate contracts with larger PBMs ► May be independent, non-profit, or consultant-affiliated ► May offer additional administrative and advisory services ► Revenue based on per claim / PMPM administrative fee
Examples	Express Scripts, Optum, CVS caremark	Navitus, BeneCard PBA	Abarca, RxAdvance, Smi+hRx	Employers Health, RxBenefits

Provide similar capabilities and offerings; directly compete for customers

Typically do not negotiate and maintain pharmacy networks and/or formularies; contract with larger PBMs

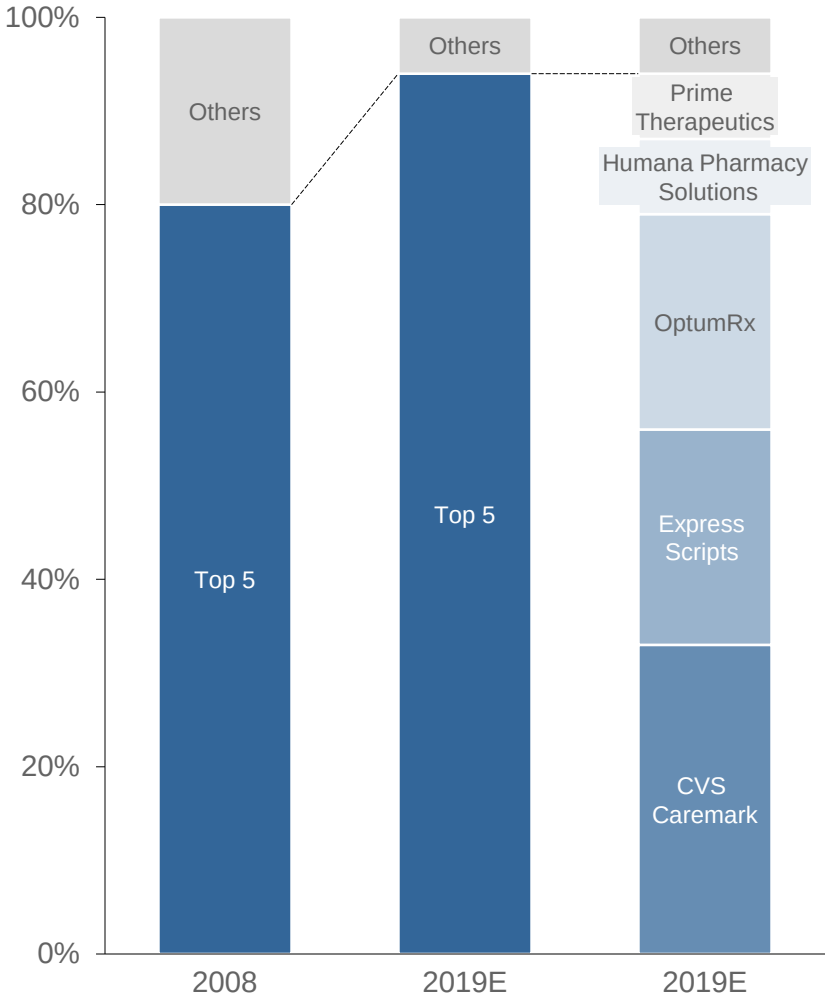
All four stakeholders are capable of performing pharmacy benefits adjudication activities including claims adjudication, customer/member service, data analytics, clinical programming, and other administrative services

Source: Company Websites, EY-Parthenon Analysis

PBM Overview: Market Dynamics

The PBM market has consolidated significantly over time; rebates and spread payment represent key revenue sources for the industry

PBM Market Share,
2008 to 2019E



1

PBM is a relatively consolidated industry with the top 3 players accounting for ~80% of Rx volume

- In 2019, CVS, Express Scripts, and OptumRx processed more than three-quarters of all prescription claims, with the top 5 handling more than 90% of total U.S. prescription claims
- The large PBMs also have a dominant share in specialty pharmacy and are well positioned to grow

2

PBMs generate revenue from multiple sources including network spread, specialty dispensing, rebate share, admin fees, and clinical program fees

- Spread payment and rebates, in which manufacturers agree to pay a rebate to PBMs to secure favorable formulary placement, constitute primary revenue streams for PBMs
- Other revenue streams include filling specialty prescriptions through their own pharmacies, claims processing fees, and co-pay assistance management fees

3

Spread payment and specialty pharmacies are the largest margin contributors to PBMs

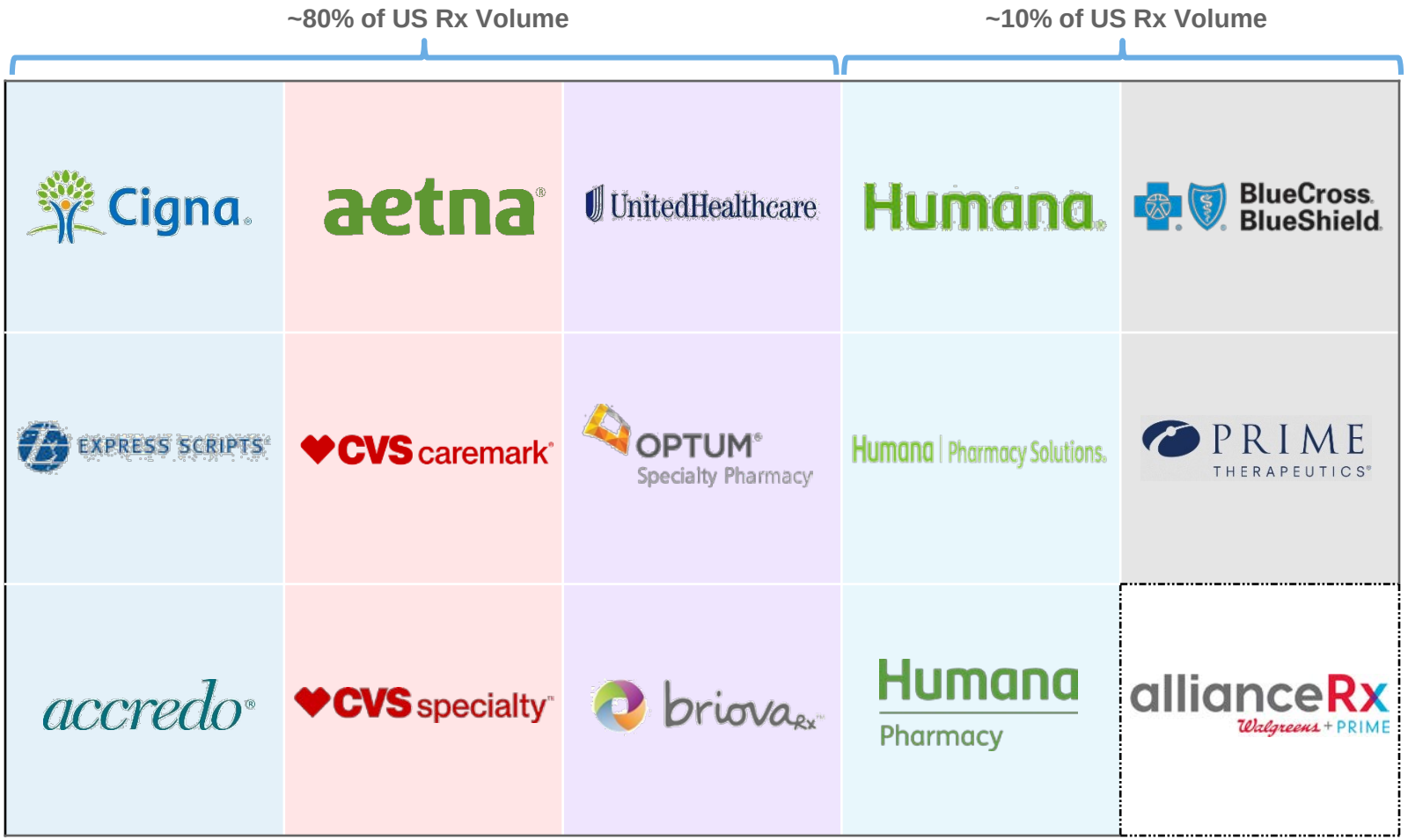
- While rebating is an important contributor to gross margin, it's not perceived as the largest as PBMs are increasingly passing through rebates to clients
- Mix shift in favor of health plans and Medicare Part D has the potential for margin compression, while specialty pharmacy dispensing remains a key catalyst for margin expansion

Source: Source: Drug Channels, JP Morgan, Company Annual Reports, EY-Parthenon Analysis

PBM Overview: Vertical Integration

The largest insurers, PBMs, and specialty pharmacies have now combined into vertically-integrated organizations

Vertical Integration among Insurers, PBMs and Specialty Pharmacies



"The strategic rational around vertical integration has been to 1) realize the ability to combine medial, pharmacy and lab data, and apply analytic tools to identify opportunities; 2) apply member engagement tools to drive behaviour change (pharmacy is typically the most frequently used health care benefit; and 3) shift patient care to lower cost settings (either through owned assets or preferred relationships" – **J.P.Morgan Equity Research**

Note: BCBS plans in the following states utilize Prime Therapeutics: IL, MT, NM, OK, TX, MN, NE, ND, WY, FL, AL, TN, NC, KS, RI, AR, NJ, WA, OR, ID, UT
Source: Drug Channels, Analyst Reports, EY-Parthenon Analysis

Industry Trends: Summary of PBM Legislation

Blame for high drug prices has fallen partially on PBMs, pressuring governments to implement legislative solutions to regulate the typically opaque industry

Perceived Issues	Proposed Areas of Regulation	Regulation Status
PBMs abuse manufacturer rebates to increase their own profits	**Rebates and Cost Transparency** Legislation that requires reporting of rebates, pricing, and costs to payors or to regulators or legislation that limits or restricts the size and distribution of rebates	**Federal** Senate Bill introduced + Presidential plan **State** >10 states with passed legislation
PBMs increase drug costs through spread pricing agreements and increase out-of-pocket patient costs	**Spread Pricing** Restrictions on the size or the ability for a PBM to impose spread pricing between what it pays pharmacies and what payors are charged **Gag Clauses and Claw backs** Prohibiting PBMs from restricting pharmacists and others from informing patients about less expensive options or charging co-pays higher than drug costs **OOP costs/Co-pay Accumulators** Legislation targeting limits on out-of-pocket costs for patients, including limits on cost-sharing and co-pay amounts and restricting co-pay accumulator programs	**Federal** Legislation Enacted to ban Gag clauses CMS rules and proposed legislation around Spread Pricing **State** >5 states with passed legislation
PBMs prevent patients from accessing the best-possible drugs from their pharmacy of choice	**Step Therapies/Formulary** Restrictions on when and how step therapy can be mandated and how PBMs are able to restriction their formularies **Network Access** Legislation to prevent PBMs from excessively restricting their network and limiting the terms of contracts with out-of-network pharmacies to ensure fairness	**Federal** Legislation proposed restricting step therapies **State** >5 State with passed legislations

Source: EY-Parthenon Analysis

Industry Trends: PBM Legislation

Blame for high drug prices has fallen partially on PBMs, leading to pressure to implement various legislative solutions to regulate the typically opaque industry

Perceived Problems	Proposed Legislative Solutions
PBMs use manufacturer rebates to increase profits instead of decreasing drug prices for patients Critics claim that the manufacture rebate system has led to profits for the PBMs as prices and rebates have increased, while both manufacturers and payors have received little added value	1. Force PBMs to fully report the amount of rebates and the final recipient 2. Force PBMs to pass all rebates through to the payor
PBMs increase drug costs through spread pricing agreements and use out-of-pocket patient costs to increase their profits PBMs profit from spread pricing, which some say are not related to services provided by the PBM. Gag clauses have prevented pharmacists from informing patients that they could pay less for their medicine through by-passing their PBM	1. Restrict the ability for PBMs to charge payors more than they pay to pharmacies for drugs 2. Prohibit gag-orders and claw backs to ensure patients are informed about the least expensive options 3. Restrict levels of cost sharing for high-priced drugs
PBM plan design prevents patients from quickly accessing the best-possible drugs from their pharmacy of choice Step therapy, where patients must try lower-cost drugs before their plan will pay for high-cost potentially more effective treatments has come under scrutiny, as well as how PBMs reimburse pharmacies outside of their own network	1. Prohibit or restrict the use of step therapies 2. Enforce fair contracting practices for independent pharmacies as compared to PBM-affiliated or PBM-owned pharmacies

Source: EY-Parthenon Analysis

PBM Legislation: Federal and State Regulations

Both federal and state governments have instituted legislation regarding PBMs, although states' abilities to enforce minimum cost requirements are under debate

Federal Legislation and Rules

- Relevant federal regulations include laws passed by congress as well as other rules from CMS or the executive branch

Federal Healthcare Regulations

Legislation	CMS Rules	Executive Initiatives
Laws passed by Congress which may impact the activity of all PBMs or might be limited to only government contracts (e.g. CMS, Military, etc.)	Rules from the Center for Medicare and Medicaid services which applies to PBMs primarily in their role in Medicare Part D plans	Executive orders or plans from the president's office that either lay out legislative and rule strategies or directly implement rules or regulations
Example The Patient Right to Know Drug Prices Act (October 2018)	Example CMS Guidance around spread pricing in Medicaid (May 2019)	Example American Patients First Plan (May 2018)

State Legislation

- Legislatures in **more than 35 states have introduced 150+ bills** which regulate seek to regulate PBM activity
- Proposed state laws can be indicative of potential future federal laws

States' ability to regulate PBMs Challenged

- *PCMA v. Rutledge* will be heard by the US Supreme Court in April to rule on whether states can pass MAC (maximum allowable cost) legislation affecting PBMs.
- **2015 - Arkansas** passed legislation in 2015 that required PBMs in increase reimbursement to pharmacies if the pharmacy's cost for a drug increased above current reimbursement levels.
- **2016 - Pharmaceutical Care Management Association (PCMA),** a PBM trade association, challenged the legislation in court, claiming that the law is preempted by the Employee Retirement Income Security Act of 1974 (ERISA)
- **2017 and 2018 -** After the District Court and the 8th Circuit Court ruled in favor of the PCMS, Arkansas is appealing the decision to the Supreme Court with the support of the US Solicitor General and many pharmacy trade organizations
- **Spring 2020**– Supreme Court was scheduled to hear arguments in April, but will be pushed back due to COVID-19

Potential Implications

- **If the court strikes down the Arkansas law**, it will establish a precedent of state's being unable to impose regulations on PBMs and will likely lead to many other state laws being overturned in lower courts
- **If the law is upheld,** PBMs will have to abide by an ever expanding landscape of state laws which can imposed maximum allowable costs (MAC)

Sources: Pharmacy Times, NCPA, US DOL, JDSUPRA

PBM Legislation : Summary of Federal Legislations

The US federal government has enacted and considered legislation around PBMs, with enacted legislation focusing primarily on Medicaid and Medicare

Type of Legislation	Federal Status	Example Regulation
Rebates and Cost Transparency	Proposed Plan	► **American Patients First Plan** addresses transparency and accuracy of rebates in the Medicaid Drug Rebate Program
	Proposed Act	► **Prescription Drug Pricing Reduction Act proposed in US Senate (December 2019)** would require CMS to publish certain information, as reported by PBMs, relating to drug discounts and rebates, and payments between PBMs, health plans, and pharmacies
Spread Pricing	Guidance Implemented	► **CMS Guidance around spread pricing in Medicaid (May 2019)** ensures that health plans monitor spread pricing in Medicaid appropriately. PBMs cannot use spread pricing to upcharge health plans and increase costs for states.
	Proposed Act	► **Prescription Drug Pricing Reduction Act proposed in US Senate (December 2019)** would ban spread pricing in all Medicaid managed care among many other regulations
Gag Clauses and Clawbacks	Passed	► **The Patient Right to Know Drug Prices Act (October 2018)** eliminates gag clauses that bar pharmacists from telling consumers when it would cost less to pay cash for a prescription than the co-pay required under their health plan
OOP Costs	Proposed Plan	► **Blueprint to Lower Prices and Reduce Out-of-Pocket Costs (May 2018)** proposes a variety of measures to increase transparency and lower drug prices across the industry with a particular focus on Medicaid
	Proposed Act	► **Lower Drug Costs Now Act (Passed House Dec 2019)** would cap out-of-pocket prescription drug costs for Medicare enrollees and direct the federal government to negotiate the price of many high-cost, lifesaving medications
Step Therapies	Proposed Act	► **The Safe Step Act of 2019** would amend the Employee Retirement Income Security Act to require group health plans to provide an exception process for step therapy so that patients can access treatment without delays
Network Access	None	► None

Sources: Company Websites, EY-Parthenon Analysis

PBM Legislation: Rebates and cost transparency

Rebates and cost transparency: Some states have implemented reporting requirements for PBMs to inform gov't entities about rebates

Potential Impact on PBMs: High

Increased legislation around rebates may push PBMs to adopt net-pricing or 100% rebate pass through models

Federal Policies

Proposed/Partially Implemented

American Patients First Plan

Addressed rebates in the Medicaid Drug Rebate Program:

*"Increasing the integrity of the Medicaid Drug Rebate Program, so that manufacturers pay their fair share in rebates, by proposing in the President's FY2019 Budget to **remove ambiguity regarding how drugs should be reported under the program**. HHS is also manually reviewing each new drug that has been reported in the Medicaid rebate system on a quarterly basis to make sure classifications are correct."*

Prescription Drug Pricing Reduction Act of 2019 (Senate Finance Bill)

Would require CMS to **publish certain information, as reported by PBMs, relating to drug discounts and rebates**, and payments between PBMs, health plans, and pharmacies

State Policies

Status	States	Policy Example
Passed Policies	AR, CT, GA, IA, LA, MA, ME, MN, NV, NY, UT	► **Utah HB 370** specifies that a pharmacy benefit manger has a fiduciary responsibility to an insurer and requires a PBM to report information about rebates and administrative fees to the state's Insurance Department ► **Minnesota SF 278/HF 728** requires a pharmacy benefit manager (PBM) to obtain a license. This measure also requires **PBMs to disclose rebate and pricing information to plan sponsors** and the state's Commissioner of Commerce. Under this bill, PBMs would be required to provide pharmacies with a maximum allowable cost (MAC) list, which must be updated every seven business days. PBMs must also **provide the sources used to determine the MAC pricing**
Proposed	36 States	► **Massachusetts S601** prohibits a pharmacy benefit manager (PBM) from charging a health carrier or health benefit plan more than what was paid to the pharmacy for those services. This measure also requires **PBMs to submit aggregate rebate information to the Division of Insurance**
Failed Proposals	AL, CO, CT, FL, MD, ME, NE, NJ, OR, TX, UT, WV	► **Florida SB 696/HB 561** requires pharmacy benefit managers (**PBMs) to submit an annual report detailing the aggregated dollar amount of rebates** from drug manufacturers and the aggregate amount of rebates passed to health insurers and the insured at the point of sale ► **Texas HB 2231/SB 2261** establishes a fiduciary duty for pharmacy benefit managers (PBMs) to health plans. This measure also **requires a PBM to transfer to a health benefit plan issuer the entire amount of any rebate that the PBM receives**

Note: Descriptions of state policies are comprised partially or fully from quotations of the National Academy for State Health Policy

Sources: National Academy for State Health Policy, Whitehouse.gov, EY-Parthenon Analysis

PBM Legislation: Gag Clauses and claw backs

Gag Clauses and claw backs are now prohibited federally by the Patient Right to Know Drug Prices Act, but have also been targeted by states

Potential Impact on PBMs: Moderate

The profits from these claw backs will be reduced, but are not primary sources of PBM income

Federal Policies
Passed
The Patient Right to Know Drug Prices Act (October 2018) Congress passed this bill which prohibits gag clauses that bar pharmacists from telling consumers when it would cost less to pay cash for a prescription than the co-pay required under their health plan

State Policies		
Status	**States**	**Policy Example**
Passed Policies	AR DE OR	► **Delaware HB 24** prohibits insurers and pharmacy benefit managers from engaging in the practice of claw backs. Under this measure, a carrier may not impose a copayment or coinsurance requirement for a covered drug that exceeds the lesser of the applicable cost-sharing amount or the amount an individual would pay for the drug if the individual were paying the usual and customary price. ► **Arkansas HB 1010** Among other measures, would prohibit pharmacy benefit managers from placing a gag over the pharmacy or pharmacist from sharing data with the patient and government entities.
Proposed	TN MN IL	► **Minnesota 3466/HF 4115 and Tennessee HB 1959/SB 2419** prohibit gag clauses in pharmacy benefit manager (PBM) contracts with pharmacies and pharmacists ► **Illinois 3642** prohibits gag-clauses as well as implementing several other PBM regulations
Failed Proposals	NY	► **New York SB 6531/AB 2836** among other things This measure also contains maximum allowable cost list pricing requirements and a method for appeal, along with a prohibition on the use of gag clauses

Note: Descriptions of state policies are comprised partially or fully from quotations of the National Academy for State Health Policy
Sources: National Academy for State Health Policy, EY-Parthenon Analysis

PBM Legislation: OOP Costs

House Democrats have proposed legislation to reduce drug prices and out-of-pocket costs while states have taken a variety of approaches to the issues

Potential Impact on PBMs: Moderate to High

Depending on the policy and implementation, revenues to PBMs could be greatly reduced or payor costs may increase

Federal Policies

Proposed

Lower Drug Costs Now Act (Passed House Dec 2019)

- "**Gives Medicare the power to negotiate directly with the drug companies,** and creates strong new tools to force drug companies to the table to agree to real price reductions, while ensuring seniors never lose access to the prescriptions they need."
- "**Makes the lower drug prices negotiated by Medicare available to Americans with private insurance**, not just Medicare beneficiaries."
- **"Creates a new, $2,000 out-of-pocket limit on prescription drug costs for Medicare beneficiaries,** and reverses years of unfair price hikes above inflation across thousands of drugs in Medicare."

State Policies

Status	States		Policy Example
Passed Policies	ME NH VA VT		► **Maine LD 2096** provides that a health insurance carrier that provides coverage for prescription insulin drugs may not impose a cost-sharing requirement on the enrollee that results in out-of-pocket costs to the enrollee in excess of $100 per 30-day supply of insulin ► **Virginia SB 1596/HB2515 prohibits co-pay accumulator programs** by requiring any carrier issuing a health plan to count any payments made by another person on the enrollee's behalf, as well as payments made by the enrollee, when calculating the enrollee's overall contribution to any out-of-pocket, cost-sharing requirement under the carrier's health plan
Proposed	NH NJ NM NY OH PA PR RI	SC TN VA VT WA WV WY	► **New Hampshire SB260** directs the Department of Health and Human Services to develop a **prescription drug assistance program to pay out-of-pocket prescription drug costs for seniors** who have reached the gap in standard Medicare Part D coverage. This will be a one-year long pilot program. ► **Rhode Island S2319/H7559 limit's beneficiaries' out-of-pocket expenditures for** prescription drugs to limits established for self-only and family coverage per year established in the Internal Revenue Code
Failed Proposals	CT FL OR TX WY		► **Connecticut HB 7174** establishes the **Connecticut Prescription Drug Program, which will purchase outpatient drugs**, make them available at the lowest possible cost to participating individuals, maintain a list of the most cost-effective and therapeutically effective drugs available, purchase and provide discounted drugs, and coordinate a comprehensive pharmacy benefit for participating individuals. The **comptroller will establish eligibility criteria and will negotiate with pharmaceutical manufacturers to secure discounts/rebates.**

Note: Descriptions of state policies are comprised partially or fully from quotations of the National Academy for State Health Policy

Sources: Speaker.gov, National Academy for State Health Policy, EY-Parthenon Analysis

PBM Legislation: Network Access

Some states are beginning to consider restricting how PBMs provide favorable treatment to their affiliated or network pharmacies to protect independent stores

Potential Impact on PBMs: Medium

By not being able to direct patients to PBM affiliated pharmacies, the impact of vertical integration will be reduced

Federal Policies

No major policies

State Policies

Status	States	Policy Example
Passed Policies	CO DE NE MT OR SC	► **South Carolina H 5038** would **prohibit a pharmacy benefits manager from restricting a covered person's ability to access prescription medications available at network pharmacies** ► **Oregon HB 2185 i**n addition to other restrictions, under this bill, **a PBM cannot reimburse a 340B pharmacy differently than any other network pharmacy** based on its 340B status and cannot retroactively adjust claims.
Proposed	AR CO GA ID IN KS KY MD MN NC NE NJ SC UT VA WA	► **Arkansas SR 9** - among other measures, **would prohibits pharmacy benefit managers from requiring pharmacy accreditation standards or certification beyond state requirements.** ► **Utah SB 138 prohibits a pharmacy benefit manager (PBM) from charging** an enrollee who uses an **in-network retail pharmacy that offers delivery or mail-order services a fee or copayment that is higher than the fee or copayment the enrollee would pay if the enrollee used an in-network retail pharmacy** that does not offer delivery or mail-order services. This measure also prohibits a PBM from reimbursing a 340B entity at a lower rate than a non-340B entity.
Failed Proposals	CO MD OR	► **CO HB 1097** would **prohibit a health benefits pla**n and its pharmacy benefit manager f**rom restricting where a covered person may fill a prescription drug**. Would prohibit imposition of financial penalties (higher copayments) or other conditions that limit or restrict covered person's choice. **Would prohibit denial of a state-licensed pharmacy or pharmacist from participating in a pharmacy network.**

Note: Descriptions of state policies are comprised partially or fully from quotations of the National Academy for State Health Policy

Sources: National Psoriasis Foundation; National Academy for State Health Policy; HHS, EY-Parthenon Analysis

COVID-19 Impact: PBMs

Most PBMs are expected see neutral to slight positive impacts from COVID-19 due to inelastic Rx demand and a shift to more profitable mail-order fills

Favorable | Neutral/ Mixed | Unfavorable

	Impact to PBMs	Description/Commentary
Changes in Short-term Rx Volume		► **Rx sales volumes have increased in the first few weeks** of social distancing due to patients "stocking up" and taking advantage of relaxed refill policies; however, those **increases are expected to be offset** by reduced sales in months to come ► *"[Rite Aid] noted the early strength was due to a pull forward, with partial fills, people refilling scripts early in the beginning of the month and 90 day conversions. That said, we note that the net impact of these actions largely represents a timing impact. While this can shift growth from one month or one quarter to the next, we believe that underlying demand remains consistent"* - J.P. Morgan
Shift to Mail Order and 90 day refills		► Some PBMs are reporting an **increase in their use of mail order services and 90-day fills**, which yield higher margins and analysts consider that some of this shift may remain after the crisis ► *"[Cigna] has seen an uptick in retail (primarily 90-day) and mail-order Rx volumes recently. It's too early to tell whether this is a short-term phenomenon caused by patients looking to have a larger Rx supply on hand or the start of a long-term trend. Either way, mail-order and 90-day retail are more profitable than traditional 30-day retail all else equal"* - UBS
Contracting and Contract Renewals		► CVS and United Healthcare have indicated that **some employers are now more likely to renewal their contracts without conducting an RFP process** to minimize disruption to their employees ► This is likely a **positive for the large incumbent players** and a potential **downside for newer entrants** ► *"RFP processes are continuing virtually in some instances versus face-to-face meetings. CVS noted that, while it hasn't seen this occur on a widespread basis yet, it believes some employers could choose to put RFP's on hold and extend current contracts rather than further disrupt employee lives"* - Credit Suisse
Medium- to Long-term Recession		► The **inelastic demand for medicines** and data from previous recessions leads most analysts to believe PBMs are quite **resilient to economic recessions** ► *"Over the medium term, we would not anticipate any significant impact to Rx volume from a potential recession. We note that demand for medications is fairly inelastic and not sensitive to the overall economic environment, as Rx trends did not see a material downtick during the recession in 2008, despite the sizeable increase in unemployment during that period"* -J.P. Morgan

Source: JP Morgan; Deutsche Bank; Morgan Stanley; UBS; Credit Suisse; EY-Parthenon Analysis

COVID-19: Response of Payers, Pharmacies and PBMs

Payers, pharmacies, and PBMs are changing behaviors to ensure continued insurance coverage, healthcare access and medication access

CVS Health / Aetna

Insurance Coverage

- Waiving co-pays for all diagnostic testing related to COVID-19
- $0 co-pay for telemedicine visits for 90 days

Medication Access

- Waiving charges for home delivery of Rx medications
- Offering 90-day maintenance medication Rx for insured and medication members
- Working with PBM clients to waive early refill limits on 30-day Rx maintenance medications

Walgreens

Medication Access

- Waiving delivery fees for all eligible Rx
- Working with plans, physicians, and states to ensure that patients have access to medication via services like 90-day refills and early refill authorizations

Healthcare Access

- Walgreens Pharmacy Chat, a secure platform available 24/7 online
- Walgreens Find Care connects customers to local healthcare services and telehealth options

Cigna

Insurance Average

- Waiving customer cost-sharing for:
  - Office visits related to COVID-19 testing
  - Telehealth screenings for COVID-19

Medication Access

- Helping customers to be treated virtually for routine medical examinations by in-network physicians
- Providing free home delivery of <90-day supplies for Rx maintenance medications available through Express Scripts Pharmacy, and 24/7 access to pharmacists

Sources: IQVIA, Company Websites

COVID-19: Overall Impact on the Value Chain

Impact of COVID-19 on the pharmaceutical value chain will depend on measures taken to mitigate the pandemic

Actions to mitigate COVID-19 spread

- The various measures implemented at the federal and state level are expected to impact all stakeholdesrs within the healthcare ecosystem

Social Distancing

- Increase in prescription size in retail channel and movement to mail order channel
- Attempts to refill early
- Stockpiling of acute symptomatic relief drugs
- Increase in refill prescription

Social Isolation

- Delayed launches and lower adoption for recently launched products
- Increased use of telehealth
- Adoption of digital tools for manufacturer to HCP engagement
- Decrease in new patient starts and switches
- Postponement of elective surgeries
- Overburdened hospital systems pushing patients to alternate sites of care

Shelter in Place

- Delayed approval of new drugs; accelerated approval of COVID-19 treatments
- Use of non-approved drugs for COVId-19 patients
- Potential drug shortages
- Financial tradeoffs for patients as economic crisis impact sets in
- Shift from commercial payers to Medicaid due to unemployment
- Increase in abandonment of prescriptions
- Increase in adherence-centric digital promotion and expanded financial assistance programs

Sources: Drug Channels, IQVIA, Analyst Reports

COVID-19: PBMs Emergency Preparedness Actions

PBMs are continuing to monitor potential drug shortages and disruptions to the supply chain

PBMs' actions during the COVID-19 outbreak

- Facilitating convenient acces to needed prescription drugs through home and mail delivery
- Minimizing impacts on patient care associated with drug shortages through collaboration with other stakeholders including pharmaceutical manufactures, pharmacies, and health plans

Express Scripts, Inc

- Operating under standard "Refill Too Soon" policies allow members to refill when 25%-35% of current prescription is remaining
- Clients have the option to trigger the Emergency Access to Benefits (EAB) which allows off cycle refills

MedImpact

- Giving clients the option to relax "Refill Too Soon" limits
- Enabling clients to implement a $0 copay tier for all COVID-19 related products determined by the plan
- Providing a backup call center to manage and support an increase in call volumes

OptumRx

- Removing "Refill Too Soon" limits across all clients for maintenance medications. If the member still has refill remaining on the prescription at retail or mail order pharmacies
- Refill will stay consistent with prior refills (i.e., 30 or 90 days)
- Extending existing PA's that are expiring on or before May1, 2020 for an additional 90 days
- OptumRx Specialty Pharmacies will offer patients a one-time option to fill a 90 day supply for key chronic Specialty medications. Acute medications will still be limited to 30 days

CVS Caremark

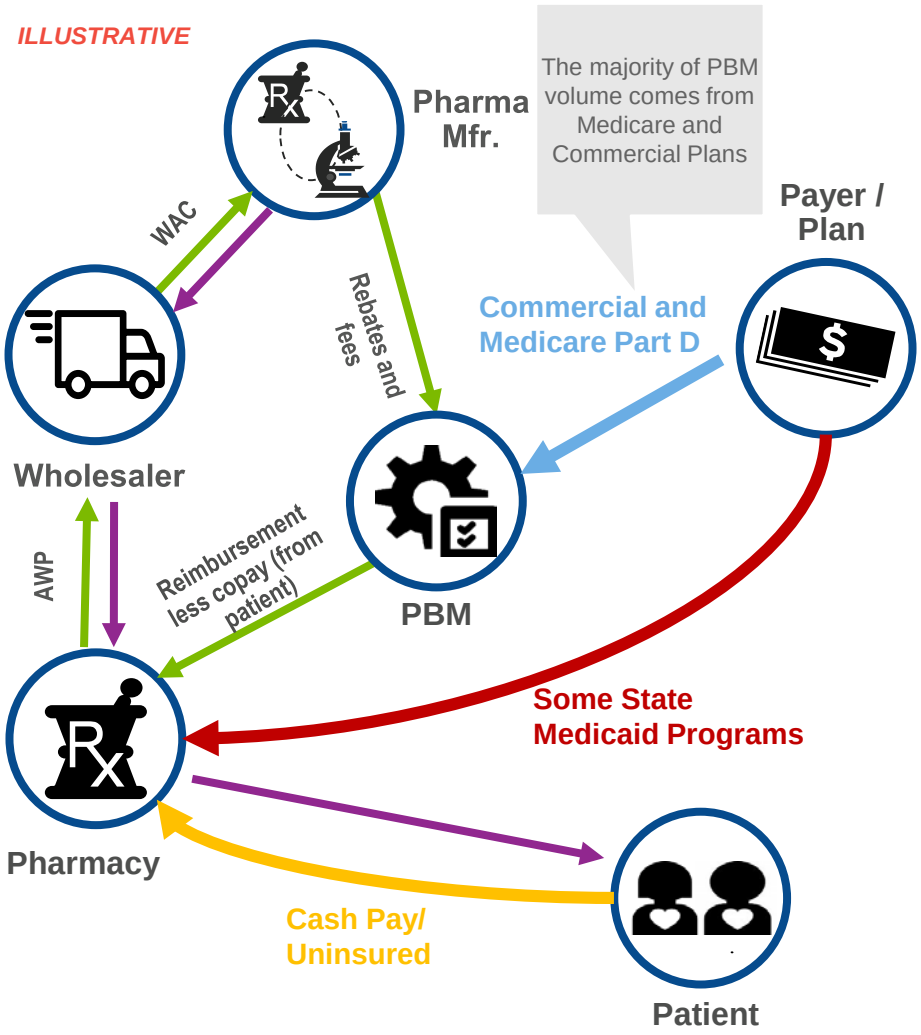
- Relaxing the 30 day "Refill Too Soon" limits on maintenance drugs. 90 day supplies are excluded from this
- Waiving charges for home delivery on all prescriptions, although not all prescriptions are eligible for home delivery
- Extending existing PA's that are set to expire before June 30 for additional 90 days
- New quantity limits are being placed on medications that potentially treat COVID-19. Members previously taking these medications are exempt from these quantity limits

Sources: PCMA, Gallagher

COVID-19 impact on Pharma Value Chain

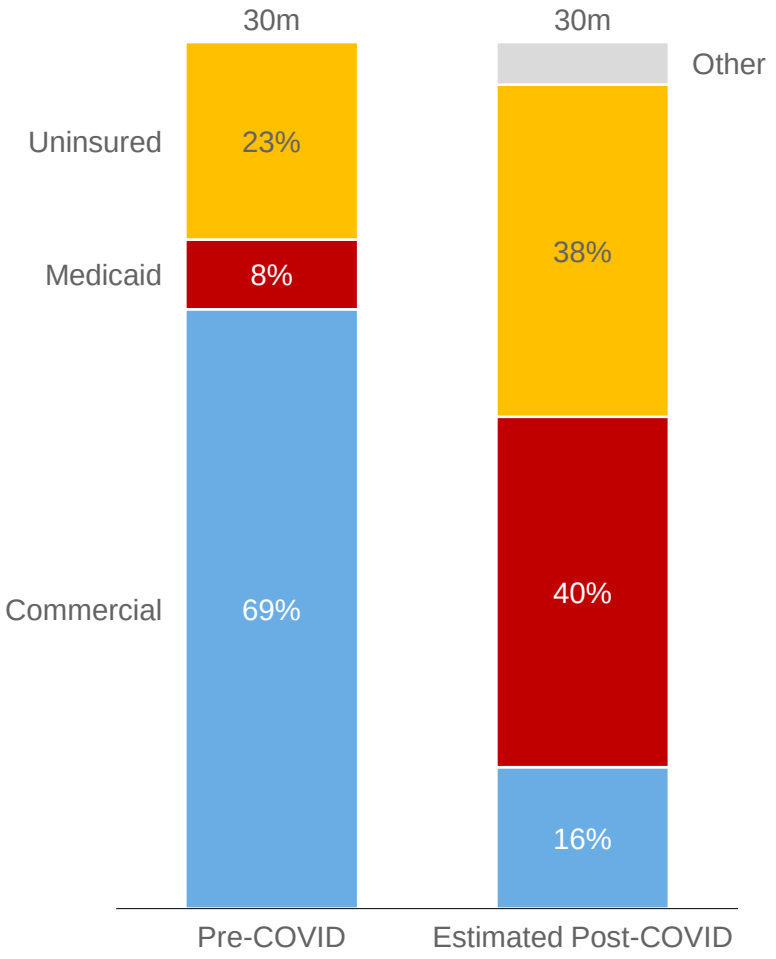
PBMs stand to lose significant volume due to shifts from employer plans to Medicaid and uninsured because of unemployment

Current Pharma Value Chain



Estimated Insurance Coverage of Workers Recently Unemployed due to Covid-19

2020Q2-2021Q1



*For carved out pharmacy benefits

Source: US Census Bureau; EY-Parthenon Analysis

Funds flow *Product flow*

COVID-19 impact on Pharma Value Chain
Supply chain risks may impact capacity planning

SUPPLIERS
- **Reliability** given recent lockdowns and production interruptions
- **Communication** of any current or foreseen issues
- **Exposure** of suppliers' suppliers to pandemic-related interruptions

MANUFACTURING
- **Prioritization** of drugs (applicable to manufacturing sites that produce a mix of drugs)
- **Consistency** in ability to produce drugs throughout the year (applicable to manufacturing sites that batch produce)
- **Capacity of production and talent** at manufacturing sites
- Alternative manufacturing site options, in addition to **transition time and cost** (if applicable)
- **Continued focus on QA and safety** given pressure from value chain constraints on raw material suppliers

RAW MATERIALS
- **Availability** of all types of raw materials (especially incipients and API) impacted by geopolitical factors, including export limitations
- **Pricing** on all categories of raw materials, given potential scarcity due to geopolitical factors

CHANNELS
- **Disruption to ecommerce, mail order, and retail** environments

FREIGHT
- **Limited airfare** available for air cargo due to reduction in flights
- **Limited harbor** options for sea cargo due to temporary harbor closures and limitations
- **Inconsistent ground transport and fulfillment** due to limited truck drivers, route closures, access points, inspections, and delays

FORECAST
- **Unrepresentative** pandemic-related consumption
- **Unpredictability** of the post-pandemic environment
- **Shift to government sponsored plans** with billions of prescriptions moving away from employer-sponsored plans to Medicare and Medicaid

REGULATORY
- **Export limit** decisions made unilaterally by national governments
- **Forced licensing** may be mandated by national governments for selected pandemic-related drugs
- **Pending legislation** per potentially mandated price controls
- **Cross-border inspections** causing delays and unpredictability

RELATIONSHIPS
- **All value chain stakeholder** (pharmacies, employers, HCPs, PBMs, etc.) relationships may increasingly be impacted as awareness of OUS reliance increases

As of May 2020

Employer Actions and Recommendations

- Require your PBM partners to fully report the actual total amount of rebates they receive by drug and manufacturer and an accounting of the aggregate dollars they are crediting your plan
- Restrict the ability of your PBM partners to charge your plan more than they pay to pharmacies for drugs – in effect, eliminate the price spreading that is occurring
- Prohibit gag-orders and claw backs to ensure patients are informed about the least expensive options
- Restrict levels of cost sharing for high-priced drugs and consider making generic drugs free to eliminate issues with affordability
- Prohibit or restrict the use of step therapies unless there is strict clinical differentiation approved by independent clinical research
- Enforce fair contracting practices for independent pharmacies as compared to PBM-affiliated or PBM-owned pharmacies that are advantaged

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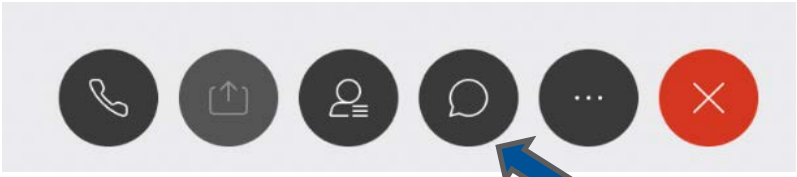

On your screen, click here to see **Q&A function.**

The **Q&A function** is found by clicking on the ellipsis icon.

- Type in your question and send to “All Panelists.”
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