C2 solutions

2024 Pharmacy and Drug Trends

What Benefits Leaders Need to Know

Table of Contents

Need a primer on the U.S. commercial pharmacy market?

01

Introduction
The High Cost of Prescription Drugs

a. About C2 Solutions

In late 2021, the Kaiser Family Foundation found that eight in ten adults say the cost of prescription drugs is unreasonable, with nearly three in ten identifying that they haven't taken their medicine as prescribed due to cost.[i]

The exorbitant costs of prescription drugs in the United States have long been a subject of public debate, evoking concerns about affordability, accessibility, and equitable healthcare. As the world's largest pharmaceutical market, the U.S. faces unique challenges in balancing drug innovation and pricing of vital prescription medicines. However, the question of who is ultimately to blame for the high drug costs of U.S. consumers remains a contentious issue, with various stakeholders pointing fingers at one another.

Pharmaceutical companies undoubtedly hold a central position in the drug pricing landscape. Their investments in research and development, production, and marketing contribute to the development and availability of life-saving medications. However, critics argue that the current pricing strategies employed by pharmaceutical companies prioritize profit margins over affordability.

Additionally, the intricate web of patents, intellectual property rights, and market exclusivity provisions can shield drug manufacturers from otherwise competitive forces, enabling them to set prices without facing traditional market constraints. Nevertheless, manufacturer-set prices are just the beginning of the drug pricing paradigm in the U.S.

Health insurance providers and pharmacy benefit managers (PBMs) also play a pivotal role in shaping drug costs.

These intermediaries negotiate drug prices with manufacturers and pharmacy providers on behalf of plan sponsors and employers, aiming to strike a balance between affordability and coverage.

However, the opacity surrounding rebate negotiations, formulary placements, proprietary pricing benchmarks, and cost-sharing arrangements often leads to confusion among patients and healthcare providers. Recently, questions have begun to arise about the role certain insurance practices may have on influencing drug costs, while federal regulators have commenced studies and investigations into the impact of health insurance sector vertical integration on access to medicine.[ii] [iii]

Healthcare professionals and patients also play a significant role in the drug pricing ecosystem:

- Prescribing decisions made by physicians, the incentives of pharmacy provider compensation, and the demand for certain medications directly by patients can contribute to drug price increases.
- Patients, burdened by high out-of-pocket expenses, may face difficult choices regarding medication adherence, leading to potential adverse health outcomes.

Understanding Prescription Drug Costs

Given that prescription drugs make up a significant portion of healthcare costs, they're a major focus for most benefits professionals. New treatments and medications are enhancing quality of life for patients nationwide. Yet these advancements are driving up the cost of drugs.

On average, about 20% of healthcare spending goes toward prescription drugs. But for some C2 member firm clients, up to 50% of their healthcare costs are related to prescription drugs.[iv]

Understanding the driving forces behind pharmaceutical spending and drug costs is vital for payers and patients alike. Data-driven insights are critical for payers to appropriately shape coverage and ensure affordability of medications.

C2 Solutions contracted with 3 Axis Advisors to assist member firms in understanding the evolving role of pharmacy benefits and prescription drug costs. This included an assessment of the existing commercial market and an understanding of pharmacy payment data. 3 Axis Advisors also sought to help articulate the C2 Solutions approach to managing pharmacy benefits across the spectrum of employer experiences.

In this report, we'll dive into actionable insights and data based on the experience of C2 Solutions member firms from 2021 to 2022. This data will help HR and benefits pros understand the drivers behind pharmacy benefit costs now and in the future with an eye toward more effectively and efficiently managing spend while supporting member needs.

About C2 Solutions

In the world of employee benefits brokers, big firms can do big business. But these brokers often lack hands-on customer service or intimate knowledge of regional nuances. Growth doesn't mean leaving your firm's personality behind. Enter C2.

C2 Solutions is an equity-owned partnership focused on collaborative solutions in the rapidly evolving landscape of employee benefits.

As a collective whose member firms maintain independent ownership, C2 Solutions member firms represent a refreshing approach to the impersonal strategy of national consolidation.

While the majority of the marketplace is served by public firms with little ability to offer unique products and services, C2 Solutions member firms serve their clients by providing the latest solutions and strategies through collaborative resourcing.

Exclusive Products

- C2 ClaimsCheck
- C2 RxAdvantage
- C2 Absence Navigator
- C2 Absence Complete
- C2 Benchmarking
- C2 Actuarial Pricing Support
- C2 Solutions Catalog
- C2 Surgery Experience

02

C2 Pharmacy Trend Data and Insights

C2 operates a national team of regional insurance experts. With member firms across the country representing countless employers with a range of employee populations and benefits approaches, there are actionable insights to be gleaned from data around C2 member drug utilization and spend.

Overall Trends

The overall drug trend for C2 member firms[i], as measured by the average cost per claim, decreased by 4.3% from 2021 to 2022. That's a contrast to national drug trends demonstrating that from 2021 to 2022 pharmacy expenditures increased.

The overall drug trend is composed of two primary types of medications, traditional and specialty.

Traditional medications are those that are easy to self-administer or require less intensive clinical monitoring, such as those used to treat diabetes and high blood pressure. In general, these are older medications and have an anticipated drug cost of less than $1,000 per prescription.

Specialty drugs have higher anticipated drug costs per prescription and are used to treat chronic, complex conditions. Specialty medications include injectable and non-injectable drugs that have one or more of the following qualities: frequent dosing adjustments and intensive clinical monitoring, intensive patient training and compliance assistance, limited distribution, and/or the requirement for specialized handling or administration.[ii]

2021

$102.67

2022

$98.30

Table of Contents

[i] *Drug Trends evaluated based upon clients participating in C2 Solutions Pharmacy Solutions that include data access (not all products include detailed data access)*

[ii] *Specialty designation as defined by PBM contract which may vary employer group to employer group within the analysis*

Table of Contents

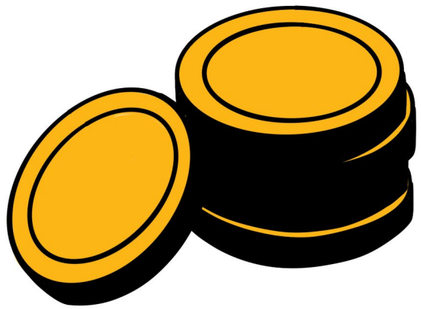
Specialty drugs were key drivers of drug expenditures in 2022. While accounting for approximately 1.1% of all claim utilization within C2 Solutions, approximately 50% of drug costs are driven by specialty products.

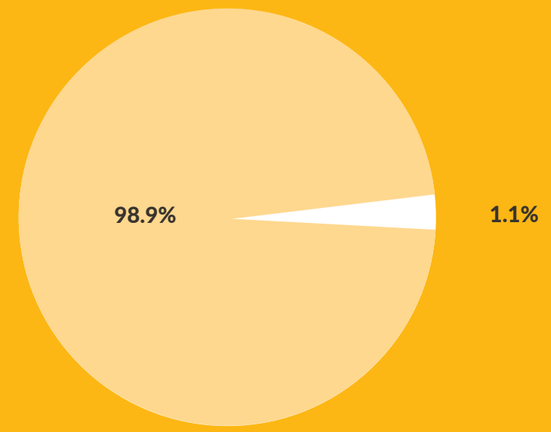
Traditional Drug Spending

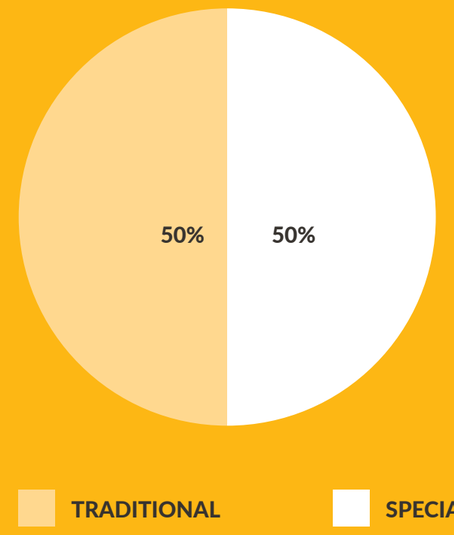
- The average gross cost per traditional medication got 5% cheaper year-over-year
- Generic drug dispensing reached 88.6% of all claims in 2022

Specialty Drug Spending

- The average gross cost for specialty medications grew by 7% year-over-year
- In addition, the use of specialty medications as a portion of overall prescriptions increased 0.1%







Top 10 Drugs by Spend

Diabetes Therapies Dominate Traditional Drug Spending

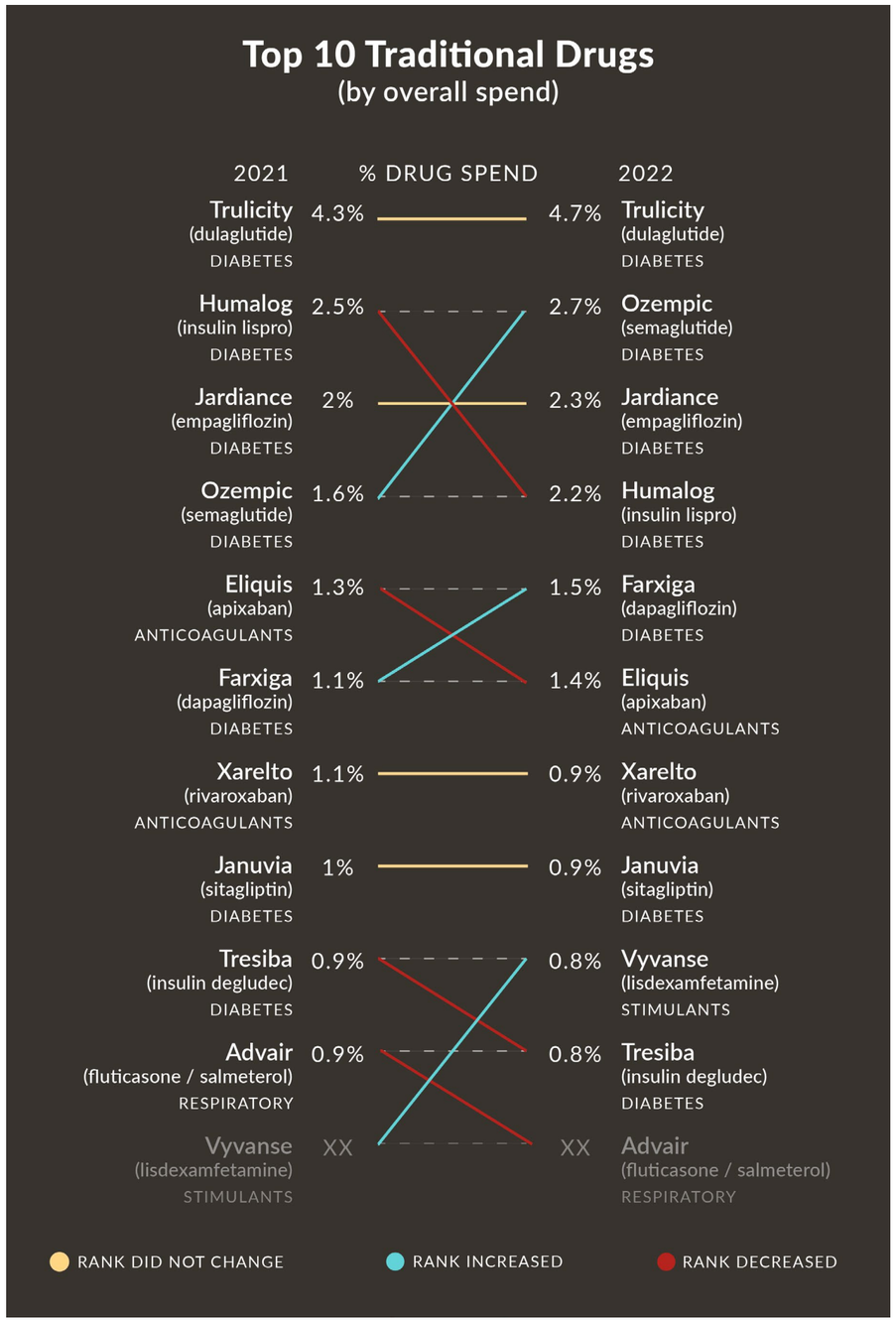
The top 10 traditional drugs by gross spending are dominated by therapies for diabetes.

This includes injectable insulins and oral tablets; however, positive trends (in terms of savings) for these drug classes are anticipated in the near term. Most insulin manufacturers have announced price decreases effective 2024 which should produce savings of 40% based upon list price lowering. Combined with increasingly available biosimilar options and anticipated generic releases of Farxiga® and Jardiance® in 2025, we anticipate that the treatment of diabetes will become significantly cheaper in the coming years.

At the same time, we anticipate certain diabetes therapies that overlap with the treatment of obesity (i.e., GLP-1s) will continue to gain market share and become the dominant traditional drug therapies in the next couple of years.

Vyvanse advanced into the top 10 for the first time in 2022, likely because it is one of the last drugs for the treatment of Attention Deficit Hyperactivity Disorder (ADHD) class without generic alternatives. Increased use of stimulants for ADHD occurred following the growth of telemedicine practices and increased diagnoses of the condition, particularly in older individuals. Conversely, Advair fell out of the top 10 due to the release of a generic alternative and rapid adoption of the generic leading to cost savings.

The top 10 traditional drugs each year represent about a third of all traditional drug spending and approximately 15% of overall drug spending.



Inflammatory Condition Drugs Dominate Specialty Drug Spending

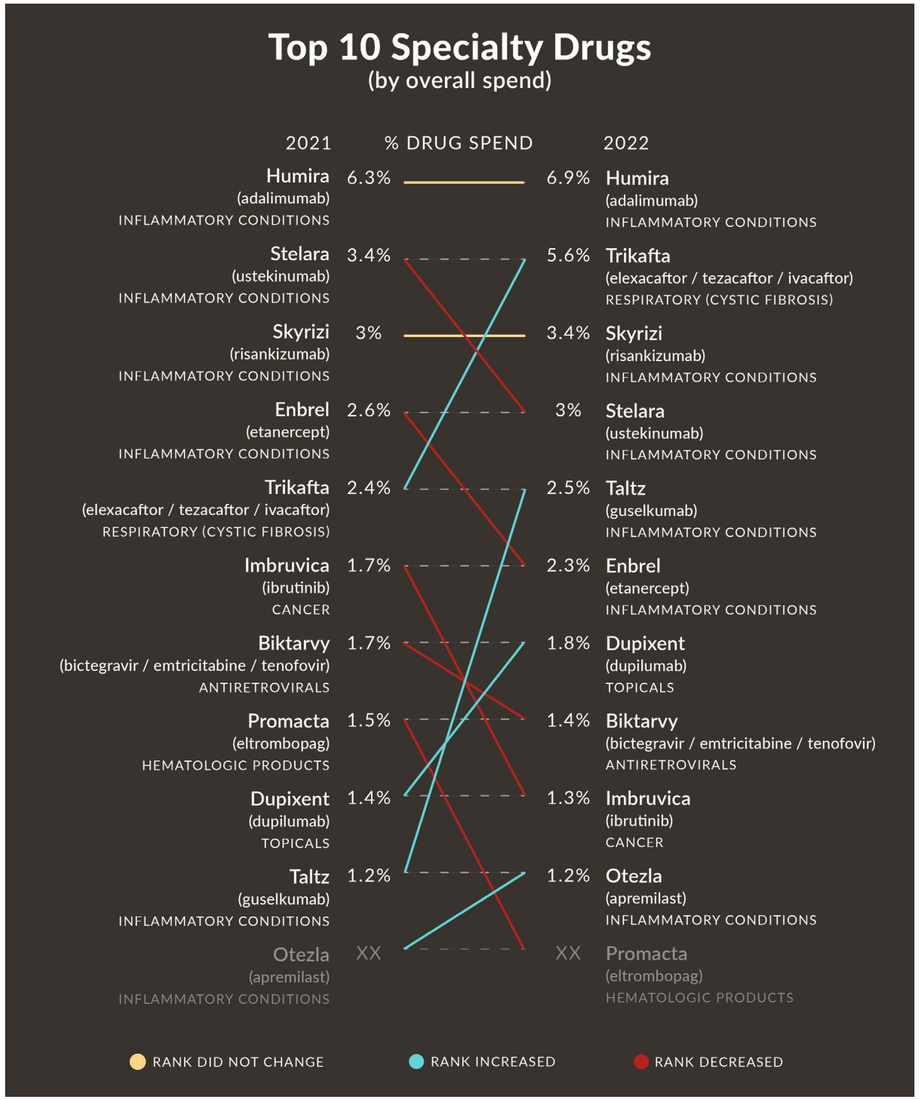
As with the traditional drugs, specialty drug expenditures are dominated by a single drug class.

Drugs used to treat inflammatory conditions such as rheumatoid arthritis and psoriasis represent approximately half of all top 10 drugs by gross spend. Adalimumab (HUMIRA® and its biosimilars) continues to be the top drug by spend; however, this may change due to biosimilar availability and competition on prices (see Humira section later).

In 2022, overall spend on cystic fibrosis (CF) drugs was up by more than double as a result of an increased number of individuals, generally children, requiring use of the therapy and the drug manufacturer increasing the list price per prescription by nearly 5%.

The top 10 specialty drugs each year represent about a half of all specialty drug spending and approximately 25% of overall gross drug spending.

This demonstrates how the overall drug trend can be highly dependent on a few drug therapies, particularly for smaller clients.



Top Drugs by Utilization

Most-utilized Drugs Reflect Most Prevalent Diseases

There is no year-over-year change in the composition of the most utilized traditional drugs. The most utilized traditional drugs reflect treatment for the most prevalent disease states in the United States, including high cholesterol, hypertension, and diabetes. As a result, it is unlikely that these agents will significantly change year-over-year.

These therapies represent approximately 20% of medications dispensed within C2 Solutions member firms each year.

Top 10 Traditional Drugs
(by number of prescriptions)

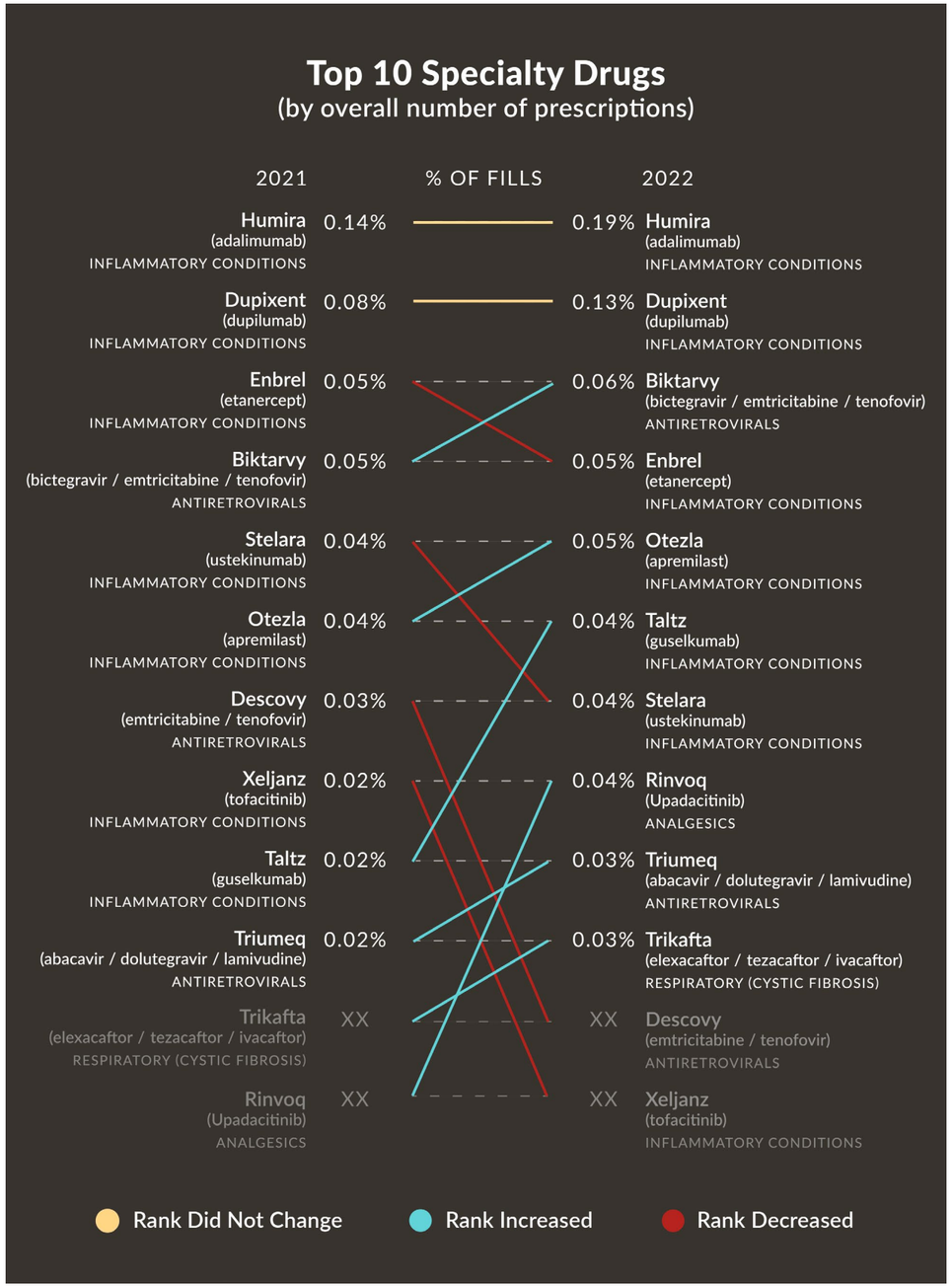
2021	% OF FILLS	2022
Atorvastatin CARDIOVASCULAR	2.7% — 2.7%	Atorvastatin CARDIOVASCULAR
Lisinopril CARDIOVASCULAR	2.2% — ▼ 2%	Lisinopril CARDIOVASCULAR
Amlodipine CARDIOVASCULAR	2% — 2%	Amlodipine CARDIOVASCULAR
Metformin DIABETES	1.8% — ▲ 1.9%	Metformin DIABETES
Losartan CARDIOVASCULAR	1.8% — ▲ 1.9%	Losartan CARDIOVASCULAR
Levothyroxine ENDOCRINE AGENTS	1.8% — 1.8%	Levothyroxine ENDOCRINE AGENTS
Metoprolol CARDIOVASCULAR	1.7% — ▼ 1.6%	Metoprolol CARDIOVASCULAR
Sertraline MENTAL HEALTH	1.6% — ▼ 1.5%	Sertraline MENTAL HEALTH
Escitalopram MENTAL HEALTH	1.5% — 1.5%	Escitalopram MENTAL HEALTH
Omeprazole AGENTS FOR THE GI TRACT	1.4% — 1.4%	Omeprazole AGENTS FOR THE GI TRACT

Specialty Drug Usage Varies More Year Over Year

Specialty drugs are more prone to year-over-year changes because of their limited utilization.

Given that specialty drugs represent 1.1% of overall claim volume, even a relatively small number of prescriptions can meaningfully impact the top 10 list. Like spending, overall utilization is generally dominated by drugs for inflammatory conditions; however, antiretrovirals also make several appearances within the top 10. While less expensive than most traditional specialty medications, the growth of therapies like Descovy for pre-exposure prophylaxis is evident within the trend data.

Overall, the top 10 generally represents about half of all specialty drug utilization in a given year.



Drug Therapy Class Trends

All of the top 10 drug classes were the same between 2021 and 2022, though their order differs slightly. Collectively the top 10 drug classes in 2022 represent approximately 80% of all gross expenditures and 61% of all utilization.

Here's a closer look at three of the most impactful conditions and medications affecting drug spend and member health.

1. Inflammatory Conditions

Across the industry, agents used in the treatment of inflammatory conditions, such as arthritis and psoriasis, continued to be the largest gross drug spend in 2022. The trends in this category are dominated by the branded products, all of which are considered specialty drugs, and carry average gross costs per prescriptions exceeding $3,000 per claim.

This category accounts for roughly three out of every four specialty products utilized within C2 Solutions.

The top three drugs in this category remain unchanged year-over-year, and are Humira® (adalimumab), Stelara® (ustekinumab), and Skyrizi® (risankizumab).

Humira® Spotlight

This category is truly dominated by Humira®, whose utilization is nearly double the next closest product and whose gross expenditures account for roughly one-third of all branded costs in this category.

Humira® has been the number one drug by gross expenditures nationally for the last several years.[v] Of all the therapies used in treating various anti-inflammatory conditions, Humira® is indicated for more conditions on average than its competitors which contributes to its dominance in this category.

However, cost relief for this medication is likely to be realized in late 2023 and early 2024. This is because for the first time there will be biosimilar, effective generic alternatives to Humira® on the market. While we anticipated uptake of the biosimilars to be slow in 2023, mostly due to historic formulary limitations, that will likely change in 2024. Several of these biosimilars have list price reductions of 50% or more relative to the brand Humira (some even exceeding 80%).

As adoption of Humira® biosimilars accelerates, expect to see costs in this category come down.

This may result in a shake-up at the top of the therapeutic class as diabetic costs are anticipated to increase over the next couple of years due to trends with weight loss drugs which may supersede these costs depending upon how well controlled utilization is handled.

2. Diabetes

The number of diabetic prescriptions increased, which was expected due to the rising prevalence of type 2 diabetes and the expansion of select diabetic therapies into non-diabetic treatments (i.e., weight loss).

Overall gross spending in this class increased by 6.7%, driven mostly by an increase in the underlying utilization, particularly for branded medications, as the average gross cost per prescription (for both brands and generics) declined from 2021 to 2022.

We expect spending on diabetic therapies will continue to grow due to the increased price of new drugs and treatment guidelines that recommend add-on therapy.

However, growth should be moderate into 2024 due to the recently announced list price decreases on diabetic therapies.[vi]

At present, there are no medications designated as “specialty” for treating diabetes. As a result, the overall brand costs for this category are generally lower per prescription than other drug classes which have specialty drugs increasing costs. Most gross costs in the diabetic class are related to brands, and brand utilization in this category exceeds that of most other drug classes due to insulin and insulin-like products (i.e., GLP-1s).

Drug costs in this class are closely aligned with both the anticipated average wholesale price discounts and drug’s estimated cost to acquire. This suggests that sourcing of products is competitive, and any cost controls needed to manage a client’s drug spending in this category are largely utilization based (i.e., prior authorization, formulary, therapeutic interchanges, patient education, etc.).

As previously indicated, outside of the GLP-1s (discussed below), there are a lot of positive cost trends on the horizon with insulin costs expected to decline by 40% in 2024 due to manufacturer price decreases and generic alternatives to the remaining branded oral products (i.e., Jardiance® and Farxiga®) anticipated in 2025.

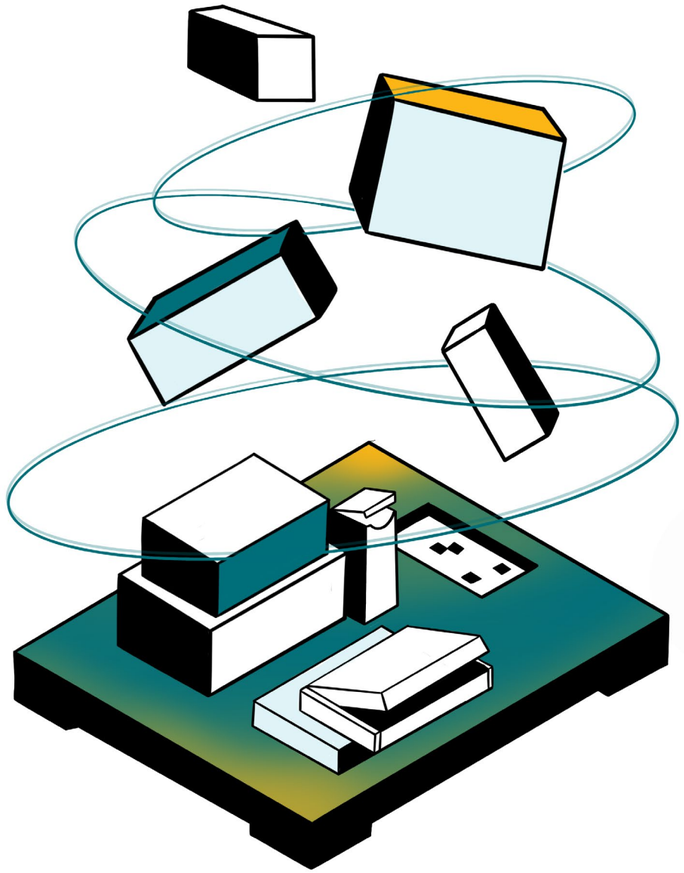
Weight Loss Drugs (GLP-1s) Spotlight

The most important class of medications within diabetic therapies to monitor in the coming years will be the GLP-1 agents. These medications, traditionally used as add-on therapies for helping to control diabetes, have gained expanded indications for the treatment of obesity.

The medications, such as Ozempic®, Wegovy®, Saxenda®, Mounjaro®, and Zepbound®, have gained attention because of their impressive weight-loss results — in many cases, 10% to 20% of a person's body weight.

GLP-1 receptor agonists mimic the GLP-1 hormone that is naturally released in the gastrointestinal tract in response to eating. This prompts the body to produce more insulin after eating, limiting the elevation of blood sugar levels after meals, and helping regulate appetite by sending signals to the brain to tell the body it is full, which inhibits overeating.

Although these drugs have been used for years to treat diabetes, with clear benefits, long-term efficacy of these therapies for weight loss is less clear. Some indications appear to suggest that patients will need to be maintained on these drugs to keep weight loss results. At the same time, there is early evidence to suggest these medications may expand indications further to treat other conditions such as substance abuse. The expansion of GLP-1 use is potentially challenging from a cost management perspective as the average gross cost of a GLP-1 drug averages $1,000 per month, or approximately three times the average cost of all diabetic therapies. Current data suggests rebates for GLP-1s approximate 40% of the gross drug costs.[vii]



3. Respiratory Conditions

The respiratory category generally covers medications for asthma and chronic obstructive pulmonary disease (COPD) – including Advair and generic alternatives. These medications are some of the most utilized due to roughly one in five Americans having the conditions of asthma or COPD.[viii]

This drug category also includes specialty therapies for rare genetic respiratory conditions.

One of the most utilized and expensive of these therapies is Trikafta®, a medication used to treat Cystic Fibrosis (CF). Utilization of CF therapies can have significant impacts on employers given their costs.

Advair® Spotlight

The first generic alternative for Advair® launched in January 2019; however, use of brand Advair® continues to dominate the respiratory category for C2 Solutions member firms. With anticipated rebates in excess of 70%, the use of this medication can increase point-of-sale gross prices for employers and beneficiaries, but can possibly be less costly for the plan in the aggregate (if the plan is realizing the full value of available retrospective rebates). This can have cash flow implications to businesses that have to manage the float between paying for therapies on a monthly basis and receiving rebates at a later point (normally quarterly).

This drug highlights the importance of having brokers who clearly understand plan design and can provide benefits that meet employers' needs.

Looking forward, Advair® is a medication expected to change its list price in 2024 due to changes in federal policies regarding drug prices (particularly in regard to Average Manufacturer Price [AMP]).[ix] As a result, the role of this therapy long term is anticipated to decline sharply in the years to come.

ADVAIR

Trikafta® Spotlight

Trikafta® is a fixed-dose combination medication used to treat cystic fibrosis (CF). The approval of the therapy in 2019 was heralded by the FDA as a breakthrough given that it addressed the most common type of CF (the F508del mutation; estimated to represent 90% of all CF patients).[x]

Cystic fibrosis, a rare, progressive, life-threatening disease, results in the formation of thick mucus that builds up in the lungs, digestive tract, and other parts of the body. It leads to severe respiratory and digestive problems as well as other complications such as infections and diabetes. Cystic fibrosis is caused by a defective protein that results from mutations in the CFTR gene. Trikafta® is a combination of three drugs that target the defective CFTR protein. It helps the protein made by the CFTR gene mutation function more effectively.

$ Per patient annual gross drug costs for Trikafta® often exceed $300,000.

Note that this price likely underestimates the total cost of treating the patient, as they will likely need other medicines and have more significant needs for medical visits (i.e., doctors, clinics, hospitals, etc.).

As a genetic condition, there is little that employers can do prospectively to avoid CF therapy costs. Consequently, solutions for managing Trikafta® often follow the "five rights," namely, the right drug, for the right patient, at the right time, the right dose, and the right route. Ensuring that the employer is well positioned to source this product and manage outcomes is key to the value proposition with this and many other high-cost therapies.

trikafta®

What's Next – A Look Ahead

C2 Solutions member firms' pharmacy claims data demonstrates the member firms' expertise in managing pharmacy expenditures.

While national drug trends demonstrate that from 2021 to 2022 pharmacy expenditures increased approximately 4%, the trend for drug spending was down from 2021 to 2022 for member firms.

However, C2 Solutions faced headwinds in 2023 and beyond primarily due to specialty drug expenditures. While C2 Solutions member firms' utilization of specialty drugs roughly tracks averages (1.1% of utilization vs. anticipated 1.3-1.5% of utilization), expenditures on these therapies trend higher than averages at 50% of total pharmacy benefits (compared to estimated 43-45% nationally).

03

Innovative Solutions to Navigating Prescription Complexity

a. Integrated Pharmacy Carve-Ins
b. Carved Out Pharmacy Solutions
c. Other Pharmacy Benefit Solutions
d. Pharmacy Monitoring Algorithm
   - A C2 Solutions Approach

To effectively manage pharmacy complexity within a health plan, a strategic and comprehensive approach is essential. Data access and reporting play a pivotal role in effective oversight and accountability.

It is critically important for plan sponsors to clearly define PBM reporting requirements, specifying the frequency and format of reports, covering key metrics, cost trends, and other pertinent performance indicators within the contracting of pharmacy benefits. Such requirements ease compliance and regulatory adherence. Employers face an increasingly complex landscape for health benefit design. Ensuring that the PBM complies with all applicable state and federal regulations related to pharmacy benefits is a fundamental aspect of regulatory compliance.

The member firms of C2 Solutions take a differentiated approach to evaluating and structuring pharmacy agreements for their clients.

The firms recognize that their clients have many unique needs and circumstances that require solutions tailored to the current state of pharmacy benefits, while also considering the evolving objectives within this dynamic landscape. The objective is to provide clients with comprehensive information on available options in the intricate realm of health benefits, secure contracts most aligned with client goals, and continually monitor benefits for performance relative to both the contract and the broader market.

This approach helps to ensure a nuanced understanding of client requirements and a commitment to delivering results in the ever-changing healthcare environment.

Member firms examine the pharmacy solutions landscape through three primary lenses, each representing the employer's philosophical approach to drug coverage management and structuring. These pathways can be broadly classified as follows:

- Integrated Pharmacy Carve-Ins
- Pharmacy Carve-Outs (Balanced and Aggressive)
- Other Pharmacy Benefit Solutions

Pharmacy solutions landscape

1 Integrated Pharmacy Carve-Ins

2 Pharmacy Carve-Outs (Balanced and Aggressive)

3 Other Pharmacy Benefit Solutions

Integrated Pharmacy Carve-Ins

Integrated Pharmacy Carve-Ins refers to a strategic approach where a health plan or employer integrates pharmacy benefits directly into their overall healthcare coverage.

In this model, the pharmacy benefits are typically managed and administered within the same entity that handles medical benefits. The administration of pharmacy benefits within a medical health plan involves a decision between in-house management or collaboration with a PBM vendor for processing claims. In instances where the employer directly contracts with the medical health plan vendor, a direct relationship with the PBM may not exist. Consequently, these plans might provide less direct insight into pharmacy spending compared to alternative arrangements.

A pharmacy carve-in is typically applied within the fully insured model for health benefits. Under this model, employers pay a premium to the insurer, transferring the risk of total claims to the insurer, potentially mitigating the employer's risk exposure and associated costs related to health benefits.

Pharmacy carve-ins may offer several advantages to employers seeking a more integrated approach to healthcare management.

- Simplified administration, reducing complexity for employers managing both medical and pharmacy benefits under a single entity
- Improved coordination of care
- A more cohesive healthcare experience for members, with a single point of contact for inquiries related to both medical and pharmacy benefits
- Improved cost control benefits through integrated management

Despite the advantages, pharmacy carve-ins present certain disadvantages for employers. One limitation is reduced flexibility in negotiating pharmacy-specific benefit terms, particularly those which might be viewed as best-in-class. Because of the reliance upon the medical insurer, employers may have less direct insight into pharmacy spending. Additionally, employers may face challenges in accessing specialized pharmacy management services, as these may not be as readily available within a pharmacy carve-in structure.

In general, employers have a limited ability in customizing pharmacy benefits. The integrated nature of the benefit can also make oversight of claim expenditures difficult, as details regarding medical and/or pharmacy expenditures may not be differentiated fully within invoices.

The decision to adopt an integrated pharmacy carve-in strategy depends on the specific needs and priorities of employers, who must carefully weigh the advantages and disadvantages within the context of their overall benefit strategy.

Carved Out Pharmacy Solutions

The alternative to integrated pharmacy carve-ins is to carve out pharmacy benefits.

A pharmacy carve-out empowers employers to separate their prescription drug benefits from their major medical carrier.

This approach may provide employers with increased transparency over pharmacy benefits. Additionally, carve-outs give employers greater control over the operations and associated costs of pharmacy benefits relative to carve-in models (where the employer's ability to direct benefit design is more limited).

By collaborating with certain PBMs, employers can gain a greater ability to prioritize access to pharmacy benefit pricing and the ability to assess program performance. For example, payers can prioritize contracting with PBMs that provide them with access during the solicitation of PBM services.

Commonly utilized by self-insured employers (estimates are that greater than 75% of self-insured plans carve out pharmacy benefits), pharmacy carve-outs offer flexibility in plan design, aiding in the reduction of overhead healthcare costs.[xi] The enhanced leverage provided by payers who directly purchase PBM services can create opportunities to gain a deeper understanding of their pharmacy benefits through prioritizing working with PBMs whose service offerings align with the payer's interest and priorities.

Pharmacy carve-outs offer several advantages to employers seeking more control and customization in managing their healthcare benefits.

- Enhanced transparency through direct contracts with PBMs
- Better evaluation of pharmacy benefit program performance, pricing structures, and utilization patterns
- More cost-effective and personalized prescription drug plans
- Direct negotiations with PBMs, potentially leading to better pricing, rebates, and access to specialized pharmacy services
- Better ability to secure enhanced accountability through securing specific audit rights within their contract

Despite the advantages, pharmacy carve-outs come with their own challenges and potential drawbacks.

One notable disadvantage is the potential for increased complexity or fragmentation in benefits administration. Managing pharmacy benefits separately from major medical plans may require additional administrative resources and coordination. There is also the risk of fragmented communication between different benefit components, potentially affecting the overall employee experience. Additionally, carving out pharmacy benefits may limit the ability to negotiate bundled discounts that could be obtained with a more comprehensive benefits package.

One of the growing challenges with carving out pharmacy benefits is the number of potential PBMs to consider. C2 Solutions is aware of more than 80 different PBMs or pharmacy benefits administrators (PBAs) in operation across their markets. However, while they often market themselves in novel ways, C2 Solutions generally categorizes PBMs/PBAs into two broad categories that reflect their overall structure and incentives.

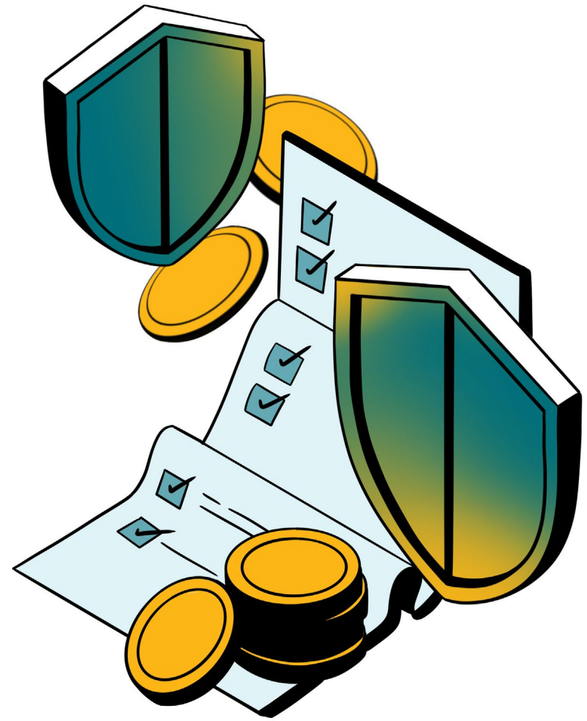
Balanced PBM Contracts

Selecting a Balanced PBM is generally best for clients who seek simplicity and convenience. Balanced PBMs often offer bundled services, providing clients with a comprehensive package that includes various pharmacy benefit management services. For clients who prefer a one-stop-shop approach and value simplicity, a traditional balanced PBM might be appealing.

Aggressive PBM Contracts

Most of the new market entrants have sought to differentiate themselves from traditional balanced PBMs by highlighting their pricing transparency and pass-through nature of drug costs. Balanced PBMs generally make revenue by charging customers different amounts than they pay pharmacies and drug manufacturers. According to Express Scripts, up to 20% of their PBM revenues are generated from pricing differences on pharmacy claims and retained rebates.[xii]

Newer PBMs are capitalizing on this behavior to claim to clients that they can offer more aggressive savings than balanced PBMs while being transparent on their drug costs (i.e., not claiming that drug prices are proprietary) and passing through all costs and revenues as they're generated for their clients (i.e., not making revenue on rebate withholds or network spreads). C2 Solutions has taken to referring to these transparent PBMs also in terms of traditional financial terms and identifies them as Aggressive PBMs.



Other Pharmacy Benefit Solutions

While in general the PBM contract will be the most impactful to a plan sponsor's drug benefit, there are other tools and methods that can also help calibrate a plan's pharmacy program.

Specialty Carve-Out

A specialty pharmacy carve-out in benefit plan design is a targeted strategy aimed at optimizing the management of high-cost and complex "specialty" medications, which historically have been loosely defined and ripe for pricing distortions.[xiii] A specialty carve-out approach involves segregating specialty pharmacy services from the broader pharmacy benefit and creating a dedicated network of specialty pharmacies.

The goal of this carve-out strategy is to improve the overall quality of care for individuals requiring specialty medications while controlling costs and ensuring a targeted and effective approach to their unique healthcare needs.

Copay or Coupon Maximizers

Manufacturer assistance programs are designed to lower patient drug costs as a means to increase utilization of their products. Changes in benefit design seek to capture the value of these manufacturer assistance programs. The most common of these programs are copay accumulators and copay maximizer programs, which may be implemented by sponsors of prescription drug benefits, in coordination with third-party vendors such as PBMs.

A copay accumulator program is a feature within an insurance plan whereby a manufacturer's payments (via patient assistance programs or coupons) do not count toward the patient's deductible and out-of-pocket maximum. The manufacturer assistance funds prescriptions until the maximum value on the program is reached. After that, the patient's out-of-pocket costs begin counting toward their annual deductible and out-of-pocket maximum.

A copay maximizer is another program within an insurance plan whereby a manufacturer's payments do not count toward the patient's deductible and out-of-pocket maximum. However, unlike the accumulator program, the maximum value of the manufacturer's assistance is applied evenly throughout the benefit year. This may change the cost of drug claims throughout the benefit period in order to ensure that the maximum value of potential assistance is captured by the drug plan (i.e., insurance).

Prescription Sourcing (i.e., International)

Efforts to address rising drug costs have led to the exploration of alternate sourcing programs, including those involving international markets. One approach involves exploring the option of importing prescription medications from countries where the same drugs are available at lower prices.

This strategy, also known as parallel importing, seeks to leverage price differentials to make medications more affordable for consumers. However, regulatory challenges can limit the reach of these programs, as can concerns related to drug safety from imported products. Cost-plus pharmacies offer an alternative to international sourcing where drug costs may be lower as pharmacy providers give transparency into true net costs rather than artificially inflated drug prices.

Pharmacy Monitoring Algorithm – A C2 Solutions Approach

Many factors can ultimately influence what benefit approach is best for employers. Because of the complexity, C2 Solutions generally relies on an algorithm to evaluate drugs both from the 'top down' as well as the 'bottom up'.

From a high level, evaluating pharmacy pricing based upon the PBM-preferred AWP-based discounts enables C2 Solutions to effectively monitor drug costs in alignment to the PBM contract and the overall market. Not all drugs have non-AWP pricing benchmarks, and the majority of the market currently pays for and evaluates drug costs along AWP. At a minimum, AWP-based monitoring helps ensure clients are getting the value their contract entitles them to. Evaluating drug spending on an AWP-basis enables C2 to monitor for potential market changes that can generate savings for their clients (such as the introduction of new generics / biosimilars[3]).

However, C2 Solutions also seeks to monitor drug spending relative to the underlying acquisition cost of the drug dispensed.

In this way, C2 monitors for potential spending that is out of alignment with the market, even if that spending may be conforming to the AWP-based discount. When C2 Solutions identifies claims that meet their AWP-based discount but are paid many multiples above the underlying acquisition cost, it can be a signal that alternative pharmacy solutions are needed. To be clear, it is unlikely that any vendor will produce savings significantly beyond contractual defined cost guarantees. This is true of PBMs which generally do not produce savings that significantly deviate from their contracted rates.

As a result, groups that fail to monitor costs from the 'bottom up' may miss costs out of alignment with the overall market. The following is an example of how this approach can work:

Imatinib Mesylate

400 mg Tab (Qty 30) Specialty Drug

PBM INVOICE COST TO PLAN	$3,769
AWP-BASED PRICING GUARANTEE	65%
ACQUISITION COST	$46.81
CONTRACT PERFORMANCE MET	Yes (AWP-based contract)
CONCERN IDENTIFIED	Yes Invoice Cost Greater than 10-fold above acquisition cost

Alternative Sourcing Solutions

MARK CUBAN COST PLUS DRUGS	$35.70
GOODRX	$79.19
BLUEBERRY PHARMACY	$37.32

3 Generics and biosimilars generally have lower AWPs than their brand counterparts, meaning that clients can often save money at the point-of-sale for dispensing these therapies over the brand alternatives.

04

Appendix: A Primer on the U.S. Commercial Pharmacy Market

a. Health Plan Design
b. Prescription Drug Contracting
c. Drug Pricing Benchmarks
d. Pharmacy Claims Data
e. Pharmacy Expertise is Needed to Control Costs

This section is intended for those who want to understand the intricacies of the U.S. pharmacy market from the claim level up. Included within this section are details regarding pharmacy claims transactions and payment as well as drug pricing benchmarks used in commercial contracts. An understanding of the various components that make up pharmacy benefit costs will enable readers to have complex conversations regarding rising prescription drug costs and what can potentially be done to address them.

Health Plan Design

In the U.S., most individuals obtain health insurance through their employer (referred to as commercial or employer sponsored health care). Employer-sponsored health plans encompass a variety of options, designed to provide healthcare coverage to employees. These plans vary in terms of cost, coverage, and flexibility.

Health Maintenance Organization (HMO):

HMOs require employees to choose a primary care physician (PCP) who serves as the gatekeeper for all medical services. Referrals are generally needed to see specialists, and coverage is limited to a network of healthcare providers.

Preferred Provider Organization (PPO):

PPOs offer more flexibility by allowing employees to see any healthcare provider, both in and out of the network. While there's greater freedom to choose specialists without referrals, employees typically pay less if they use in-network providers.

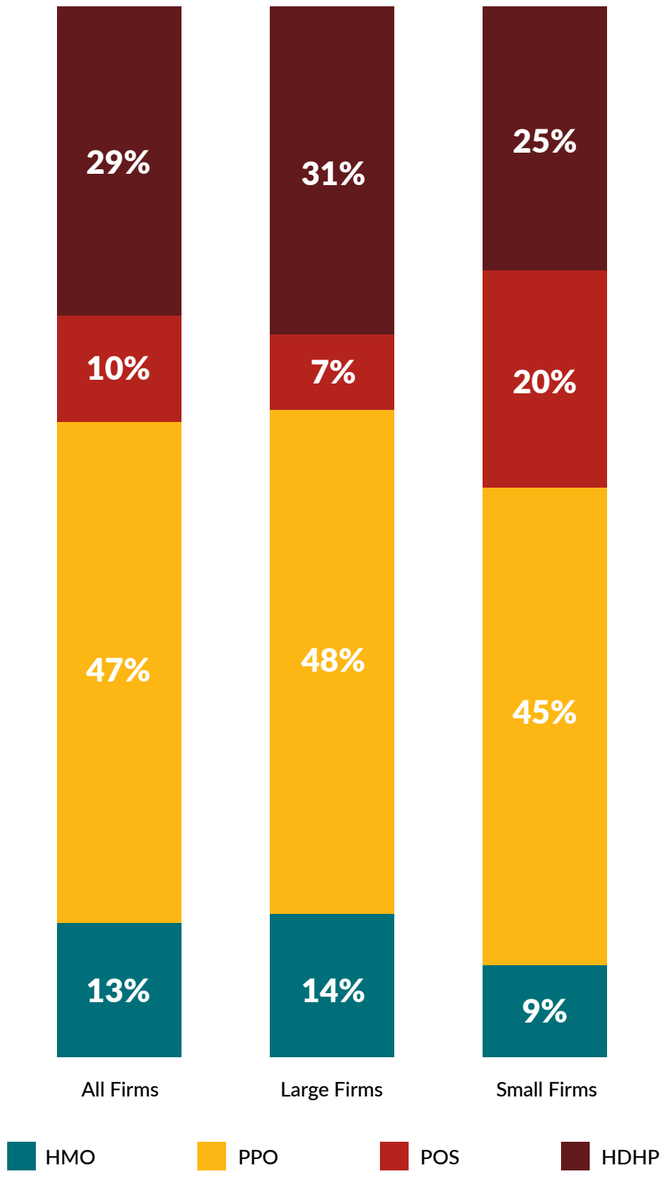
Point of Service (POS):

POS plans similarly blend features of HMOs and PPOs. Employees are generally required to choose a primary care physician and need referrals for specialists, but they have the option to see out-of-network providers, albeit at a higher cost.

High Deductible Health Plan (HDHP):

HDHPs come with higher deductibles but lower premiums. They are often paired with Health Savings Accounts (HSAs), allowing employees to contribute pre-tax dollars to cover medical expenses. These plans are common in conjunction with cost-saving measures.

KFF: Distribution of Health Plan Enrollment



According to research by KFF, the most common offering by employers is a PPO plan design with the least common offering being a POS plan.[xiv] There is variability in offerings by employer size, with small firms (<200 employees) generally being more inclined to offer a POS plan than larger firms (200+ employees). At the same time, larger firms are more likely to utilize high deductibles within their health plans than smaller firms.

Enhancing Savings with Supplemental Benefits

To assist employees with healthcare costs, including prescription drugs, such as plans with high deductibles, employers may include supplemental benefits to help pay for healthcare services. These generally take the form of one of the following programs:

Health Savings Account (HSA):

HSAs are not health plans on their own but are often paired with HDHPs. Employees and/or employers contribute pre-tax funds to an HSA, which can be used to cover qualified medical expenses. Unused funds can be rolled over from year to year.

Flexible Spending Account (FSA):

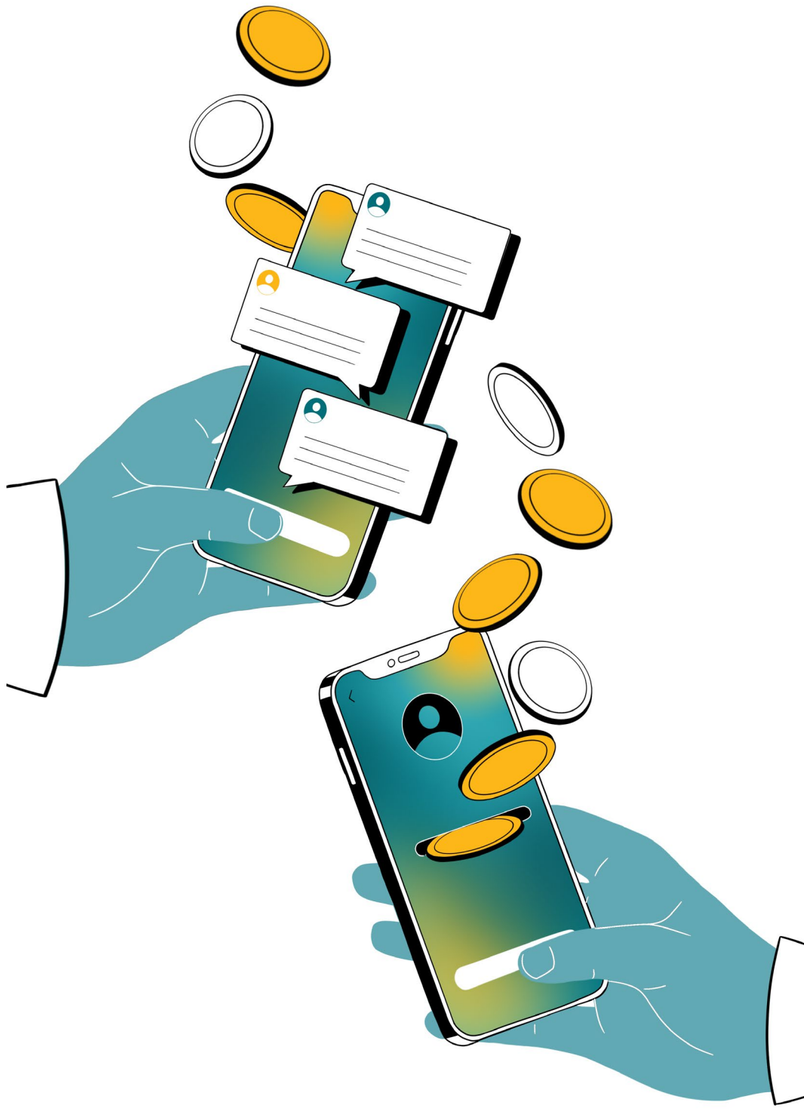
FSAs allow employees to set aside pre-tax dollars to cover eligible medical expenses. Unlike HSAs, funds do not roll over from year to year, and there may be a “use it or lose it” provision.

Employee Assistance Programs (EAPs):

While not health insurance plans, EAPs are employer-sponsored programs that offer counseling and support services to employees dealing with personal or work-related challenges, including mental health issues.

Wellness Programs:

Employers may offer wellness programs that encourage healthy behaviors and provide incentives for employees to maintain or improve their health. These programs can include fitness initiatives, smoking cessation support, and preventive screenings.



The Value of Brokers and Targeted Expertise

As can be seen, U.S. healthcare decisions are complex and involve a great deal of expertise in order to make appropriate decisions that benefit both the employer and their employees. As a result, employers often enlist the services of a healthcare broker, such as the member firms of C2 Solutions. Healthcare brokers can bring valuable expertise and industry knowledge to the table, staying abreast of the latest trends, regulations, and market offerings.

By maintaining relationships with various insurance carriers, brokers can provide employers with access to a diverse range of healthcare plans, facilitating the selection of options tailored to the unique needs of their workforce.

Through skilled negotiation, brokers can secure competitive rates, resulting in potential cost savings for employers relative to the prices of healthcare goods and services in the open market without having to compromise comprehensive coverage for employees.

Employers can also benefit from the time and resource efficiency offered by brokers, who can shoulder some of the administrative burden associated with managing healthcare benefits. Examples include, but are not limited to, helping ensure compliance with complex healthcare regulations, providing employee education, assisting with employee health plan enrollment, and providing ongoing support to monitor plan performance and recommend adjustments as needed. The relationship between an employer and health broker can extend beyond initial plan selection and enrollment, encompassing ongoing support and the potential integration of technology solutions for benefits administration. Further, due to the notorious complexity of the U.S. healthcare system, brokers and consultants can work to bridge the knowledge gap and provide expertise that isn't always as readily available in-house. Ideally, the engagement of healthcare brokers allows employers to focus on core business activities while ensuring the effective and competitive provision of healthcare benefits for their employees.

Prescription Drug Contracting

Prescription drug insurance (i.e., pharmacy benefits) helps individuals and families afford the medications they need to prevent illness and treat disease. It does so by offering financial assistance for the cost of medications, generally as part of a broader package of health insurance benefits. According to surveys, more than 80% of Americans have prescription drug coverage, either through an employer-sponsored health plan, government plan, or shopping the individual marketplace of health plans.[xv]

Under the law, insurance companies and group health plans will provide consumers with a concise document, called the Summary of Benefits and Coverage, that details, in plain language, information about health plan benefits and coverage.[xvi] Because there is no universal form of healthcare in the U.S., health insurance coverage is highly individualized and ultimately directed and determined by contracts.

This approach to healthcare helps explain why the same set of services can be expensive to one individual and more affordable to another – simply put, an individual's insurance coverage entitles them to different levels of financial assistance for those services.

While this overview is true for U.S. healthcare broadly, it is certainly true for prescription drugs. The coverage an individual has for prescription drugs, including the costs they pay, are ultimately determined by contracts. This includes the contract between the patient and their health plan, but also includes the contract between the health plan (generally through their employer) and the pharmacy benefit manager (PBM) and the contract between PBM and pharmacy providers.

Patient to Health Plan Contracts

According to data from the Kaiser Family Foundation, the majority of Americans contract for health insurance (and prescription drug coverage) through their job in what is typically referred to as employer-sponsored healthcare coverage.[xvii] Beyond the wage an employee receives for their job, most jobs also pre-negotiate healthcare coverage that their employees can purchase through their job as a benefit (hence this form of insurance is also referred to as group health insurance). From one employer to the next, each may offer differing levels of financial assistance for healthcare, and the benefit package ultimately offered from employers can offer competitive advantages to employers when competing for labor. At the same time, employer-sponsored healthcare coverage means that the average consumer has little insight into the process of negotiating a healthcare benefit package.

Although there are many ways by which healthcare benefits can be handled (HMOs, PPOs, EPOs, etc.), surveys indicate that most employees have limited options within their employer regarding which plans are available for them to sign up for.[xviii] Furthermore, the high cost of healthcare generally discourages individuals from foregoing health insurance through their employer and just paying cash for healthcare goods and services.

Unsurprisingly, many individuals find the process of selecting coverage confusing and frustrating. It can be difficult to compare plans, particularly when individuals report feeling underqualified to evaluate their plan choices and do not fully understand the terms and conditions of the policy.[xix]

Furthermore, life is unpredictable. The coverage limits selected at the start of the year may not ultimately align with an individual's healthcare needs during the year.

Regardless of how a person obtains coverage, none are going to directly negotiate the rate of prescription drug costs within their health plan. Rather, the health plan will have negotiated payment rates for drugs through contracting with a PBM.

Health Plan to PBM Contracts

When health plans provide drug coverage to their covered enrollees, they typically do so based upon a contract with PBMs. Specifically, health plans engage in a negotiation process to establish agreements that govern the management of prescription drug benefits for their members. The negotiated contract terms outline the responsibilities, and financial arrangements between the health plan and the PBM, with the goal of ensuring efficient and cost-effective access to medications for plan members.

The contract between a health plan and a PBM is generally a voluminous document that discusses provisions such as the list of drugs members will have access to (the formulary), and under what set of circumstances they can obtain that access (e.g., the prior authorization criteria). In addition, the contract will outline requirements for network adequacy, or the idea the members will be generally able to access medications via conveniently located pharmacy providers. This in turn means that the PBM will be responsible for developing and maintaining a network of pharmacies that enrollees can present their drug insurance card at to get the financial benefit of their insurance.

Health plans and PBMs will ultimately agree to the benefit and cost management strategy of the negotiated drug coverage.

This involves determining not only the health plan's cost for prescription medications, but also the member cost-sharing responsibilities such as copayments, coinsurance, and deductibles. Health plans need to understand their drug cost such that they can properly underwrite their insurance policies for sale to their customers (either individuals directly purchasing plans or employer groups) and ensure compliance with regulations that govern insurance offerings (such as compliance with the Medical Loss Ratio [MLR]).

In general, health plan costs for drugs are tied to drug pricing benchmarks of either the dispensing pharmacy or the drug manufacturer. Health Plans and PBMs use these cost benchmarks to ultimately underwrite their insurance policies to ensure sufficient financial reserves exist to service enrollee health claims and support the business.

PBM to Pharmacy Provider Contracts

Before detailing drug pricing benchmarks, we need to briefly discuss how PBMs develop a pharmacy network. In order for prescription drug insurance to be of value, people need to be able to use their prescription drug benefit card in the places where they get their prescriptions filled – namely, pharmacies.

Pharmacy network contracting is a process through which PBMs negotiate agreements with pharmacies to establish which pharmacies will provide prescription medications to their plan members and under what terms. The main objectives of pharmacy network contracting are to ensure convenient access to medications for plan members while at the same time helping to lower drug costs. By establishing a network of pharmacies, insurance companies and PBMs aim to create a network of preferred providers with which they have negotiated pricing arrangements and other terms.

Pharmacy providers can, and do, sell medications to individuals without insurance. In general, the sale of a medication to an individual without insurance is done at the pharmacy's usual & customary (U&C) rate. The U&C rate, properly set, will cover the cost the pharmacy paid to acquire the medication from their wholesaler, the cost of labor to prepare the medication for the individual's prescription, and profit to sustain and grow the business.

In most situations, negotiated rates by PBMs are lower than the pharmacy's U&C rate. This is because in exchange for accepting lower payment, the PBM is able to direct their enrolled members to the pharmacy's business. Recall that eight out of every ten Americans have drug coverage.

To forgo participation in a PBM network is to risk losing out on the overwhelming majority of a pharmacy's potential customer base.

However, pharmacies obviously have concerns about what prices a third-party may choose to reimburse them for their products and services – especially larger PBMs that may represent a significant portion of their covered patient base. As a result, their pharmacy network contract with the PBM generally sets reimbursement terms in relation to prescription drug pricing benchmarks.

Drug pricing benchmarks represent published prices for drugs based upon various attempts to contextualize aspects, including pricing behavior, of the U.S. prescription drug supply chain. Therefore, the pricing benchmark selected plays a key role in determining the finances of both the pharmacy provider, but also the insurer / PBM, which can also impact patient cost-sharing.

Drug Pricing Benchmarks

Many are surprised to learn that despite all the public fervor over the prices of medicines, there is no single price for prescription drugs.

In order to bring a drug to market, a manufacturer will have statutory obligations to establish a multitude of drug prices. Depending on the way the drug is sold, this can include, but is not necessarily limited to, an Average Sales Price (ASP), an Average Manufacturer Price (AMP), a Wholesale Acquisition Cost (WAC), and an Average Wholesale Price (AWP) or Suggested Wholesale Price (SWP).

From there, other drug supply chain participants may have obligations or contribute to other potential drug pricing benchmarks (such as the U&C prices set by pharmacies). All told, there are more than a dozen ways to contextualize drug prices within our drug supply chain. The following provides an overview of the most critical benchmarks to understand when evaluating pharmacy drug expenditures.

Wholesale Acquisition Cost (WAC)

WAC is the list price drug manufacturers make available to drug wholesalers. By definition, this price does not include discounts, rebates, or other reductions when published. Said differently, there are allowable retrospective price concessions that will reduce the net transaction price (the final price paid) paid by the drug wholesaler.

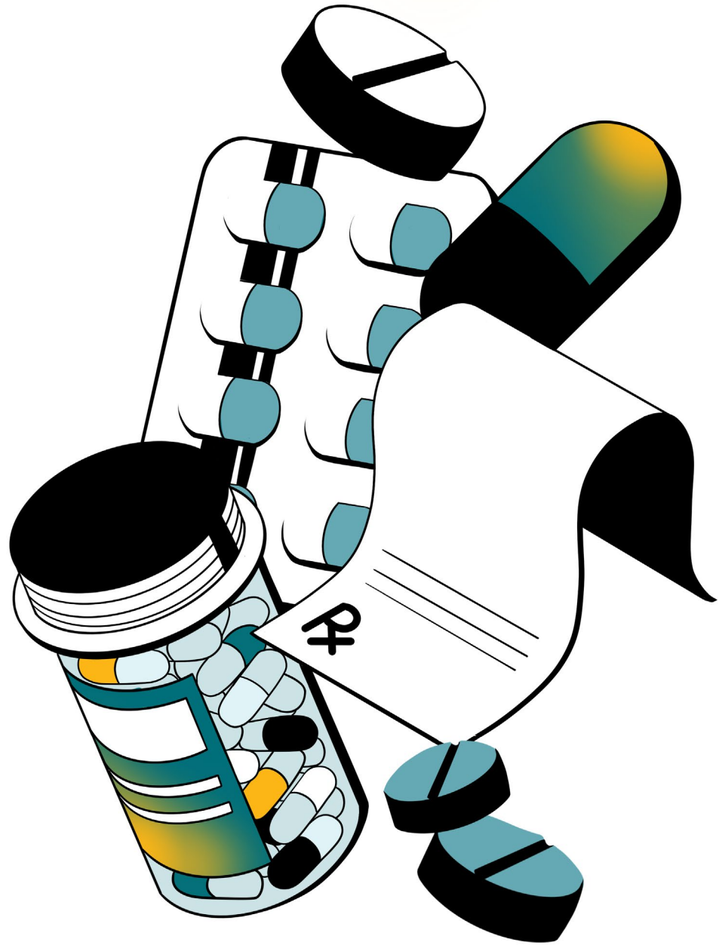


Table of Contents

Average Wholesale Price (AWP)

Prescription drugs also have a “sticker price” that is above the actual cost to acquire, and that enables the supply chain to make money. This “sticker price” is known as AWP, which unlike the prior pricing benchmark of WAC, AWP has no federal statute that can reliably inform us what AWP is supposed to represent. As a result, AWP can be many times greater than any other pricing benchmark. Traditional PBMs attempt to overcome the unreliability of AWP not by abandoning the pricing benchmark, but rather, through discounting the AWP and/or creating upper limits on payments.

Maximum Allowable Cost (MAC)

MAC pricing is a PBM-generated catalog that includes an upper limit for the listed drug products. In general, MAC lists are limited to competitive, multisource drugs (frequently referred to as generic drugs). Note that MAC lists frequently lack a consistent, binding legal definition for how they are to be explicitly determined, nor are they generally published by drug reference sources. A frequent criticism of MAC lists are that they are often not reflective of actual market conditions and therefore do not create incentives for efficient purchases.[xx]

National Average Drug Acquisition Cost (NADAC)

The National Average Drug Acquisition Cost (NADAC) is a newer alternative to paying for medicines. Unlike the previously discussed pricing benchmarks, NADAC is not a manufacturer or PBM-set price, as it is created via a survey of pharmacy invoice acquisition costs for medications. As a result, NADAC represents the average invoice cost a retail pharmacy pays to acquire a drug.

Pharmacy Claims Data

To properly understand and contextualize pharmacy spending data (including those made available to employers when evaluating annual drug spend and PBM performance), we need to know more than the expenditures and drug reference prices – we should also appreciate how pharmacy claims data is generated.

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Internal Revenue Code of 1986 was amended to improve portability and continuity of health insurance coverage in the group and individual markets. As part of the efforts to streamline the exchange of information between healthcare parties, and enable them to more efficiently carry out financial or administrative activities related to healthcare, the U.S. Secretary of Health and Human Services (HHS) was required to develop certain standards for the electronic exchange of healthcare data. Healthcare data that ultimately became standardized through this legislation included payment transactions and remittance advice.[xxi]

Similarly, HIPAA-covered entities, such health plans and healthcare providers, who conduct any of the aforementioned transactions electronically were required to use the adopted standards. Ultimately the standards that were developed, adopted, and are in place today are overseen and administered by either the Accredited Standards Committee (ASC X12N) or the National Council of Prescription Drug Programs (NCPDP). For our purposes, we will focus on those standards applicable to pharmacy claim transactions.

Pharmacy Claim Transaction

The pharmacy billing pathway in most community pharmacies can be broken into the following steps:

1. Receiving the prescription, gathering patient data, and entering data into the computer system
2. Transmitting the pharmacy claim to the insurer/pharmacy benefit manager
3. Third-party payor adjudication of the pharmacy claim
4. Dispensing of medication to patient and collecting any patient copayment (Point-of-Sale)
5. Payment processing from insurer/pharmacy benefit manager

When an individual with prescription drug insurance brings a prescription to be filled at a pharmacy today, in order for the claim to be billed to the individual's prescription drug plan, the pharmacy must transact the claim according to the currently mandated pharmacy transaction standards.

After the claim transacts between the pharmacy and PBM, the pharmacy will receive a reimbursement payment for the drugs dispensed, and the PBM's client will receive a bill for those claims; each pharmacy and PBM client is reimbursed and billed according to their individual contracts. These contracts can vary across pharmacy types, pharmacy chains, and by PBM client.

Ingredient Cost

The ingredient cost paid component of the claim payment is intended to represent the cost the pharmacy incurs to acquire a drug from a drug wholesaler or manufacturer. The typical PBM contract with a pharmacy reimburses a pharmacy claim at the lesser of the pharmacy's submitted cost for service or a discount of some percent to a drug pricing benchmark, such as Average Wholesale Price (AWP), Wholesale Acquisition Cost (WAC), or a Maximum Allowable Cost (MAC).

It is important to know that PBMs usually do not make their pharmacy pricing structure available in the public domain (and at times may not offer all the details of it to their clients) and may not offer the same terms to all pharmacies within their networks.

Dispensing Fees

If the goal of the ingredient cost is to provide reimbursement sufficient to cover the cost pharmacy providers incur to acquire medications, a dispensing fee compensates the pharmacy for the work associated with transferring the drug from the pharmacy to the patient, including the overhead costs necessary to do so, such as payroll costs, time necessary to perform drug utilization review (DUR), prescription department cost (i.e., prescription containers, insurance, licenses, technology fees, and transaction fees), facility costs (i.e., rent, utilities, maintenance), and technology fees (i.e., software, electronic submission charges).[xxii]

Recent research from the National Association of Chain Drug Stores (NACDS) estimates the average retail pharmacy cost to dispense at roughly $12.40 (for non-specialty drugs).[xxiii] Most states have an obligation to identify the average cost to dispense a prescription through the government-run program of Medicaid.

As a result, we know that the average dispensing cost is between $9 and $12 per prescription.

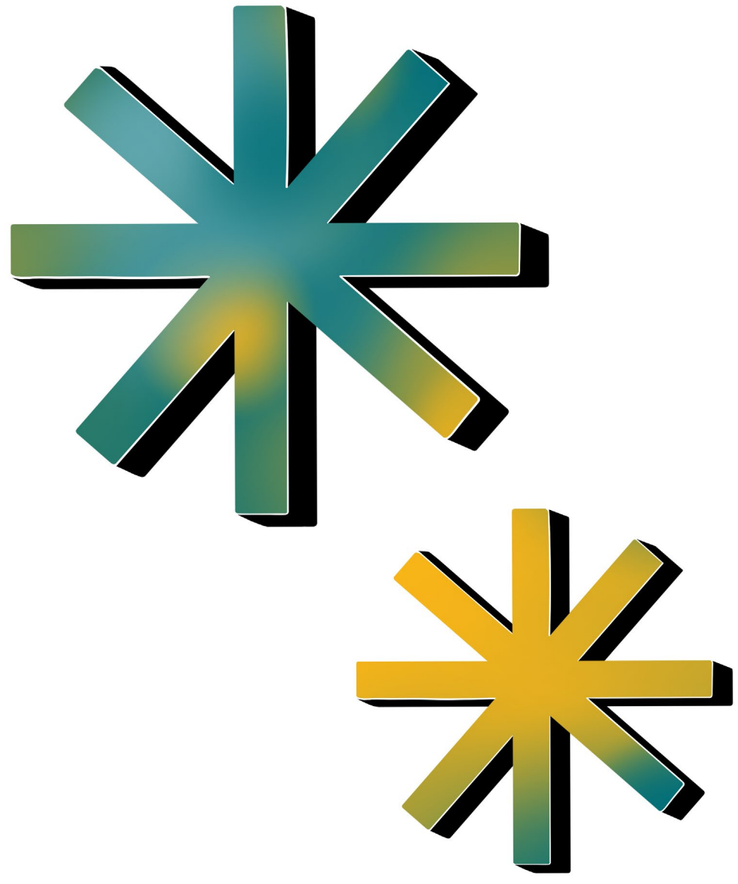
Dispensing fees are calculated based upon surveys of the average cost a pharmacy incurs to dispense a medication and must be reevaluated whenever state Medicaid programs propose to make changes to either pharmacy ingredient cost reimbursement or dispensing fees.[xxiv]

Basis of Retail Costs

To demonstrate the value of understanding claim adjudication, one of the key fields within pharmacy claims is known as the Basis of Cost Determination. This field is defined within the NCPDP standard (Field # 490-UE) and represents why the point-of-sale drug price was what it was.

Pharmacy Expertise is Needed to Control Costs

The disparate nature of drug prices, even when the basis of reimbursement is the same, highlights that the entity best positioned to improve pharmacy spending for employers and patients is the PBM. At the same time, the variability suggests a strong need for pharmacy expertise in evaluating drug costs, and robust oversight of the PBM to ensure that pricing is reasonable, fair, and aligned to market conditions.



[i] https://www.kff.org/health-costs/poll-finding/public-opinion-on-prescription-drugs-and-their-prices/

[ii] https://www.warren.senate.gov/newsroom/press-releases/warren-braun-urge-department-of-health-and-human-services-hhs-inspector-general-to-determine-if-vertically-integrated-health-care-companies-are-hiking-prescription-drug-costs-evading-federal-regulations

[iii] https://www.ftc.gov/news-events/news/press-releases/2022/06/ftc-launches-inquiry-prescription-drug-middlemen-industry

[iv] https://www.healthcaredive.com/news/employers-pharmacy-spend-mental-health-business-group-on-health/691427/#:~:text=According%20to%20the%20survey%2C%20employers,2021%20to%2024%25%20in%202022.

[v] https://www.statista.com/statistics/258010/top-branded-drugs-based-on-retail-sales-in-the-us/

[vi] https://www.usatoday.com/story/news/health/2024/01/03/insulin-price-cap-diabetes/72093250007/

[vii] https://www.beckershospitalreview.com/pharmacy/north-carolina-state-health-plan-drops-weight-loss-drug-coverage-to-incur-54-million-rebate-loss.html#:~:text=With%20the%20state%20board's%20decision,increase%20%2454%20million%20in%202024.

[viii] https://pubmed.ncbi.nlm.nih.gov/31162945/

[ix] https://www.reuters.com/business/healthcare-pharmaceuticals/gsk-cut-us-prices-advair-valtrex-lamictal-2023-12-22/

[x] https://www.fda.gov/news-events/press-announcements/fda-approves-new-breakthrough-therapy-cystic-fibrosis

[xi] https://www.milliman.com/-/media/milliman/pdfs/articles/best-practices-pharmacy-benefits-carve-in-carve-out.ashx

[xii] https://www.modernhealthcare.com/finance/cigna-earnings-express-scripts-pbm-legislation-david-cordani#:~:text=Cigna's%20Express%20Scripts%20subsidiary%20is,during%20a%20call%20with%20investors.

[xiii] https://www.46brooklyn.com/research/2023/5/10/how-pbms-distort-and-undermine-specialty-drug-pricing-guarantees-blac

[xiv] https://www.kff.org/report-section/ehbs-2023-summary-of-findings/

[xv] https://health.gov/healthypeople/objectives-and-data/browse-objectives/health-care-access-and-quality/increase-proportion-people-prescription-drug-insurance-ahs-03/data

[xvi] https://www.healthcare.gov/health-care-law-protections/summary-of-benefits-and-coverage/#:~:text=You%20have%20the%20right%20to,health%20coverage%20and%20medical%20care

[xvii] https://www.kff.org/health-costs/state-indicator/total-retail-rx-drugs/?dataView=1&currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[xviii] https://www.kff.org/report-section/ehbs-2022-section-4-types-of-plans-offered/

[xix] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9860376/

[xx] https://www.frierlevitt.com/wp-content/uploads/2021/04/FL_Maximum-Allowable-Cost-MAC-Law-News_Spring-2021.pdf

[xxi] Health Insurance Portability and Accountability Act of 1996. The Assistant Secretary for Planning and Evaluation (ASPE). (n.d.). https://aspe.hhs.gov/reports/health-insurance-portability-accountability-act-1996.

[xxii] Causey LL. (2009). Nuts and Bolts of Pharmacy Reimbursement: Why it Should Matter to You. Retrieved from https://www.law.uh.edu/healthlaw/perspectives/2009/(LC)%20Pharmacy.pdf

[xxiii] https://www.nacds.org/pdfs/pharmacy/2020/NACDS-NASP-NCPA-COD-Report-01-31-2020-Final.pdf

[xxiv] CFR § 447.518

Strengthen Your Industry Presence

As a collective benefits organization, C2 fosters direct, open collaboration with each of its member firms. We host cross-training opportunities, encourage peer-group sharing at the leadership level and offer open access to vital industry tools.

CONNER STRONG & BUCKELEW

Joe DiBella
Executive Partner
National Employee Benefits Leader
P 856-552-4618 C 732-794-3627
jdibella@connerstrong.com
connerstrong.com

Kristine Klepper
Executive Partner
Chief Operations Officer
Employee Benefits Practice
P 856-552-4680 C 732-208-3116
kklepper@connerstrong.com
connerstrong.com

THE PARTNERS GROUP

Gary Alton
Senior Vice President
National Accounts
P 503-726-5722
galton@tpgrp.com
thepartnersgroup.com

McGohan Brabender

Dr. Jeff Eichholz
McGohan Brabender
Vice President of Pharmacy Solutions
P 937-637-8608 C 314-607-9751
mcgohanbrabender.com

Sterling Seacrest Pritchard

Garry Hill
Partner
C 404-849-3334
ghill@sspins.com
sspins.com

HOLMES MURPHY

Holmes Murphy
holmesmurphy.com

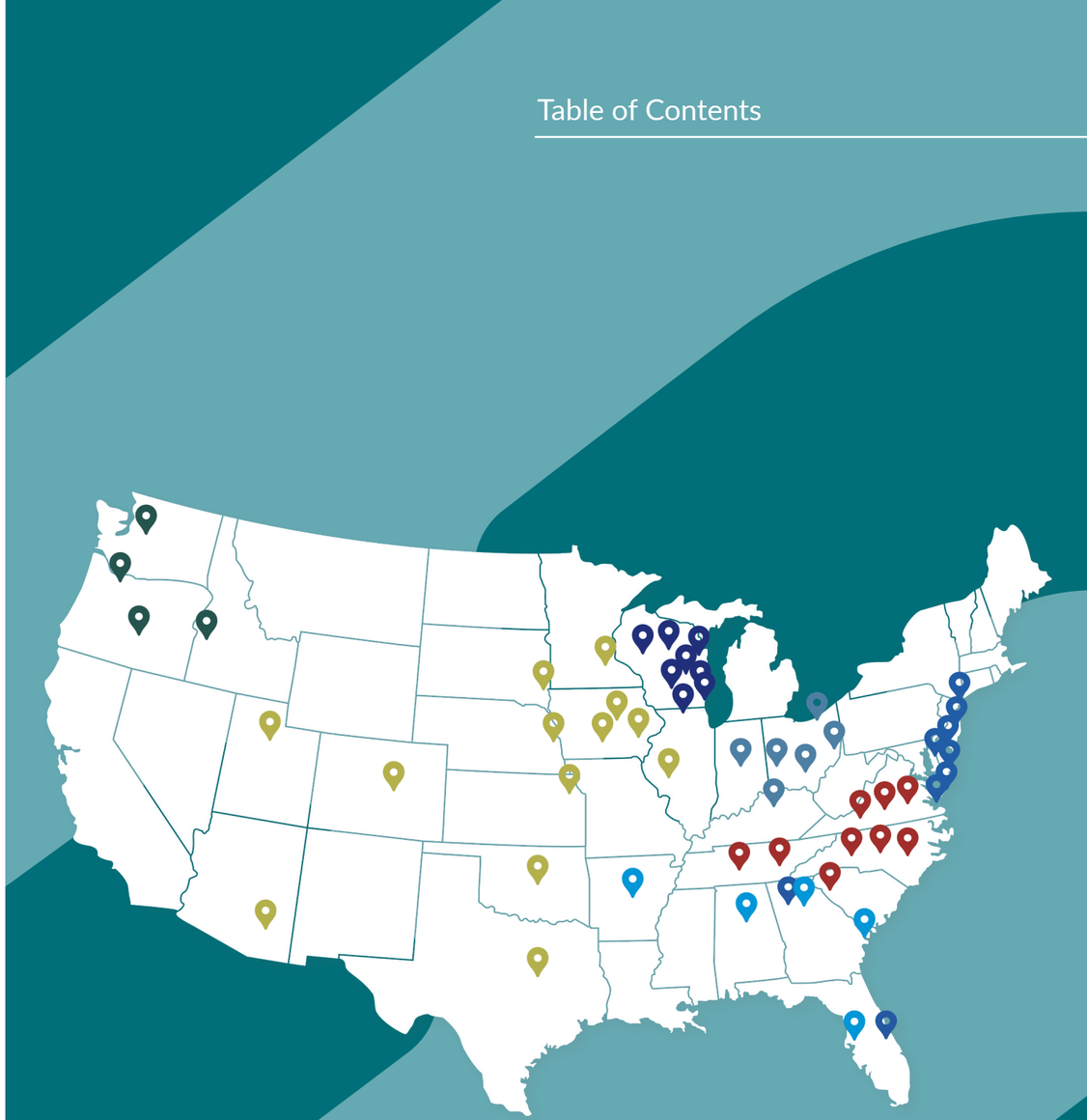
M3 INSURANCE

Connie Perry, PharmD
Managing Director, Pharmacy Solutions
P 414-567-6160
connie.perry@m3ins.com
m3ins.com

SCOTT

Scott Insurance
Contact your Scott Insurance contact.
scottins.com

C2 solutions



C2 solutions

C2 is an equity-owned partnership focused on collaborative solutions in the rapidly-evolving landscape of employee benefits.

Poweredbyc2.com