MARSH & McLENNAN AGENCY

Volume 2, Issue 3

Rx Newsletter

In This Issue

Rx trion
Prescription Drug Coalition
Marsh & McLennan Agency, LLC Company

Market Trends

With More High Cost Therapies Hitting the Market Is Pooling the Answer?

Should Plan Sponsors consider dipping their foot in the high risk pool?

By now, every Plan Sponsor knows about the drug Zolgensma and its $2.1-million-dollar price tag, but most plan sponsors are unsure how their plans could afford to pay that cost. Those concerns grow significantly when we consider the emerging gene therapy pipeline. According to the FoCUS Drug Development Research Team at MIT (January 2019) we should anticipate 40 to 60 gene therapies launched by the year 2030. While stop loss can cap or limit the Plan Sponsors' exposure long term, the likelihood of lasers being deployed to protect the overall book of business from significant rate action increases.

Several solutions being discussed at this stage are: gene therapy carve outs, government intervention via high risk pools or leveraged purchasing, shifting patients to Medicare like we do for end stage renal disease, or stop loss or reinsurance specific to these therapies. The challenge with any such pooling is how to set the premium or rate to sustain the risk, while maintaining overall affordability. While more details and evaluation are needed on these conceptual solutions, interest from Plan Sponsors is high, as shown by the results of the NBGH 2020 Large Employers' Health Care Strategy and Plan Design Survey where 46% of employers are willing to consider government involvement in managing high cost drugs.

Should Plan Sponsors Carve Out Gene Therapy?

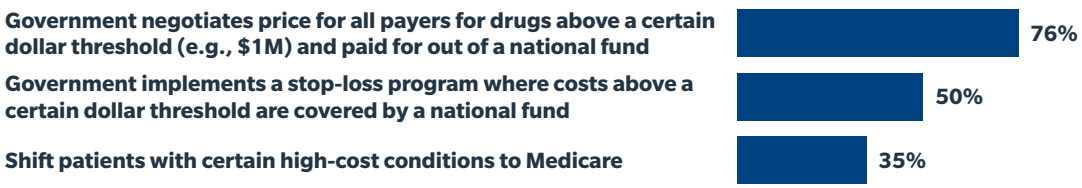
Express Scripts (ESI) recently announced their Embarc Benefit Protection℠ program, administered by EviCore. The program targets Luxterna and Zolgensma and will be available to not just ESI or Cigna customers, but to other payers and PBMs to leverage, with the goal of pooling as many members in this capitated program as possible. ESI is anticipating costs of $1 PEPM, but the final cost will be dictated by the size of the market pool.

ESI has advised that this will be the first of three generation solutions they are looking to bring to the market. The second generation will look to target gene therapies for conditions like hemophilia and sickle cell anemia. Valoctocogene Roxaparvovec, the gene therapy for Hemophilia, has a targeted launch in 2020 and forecasted US sales of $658M by 2024. LentiGlobin (Zynteglo), used to treat beta-thalassemia and sickle cell anemia is expected to launch sometime in 2020-2021, with a staggering $847M in expected US sales forecasted by 2024. The third generation will look to cover all high cost drugs within this type of large risk pooled arrangement and will be very much dependent on the ability to offer this solution at a cost perpetually lower than the market, while remaining adequately funded.

While we wait for more details on how the Embarc program will work, specifically for Luxturna and Zolgensma, we do want to make sure to point out two items. First, while being promoted as having no member cost share, that is only true for the cost of the drug. Member cost share would still apply to claims related to administration of the drug, as well as, services rendered due to complications, etc. Second, while we understand the intent to limit the potential for high out-of-pocket costs for members on these drugs, we do need to note that as of the announcement, ESI was unaware of how, and if, this could be allowed under high deductible plan rules, which per IRS regulations, require the member to satisfy the deductible prior to no cost share applying to non-preventive care.

Innovations like gene therapies are delivering life changing and sometimes lifesaving therapies. Now we just need the market to catch up from a financing perspective.

Large Employers' Views of Government Intervention with High-Cost Drug Therapies, 2019



Employers would consider a role for the government in the financing of high-cost drug therapies

Chart source: National Business Group on Health 2020 Large Employers' Health Care Strategy and Plan Design Survey.

Pharmacy 101

What is a "Biosimilar"?

A biosimilar is a biological product that is very similar to a reference biologic (often called an "innovator drug") and for which there are no clinically meaningful differences in terms of safety, purity, and potency. Biosimilar drugs are often confused with generic drugs, as both are marketed as cheaper versions of costly name-brand drugs, available when drug companies' exclusive patents on expensive new drugs expire, and are designed to have the same clinical effect as their pricier counterparts.[1] However, biosimilar drugs and generic drugs are very different — mainly because while generic drugs are identical to the original in chemical composition, biosimilar drugs are only "highly similar," but close enough in duplication, to accomplish the same therapeutic and clinical result.[1] Another key difference is that generics are copies of synthetic drugs, while biosimilars are modeled after drugs that use living organisms as important ingredients.[1]

What Does This Mean for the High Cost of Specialty Drugs?

Like generics, many experts hope that eventually biosimilars will dramatically lower the cost of biologic drugs. In 2010, Congress passed the Biologics Price Competition and Innovation Act, which established an abbreviated regulatory process for biosimilars and paved the way for their approval.[1] For a biosimilar drug to receive US Food and Drug Administration (FDA) approval, it must be highly similar to the original biological drug and contain no clinically meaningful differences, although there may be minor differences in clinically inactive ingredients.[1] Generic drugs are chemically identical to the original branded drug and, as such, cost significantly less because they do not require much testing. Because biosimilars are made from living organisms and do not contain identical ingredients to their name-brand counterparts, they require some additional testing. As a result, although biosimilars cost more than generics (which are usually 40-50% less than the brand product), they are still typically about 15-20% less than the branded biologic.

Since the first US biosimilar was approved in 2015, the number of approved biosimilars has increased steadily year-over-year.[2] In fact, in 2018, the FDA approved seven biosimilar medications, compared to five the year before.[2] As of August 2019, the FDA approved 17 biosimilars, with at least 10 more currently under review, of which any, or all, could be approved before the end of 2019. None are "first-time" biosimilars, but if launched, they will increase competition with their corresponding branded products.[2] Of those already approved, highly anticipated for 2019-2020 are the launches of Ogivri and Truxima, the first biosimilars for cancer drugs Herceptin and Rituxan, which consistently rank in the top 10 drugs by spend.[2] Also anticipated is the potential launch of Erelzi, a biosimilar for Enbrel. Although biosimilars to Avastin and Humira have been approved by the FDA, their launches are likely to be delayed until 2020 and 2023, respectively, due to ongoing litigation and/or settlement agreements.[2]

Challenges Ahead

Of the 17 biosimilars that have been approved by the FDA, just 7 have been launched primarily due to delays from ongoing patent litigation or agreements to defer market entry as a result of settling a patent dispute. Arguably, the most notable case involves adalimumab (Humira), the top-selling drug in the world.[3] AbbVie, adalimumab's manufacturer, sued the manufacturers of adalimumab biosimilars, including Amgen, Pfizer and Sandoz, among others, for patent infringement, with settlements having been reached in all but one case.[3] These settlements entail a licensing deal in which the biosimilar manufacturers delay entry and pay AbbVie a royalty after they do reach the market.[3] As a consequence of these settlements, the first biosimilars for adalimumab are anticipated to enter the US market in January 2023, despite having been approved as early as September 2016. Originator manufacturers have also deployed formulary exclusivity tactics to limit patient availability, resulting in lower overall patient awareness of biosimilar availability. Consequently, many patients, and even prescribers, are apprehensive to use or prescribe the biosimilar over the biologic.

Sources

1. Cancer Treatment Center of America (CTCA) 2018. "What's the difference? Biosimilar and generic drugs," available at https://www.cancercenter.com/community/blog/2018/12/whats-the-difference-biosimilar-and-generic-drugs, accessed September 16, 2019.
2. Express Scripts, Inc. (ESI) 2019. "Biosimilars in the US: More Approvals But Not Access," available at https://lab.express-scripts.com/lab/insights/drug-options/biosimilars-in-the-us-more-approvals-but-not-access, accessed September 16, 2019.
3. American Medical Association (AMA) Journal of Ethics 2019. "Why Are Biosimilars Not Living up to Their Promise in the US?" available at https://journalofethics.ama-assn.org/article/why-are-biosimilars-not-living-their-promise-us/2019-08, accessed September 16, 2019.

Disease Spotlight

Opioid and Alcohol Dependence

Opioid and alcohol dependence are chronic and relapsing brain diseases that require ongoing care and treatment. Many people first use opioids when they are prescribed them following an injury or routine procedure/surgery. Commonly prescribed medications include Codeine, Fentanyl, Hydrocodone, Morphine, or Oxycodone.

For a variety of reasons, some people misuse opioids. Once this misuse begins, many people seek to obtain these prescription medications from a variety of sources, including additional prescriptions from doctors and/or the medicine cabinets of family and friends. Once these sources are exhausted, people often switch to heroin since it is cheaper and easier to acquire.

A person who is addicted develops an overpowering urge, or craving, for the drug, developing a dependence on opioids and/or alcohol. Addiction affects the parts of the brain associated with motivation, decision making, risk and reward assessment, and impulse control. Most people who are addicted to opioids cannot taper off the use of these drugs without help. When people become dependent on opioids, they feel sick when there are no opioids left in their system. This sickness is known as withdrawal. The combination of intense cravings and symptoms of withdrawal can make recovery difficult.

By helping to reduce cravings and, with some medications, the effects of withdrawal, medicated-assisted treatment (MAT) can help a person focus solely on recovery. In addition to tailoring medications to address cravings and the symptoms of withdrawal, a comprehensive treatment approach also includes counseling to address behavioral issues.

Medication-assisted Treatment (MAT)

MAT uses anti-craving medicine such as naltrexone (Vivitrol), buprenorphine (Suboxone), or methadone — along with comprehensive therapy and support — to help address issues related to opioid dependence, including withdrawal, cravings, and relapse prevention. Evidenced-based treatment approaches like this are often needed to successfully overcome addiction and maintain long-term recovery.

Naltrexone

Naltrexone is an office-based non-addictive opioid antagonist that blocks the effects of other narcotics. Naltrexone is a medication approved by the Food and Drug Administration (FDA) to treat opioid use disorders and alcohol use disorders. It comes in a pill form or as an injectable. The pill form of naltrexone (ReVia, Depade) can be taken at 50 mg once per day. The injectable extended-release form of the drug (Vivitrol) is administered at 380 mg intramuscular once a month. Vivitrol is also the only drug indicated for the prevention of relapse. Naltrexone can be prescribed by any health care provider who is licensed to prescribe medications, special training is not required. To reduce the risk of precipitated withdrawal, patients are warned to abstain from illegal opioids and opioid medication for a minimum of 7-10 days before starting naltrexone. If switching from methadone to naltrexone, the patient has to be completely withdrawn from the opioids.

Naltrexone for Opioid Use Disorders

Research has shown that naltrexone decreases reactivity to drug-conditioned cues and decreases craving. Extended-release naltrexone should be part of a comprehensive management program that includes psychosocial support.

Naltrexone for Alcohol Dependence

When used as a treatment for alcohol dependency, naltrexone blocks the euphoric effects and feelings of intoxication. This allows people with alcohol addiction to reduce their drinking behaviors enough to remain motivated to stay in treatment and avoid relapses. Naltrexone is not addictive, nor does it react adversely with alcohol.

Medication-Assisted Treatments (MAT) for Opioid Dependence

Treatment Option	Agonist Therapy (Methadone)	Partial Agonist Therapy (Suboxone)	Antagonist Therapy (Vivitrol)
Administration	Daily oral concentration	Daily sublingual film, sublingual tablet, buccal film, or 6-month subdermal implant	Daily oral medication or monthly intramuscular injection
Setting	Provided at certified opioid treatment program settings	Sublingual film, sublingual tablet, or buccal film can be initially provided in a physician's office as a take home medication. 6-month subdermal implant requires administration by a health care professional	Daily oral medication can be provided as take home medication. Monthly injection requires injection by a health care professional
DEA schedule	Schedule II controlled substance	Schedule III controlled substance	Not Scheduled
Requires detox	No	No	Yes
Requires counselling	Yes	Yes	Yes

Disease Spotlight

Buprenorphine

Buprenorphine is an office-based opioid agonist/antagonist that blocks other narcotics while reducing withdrawal risk. Buprenorphine is used in medication-assisted treatment (MAT) to help people reduce or quit their use of heroin or other opiates, such as pain relievers like morphine.

Unlike methadone treatment, which must be performed in a highly structured clinic, buprenorphine is permitted to be prescribed or dispensed in physician offices, significantly increasing treatment access. Under the Drug Addiction Treatment Act of 2000 (DATA 2000), qualified US physicians can offer buprenorphine for opioid dependency in various settings, including in an office, community hospital, health department, or correctional facility.

The FDA has approved the following buprenorphine products:

- Bunavail (buprenorphine and naloxone) buccal film
- Cassipa (buprenorphine and naloxone) sublingual film
- Probuphine (buprenorphine) implant for subdermal administration
- Sublocade (buprenorphine extended-release) subcutaneous injection
- Suboxone (buprenorphine and naloxone) sublingual film for sublingual or buccal use, or sublingual tablet
- Subutex (buprenorphine) sublingual tablet
- Zubsolv (buprenorphine and naloxone) sublingual tablets
- Buprenorphine-containing transmucosal products for opioid dependency

Methadone

Methadone is a clinic-based opioid agonist that does not block other narcotics while preventing withdrawal while taking it. There are two FDA approved methadone products; Dolophine tablets and Methadose oral concentrate. Patients taking methadone to treat opioid addiction must receive the medication under the supervision of a physician. After a period of stability (based on progress and proven, consistent compliance with the medication dosage), patients may be allowed to take methadone at home between program visits. By law, methadone can only be dispensed through an opioid treatment program (OTP) certified by the SAMHSA.

The length of time in methadone treatment varies from person to person. According to the National Institute on Drug Abuse publication, Principles of Drug Addiction Treatment: A Research-Based Guide – 2012, the length of methadone treatment should be a minimum of 12 months. Some patients may require treatment for years. Even if a patient feels that they are ready to stop methadone treatment, it must be stopped gradually to prevent withdrawal. Such a decision should be supervised by a doctor.

Naloxone

In addition to the MATs discussed previously, Naloxone is a medication that rapidly reverses the effects of opioid overdose and is the standard treatment for overdose. The FDA approved Narcan nasal spray, a life-saving medication that can temporarily stop or reverse the effects of an opioid or heroin overdose. This prescription product is approved for use in adults and children, and can be easily administered by first responders, family members, or caregivers. Naloxone is not used in the treatment of substance abuse addiction, but rather as an emergency treatment to reverse the effect of an opioid overdose.

MAT Cost Considerations

The cost of different medications used in MAT varies, and needs to be taken into account when considering treatment options. The Affordable Care Act now requires most insurers to cover addiction treatment benefits. In addition, The Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 requires health insurers and group health plans to provide the same level of benefits for behavioral health services that they do for primary care. However, not all insurance plans cover every available addiction treatment medication. And some plans cap the number of dosages and prescription refills a MAT patient receives. These limitations also factor into how people pay for MAT.

It should be noted that only medication options that can be prescribed by a physician and filled at a retail pharmacy are likely to be covered by an employer's Prescription Drug plan. Methadone can only be administered in a certified treatment center and would be covered under an employer's medical plan. Vivitrol (monthly intramuscular injection) is also typically covered under an employer's medical plan, although in some instances it is covered under the Specialty pharmacy benefit under the Prescription Drug plan.

More must be done to facilitate treatment options and the development of therapies to address Opioid Use Disorder as a chronic disease with long-lasting effects. This means helping more people secure medicated-assisted treatment, which requires breaking the stigma often associated with some of the medications used to treat Opioid Use Disorder. It also requires us to find new and more effective ways to advance the use of medical therapy for the treatment of Opioid Use Disorder.

CLINICAL SPOTLIGHT

Is Your Plan Ready for the Coming Year?

Whether your prescription drug plan is running well, or actual costs are exceeding projections, it's important to review the overall program on a regular basis to determine areas of need and identify potential solutions. Plan sponsors need to understand utilization patterns, particularly when high cost therapies are prevalent. It's equally important to identify potential programs that could be implemented to help manage utilization and influence the use of the most cost effective medications.

Hit the "Easy Targets"

Review basic plan design features to make sure your plan has appropriate copays, coinsurance, and quantity/days' supply limits. Consider whether or not the member cost share is driving the desired generic and mail-order utilization. This doesn't always mean increasing copays. It could mean reducing member cost share for generic drugs, or even for preferred brand-name drugs, to help drive utilization to low-cost generics and to the brand-name drugs that maximize rebates. It could also mean offering some drugs for free, particularly those for chronic conditions such as diabetes, hypertension, and hyperlipidemia, in an effort to maximize medication adherence by removing any potential cost barriers. While prescription drug plan sponsor costs may increase under these value-based programs, the cost avoidance savings achieved by the plan itself should be significant. For example, the adherent diabetic will not incur significant hospitalization and or outpatient costs.

Look for "Hidden Opportunities"

Look for ways to control cost without sacrificing the member experience.

The two are not always mutually exclusive.

Determine if a narrow network is available through your carrier or Pharmacy Benefit Manager (PBM) that allows members greater flexibility and savings when filling maintenance drugs, while also achieving more favorable costs for the plan. A narrow network is typically made up of one or two of the large retail pharmacy chains and is required to be used by members filling maintenance drugs as an alternative to the mail-order pharmacy. Often, the potential savings for a narrow network approach can far outweigh the member disruption associated with requiring members to fill their prescriptions for maintenance medications at certain pharmacy chains, or through mail.

Consider sharing rebates with your members. Most PBMs are making rebates available at the point-of-sale, meaning patients that have a deductible and coinsurance would pay a lower cost, since the rebate would be factored into the cost of the drug when the member gets it, rather than when the rebate is actually shared with the plan, often several months after the drug has been dispensed. While this approach is beneficial to members in plans with deductibles and whose cost share is based on coinsurance rather than a flat copay, it will add some cost to the plan, since rebates will be shared with the member, rather than issued solely to the plan.

Check with your PBM to see if they have a program that promotes using manufacturers' assistance or drug coupons. Drug manufacturers widely distribute coupons used to offset the member's cost share for high cost brand-name drugs. Historically, members would present these coupons at the point of sale and their cost would be offset, but the plan would still pay the resulting net cost and wouldn't get credit for the coupon. There are now programs available that identify patients taking high cost drugs that are eligible for manufacturers coupons and help patients secure the coupons, ultimately reducing their cost share and the cost to the plan. Additionally, there are ways to further protect the plan by only allowing the true member cost share to accumulate toward the member's deductible and out-of-pocket maximum, excluding the value of any manufacturers coupons from these accumulators. This is a strategy to follow closely, as recent regulations initially indicated that this practice would only be permissible for drugs with a generic alternative, but later, the Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury jointly issued an FAQ that at least delayed this requirement. Further guidance is expected, likely in the spring of 2020.

Know What Your PBM Offers

Work with your PBM to identify what clinical programs you can implement that can help control utilization and cost, and evaluate whether or not they make sense for your plan and members. When considering clinical programs, it's important to weigh both the estimated cost savings and the impact to members to avoid sacrificing member satisfaction for cost savings. It's not too late to consider programs now, even if your plan is a calendar year plan. While deductibles, copays and coinsurance are usually determined on a plan year cycle, clinical programs can be implemented any time, even if off of your calendar year or open enrollment cycle.

Pipeline

Pending Drug Approvals

Drug Name	Manufacturer	Indication/Use	Expected FDA Decision Date
semaglutide	Novo Nordisk	Type 2 diabetes (T2DM)	9/20/2019
Descovy®	Gilead	HIV-1 infection pre-exposure prophylaxis (PrEP) to	10/4/2019
Eylea®	Regeneron	Wet AMD	October 2019
Zilretta®	Flexion	Osteoarthritis of the knee	10/17/2019
Baxdela®	Clearside	CABP	10/24/2019
naloxone	Adamis	Substance use disorder	10/31/2019
Brolucizumab	Novartis	Wet age-related macular degeneration (AMD)	November 2019
Lasmiditan	Eli Lilly	Acute treatment of migraine in adults	11/14/2019
RVT-802 (postnatal thymus tissue transplant)	Enzyvant	Pediatric congenital athymia	Nov-Dec 2019
luspatercept	Acceleron	Beta-thalassemia	12/4/2019
Cabotegravir + Rilpivirine	Viiv	HIV-1 infection	12/27/ 2019

Brands Losing Patent

While these drugs are nearing the end of their patent term, the release of generics may be delayed due to litigation or exclusivities.

Brand Name	Generic Name	Indication/Use	Date Generic Available
CYSTARAN	Cysteamine hydrochloride	cystinosis	10/2/2019
LUMASON	sulfur hexafluoride lipid-type a microspheres	Ultrasound contrast agent	10/10/2019
SYNRIBO	omacetaxine mepesuccinate	chronic or accelerated phase CML	10/26/2019
IONSYS	fentanyl hydrochloride	acute postoperative pain	11/2/2019
SIMBRINZA	brimonidine tartrate	open-angle glaucoma or ocular hypertension	12/7/2019
DUREZOL	difluprednate	inflammation and pain associated with ocular surgery	12/13/2019

For more information about Rx and other solutions from Trion, visit www.Trion.com, or contact your local representative.

Theresa Stenger
+1 610-684-3323
theresa.stenger@trion-mma.com

Lynn Moakley
+1 484 844 5114
lynn.moakley@trion-mma.com

Contributors
Adrianne Berger
Jenna Berger
Ellen Butcher
Lynn Moakley
Theresa Stenger
Jillian Turner