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PHARMACEUTICAL CONSULTANTS, INC.

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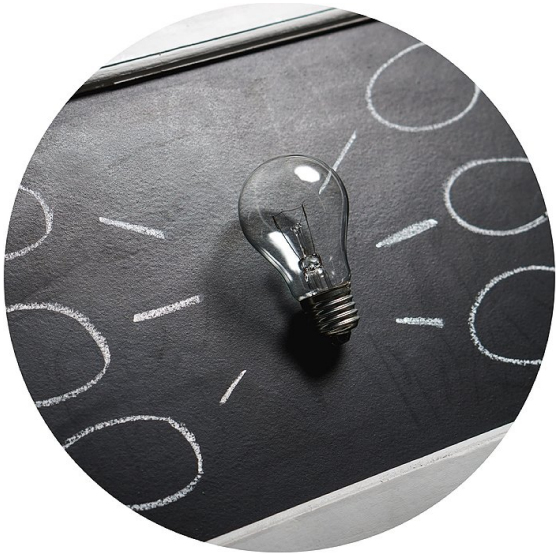

01 | COMMENTARY: IS AMAZON THE DISRUPTOR?

A significant amount of news has been attributed to the actions of Amazon in entering the health care space. This is warranted as cloud-based solutions and significant improvements in distribution and access flow from Amazon's market presence and history as a disruptor of bricks and mortar business models.

However, the question is whether Amazon is unique or if it is the most public of the movers to focus on access, efficient purchasing, and targeting purchaser desires.

Much of the news has focused on Amazon's entrance into the pharmaceutical marketspace. Historically, Amazon has had no presence in pharmaceutical distribution or pharmacy business. The recent news about wholesale licenses in twenty-seven states or so, and the purchase of PillPack indicate that the barriers to entry are low for a company with Amazon's financials. However, we should be aware that Walmart, Costco and other deep discounters are already in the pharmaceutical space with distribution networks and both prescription and over-the-counter pharmacy outlets. Walmart has purchased Jet.com to expand its cloud-based offerings and developed international networks with Cornershop in Mexico/Chile, and Snapdeal in India. Costco has increased its online business in competition with Amazon. Target is selling products through Shipt and has CVS presence in its 1672 stores, so CVS online sales promotions benefit Target as well. Online pharmacies continue to thrive. In Europe Aldi and Lidl are deep

discounters selling grocery items on the cloud, but not yet with a pharmaceutical presence. All these entities are including self-care as a growing option alongside prescription pharmaceuticals.

Hence, Amazon may deservedly be the face of disruption of the pharmacy business, but they are not alone. The focus on customer wants, needs and desires has moved into groceries, pharmaceuticals, electronics, clothes, etc. The disruption is not cloud versus bricks-and-mortar, it is attention to customers and the changing needs of younger shoppers versus older adults. The disruption is predicated on making price, distribution and selection more efficient and seamless.

The bottom-line is watch the entire deep discount space march to change the entire purchase decision. Pharmaceuticals are only one element of this movement. The risk is foreign products with poor quality control, or cheap products with poor good manufacturing procedure oversight, that can kill the perception of product, company, and the value of the distribution solution. The speed of information dissemination is so fast today, that good solutions can become history in moments when trust is questioned.

Analytics At Work | Pre-Certification of Specialty Medications

Problem: One of our clients was concerned about comparing the medical versus the pharmacy specialty spend. Their primary concerns were the location of service and applicable costs, as well as the overall gross trend of their per-member-per-month (PMPM) trends. Separately, the clinical group within the organization wanted to know if their clinical cost control methods were effective on a total Plan as well as on a per provider basis.

Methodology: We analyzed every specialty medication claim from both medical and pharmacy data for this client each month. All findings were filtered by location of service, PMPM, provider specialty, disease/condition, provider, etc.

The analyses reported overall performance and compliance with a series of outliers – e.g., unmatched diagnoses, medications without applicable genomic testing, dosage within labeled min/max ranges, quantities within expected usage, pricing vs. lowest cost, pricing in compliance with contracts, rebates, value of wastage, etc. For the clinical group, all claims were analyzed for prior authorizations (PAs) for formulary exclusions, efficiency of prior authorizations and step therapy, adherence by drug and by category, etc.

Outcome: Financial savings for our client were identified on average of 42-44% of paid amounts. Clinical analyses identified beginning compliance of 50% and cost control methods, including PAs at 60% efficiency. After the implementation of the new process, the compliance increased above 80% and clinical cost control efficiency was above 70%.

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02 | COMMENTARY: MEDICARE FOR ALL (M4A) – THE MATH ARGUMENT

The recent involvement in Congress over whether to save or kill the Affordable Care Act, i.e., Obamacare, has led to some arguing for universal care. Senator Bernie Sanders is certainly the standard bearer for universal care, but he is supported by 16 other Senators.

Senator Bernie Sanders is certainly the standard bearer for universal care, but he is supported by 16 other Senators. Aside from everyone's personal political beliefs, it is important that everyone put their cards on the table, so to speak, so that all sides understand each other's argument. While we do have a position on this matter, it is even more important that we understand the facts and estimates so that reasoned decisions can be made. Objectively, here is the math argument for universal care.

Milliman actuaries indicate that the average American family of four will cost $30,000 for employer-based healthcare. The family will pay $12,378 of the total through premiums, copays and deductions. The employee will lose some income presumably, since the employer cannot raise wages adequately while also paying for healthcare. The current proposals for M4A include a 4% income tax increase. For example, a family making $75,000 per annum would pay an additional $2,000 in taxes after standard deductions. The argument is that this $2,000 in taxes would save $5,674 of the $7,674 in premiums (average premium to insurer). This $2,000 in taxes would also save an additional average of $4,704 in out-of-pocket costs. Estimated savings for the family of four total $10,378. The M4A proponents indicate that the savings include average costs of expensive care that are hopefully not required every year.

The employer argument for M4A starts with the average $16,000 that employers currently pay for healthcare for the family of four above. (The actual difference from above is $17,622, which presumably does not include discounts.) The

proponents of M4A argue that the $16,000 is replaced with a proposed premium of 7.5% of salary leading to an actual employer spend of $5,625.

The pharmacy spend is estimated to reach $360 billion in 2018. The current overall inflation rate for pharmaceuticals is 6%. The estimate, then, of the 10-year cost will exceed $4 trillion. The proponents of M4A argue that US drug prices are about three times higher than in Great Britain, so there is room for the US to negotiate reductions in drug spend.

The Public Policy Project added an argument for M4A by estimating that about 320,00 people will die over a 10-year period if M4A is not passed.

This is not a political column, but it is necessary that we point out several issues with the M4A argument so that everyone argues from a position of facts, not just emotion. The concerns about the M4A argument reside in the assumptions. Concerns include:

1. How do these numbers apply to the individual insurance market?
2. The proponents of each side argue over "invisible taxes" such as average premium paid to private insurers, estimated savings based on current taxes, costs of emergency care, alternative funding sources besides a 7.5% salary tax, etc.
3. Drug cost inflation of 6% does not adequately reflect the growing cost of specialty medications who encompass about 50% of drug spend at an 11% inflation rate that could easily grow to their prior rate of 17% over the next few years as new chronic medications are approved.
4. Estimates of time spent for health care, i.e., doctor's office, pharmacy, etc., are looked at in different ways as either a cost increase, or less time leading to improved worker productivity.
5. M4A proponents argue that their model can save through greater economies of scale, improved claim management, better fraud detection, etc.

Regardless of which side you take, the argument must be placed on the assumptions, of which some samples are listed above. Of greater importance is the argument over healthcare as a right or a privilege. The actual increasing prevalence of obesity and diabetes will drive this to a necessity.

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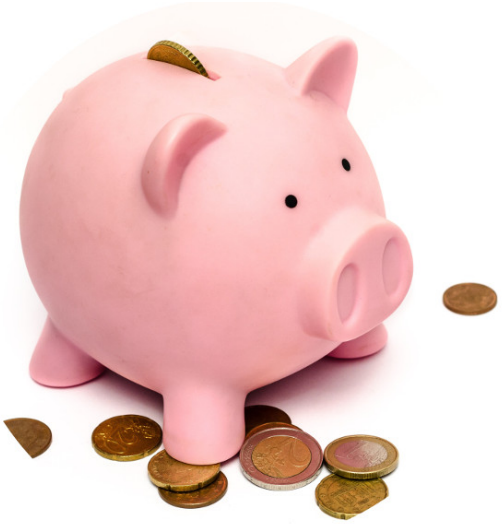

03 | COMMENTARY: DRUG-PRICING CONTROLS TAKE CENTER STAGE

The constant refrain for lower drug cost has led to debates between Health Plans, PBMs, pharmaceutical manufacturers and the public about how to do this. According to the Decision Resources Group as published in Med Ad News (8/18) the top five factors affecting drug pricing are:

1. Shareholder pressures on innovator manufacturers to deliver financial performance, and thus leading to aggressive pricing strategies
2. Economic pressures on the healthcare system focusing on budget impact and sustainability
3. Payer demand for justification of value leading to a favorable trade-off for price
4. Payers interested in testing outcome-based contracts
5. Use of real-world evidence that demonstrates a compelling value of innovation through the product's life cycle

While all factors do not have immediate solutions, there are at least three options that are currently being implemented.

- First, point-of-sale (POS) rebates – This was supposed to be an element of Medicare Part D, but PBMs and Plans indicated that rebates were paid after the fact. The recent furor over DIR (direct and indirect rebates) between pharmacies and PBMs has led pharmacies, Plans and PBMs to offer rebate discounts at POS. This should help with the transparency argument over

drug prices. Examples include UnitedHealthcare and Aetna POS rebates to fully insured clients, CVS/Caremark and Express Scripts offering POS benefit designs to clients, and CMS applying POS rebates to Medicare and Part D.

- Second, copay accumulators – Health Plans have objected to manufacturer coupons paying for copays. Plans have responded with copay accumulator programs that restrict manufacturer coupons to apply to deductibles and out-of-pocket maximums (OOPM). The result is that patients pay more for their drugs, especially expensive specialty medications. Examples include UnitedHealth's Coupon Adjustment: Benefit Plan Protection, and Express Scripts' Out of Pocket Protection Program. The manufacturers have responded with prepaid debit cards to cover patient OOPM expense. Examples include programs from Amgen and AbbVie.
- President Trump's drug-pricing proposal includes prohibition of "gag clauses" and manufacturers publishing drug cost in their advertisements. The gag clause or allowing pharmacies to offer lower cash prices will probably be approved by Congress. The publication of drug prices is finding stiff resistance and has been removed from Congressional consideration.

As we have indicated before drug prices is a process. Each of these solutions can be mitigated by the opposing stakeholders. As a result, there is no magic silver bullet. Time will tell if any, or all, of these solutions has a benefit.

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Pro Pharma provides customized support to Health Plans, Self-Insured Employers, Physician Groups, and Workers' Compensation Companies, among others, both in the private and public sectors.

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