UFCW Unions and Participating Employers Health and Welfare Fund

Managed Pharmacy Report

Board of Trustees Meeting

December 5, 2024

December 5, 2024/Nancy J. Eid, Vice President and Sr. Pharmacy Consultant

Segal

Agenda

- **Q’3 2024 Plan Performance**
- **Status Update: Follow-Up from June Board of Trustees Meeting**
- **GLP-1s**
  - **A Look Ahead at GLP-1 Trends**
  - **Advanced Strategies for Managing GLP-1s**

Q’3 2024 Plan Performance Headlines

The Fund’s Q’3 2024 trend is 13% compared to Q’3 2023.

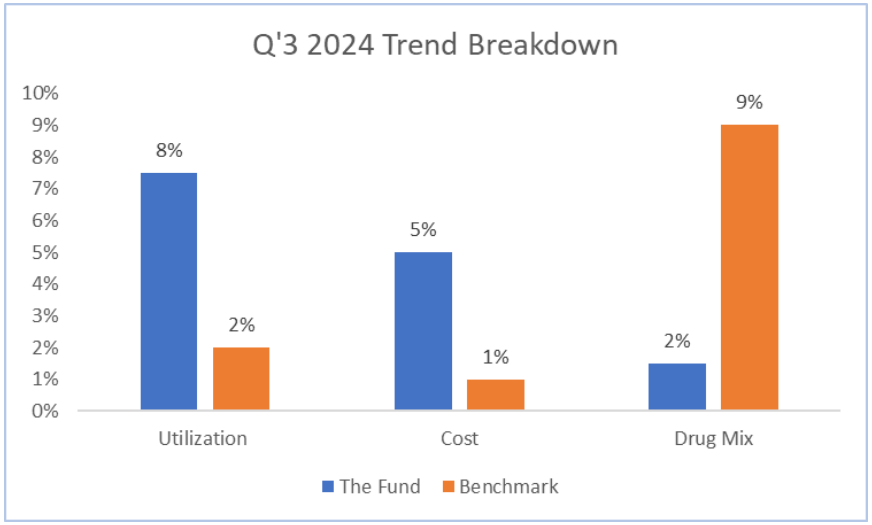
Non-Specialty trend: 30% | Specialty trend: -4%

Negative Specialty Trend is unprecedented for the Fund.

Q’3 2024 Trend Drivers (in descending order)

- Utilization (8%): the rate of change in the total number of days of medication prescribed.
- Cost (5%): the rate of change in the unit cost of the drug, due to inflation.
- Drug Mix (2%): a shift in the types of medication prescribed or used, moving toward more expensive and newer medications.

- The following chart shows the breakdown of the Fund’s Q’3 2024 trends compared to OptumRx Labor Group Benchmarks.

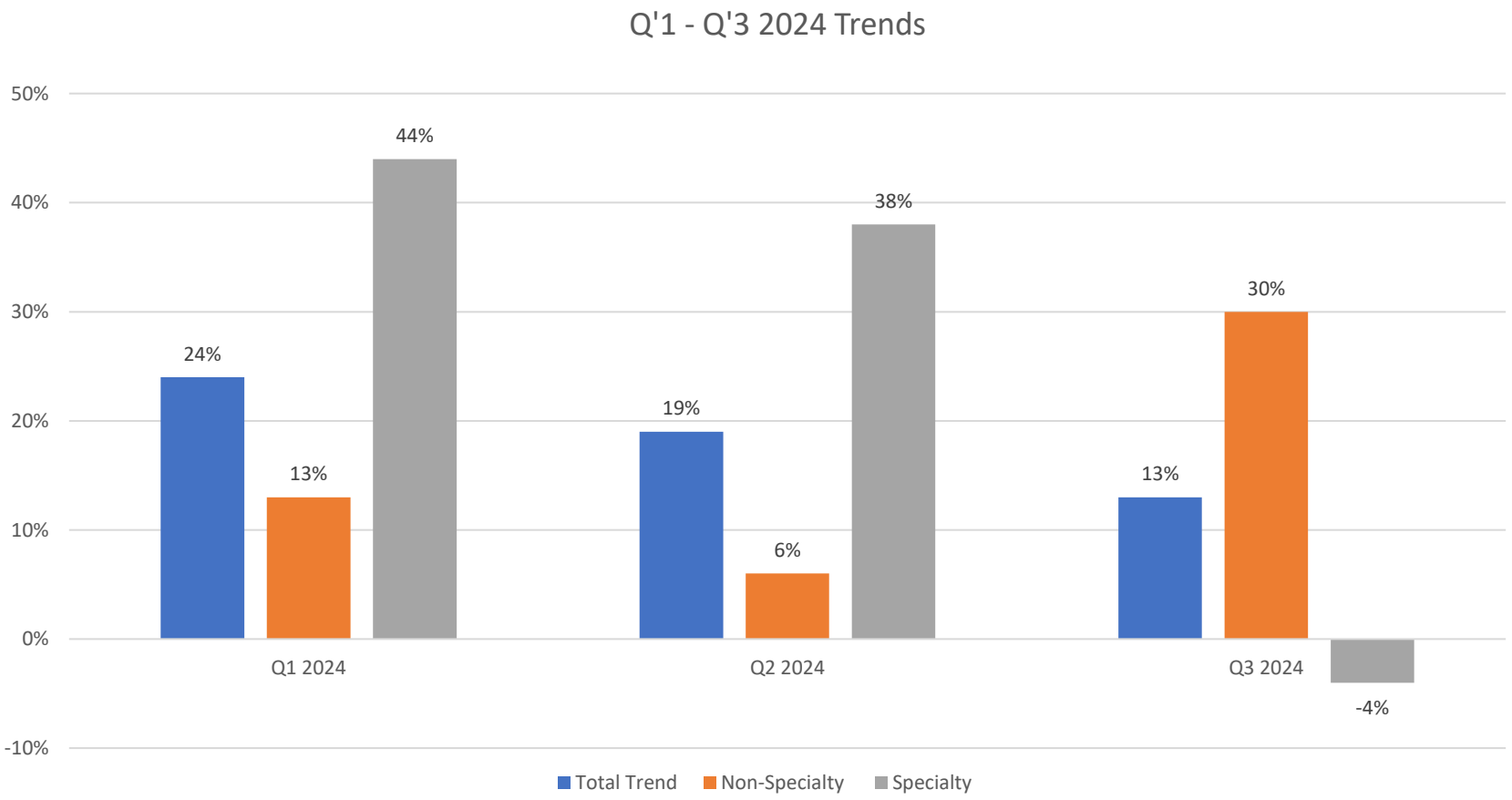


Plan performance data in this report was provided by OptumRx (iQPR July-Sept 2024 vs July-Sept 2023).

2024 Trends
Q'1 – Q'3

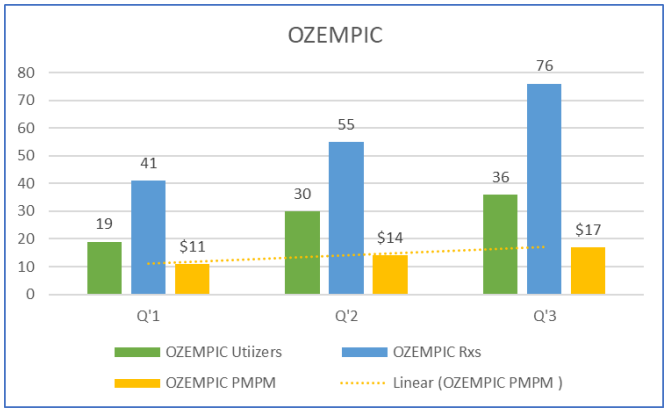
The chart below illustrates the shift in the Fund's non-specialty and specialty drug trends.

- Diabetes is the #1 disease state driving costs, accounting for 25% of total plan paid; Ozempic was the top non-specialty drug.
- The sharp decline in specialty trend for Q'3 2024 is the result of a 17% decrease in utilization compared to the previous period; specialty accounts for 41% of total plan paid, down from 49% in the previous period.

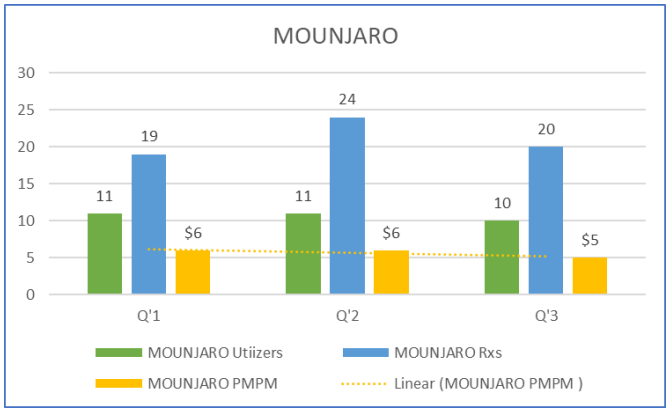


GLP-1 Utilization and Costs Q'1-Q'3 2024

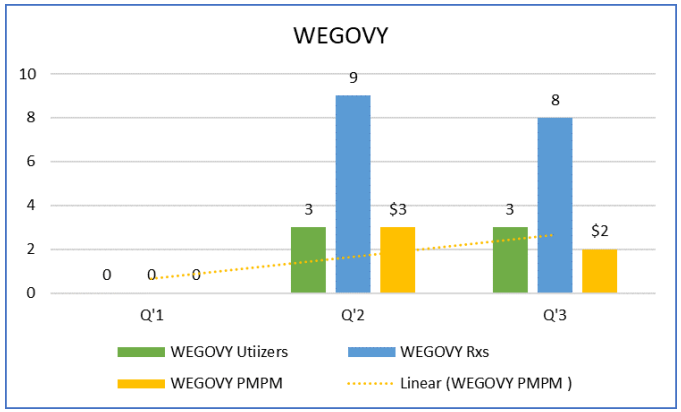
Ozempic is #1 by plan cost PMPM



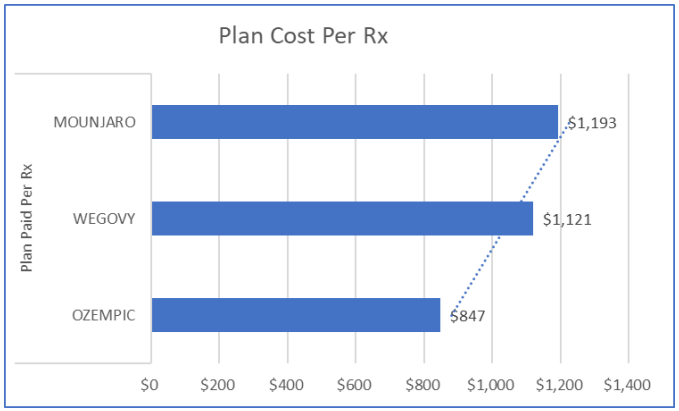
Mounjaro utilization decreased slightly in Q'3 2024



Wegovy utilization is expected to increase in 2025 due to expanded indications preferred formulary status



Mounjaro cost per Rx is 41% higher than Ozempic



Q'3 2024 Key Performance Indicators

Headlines:

- PMPM Trend increased 16%
- Total Plan Cost increased 6%
- Plan Paid per Rx increased 7%
- 50% of plan participants used the prescription drug benefit from Q'3 2023 – Q'3 2024.
- The average number of Rxs per member per month increased 6%
- The Generic Dispensing Rate decreased 3%

			Change		
Description	**Q3 2024**	**Q3 2023**	**%**	**Peer**	**% Change**
Average Members per Month	1,238	1,314	-6%		
Utilizers	609	640	-5%		
Total Plan Cost	$882,832	$829,617	6%		
Total Plan Cost PMPM	$238	$211	13%	$137	13%
Specialty Percent of Plan Cost	41%	49%	-15%	46%	4%
Retail - Maintenance 90 Utilization	41%	40%	2%	17%	3%
GDR	83%	86%	-3%	87%	-3%
Rxs PMPM	0.92	0.87	6%	0.73	2%
Plan Paid per Rx	$258	$242	7%	$188	12%
Member Paid Per Rx	$14	$11	27%	$14	-2%
Member Paid Share	5%	4%	17%	7%	-12%

The estimated rebate offset for the reporting period is $239K, reducing total plan paid to $173 PMPM. Actual results may vary.

Top 20 Drugs by Net PMPM Cost

Notable changes in the Top 20 Drugs by Net PMPM Cost:

- 3 of the 4 GLP-1s moved up in ranking; Ozempic moved from #10 to #2.
- Net Plan Cost for the Top 20 Drugs is $168 PMPM (71% of total PMPM).
- Chronic Inflammatory Disease accounts for $28 PMPM.
- The 2025 formulary includes Humira and Stelara biosimilars on Tier 2 (preferred); OptumRx estimates the list price for Low-WAC[1] versions of these biosimilars will be up to 60% less than the originator drug.

Top 20 Drugs by PMPM Cost									
Rank			Q3 2024						Q3 2023
Current	Previous	Peer Rank	DRUG NAME	THERAPY CLASS	Utlzr	Rxs	Plan Paid Per Rx	Plan Cost Net PMPM	Plan Cost Net PMPM
1	2	294	SOMAVERT	Growth Hormones	1	1	$75,064	$20	$18
2	10	1	OZEMPIC	GLP-1 Agonists	36	76	$847	$17	$7
3	2	317	SIGNIFOR LAR	Endocrine Disorders	1	3	$19,907	$16	$12
4	1	2	HUMIRA PEN	Chronic Inflammatory Disease	3	6	$9,193	$14	$23
5	7	37	LENALIDOMIDE	Oncology	3	2	$17,381	$14	$8
6	5	66	BIKTARVY	HIV	1	1	$8,565	$14	$10
7	6	5	JARDIANCE	SGLT-2 Inhibitors & Combos	30	32	$1,211	$11	$8
8		36	SPRYCEL	Oncology	1	2	$18,173	$10	$0
9	9	210	MAYZENT	Multiple Sclerosis	1	1	$30,251	$8	$7
10	8	32	COSENTYX SENSOR READY PEN	Chronic Inflammatory Disease	1	4	$7,513	$8	$7
11	14	8	ELIQUIS	Oral Anticoagulants	16	24	$889	$6	$4
12	173	3	MOUNJARO	GLP-1 Agonists	10	20	$913	$5	$3
13	15	102	SYMTUZA	HIV	1	4	$4,524	$5	$3
14	16	12	FARXIGA	SGLT-2 Inhibitors & Combos	11	12	$1,203	$4	$3
15	11	4	STELARA	Chronic Inflammatory Disease	1	1	$12,634	$3	$3
16	30	50	DOVATO	HIV	2	3	$4,081	$3	$7
17	23	7	DUPIXENT	Chronic Inflammatory Disease	1	3	$3,789	$3	$1
18	20	109	TOUJEO SOLOSTAR	Insulin	3	4	$2,337	$3	$2
19	13	9	TRULICITY	GLP-1 Agonists	8	11	$819	$2	$5
20	29	10	WEGOVY	GLP-1 Anti-Obesity Agents	3	8	$1,121	$2	$1

[1]Low-WAC biosimilars are generally not rebate eligible.

Status Update: Follow-Up from June 2024 Board of Trustees Meeting

Follow Up
June 2024 Board of Trustees Meeting

AOM Coverage Rules

Updated AOM coverage rules were sent to Fund Chair and Secretary on November 26, 2024, for their review and approval.

Gene Therapy

July 2024: Segal issued a Request for Proposal ('RFP') for Stop Loss Coverage on behalf of the Fund. RFP results were submitted in a report to the Board of Trustees on October 17, 2024.

September 2024: Segal sent a memo to the Board of Trustees with background information on gene therapy, payer strategies, and potential solutions for managing the cost and care of gene therapy. Additionally, Segal provided four (4) summary plan descriptions ('SPD's) used by plan sponsors who cover gene therapy.

October 2024: A meeting between the Board of Trustees, Fund co-counsel, and Segal was scheduled for October 18, 2024, to continue the gene therapy coverage discussion and review the Stop Loss RFP results. The meeting was canceled, providing additional time for review of the RFP Results. A new meeting date will be set as needed or requested by the Board of Trustees.

GLP-1s

A Look Ahead at GLP-1 Trends

- GLP-1s have revolutionized the treatment of obesity, type 2 diabetes, and their comorbidities. There are limited examples from the history of drugs that have generated such an impact.
- JP Morgan Research forecasts:
  - Total GLP-1 users in the U.S. will reach 30mn by 2030 (~9% of overall population).
  - The increased demand for obesity drugs will have myriad implications, boosting sectors such as biotech and creating headwinds for industries such as food and beverage[1].
- Other analysts note the actual future market size will depend on whether GLP-1 drugs are used as long-term treatments.
- Multiple factors will drive these changes, including:
  - The increasing prevalence of obesity in children, adolescents, and adults.
  - The practice of finding new medical uses for existing GLP-1 therapies.
  - New drugs entering the market and current drugs losing exclusivity.
  - Access to easier-to-use oral forms of these medications.
  - Improved side effect profiles.
- Manufacturers are investing millions of dollars into research and development of GLP-1 strategies that will extend their revenue streams and facilitate access to new markets.
- Payer strategies are evolving from utilization management to long term, sustainable care and cost management strategies that are multifaceted and holistic.

[1]JP Morgan Global Research: The increase in appetite for obesity drugs, Nov 29, 2023

A Look Ahead at GLP-1 Trends

The table below summarizes current manufacturer studies for a wide range of new and expanded indications that include Alzheimer's disease, heart failure, chronic kidney disease, and nonalcoholic fatty liver disease.

Six (6) of the 9 studies are currently in Phase III[1] clinical trials.

Drug Name	Manufacturers	Phase	Indication
Efocipegtrutide	Hanmi Pharmaceutical[1]	Phase II	Treatment of non-alcoholic steatohepatitis (NASH).
Efocipegtrutide	Hanmi Pharmaceutical/Merck	Phase II	Treatment of non-alcoholic steatohepatitis (NASH) in adults.
BI 456906[2]	Boehringer Ingelheim/ Zealand Pharma	Phase II	Treatment of non-alcoholic steatohepatitis (NASH) and fibrosis.
Rybelsus	Novo Nordisk	Phase III	Treatment of early Alzheimer's disease.
Ozempic	Novo Nordisk	Phase III	Treatment of non-alcoholic steatohepatitis (NASH).
Zepbound	Eli Lilly	Phase III	Reduction in the risk of major adverse cardiovascular events in obese adults; established cardiovascular disease, or with risk factors for cardiovascular disease.
Mounjaro	Eli Lilly	Phase III	Reduction in risk of major adverse cardiovascular events in adults with type 2 diabetes and established cardiovascular disease.
Ozempic	Novo Nordisk	Phase III	Treatment of peripheral arterial disease in adults with type 2 diabetes.
Rybelsus	Novo Nordisk Pharmaceuticals	Phase III	Reduction of risk of major adverse cardiovascular events in patients with type 2 diabetes and cardiovascular disease.

*Expanded indications for current GLP-1 therapies.

[1] The goal of a Phase III trial is to determine if the new drug or combination of drugs is better than or equivalent to the standard of care. Phase III trials compare the outcomes, and in some cases, the survival rates, of the new drug, with the fewest side effects.
[2] Hanmi Pharmaceutical is a Korean R&D-centric biopharmaceutical company established in 1973 by pharmacist Sung-ki Lim.
[3] BI 456906 is a novel glucagon receptor/GLP-1 receptor dual agonist for the treatment of people with a Body Mass Index (BMI) ≥ 27 kg/m2 as well as for the treatment people living with metabolic dysfunction-associated steatohepatitis (MASH).

GLP-1 Management Strategies for the Fund's Consideration

Segal recommends the Fund consider adopting a muti-pronged strategy for managing GLP-1s as described below.

I. Assess and mange the Fund's Risk. Conduct risk stratification to effectively identify, prioritize, and manage potential risks for plan participants. Results can be used to guide decisions that include choice of care management programs and resource allocation.

II. Preferred GLP-1 Drug Strategies. Collaborate with the PBM to implement an evidence-based approach to selecting 'best value' GLP-1s by therapy class. Selection criteria should include demonstrated efficacy in managing blood sugar and promoting weigh loss, treating comorbidities, dosing frequency, and side effect profiles. Refine the selection as new therapies emerge, including longer-acting GLP-1s that improve efficacy, and market competition brings down prices, setting the stage for outcomes-based contracting.

III. Limit the number of GLP-1 Prescribers. Criteria for selecting prescribers should include accessibility and frequency of med-checks; specialists in relevant areas such as endocrinology, internal medicine, osteopathic medicine, bariatric healthcare, and family practice; and prescribing patterns aligned with the formulary.

IV. Plan Design. Consider changes to plan design that strengthen long-term viability while still providing access to best value therapies. Design options include but are not limited to differential copays for preferred and non-preferred GLP-1s; a custom copay structure for all GLP-1s; a 3-tier plan design with at least a 15-20% copay differential between Tiers 2 and 3. It's assumed any changes to plan designs must be collectively bargained.

V. Prevent medication stockpiling and waste by (i) prohibiting auto-refills for GLP-1s, or (ii) increasing refill too soon thresholds for Retail 30 and Retail 90, or (iii) a combination of both strategies.

At the Fund's request, Segal will submit a proposed Statement of Work that includes timelines and costs for implementing some or all of these strategies.

[1] Differential copays could be used with other high cost, chronic conditions that have multiple therapeutic alternatives.

Thank You