Vertical Integration Heats Up in Drug Industry

Will Medication Price Hikes Cool Down as a Result?

Stephen Barlas

Maybe it is industry anticipation of price-dampening, bottom-line–threatening federal legislation or regulation that has caused a quickening search for new sector combinations. The right partners and purchases might just allow a more flexible and muscular response to what the public views as too many unconscionable drug price increases and lofty introductory charges for new drugs. That is one explanation for the moves around vertical integration—both announced and rumoured—by Anthem, CVS Health, UnitedHealth, Express Scripts, Prime Therapeutics, and Walgreens and lower-visibility moves by those and other companies.

“What you have seen in 2017, probably for the first time, is a closer look at supply chain and PBM [pharmacy benefit manager] dynamics you haven’t seen before,” says Rujul Desai, Vice President of Market Access and Reimbursement Practice at Avalere Health, a national consulting company.

Might this consolidation be the industry responding to President Trump’s repeated denunciation of high drug prices and congressional hearings on the issue? In October, at the second of two hearings held by the Senate Health, Education, Labor, and Pensions (HELP) Committee, top-ranking commit- tee Democrat Senator Patty Murray of Washington said high drug prices are forcing many Americans to choose between food and other necessities or paying for their prescriptions. “This is a challenge we need to meet, and meet it quickly.”

Stories in the media about individuals foregoing needed but expensive medications, particularly specialty drugs, tumble from front pages with increasing alacrity.

Drug Price Reduction Cited by Industry to Explain Integration

Executives at the companies making deal news have been quick to raise the drug price reduction banner. In a conference call with analysts on October 18, 2017, Brian T. Griffin, President of the Anthem Commercial and Specialty Business Division, said, “Our new PBM [IngenioRx] is committed to transforming a complex and ambiguous industry.” Griffin did not explain what was transformative about IngenioRx, but he did say Anthem expects to save $4 billion on drug costs with IngenioRx compared with its current contract with Express Scripts. Of that $4 billion, which apparently includes savings from medical management, not just lower drug costs, 20% will go to shareholders and 80% “will work its way into the help with the affordability of health care of our customer base,” according to John Gallina, Chief Financial Officer of Anthem.

Rather than doing anything revolutionary, it appears Anthem hopes to replicate the vertical integration benefits enjoyed by UnitedHealthcare, whose executive, Gail Boudreaux, it just poached to become its new chief executive officer (CEO). UnitedHealthcare bought the Catamaran PBM in 2015 and combined it with its Optum division, leading to its freestanding OptumRx, which subsumed Catamaran’s BriovaRx specialty pharmacy and created a pharmacy services octopus.

Reducing drug costs also factored into Express Scripts Holding Company’s October 2017 agreement to acquire privately held eviCore Healthcare, which manages medical benefits for 100 million people, particularly in the categories of radiology, cardiology, musculoskeletal disorders, post-acute care, and medical oncology—all areas with a panoply of expensive specialty pharmaceutical solutions. “The rising cost of health care is one of the most important issues facing Americans today,” said Tim Wentworth, President and CEO of Express Scripts.

Not to be outdone in the pell-mell rush to consolidation, in early October, major PBM Prime Therapeutics and Walgreens Pharmacy launched the new AllianceRxWalgreens Prime, a combined central specialty pharmacy and mail services company.

“What has happened over time is that PBMs have moved from a revenue model for themselves to one where they are being acquired by health insurers who, as they become vertically integrated, no longer have to pay for the middleman services they previously paid to PBMs and other assorted ancillary service firms,” Desai says. “The large payer says ‘I will retain all that profit.’” In that context, there has been speculation that Humana, which owns its own small PBM, may be readying an effort to acquire Express Scripts to keep up with UnitedHealthcare and Aetna.

The $69 billion CVS proposes to spend to acquire Aetna would result in the largest combination in health insurance history. One objective is to allow Aetna, which would become a subsidiary, to better control patient costs, especially by using CVS retail sites and personnel to counsel patients just released from the hospital to prevent expensive rehospitalizations, and to provide primary care via MinuteClinics, reducing emergency room visits. CVS gets to reduce its reliance on retail sales and become a force in primary care. The move is viewed by many on “the Street” as a strategic play to bolster the defenses of both companies against a potential move by Amazon into the industry.

Amazon, however, appears to be restricting its initial foray into health care to sales of medical devices, not drugs, based on details from pharmacy licenses it obtained in Tennessee and Indiana, according to the investment firm Jefferies. Asked about Amazon’s interest in health care on its most recent earnings call, Dave Fildes, Amazon’s Director of Investor Relations, said that most of the company’s energy is currently

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focused on its Amazon Business offering to hospitals, labs, and government agencies, as well as interacting with that sector via its cloud services business. But Amazon is cagey. In early December, CNBC reported that Amazon has had discussions with generic drug-makers—Mylan and Sandoz among them—about strategies for entering the industry.³

No one in the pharmaceutical industry is waiting for a clear picture of Amazon’s intentions before making their moves, and that includes wholesalers. In early November, McKesson Corporation signed a definitive agreement to purchase RxCrossroads, a provider of tailored services to pharmaceutical and biotechnology manufacturers, from CVS Health. John Hammergren, Chairman and CEO of McKesson Corporation, pointed out that the investment will, among other things, allow the wholesaler to strengthen its patient assistance programs, which provide drug company customers with discounts on the purchase price of drugs. Drug wholesalers have argued that they are only middlemen and have little to do with drug pricing. However, the “big three” all own pharmacy services administrative organizations, which serve as a sort of group purchasing organization for independent pharmacies.

CVS is also tending to its pharmacies, having announced a new 30,000-store performance-based pharmacy network anchored by CVS Pharmacy and Walgreens, along with as many as 10,000 community-based independently owned pharmacies across the United States. The network is not only designed to deliver unit cost savings, but also to improve clinical outcomes that will lead to lower overall health care costs for CVS Caremark clients and their members. “Steadily increasing drug costs, and the current transition in health care from volume to value, require us to continually develop and implement innovative solutions to help our clients manage pharmacy costs while improving health outcomes,” Jon Roberts, Chief Operating Officer of CVS Health, said in a press release.⁴ A CVS spokeswoman did not respond to a request for details on what “innovative solutions” Roberts was referring to.

Drug manufacturers, too, are searching for ways to get off the public’s firing line over drug prices. Last May, Merck and OptumRx announced they will collaborate to develop and simulate the performance of contractual reimbursement models in which payment for prescription drugs is aligned more closely with patient health outcomes. The companies will explore value-based and pay-for-performance models, known as outcomes-based risk-sharing agreements. “Ensuring that health care dollars are spent on interventions that improve patient care and health outcomes is a shared goal for all stakeholders,” Curt Medeiros, President of Optum Life Sciences, said in a statement. Susan Shiff, Senior Vice President of the Center for Observational and Real-World Evidence at Merck, added, “The collaboration between Merck and Optum will help advance both organizations’ common goals of improving patient health outcomes, expanding access to innovative therapies, and ensuring the best use of health care spending.”⁵

Will Industry Manuevering Affect Drug Prices Positively?

It is unclear whether any of this corporate collaboration will get at some of the significant, underlying problems in the drug pricing space. Just to cite two issues, rebates obtained by PBMs from drug manufacturers for favored placement on formularies obfuscate drug prices, and those rebates are rarely passed along to the ultimate consumer. A favorable alternative to rebates, in terms of consumer relief, would be point-of-sale (POS) discounts—reflecting rebates—at the pharmacy counter.

In fact, announcements like Anthem’s establishment of IngenioRx and Express Scripts’ purchase of eviCore represent nothing radical. Health insurers are simply extending their reach into data analytics, medication therapy management, and other services with their fingers crossed that somehow statements they make about reducing health care costs will come true. There is no guarantee that health insurer/PBM combinations and innovations will result in lower specialty drug costs to employers or Medicaid and Medicare, for either Part D or Part B infusion costs.

In September, the Midwest Business Group on Health (MBGH) released a report⁶ that suggested ways companies (and theoretically the federal government) could reduce drug costs, which, in regard to specialty drug costs specifically, have been increasing faster than medical costs, according to Desai.

“Most pharmacy benefit manager arrangements are complex, making it difficult for employers to identify the true cost of drugs and all the sources of PBM revenue,” Cheryl Larson, MBGH Vice President and primary report author, said in a press release. The middlemen that profit the most from hidden costs in pharmacy benefit contracts are PBMs, according to the MBGH. One of its suggestions for lowering pharmacy costs is for employers to use an independent P&T committee to do an inclusive analysis based on formulary, quality, and cost. Another suggestion is to use a transparent/pass-through PBM or pharmacy benefit administrator model. These contracts disclose all financial flows, including PBM revenue streams, with all rebates and discounts passed onto the employer so true costs (not just price) are known.⁷

“The use of independent P&T committees is beginning to gain a little interest by employers,” Larson notes. “Caterpillar is one that has been doing it for years. They have devised their own drug formulary with internal physicians and pharmacists based on clinical efficacy, not rebates. In addition, a few employer coalitions and jumbo employers are utilizing academic institutions to provide guidance on what drugs should be placed on formulary.”⁸

Jennifer Luddy, a spokeswoman for Express Scripts, acknowledges, “Some of our clients do have their own independent P&T committees and make their own custom formulary decisions. However, many clients see that as a value-added service that we provide.”

Trying to wrestle lower specialty drug prices from PBMs and health insurers is one challenge; convincing drug manufacturers to lower their prices is another. There have been a few value-based drug contracts between health insurers and drug manufacturers. Whether the Merck/Optum collaboration will push the ball forward remains to be seen. Meanwhile, there has been zero progress in either convincing or forcing drug manufacturers to publicly disclose how they came to particular tens of thousands of dollars in cost per year for particular new specialty drugs. Having to be transparent in that regard might incentivize pharmaceutical manufacturers to restrain introductory prices.
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Much Concern in Washington, But Little Action

Some hold out hope that the federal government will revolutionize the drug pricing system. But there is no evidence—despite President Trump’s frequent allusions to drug pricing problems—that is happening. For example, the Centers for Medicare and Medicaid Services (CMS) has not pushed for value-based pharmacy contracts in either Medicare or Medicaid. Pharmaceutical manufacturers and health insurers argue that federal laws stand in the way of these contracts. For example, the Anti-Kickback Statute (AKS) prohibits offering or receiving remuneration (broadly defined) to induce or reward referrals for items or services paid for by federal health care programs. Statutory and regulatory safe harbors protect certain arrangements from AKS liability, but it is unclear how enforcement agencies would apply these safe harbors to value-based arrangements, according to a joint memorandum put out in January 2016 by Eli Lilly and Company and Anthem. They also say that requirements to report prices in federal health programs make it difficult for a manufacturer to enter into a value-based contract.1

Members of Congress have been long on rhetoric, but short on action. Murray was particularly incensed by recent patent extension deals by Allergen, Biogen, and AbbVie, which the companies used to block competition. But there is no legislation in Congress that would have an earth-shattering effect on consumer drug prices. Even smaller-bore bills reining in direct and indirect remuneration fees charged by drug manufacturers to Part D plans, which raise prices, and risk evaluation and mitigation strategies, which limit competition to branded, patented drugs, have been stuck in the mud for years. The House and Senate have held hearings on drug prices that focused on some of the techniques used up and down the distribution chain to set prices, techniques that are obscure to the public and even to politicians who sit through those hearings. At the October 17, 2017, hearings held by the Senate HELP Committee, Chairman Lamar Alexander (R-Tennessee) said he is confused as to how drug prices are set. “Where the money goes with prescription drugs is quite complicated,” he said. “I have yet to figure that out at all.”1

Drug manufacturers have done their own finger pointing. For example, Lori M. Reilly, Executive Vice President of Policy, Research, and Membership for the Pharmaceutical Research and Manufacturers of America, told the Senate committee that prices are being inflated by the $100 billion a year in rebates that manufacturers offer PBMs and health plans, a large percentage of which don’t find their way to consumers. “The PBMs and the health insurers prefer to have high prices and high rebates because the money flows back to them,” Reilly told the Senate committee.3

“Rebates are used to drive market share and in our view are not a benefit to the patient,” added Thomas E. Menighan, Executive Director and Chief Executive Officer of the American Pharmacists Association.1

But Mark Merritt, President and Chief Executive Officer of the Pharmaceutical Care Management Association (PCMA), the PBM industry trade group, pointed his finger at the health insurers. He stated, “Ninety percent of rebates are passed back to the client and 50% of large employers require 100% of the rebates to be passed back. Once the rebates are passed back, the health plan decides what to do with them.”11

The dependence of health insurers on rebates is borne out by a sentence in the 2017 third quarter financial statement from Humana. It says, “If Humana does not continue to earn and retain purchase discounts and volume rebates from pharmaceutical manufacturers at current levels, Humana’s gross margins may decline.”10

But Avalere’s Desai says just talking about rebates is too simple a conversation. “As you look at the supply chain, there are discrete fees, for administration, discounts, price protection, marketing program. They can all be calculated as a percent of the list price. If you tackle one bucket, such as rebates, and leave the others alone, you may not be solving the problem.”

Theoretically, manufacturers, PBMs, and health insurers could ditch rebates and simply pass along any discounts in the form of rebates for formulary placement in the form of discounts the consumer could pick up at the pharmacy counter, where most drugs are purchased. “The problem is that these discounts are not making it back to consumers at the point of sale,” Reilly told the Senate committee.1

There have been some baby steps toward POS discounts. Express Scripts offers a POS benefit design called SmartShareRx. “The company tells me that few clients have chosen to share rebates directly with patients,” Adam Fein wrote on his Drug Channels website. “It doesn’t appear that Express Scripts is actively marketing this solution. My Google search for ‘SmartShareRx’ turned up zero results.”11

If none of the new company combinations in the drug industry will result in consumer discounts at the pharmacy counter, the next best thing may be information about which drugs within a category—ostensibly with similar outcome and adverse effect profiles—will be cheapest at the pharmacy counter given the consumer’s health plan. That is the information UnitedHealthcare will be supplying to a patient’s physician with its new PreCheck MyScript solution offered through its OptumRx PBM in conjunction with Allscripts. The major objectives here, however, may be saving physician time during patient encounters and saving United money. “With PreCheck MyScript, physician practices will spend more time with their patients and less time on administrative tasks,” Sam Ho, MD, Chief Medical Officer for UnitedHealthcare, said in a statement.12

How Strong Are the Incentives for Change?

It is often the case that any industry—pharmaceuticals, steel, finance—doesn’t make revolutionary changes on pricing or anything else unless either the market, in an Adam Smith sense, forces it or the federal government mandates it. Drug companies up and down the pipeline are generally making very healthy profits. No one is going out of business. So the incentive to do something revolutionary on consumer costs is absent. Likewise, neither employers nor Medicare or Medicaid are pushing insurers, PBMs, wholesalers, and ancillary service providers to change their model to benefit consumers. Even a request for information from Medicare in its proposed rule on potential Part D and Part C (Medicare Advantage) changes in 2019 drove the PBM industry to distraction. The PCMA pushed back hard, arguing: “According to CMS, requiring plans to estimate and apply manufacturer rebates at the point of sale would raise premiums by up to $28 billion and taxpayer costs continued on page 39
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by up to $82 billion over the next decade. Such a requirement would also create a windfall for drug-makers, who would pay up to $29 billion less in donut-hole discounts.”13

PBMs argue they are cutting costs for payers, often because of formulary decisions. For example, Express Scripts’ Luddy points out that through its Hepatitis Cure Value Program, the company cut costs for payers for pharmaceuticals by 50% by expanding its formulary from just AbbVie’s Viekira Pak (dasabuvir, ombitasvir, paritaprevir, and ritonavir) to that plus Harvoni (ledipasvir and sofosbuvir, Gilead) and Sovaldi (sofosbuvir, Gilead). If that is true, and Express Scripts has not published statistics legitimizing that claim, one would have to go client-by-client to see what the insurance company or employer did with those savings. Were they pocketed? Did they allow the employer or insurer to reduce copays or deductibles? That seems unlikely given the trends in health insurance for higher deductibles, premiums, and copays. Or were the prices that consumers paid cut at the pharmacy counter?

“It’s not always about cost,” Luddy adds. “Improved outcomes have health and financial benefits for both the patient and their plan.” But a patient who has to spend his or her life savings on pharmaceuticals to be cured of hepatitis C may not be convinced of the value of saving what might have been $100,000 in hospital costs over the next decade.

REFERENCES


