Beyond the PBM: a new order for healthcare delivery

The ongoing migration of healthcare currency, from volume to value, is reshaping the healthcare ecosystem. A recent spate of vertical integration, the arrival of new players and partnerships, and the reinvention of the PBMs, continue to disrupt and transform the healthcare value chain.

What are the threats and opportunities for Pharma, Payers, Providers, and Patients?
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Transformation of the healthcare value chain

Four dynamic macro trends continue to reshape the healthcare commercial model.

1. Pace and speed of scientific innovation
2. Healthcare delivery transformation
3. Healthcare funding evolution
4. Digital and data renaissance

In this report, DRG experts examine how healthcare delivery transformation trends, such as the recent spate of vertical integration, the arrival of new players and partnerships, and the reinvention of pharmacy benefit managers (PBMs), will impact the healthcare ecosystem and its stakeholders.
Beyond the PBM: how will transformation impact your business?

The turn of the year brings even more evidence of rapid transformation and stakeholder role expansion within the modern-day healthcare industry, such as:

• A flurry of vertical integration activity during the first week of December, including the announcement of two major deals – CVS’s $69 billion acquisition of Aetna and Optum’s $4.9 billion purchase of DaVita Medical Group. Also in March 2018, Cigna announced that it is acquiring Express Scripts for $67 billion-signaling a marked acceleration in the evolution of the PBM competitive landscape.

• Several health systems announcing their partnership with the US Department of Veteran Affairs to form a generic drug company to address supply shortages and reduce costs for patients – thereby cutting out intermediaries in the healthcare value chain.

• Amazon, Berkshire Hathaway, and JPMorgan Chase publicizing plans to form an independent not-for-profit health care company for their US employees, a sure signal amidst the many speculations on how Amazon might disrupt the healthcare value chain.

Such changes have been a long time coming. PBMs continue to face pressure from all sides, not least from pharma companies who question their transparency and value, namely whether drug discounts are being passed through the system to enhance patient access and affordability. Meanwhile, payers and providers are looking for services to support the trend towards value-based care.

On the pages that follow, we will discuss the nature of these changes and assess their impact on four key stakeholders (pharma, payers, providers, and patients), offering what we feel are the key opportunities and threats specific to each. We have drawn from the collective expertise of our in-house analysts to paint a knowledgeable picture of these new models. The objective is to create awareness, spark discussion, and to help pharma and other stakeholders prepare for this evolving landscape.

Key business questions this report will help you address:

What’s driving change in the PBM sector? What are the major players doing? And what do these new models look like?

How will the recent spate of vertical integration activity impact the healthcare value chain?

What specific threats and opportunities do these trends present to four key stakeholders: pharma, payers, providers, and patients?

What approaches can pharma take to minimize the threats and maximize the opportunities?
Model behavior: How the ‘big three’ PBMs are stacking up

PBM evolution is a key trend within healthcare delivery transformation with significant implications for system stakeholders.

Consolidation in the PBM sector has resulted in just three companies – Express Scripts (ESI), Optum and Caremark – representing 75% of the market by scripts. In order to protect and further grow their margins, and to fend off potential future plays from the likes of Amazon, the big three are reinventing themselves within vertically integrated conglomerates allowing them to tap into other parts of the healthcare value chain.

They are building out systems, scaling up capabilities, and diversifying service lines. These vertically integrated entities will have a greater focus on total cost of care, and with the pharmacy and medical benefits housed together under one roof, integrated PBMs should be more receptive to engaging in value-based contracts.

The chart below depicts the new state of PBM models in the healthcare market.

The CVS-Aetna merger adds a large insurer to the retail/PBM combination, with a view to improving care coordination and controlling costs by utilizing CVS’ in store clinics as community health hubs and steering patients towards less expensive care options.

Optum is adding value by providing data services and monetizing the data it collects. Already tied to a large insurer, UnitedHealth, the DaVita purchase adds a significant provider component, creating a powerful integrated entity.

The recent mega-merger of Express Scripts and Cigna would mark the end of Express Scripts as the last major stand-alone pharmacy benefit manager. For Express Scripts, a merger with Cigna makes sense. After losing Anthem as its client, it would have trouble surviving independently, and merging with Cigna will provide quick stability. The move suggests Express Scripts continues to expand with further integration - last year, the PBM acquired eviCore to gain control and oversight into the medical benefit for total patient management.

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### Integrated or carve-in PBM emerging model

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| • A better customer experience  
  • Delivering on the promise of connected care | • Fewer players could mean fewer choices, higher prices  
  • More convenience, but at the risk of chaos | |
Implications for: Pharma

The need to drive the value conversation

Under the current model, pharma typically charges prices high enough to sustain rebate concessions to PBMs for product access. The problem for pharma is that these discounts are not being passed along the supply chain, be it to the health plan, the employer, or ultimately the patient, resulting in increased public outcry about drug pricing and patient cost burden. Of course, manufacturers end up paying twice, by also tackling affordability at the patient level. And so margins continue to erode.

While the new vertical models could answer the call for a more transparent pricing landscape – arguably both an opportunity and a challenge – the big threat is surely the greater negotiating power that these integrated entities will be able to wield. Pharma needs to make stronger, more measurable, and increasingly complex value arguments.
Implications for: Pharma

The Opportunities

Value-based contracting
PBMs traditionally have not been receptive to value-based contracting. But the integration of PBM and health plans, with a greater focus on total cost of care and visibility of data, should make integrated PBMs more receptive to engaging in value-based contracts with pharma. That said, PBMs may still need to overcome implementational barriers such as outcomes data-gathering and analysis.

Convergence of pharmacy and medical benefits
Having medical and pharmacy side by side might be a good thing for pharma. If you believe there is leverage in the cost of medicine – that it’s a lot cheaper than ER visits and hospitalizations – having truly connected businesses where you see the medical and pharmacy costs in one place, allows you to assess if you are lowering the total cost of care. This means that PBMs will be able to realize gains from nuanced outcomes and endpoints, previously difficult to measure and pay for in a world where prescription and medical benefits were managed in silos – and increasingly important in areas such as specialty and oncology. This makes it more important to tell a value story that extends beyond traditional, Rx-centric outcomes.

Potential for a better pricing model
As PBMs are increasingly built into larger vertical structures, and the rebate and “spread” become less essential to their function, it’s possible that the pharma pricing model can start to move away from rebates and towards a more transparent and patient-friendly approach, focusing on front-end affordability. This will have implications on optimal pharma contracting strategies, which may vary as PBM and payer models evolve to change where dollars can best be spent to ensure access and outcomes. Account managers and brand teams must understand the nuances of PBM models more than ever.

Diverse offerings of PBMs
The big PBMs are getting bigger, while the smaller PBMs are becoming more specialized. While pharma may be experiencing a loss of control, particularly regarding drug exclusion lists and the increased bargaining power of integrated entities, they may still achieve access by aligning with PBMs’ varied offerings and objectives. Even the bigger ones, Caremark and ESI, for example, tend to take opposite stances on which drugs and companies they are going to cover. These dynamics may require that pharma contracting strategies evolve to drive cost-effective access, requiring deep understanding of PBM model dynamics.

Brian Corvino
Senior Vice President & Managing Partner, DRG Consulting

The vertical vision for maximizing value
“In the long term, there’s real value to be created where you are aligning incentives for total care value, and not just pharmaceutical care value... In the short term, as an aggregated, concentrated player with a massive amount of lives, PBMs will immediately have greater bargaining power with pharma.”
Implications for: Pharma

Threats

Up against greater bargaining power
It stands to reason that a combined organization controlling even more patient lives will have greater negotiating power with regard to rebates and discounts.

Limited access for specialty products
A lot of the newer, high-cost, specialty products fall under the medical benefit, and health plans have been concerned about managing these costs. The potential for integrated PBMs to manage the medical benefit with the same level of utilization applied to the pharmacy benefit, might limit access to some of these specialty products.

Pressure to justify drug prices
Although this is a potential opportunity, it could also be construed as a threat, pressuring manufacturers to justify their high prices. While the large, integrated entities will create transparency, there are also a handful of smaller, standalone PBMs, such as Navitus and MedImpact, that are putting transparency at the center of their value propositions.

Generics utilization
With a greater focus on total healthcare costs, vertically integrated entities could drive use of generic drugs, particularly in the case of CVS-Aetna, where an expanding retail clinic environment might greatly favor generics dispensation.

Drug exclusion lists
The relatively recent phenomenon of drug exclusion lists could pose an even greater threat to pharma, should PBMs gain greater authorization control within the new vertically integrated models. While Caremark showed a somewhat softened stance with its latest list, ESI continued its aggressive approach, excluding 64 drugs this year.

Patient steerage fallout
As payer, PBM, and provider integration accelerates, the resulting collective organizations have greater control over where patients receive care, and may more actively steer patients toward preferred providers or pharmacies, which could threaten pharma from an access perspective. While this may result in a simple consolidation of control, the changes in where control truly lies may be rapid and difficult to measure in transition.

John Stahl
Partner, DRG Consulting

“Caremark, Express Scripts and Optum offer different opportunities for pharma, but the central challenge with each is these exorbitant rebates that are not making it to the end customer – and pharma is trying to figure out how to address this.”
What questions should pharma be thinking about?

Where should you place your bets for ground-breaking R&D innovation to differentiate? Which metrics will be most meaningful to payers, and how can you build outcomes data into clinical development to best demonstrate that value?

Are there opportunities to improve and streamline the clinical development process by getting input from payers earlier and more often?

Which customers matter most for your business, and which ones are going to be impactful from a product-access standpoint? How can you best engage, show value, and collaborate with payers, PBMs, hospitals and other key organizations?

Does your reimbursement model need to evolve with the changing market? Are there scenarios for bypassing intermediaries in the system, such as applying one-time discounts up front vs. handing out rebates and co-pays on the backend?

Should you invest more in evaluating value-based contracts with payers directly to build brands on the real value of treatments? How can you set up the right target, deal structure, and benchmarking for risk-sharing?

Where should you implement pay for performance models to differentiate in competitive markets and reduce payer uncertainty?

How should you leverage real world evidence data to show value and effectiveness, and best communicate this to critical stakeholders?

Are there opportunities to partner with technology and consumer-focused companies to optimize care and improve outcomes? Which types of digital tools and platforms could move the needle in patient care?

Sonali Prusty
Lead Analyst, Market Access Insights

“Amidst the evolving market, pharma must redefine and start building profound relationships with payers in order to be successful. Working together and creating value for each stakeholder should be the key focus.”
Implications for: Payers

Breaking down the walls, reining in the costs

Most of the large, national payers have already moved, or are in the process of moving, formulary management in-house, deploying PBMs mainly for channel management services. This first phase of vertical integration of the healthcare value chain has given payers more control over healthcare costs and has better positioned them to link directly with providers and to negotiate value-based contracts.

The recent deals by UnitedHealth/Optum to acquire DaVita, CVS Caremark to buy Aetna, and Cigna to acquire Express Scripts have created new verticals with the potential for clinical integration and improved access to low-cost care, aligning medical and pharmacy benefits with healthcare provider networks, and further increasing payers’ influence on prescription drug sales.
Implications for: Payers

The Opportunities

**Reduction of healthcare costs**  
Vertical integration offers opportunities to lower healthcare costs, improve outcomes, extend relationships with providers, and reduce costly in-patient and ER usage. There are potential savings to be realized by eliminating the wall between PBMs and insurers, particularly if plans are able to effectively leverage PBM tools to manage the medical benefit.

**Greater negotiating power and formulary control**  
The sheer size of combined entities will result in greater negotiating power with pharma, which could mean higher rebates and discounts on drug prices, and larger profit margins. Payers will have more purchasing power over formulary and prescription drugs, the potential to lower drug prices and increase the use of generics in a more transparent system.

**Creating a consumer-centric system**  
The new models offer the potential for greater care coordination and the ability to holistically engage patients, which, to date, insurers haven’t done well. Potentially some of the cost savings could be passed on to patients. For example, Aetna might be able to offer commercial plans with attractive features like co-pay-free primary care services via MinuteClinics, or a pre-deductible for chronic care management.

**Value-based contracting**  
The effective integration of claims data and prescription drug data creates the potential for increased value-based contracting between payers and pharma based on health outcomes.

Aetna and Cigna have focused on forming value-based arrangements with IDNs, hospitals and provider groups in its major markets, while Aetna and CVS have been among the more active payers/PBMs in outcomes-based contracting with drug companies. Given the increased scope of a combined entity, collaboration will likely accelerate.

**Steering patients**  
Vertically integrated systems might allow payers to steer patients towards lower-cost care options, or to particular providers or pharmacies – especially now that narrow networks are seen as increasingly acceptable by employers and consumers, which gives payers greater leverage. Anthem already steers outpatient care by not reimbursing inpatient MRIs and CTs, and CVS and Aetna look certain to adopt a retail pharmacy steerage strategy.
Implications for: Payers

**Threats**

**Consumer pushback**
Of course, payers also risk taking the heat for limiting patient choice. CVS-Aetna, for example, must guard against members feeling overly restricted, or confined to CVS pharmacies or Aetna-affiliated providers, by promoting advantages of staying in-network. Aetna would need to socialize and transition the many seniors who are reluctant to use walk-in clinics, preferring their own doctors instead. Similarly, formulary restrictions enforced by the combined entity could affect up to 12 million additional pharmacy lives held by Aetna.

**Provider pushback**
Providers, too, might push back against patient steerage. Physicians may oppose their patients being sent to a retail clinic after picking up a symptom on a home monitoring system, perceiving it as interference. For patients with complex disease, physicians may consider retail clinics ill-equipped to provide proper treatment.

**Federal and state regulations**
Federal regulators could restrict the degree of linkage in a vertically integrated entity. For example, Aetna could be barred from openly steering patients toward CVS pharmacies, or either CVS or Aetna may have to shed some Medicare assets for the merger to be approved. And at the State level, because retail clinics are generally run by advanced NPs and different states regulate the scope of practice differently, it will be difficult to achieve the same range of services from one state to the next.

**Increased competition within payers**
Mergers such as CVS–Aetna and Cigna–Express Scripts continue to realign the healthcare system. They also signal that despite UnitedHealth Group outpacing its rivals by establishing its PBM unit first, competition among national insurers will only increase.

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**Paula Wade**
Principal Analyst, Market Access Insights

“What we are seeing is a smashing of the silos in response to the frustration that payers have for feeling like they are getting nickel-and-dimed at every step and by every player in the pharmacy chain.”
Implications for: Providers

The battle for control of patient referrals

Primary care has become the battleground on which both integrated delivery networks (IDNs) and payers are fighting for control of arguably the most valuable currency in the healthcare value chain – patient referrals. IDNs are buying up primary care in pursuit of the vision to becoming self-contained health systems.

But recent major vertical integration moves are challenging the IDN model with significant integrated offerings that will sit PCPs and payers side by side on the frontline, armed with pharmacy and medical benefits management, and with a legitimate readiness for value-based transactions. And then there’s the uncertainty in Washington. How will this play out?
Implications for: Providers

The Opportunities

Better care coordination
Systems where payer, PBM, and provider stakeholders are aligned may lead to better patient care coordination across settings of care. There may be fewer instances of patients being referred to out-of-network providers, being prescribed non-covered drugs, or being denied reimbursement for post-acute care or other auxiliary services. Additionally, concerted direction of patients to appropriate sites of care or resource, i.e. retail clinics for cold symptoms, may alleviate the workload of primary care physicians, and allow time and attention to be concentrated on those patients with the greatest needs.

Better value-based care pull-through
Vertical integration may enhance value-based contracting pull-through by aligning stakeholder incentives and system capabilities. Payers and providers operating under a value-based contract, within the same system, would inherently be aligned on cost reduction and shared savings objectives. Moreover, connected platforms and data availability would support the implementation, monitoring, and optimization of an alternate care delivery model.

Better adherence and outcomes
Treatment adherence and outcomes can be compromised by various factors, many of which can be mitigated in a integrated system. Providers well-informed about patient out-of-pocket costs could prescribe optimally affordable and effective drugs, and reduce pharmacy abandonment. Pharmacist medication therapy management at network retail clinics could provide patient education and follow-up to improve treatment adherence. These capabilities would support not only better outcomes but potentially lower overall system costs due to reduced hospitalizations.

“If you can put providers at the front line where the payers are, and combine those under one roof, you put the provider at the front of the value-based discussion, and that can give them more cost control over patients.”

Michelle La Vone Richardson
Analyst, Market Access Insights
Implications for: Providers

**Threats**

**Narrow network acceptance gives insurers greater leverage**
As criticism of overly restrictive HMO networks quietens and consumers increasingly accept narrow networks, insurers have greater reign to leverage them to concentrate patient volume and drive down cost of care. In cases where payer organizations own provider groups, payers would not only have control over where patients go for care but also how providers give care through incentives and performance measures.

**Independent providers facing threat of exclusion**
As payers and PBMs join forces and consolidate control over large membership populations, providers must consider how to engage with these conglomerates to ensure network inclusion and patient volume. Even if included within the network of an entity like UHC/Optum for example, external providers may face an upward battle competing against internally-owned provider groups such as DaVita Medical Group.

**Breaking the care continuum**
There has been some concern the retail clinic industry could sabotage the patient-centered medical home concept of care and drive up costs for primary care providers. If the least sick, low-cost patients are channeled toward the retail clinics, after all, PCPs would be left to shoulder the higher-cost patients. That said, higher-cost patients with more complex ailments ultimately determine payment in the value-based reimbursement environment, rather than sheer ratio of low- to high-acuity patients. Aside from potential costs, many physicians find retail clinics inappropriate for managing chronic disease, an area of high-involvement by retail clinics via screenings and checkups. Physicians and IDNs are remedying the situation by interjecting themselves as partners, rather than competitors or bystanders, in consumer health.

**Stephanie Chen**
Consultant

“Payer-provider integration would facilitate actualization of value-based contracting through alternative care delivery and payment models. Better payer control over outcomes and better provider understanding of program goals could enhance receptivity to innovative models.”
Implications for: Patients

A new “front door to care”: opening onto a narrow network

Driving CVS’ marriage with Aetna is this proposition: in pairing the reach and convenience of CVS’ mammoth retail pharmacy footprint with Aetna’s increasingly data-driven health management capabilities, the combined company can deliver a superior customer experience at lower cost to patients and payers alike. In announcing the deal, CVS Health CEO Larry Merlo pledged to “create a healthcare platform built around individuals… [that is] easier to use and less expensive for consumers.”

Improving the patient experience is one of the legs of the Triple Aim framework on which recent health reform efforts rest. Payers and providers are increasingly being reimbursed on patient satisfaction scores, and the patient experience is key to the population health paradigm inhabited by ACOs striving to keep patients in network and on treatment. With a vast store of digital information at their fingertips, the healthcare consumer is increasingly in charge, and healthcare companies are beginning to think about customer service much as their counterparts in retail, travel or finance do.
Implications for: Patients

The Opportunities

A better customer experience
American patients must navigate an oftentimes mind-boggling maze of appointments, referrals, prior authorizations and claims denials to access care. Companies like CVS envision paring back the barriers and veto points while making use of digital technologies to provide patients a smoother path to care and to deepen engagement.

Delivering on the promise of connected care
CVS is counting on a bundle of emerging technologies, from health trackers to telemedicine and remote monitoring, to connect patients to providers and fill in the gaps between visits. The soup-to-nuts, vertically-integrated healthcare behemoths that CVS and other players are assembling could use these technologies to extend the patient relationship from a series of discrete touchpoints to a semi-automated, AI-enabled continuous feedback loop.

However, while the component technologies of digital medicine are coming online, many are not yet mature, and assembling them into functioning systems will take time – along with plenty of trial-and-error iteration.

58% of U.S. adults say they are more likely to take better care of their health when they have a positive experience with their provider.

Source: Cybercitizen Health® U.S. 2017
Implications for: Patients

Threats

**Fewer players could mean fewer choices, higher prices**
Achieving greater scale and cutting out middlemen should allow companies like CVS Health to cut medication costs in the short term, as they’ll enjoy greater leverage over the drug and device companies across the table and can realize efficiencies when they control the point of care, the means of distribution and the purse strings.

U.S. healthcare consumers could use the help – 62% expect their healthcare costs to increase over the next two years (Source: Cybercitizen Health 2017). However, it remains to be seen how much of the savings will be passed on to the consumer. The knock on traditional PBMs has been that they pocket the discounts they negotiate with drug companies. And increasing costs will compel payers to use narrower networks, more restrictive formularies and higher deductibles. No wonder 2 in 5 U.S. online adults are concerned that they won’t be able to see their preferred doctor due to changes in their insurance (Source: Cybercitizen Health 2017).

**More convenience, but at the risk of chaos**
CVS hopes to make healthcare more efficient by steering patients away from the ER and into its retail pharmacy stores and urgent care clinics, from which they initiate a virtual consult with a nurse practitioner or physician. For the parent tending to a bad scrape or a persistent cough, no-wait, walk-in service a short drive away is a real plus.

There is substantial consumer demand for one stop shopping in healthcare, with 42% of U.S. online adults saying that getting most of their healthcare needs taken care of in one facility is of utmost importance to a good patient experience (and another 37% citing no-wait service). The downside of a health system with many overlapping points of care is the potential interoperability SNAFUs which may trump the convenience factor. Greater competition and the availability of many avenues for care could spur healthcare companies to innovate and improve the user experience all around, EHRs are not sufficiently interconnected, it’s a recipe for mayhem.

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**Rory Stanton**  
Director, Digital Insights

“There’s a direct connection between the quality of the healthcare customer experience and how engaged patients are in their care. By prioritizing customer experience initiatives, healthcare companies like CVS could help patients live healthier, longer lives and reduce overall healthcare cost per patient.”
Where do we go from here?

PBMs and the healthcare value chain

The healthcare value chain will likely continue to transform and create few dominant vertically integrated managed care companies which assume medical risk, have PBM/pharmacy capability, and deliver care. Large, national PBMs and health plans will continue to grow while smaller organizations will continue to become more specialized, handling government contracts, regional importance, and evolving niche offerings, such as transparency and value-based services.

An important consideration regarding large-scale mergers will be anti-trust reviews. While vertical integration appears to be viewed more favorably than horizontal integration, concerns around purchasing power and consumer choice persist, causing potential for government intervention for example, limiting CVS’s ability to steer Aetna patients into its pharmacy networks.

A question mark also remains on how transaction margins and potential costs savings will be handled. With PBMs and insurers under the same roof, it remains to be seen if they will consolidate the amounts they each extract from the contracts with pharma and pass the savings down the end customer, or whether they will “have their cake and eat it”, and continue to double up on revenue.

The looming threat of Amazon

The industry continues to speculate on the implications of Amazon growth and entry into healthcare sectors – with the announcement of Amazon, Berkshire Hathaway and JPMorgan’s plans to form an independent healthcare company for their U.S. employees being the latest fuel to the fire.

In order to enhance employee healthcare simplicity, quality, and affordability and support future program expansion, each founding company is bringing deep assets and market expertise – Amazon in supply chain, technology, and logistics; Berkshire Hathaway in underwriting through Geico; and JPMorgan in payment and financing. As of April 2018, Amazon, Berkshire and Chase are actively looking for a CEO with both public and private company experience for their combined venture.

However, in the near term, radical overhaul beyond technology upgrades and supply chain margin enhancements for mail order generics and consumables seems unlikely. Similarly, it seems unlikely that Amazon will go beyond competing on margin to quickly disrupt the PBM landscape on account of its historical reticence to enter markets with low net promoter scores, particularly in a business-to-business setting. Additionally, with Cigna buying Express Scripts and all the other large PBMs merging with insurers, there’s no obvious large partner remaining for Amazon.

Where Amazon is better poised to make an impact more immediately is in consumer engagement, by potentially leveraging its personalized lifestyle data (diet, exercise) and Amazon Web Services and deploying its suite of connected home devices including Amazon Show, Echo, and Alexa at the front end to change behavior and promote wellness. Amazon is also likely to pursue a major play in data solutions, perhaps in the aggregation of EMR data or other health information such as claims, real world evidence, and patient reported outcomes data on the back end.

And now providers want to be manufacturers?

Healthcare value chain transformation took an unprecedented turn with the recent news that four health systems – Intermountain Healthcare, Ascension Health, SSM Health, and Trinity Health – are partnering with the US Department of Veteran Affairs to establish a not-for-profit generic drug company. Representing more than 450 US hospitals, the objective is to address shortages of essential generic drugs, and to make them more affordable to patients. It’s an ambitious plan that will shorten the healthcare value chain and bring some much-needed generic competition to the market. The partners expect more healthcare systems to join them but it remains to be seen if the initiative will be a success and whether other systems will follow suit.

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Also, as of February 2018, Amazon has announced its advancement into the healthcare retail business. Amazon has launched an exclusive line of over-the-counter health products, called as Basic Care in collaboration with Perrigo. The ecommerce giant has also made its entry into Medicaid market by offering a deep discount of 54% on its Prime
The continued transformation of the healthcare value chain raises critical questions for pharma.

Pharma companies will benefit from identifying priority customers who are going to be impactful and influential for product-access. Additionally, pharma will need to assess the balance of power between stakeholders, such as IDNs and payers, on the local, regional and national levels, in order to develop their value proposition.

There are also concerns over patient affordability, particularly with the rise of high-deductible health plans and other measures increasing patient cost sharing. Patient access will be affected by how high-priced specialty products are going to be managed in the future, especially in this exciting new era of one-shot cures, which is not effectively supported by the current reimbursement mode.

Some stakeholders are wondering if the system needs PBMs at all, and whether there isn’t a scenario for bypassing the intermediaries in the system, such as applying one-time discounts up front, instead of handing out rebates and co-pays on the backend.

Nothing trumps true product innovation, a good example being the recent dramatic impact (not to mention sales) of groundbreaking therapies in Hepatitis C. But demonstrating value has become a crucial component of the process where outcomes data is being incorporated into clinical development, at Phase I and Phase II. Manufacturers should be thinking, not only about how to gain FDA approval, but also what metrics will be the most meaningful to those who will ultimately be paying for care.
Our experts are constantly tracking the fast-moving healthcare landscape and helping clients prepare for the changes ahead.

If you would like to continue the conversation around healthcare delivery transformation or other pressing healthcare topics for your business, our team would love to hear from you. Contact questions@teamdrg.com.
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