Are HSAs an obstacle to on-site clinics?

Many large employers want to offer no-cost primary care visits near the workplace to make it as easy as possible for workers to get care. But high-deductible plans paired with health savings accounts may throw a wrench in those works. Employers can't provide workers "significant medical benefits" to patients with HSAs, according to Internal Revenue Service rules. That means charging a copay for those visits. Mercer consultant David Keyt doesn't see that as meaning companies will give up on on-site clinics, but it may give them pause. Half of respondents to the Mercer survey said they'd get better utilization of their clinic if they didn't have to charge a copay. Legislation is pending in Congress that would clear the way for HSA holders to get free visits at a workplace clinic; HR 6199 was approved by the House in 2018 but has not yet moved in the Senate.

More Sunshine, Say Some PBM Forecasts. More of the Dark Arts, Say Others.

By Robert Calandra

When the Justice Department last fall blessed the mergers of Express Scripts and Cigna, and of CVS and Aetna, it pretty much closed the book on the large, stand-alone pharmacy benefit managers.

What the mergers didn't do, however, was quiet the growing frustration and concern employers, pharmacists, consumer advocates, state legislators, and some members of Congress have with the PBMs' lack of transparency.

But the knots are tied and the PBMs are in the process of vertically integrating with their new health insurance partners. So inquiring minds (that is to say, all those folks mentioned above) want to know: What does vertical integration mean for them?

Will it bring an end to secretive pricing systems, convoluted contract language, and the general lack of transparency that PBMs have become infamous for? Or will PBMs and their new insurer owners come clean about exactly how much they take from administrative fees, discounts, and various side deals?

Will these mergers mean the end of rebates, or, at the very least, more of the savings funneling down to the point of sale and consumers? And will PBMs finally stop crying "proprietary information" every time a client, legislator, or judge asks to look at the books?

An optimistic view

Don't expect answers to those questions anytime soon. People knowledgeable about mergers say it can take years for large companies to integrate systems and initiate changes. That is especially true in health care mergers, says Benjamin Isgur of PricewaterhouseCoopers. "With health care, especially, you have the integration of data and that can take a lot of time with all the disparate systems that need to work together," says Isgur, leader of PwC's health research team. "And then you have to really start doing analytics and thinking about where can we be more efficient."

When those answers finally begin to roll out and whether or not the hybrid companies offer enough information to quell the criticism will depend on a Rubik's Cube of factors—and your vantage point and outlook.

Isgur believes the chances are good that the new companies will be more transparent, if for no other reason than they are no longer operating as independent middlemen concerned only with the pharmaceutical side of medical treatment.

"I'm not being Pollyannaish or wearing rose-colored glasses here," he says. "But I think, over time, it takes a layer of obfuscation out of the formula. The insurance company is really, ultimately, responsible for administering the medical and drug bill together."

That's not the only reason behind his optimism. American businesses, he says, are fed up with the ever-upward spiral of prescription drug costs. Over the past decade, drug prices have increased by 20%, according to PwC's health research team. Businesses have used every tool in their arsenal to control drug cost—to no avail.

Meanwhile, a PwC survey found that 25% of consumers are either cutting their pills in half to save money, or simply not filling their prescriptions.

"From the buyers' point of view, there is a lot of pressure out there for what is going to bring some of these costs down and make it more sustainable," Isgur says.

Pharmaceutical manufacturers are also getting the message that businesses have had it, Isgur says. In another PwC survey, 70% of drug manufacturers said that developing lower-cost drugs is more important now than it has been in past years (although price hikes are still the rule and not the exception; drugmakers increased prices by about 6% at the beginning of this year).

Prior to the mergers, Isgur says, health care was a house divided with insurance companies looking at the medical side and PBMs focusing on pharmaceuticals. Integrating the two sides provides insurers with a whole-world view.

"It's not just a choice between which drug goes on the formulary but actually opening up to a smorgasbord of treatments," he says. "Now we're getting into things like digital therapeutics, where treatments are being implemented through digital means."

The integration of the two sides may also lead to the resurgence of ideas like value-based pricing, whereby drug prices are based on efficacy rather than historical pricing. But the road to more transparency, Isgur believes, begins with rebates.

"The conversation about rebates is definitely at the forefront," Isgur says. "Does that mean that everything immediately becomes 100% transparent and all the rebates are passed down? Obviously, it does not mean that. What it does mean is that it is a little bit less of a shell game for the ultimate payer."

'It's very depressing'

PBM critics are less optimistic. Vertical integration, they say, will benefit no one other than the PBM and insurers. Why, they ask, would the hybrid companies voluntarily do anything to lower revenues? What's the motivation?

They have a point. Even before the mergers, Express Scripts and CVS Caremark, along with Optum (UnitedHealth Group) and Prime Therapeutics (Blue Cross and Blue Shield plans), controlled roughly 80% of the marketplace. Pharmaceutical manufacturers are still selling their exclusive, patent-protected products to PBMs with rebates to ensure their products make it on formularies. If anything, vertical integration is the suspenders to the PBMs' belt around the market.

"The rules have not changed just because these companies have merged," says David Henka, CEO of ActiveRADAR, about vertical integration. The game is going to be played much the way it has been played.

"The rules have not changed just because these companies have merged," says David Henka, president and CEO of ActiveRADAR, which specializes in pharmacy cost-reduction programs. "That is the way the game is going to be continued to be played until somebody changes the rules."

Linda Cahn, founder of Pharmacy Benefit Consultants in Morristown, N.J., and a long-time critic of PBMs, agrees.

"You have two big insurers operating PBMs, and Caremark operating its own retail pharmacy chain, all in vertical arrangements," she says. "Will anything change?

"Yes, things are likely to get far worse. Each of these insurers and each of these PBMs locked in more clients, more beneficiaries, making it easier to engage in even worse conduct. It's very depressing."

Henka concedes that vertical integration could mean some economies of scale and savings in care management, total cost of claims, and projecting future costs. But those efficiencies will not be "a broad stroke 15% or 20% reduction in costs." Any savings, he says, will most

likely find their way into shareholders' pockets, not in lower prices for employers or consumers.

"A lot of people in the financial markets know that [consolidation] is going to greatly benefit the shareholders of these new companies," Henka says. "Does that ever translate to lowering prices, improving services, and having better outcomes?"

Staying separate

Another view is that while PBMs and insurers may appear to be operating as one, they won't necessarily behave that way. That was Henka's experience when he negotiated with Optum and UnitedHealthcare.

"The two organizations do not work collaboratively for the large employer segment," he says. "The UnitedHealth people didn't talk to the Optum people and the Optum people didn't talk to the United people. They were separate companies that happened to be under the same corporate umbrella."

But being under the same umbrella, says Cahn, means the partners can cross-sell their services. Caremark has clients who aren't insured by Aetna and Aetna has clients who don't use Caremark.

"Aetna will try to ensure its clients use Caremark, which already steers beneficiaries to use CVS pharmacies," Cahn says. "Prices of CVS drugs tend to be far higher than many other pharmacies. Clients rarely run analyses to detect cost differentials, so they'll never know why their costs are increasing."

Cahn counsels her clients to carve out their prescription drug coverage from their health insurance coverage and have separate contracts with health insurers and PBMs. She also urges clients to check prescription prices at different pharmacies to find the best price.

"When I started investigating the PBM marketplace in 1997, if somebody told me it would get worse, I would have said, it can't," Cahn says. "But every year it gets worse. These vertical integrations, holy smoke."

Short of legislation that will change the rules, Cahn and Henka believe PBMs will continue operating in the same way they have for years. That change may be coming. In his State of the Union address, President Trump said the price of prescription medication in America was "unacceptable." The president called on Congress to pass legislation that "delivers fairness and price transparency for American patients."

The day before the president's speech, the Pharmaceutical Care Management Association, which represents PBMs, announced it was launching OnYour RxSide, to "increase public awareness" of the value of pharmacy benefit managers.

"This campaign is designed to break through the noise in the drug pricing debate and clearly demonstrate how PBMs are the advocates for consumers in the fight to lower prescription drug costs," J.C. Scott, president and CEO of the PBM organization, said in a press release.

Nevertheless, some state legislators and members of Congress are taking steps to regulate PBMs—or take their business elsewhere.

In January, Ohio Medicaid officials said they were going to end the program's contracts with its PBMs because of the spread pricing, a common PBM practice whereby the amount billed to the employer for a drug is not the same as what the PBM pays the pharmacy. The difference is kept by the PBM as revenue. Ohio officials made the change after the *Columbus Dispatch* reported about PBMs profiting from spread pricing. CVS Caremark is the PBM for four of Ohio's five managed care plans.

Meanwhile, the new chair of the House Oversight and Reform Committee, Elijah Cummings, has launched what is being billed as a major investigation into prescription drug pricing, including the role that PBMs play.

Cahn applauds the growing legislative interest in prescription drug prices. But so far, she says, what legislators are doing is "nothing but little Band-aids."

"What we need is more transparency, more information, real marketplace competition," Cahn says. "Instead, we have vertical integration of industry giants undermining all three matters." MC

Robert Calandra, a regular contributor to Managed Care, *is an independent journalist in Philadelphia.*