Could Acquisition of Whole Foods Help Amazon Gain Foothold in Pharmacy Space?

When CNBC reported in mid-May that Amazon.com Inc. was considering a shift into the pharmacy and/or PBM industry, the news made headlines for days. But that was overshadowed by the attention the company received last week when it said it planned to purchase Whole Foods Market Inc. While many pharma industry observers remain skeptical on the potential for Amazon to break into the market for prescription drugs, others say not only that it’s possible but also that Whole Foods helps in this regard.

The May 16 CNBC article cited sources who said that Amazon “for the last few years...has held at least one annual meeting at its Seattle headquarters to discuss whether it should enter the pharmacy business.” This year, though, it’s “ready to get more serious” due to the increasing number of high-deductible health plans and more out-of-pocket costs being shifted to patients. The company also “is hiring for its ‘professional health care program,’” according to the article. And Amazon has hired Mark Lyons from Premera Blue Cross to serve as senior manager of pharmacy benefits, where his duties include creating an internal PBM for the company’s employees.

Lyons served as director of integrated health management consulting for Premera and prior to that was manager of pharmacy services at Premera, according to his LinkedIn account. He also served from 1998 to 2000 as a pharmacy consultant for PBM AdvancePCS Inc., which was purchased by Caremark Rx, Inc. in 2004 (DBN 3/12/04, p. 1; 9/12/03, p. 1). At the time of the deal, AdvancePCS, Medco Health Solutions, Inc. and Express Scripts, Inc. were the largest PBMs in terms of market share (DBN 8/29/03, p. 1).

Connecticut, Nevada and Maryland Bills to Tackle Drug Prices Along Supply Chain

Lawmakers in three states have approved legislation intended to lower the prices consumers pay for prescription drugs, mainly by requiring more disclosure of pricing information from pharmacy benefit managers (PBMs) and drug manufacturers.

The bills from lawmakers in Connecticut, Nevada and Maryland target different parts of the pharmaceutical supply chain. But they join legislative efforts in other states to rein in what some lawmakers view as out-of-control drug prices (DBN 5/5/17, p. 8).

Here’s a rundown of what the three states are doing:

In Connecticut, lawmakers overwhelmingly approved legislation (S.B. 445) in June that would ban insurers and PBMs from imposing so-called “gag orders” that prohibit pharmacists from telling consumers they can save money by paying out of pocket for prescriptions, or that there might be therapeutic alternatives to their prescriptions. The legislation also “allows indirect purchasers to recover against drug manufacturers for antitrust violations,” according to a summary of the bill.

State Senate lawmakers voted unanimously 36-0 for the legislation, while the state House approved it 127-22 — both veto-proof majorities.
However, the Connecticut bill has seen some unusually personal controversy on its way through the legislative process. Two of its sponsors, Sens. Martin Looney (D-New Haven) and Len Fasano (D-North Haven) warned the state’s insurance commissioner, Katharine Wade, in a letter sent May 24 to stop trying to water down the bill. Wade is a former Cigna Corp. lobbyist appointed to head the Connecticut insurance department in 2015.

Following the letter from Looney and Fasano, Gov. Dannel Malloy (D) defended Wade and said the bill takes an “unnecessarily antagonistic” approach toward the insurance industry in Connecticut. Malloy has been a strong supporter of insurers in his state, and last month pleaded unsuccessfully for Aetna Inc. to keep its headquarters in Hartford.

Malloy spokesperson Meg Green says he hasn’t made a decision on the bill yet. “After it is transmitted to his office, the governor and his staff will review the final language that was included in the legislation,” Green tells AIS Health.

For its part, the Pharmacy Care Management Association (PCMA) says it doesn’t oppose the bill: “We support the patient paying the lowest price available at the pharmacy counter for the prescribed drug,” the group said in a statement.

In Nevada, Gov. Brian Sandoval (R) signaled he would sign legislation that requires drugmakers and PBMs to disclose pricing information on specific diabetes medications when prices increase significantly. Sandoval made the statement despite vetoing on June 2 similar legislation sponsored by Democrats that applied only to drug manufacturers.

The new bill, S.B. 539, includes language from both sides of the aisle and targets PBMs along with drug manufacturers. S.B. 539 would require manufacturers of insulin and biguanides (metformin immediate release and slow release are the only two biguanides on the market currently) to disclose the costs of producing and marketing the drug. They also would have to reveal rebates.

PBMs, meanwhile, would have to tell the state the total amount of rebates they receive from drugmakers, along with how much of those rebates they retain and how much they pass on to health plans.

We support the patient paying the lowest price available.

The original bill that Sandoval vetoed contained a provision requiring drug manufacturers to provide 90 days’ notice to the state before making any price increases on insulin or biguanide products.

However, opponents said that could lead to drug stockpiling and other market distortions, and Sandoval specifically called out that provision in his veto message, saying that “the price-increase notice requirements in S.B. 265 will also spur the growth of the so-called ‘gray market’ in health care products. In that gray market, the choice to sell critical shortage drugs to the highest bidder will be all the more attractive, particularly when states with less stringent rules and regulations are involved. This scenario could leave more Nevadans with higher costs, fewer choices, and less access to the medicine they need.” The 90-day notification provision was not included in S.B. 539.

Pharmaceutical Research and Manufacturers of America (PhRMA) and PCMA both said they oppose the legislation.

“We are deeply disappointed in Gov. Sandoval’s decision to sign this harmful legislation, considering that just days ago he vetoed legislation that included language almost identical to S.B. 539, arguing that it ‘poses serious risks of unintended and potentially detrimental consequences for Nevada’s patients,’” PhRMA said in a statement.
PhRMA pointed fingers at insurers and PBMs, saying the new law “sheds no light on the fact that the large rebates and discounts insurance companies are receiving are not being passed on to patients at the pharmacy counter, like a patient with diabetes in a high deductible plan who pays $350 a month for insulin and could be paying hundreds more annually than their insurer. There is nothing in S.B. 539 that will help that patient get the same savings their insurance company is getting.”

Meanwhile, PCMA argued that the Nevada law would raise costs “by giving drug companies inside information that would empower them to collude with their competitors.” The organization also says that the “costly fiduciary mandate in this bill is similar to those that have been rejected by federal courts on constitutional grounds for conflicting with federal benefits law (Employee Retirement Income Security Act).”

In Maryland, Gov. Larry Hogan (R) allowed a bill (H.B. 631) to become law without his signature that allows the state’s attorney general to investigate and fine manufacturers and distributors of generic medications for “price gouging.”

---

**CVS/caremark’s Health Plan Clients**

According to AIS’s Directory of Health Plans: 2017, 66 health plans name CVS/caremark as their exclusive PBM. These plans represent a total of 36,973,446 medical lives, or 11% of the national health insurance market. Since 2016, CVS/caremark has seen a net gain of two clients representing 1,758,120 lives, despite the loss of its biggest health plan client, Health Net, Inc., which merged into Centene Corporation last year.

**CVS Health Plan Clients, Listed by Total Medical Enrollment:**

<table>
<thead>
<tr>
<th>Health Plan</th>
<th>Total Medical Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Molina Healthcare, Inc.</td>
<td>Fallon Health</td>
</tr>
<tr>
<td>Blue Shield of California</td>
<td>Maryland Physicians Care (MPC)</td>
</tr>
<tr>
<td>CareFirst BlueCross BlueShield</td>
<td>Employees Group Insurance Division</td>
</tr>
<tr>
<td>WellCare Health Plans, Inc.</td>
<td>Sharp Health Plan</td>
</tr>
<tr>
<td>Medica Health Plans</td>
<td>CareConnect Insurance Company, Inc.</td>
</tr>
<tr>
<td>CareSource</td>
<td>Universal American Corp.</td>
</tr>
<tr>
<td>Fidelis Care, Inc.</td>
<td>HMO Partners, Inc.</td>
</tr>
<tr>
<td>Wellmark Blue Cross and Blue Shield of Iowa</td>
<td>FamilyCare Health Plans</td>
</tr>
<tr>
<td>Healthfirst</td>
<td>Phoenix Health Plan</td>
</tr>
<tr>
<td>Tufts Associated Health Plans, Inc.</td>
<td>SIHO Holding, LLC dba SIHO Insurance Services</td>
</tr>
<tr>
<td>Trustmark Companies</td>
<td>Viva Health, Inc.</td>
</tr>
<tr>
<td>BlueCross BlueShield of South Carolina</td>
<td>Oscar Insurance Corporation</td>
</tr>
<tr>
<td>Capital BlueCross</td>
<td>DAKOTACARE</td>
</tr>
<tr>
<td>Hawaii Medical Service Association</td>
<td>Physicians Health Plan</td>
</tr>
<tr>
<td>North Carolina State Health Plan</td>
<td>Peoples Health</td>
</tr>
<tr>
<td>Arkansas BlueCross BlueShield</td>
<td>MediGold</td>
</tr>
<tr>
<td>Government Employees Health Association</td>
<td>Johns Hopkins Employer Health Programs</td>
</tr>
<tr>
<td>MVP Health Care</td>
<td>University of Maryland Health Partners, fka Riverside Health, Inc.</td>
</tr>
<tr>
<td>Blue Cross of Idaho Health Service, Inc.</td>
<td>United Mine Workers of America</td>
</tr>
<tr>
<td>MetroPlus Health Plan, Inc.</td>
<td>Piedmont Community Health Plan</td>
</tr>
<tr>
<td>Neighborhood Health Plan</td>
<td>Everence Financial</td>
</tr>
<tr>
<td>USHealth Group</td>
<td>Clover Health</td>
</tr>
<tr>
<td>Capital District Physicians’ Health Plan, Inc. (CDPHP)</td>
<td>Allegian Health Plans, Inc.</td>
</tr>
<tr>
<td>Mercy Care Plan</td>
<td>Community Care Alliance of Illinois</td>
</tr>
<tr>
<td>AvMed</td>
<td>Timber Products Manufacturers Trust</td>
</tr>
<tr>
<td>CalViva Health</td>
<td>Elderplan, Inc.</td>
</tr>
<tr>
<td>Paramount Insurance Company</td>
<td>ITASCA Medical Care</td>
</tr>
<tr>
<td>Wellmark Blue Cross and Blue Shield of South Dakota</td>
<td>Johns Hopkins Advantage MD</td>
</tr>
<tr>
<td>Affinity Health Plan</td>
<td>Bright Health</td>
</tr>
<tr>
<td>University Health Care Inc., dba Passport Health Plan</td>
<td>Health Services for Children with Special Needs (HSCSN)</td>
</tr>
<tr>
<td>Priority Partners</td>
<td>Catholic Special Needs Plan, LLC/ArchCare Advantage</td>
</tr>
<tr>
<td>PacificSource Health Plans</td>
<td>UTMB Health Plans, Inc.</td>
</tr>
<tr>
<td>Family Health Network</td>
<td>Hopkins ElderPlus</td>
</tr>
</tbody>
</table>

**SOURCE/METHODOLOGY:** AIS’s Directory of Health Plans: 2017. Visit https://aishealthdata.com/dhp for information on the online version, and play around with a demo of the Dashboard and online search tool; email Sales@AISHealth.com to order. See https://aishealth.com/marketplace/ais-directory-health-plans for more information.
The new law authorizes the Maryland Medical Assistance Program to notify the attorney general of price increases in generic drugs, and the attorney general then may request “any records or documents relevant to determining if a violation of the prohibition on price gouging has occurred,” a summary of the legislation says. Penalties can include rolling back the price increases and levying fines of up to $10,000 for each violation.

The legislation will cost the state around $110,000 a year to hire a full-time pharmacist to monitor off-patent and generic drug prices. It ultimately could save money for Maryland’s Medicaid and state employee plans, the legislative analysis says.

In his message to lawmakers announcing his decision to allow the bill to become law without his signature, Hogan said its goal of combatting price-gouging is “laudable.” But he added: “I am not convinced that this legislation is truly a solution to ensuring Marylanders have access to essential prescription drugs, and may even have the unintended consequence of harming citizens by restricting their access to these drugs.”

PhRMA spokesperson Caitlin Carroll tells AIS Health that the organization is “committed to addressing egregious behavior that stems from a lack of competition.” But she adds that “we continue to have concerns about the broad and ambiguous powers this bill grants to the Office of the Maryland Attorney General.”


Year-Round Readiness Helps With CMS Pilot MTM Enforcement Audit

Without a year-round audit readiness approach, SCAN Health Plan would not have been able to successfully negotiate the complexity and challenge of a CMS pilot medication therapy management (MTM) enforcement audit, according to Crystal Chang, manager of clinical pharmacy services at SCAN.

Because SCAN, the Long Beach, Calif.-based managed care plan, was the first plan to be audited in the 2016 pilot, “it was a learning experience” for both CMS and SCAN, Chang said in a panel session of the May 11 CMS conference on the audits.

SCAN’s audit, which began last March, has taken more than a year and is still in the final stages, Chang said. During the audit, SCAN was assisted by its PBM, PharmMD Solutions, LLC.

CMS annually audits Medicare Advantage (MA) and Prescription Drug Plans (PDPs) to ensure that Medicare enrollees have adequate access to health care services and medications. CMS also verifies that these organizations are in compliance with their CMS contracts, which entail meeting requirements under the areas of program effectiveness; Part D formulary and benefit administration; coverage appeals and grievances for Parts C and D; and special needs plans model of care, according to the latest CMS program audit report, released May 9.

The audit had some tight turnaround times, according to Chang. SCAN had 15 business days after it received notice of the audit to submit the audit universes needed by CMS. In addition, when CMS gave SCAN the 50 audit samples, SCAN had only two business days to provide the documentation needed for the live audit, she said.

“We knew we’d have to be able to seamlessly move through our data, so we practiced with our own samples.”

The short amount of time to provide new data elements that were not coded and not necessarily captured as a requirement in previous years was also difficult, Chang said. “What helped was having open and frequent conversations with CMS,” she said. “We worked with CMS to clarify the meanings behind the new data elements, and we relied on PharmMD to pull the data that was needed. CMS was prompt and responsive and allowed us to work with PharmMD to make adjustments as needed.”

Chang said another way that SCAN prepared was to practice providing audit data in advance. “We knew we’d have to be able to seamlessly move through our data, so we practiced with our own samples,” she said. During these practices, SCAN staff practiced taking screen shots, pulling the letters needed and making sure they could move through SCAN’s systems with ease.

“Until a plan goes through the process of trying to retrieve the data, it won’t know what is involved,” she said. SCAN also elicited help from its compliance and IT department on the mock audits. “It was helpful to have all departments ready to support any audit requirements with short notice.”

Chang discovered through the audit that it is critical to capture every aspect of the MTM process because CMS will ask for this evidence. She advised storing all the letters and calls in an easily retrievable way. Because CMS relied heavily on data to support the cases, having a
data analyst ready to assist in the audit was also helpful, Chang said.

“As much as you can prepare for the audit, you can’t have everything ready,” she said. “It was a challenge to do all of this in the time allotted.” She added that it was vital that PharmMD had “all hands on deck” to help with the audit.

Have a ‘War Room’ Ready

Kempton Presley, vice president of business information solutions and client performance at PharmMD, said the PBM had a “war room” set up to handle the audit. “I can’t emphasize the criticality of everybody being in lock-step at the critical time,” he said during the conference.

Presley advised organizations not to give up if the elements CMS wants are not capturable within the present IT system a plan or PBM is using. “When we looked through all the elements, [sometimes we] realized we wouldn’t be able to give them everything because it’s not how our program worked,” he said. In these cases, CMS worked with PharmMD for other ways to provide the information.

It was also important to have a point person from both the health plan and the PBM to field concerns and communicate between the two companies, Chang said.

Despite the difficulty of the experience, both companies benefited from the pilot. “It was a great opportunity to step back and look at our MTM program with a microscopic lens,” Chang said.

The audit pushed PharmMD to get a more comprehensive view of its population, Presley said.

Wisconsin-based Network Health, a health plan co-owned by provider systems Ministry Health Care and Froedtert Health, underwent a pilot audit last summer based on 2015 data, according to Director of Pharmacy Services Theodore Regalia, also a speaker at the CMS conference. The plan was asked to submit four universes to CMS, including enrollment, disenrollment, comprehensive medication review (CMR) and targeted medication review (TMR) for a 50-member sample.

Like SCAN’s audit, it was performed via video and took place over three days. Ministry asked its PBM to be present during the entire audit to help field questions. (Regalia did not say who the PBM was.) “I want to emphasize how important this is,” he said.

As a result of the audit, Ministry received one corrective action plan (CAP) for failing to offer comprehensive medication review within 60 days of enrollment, according to Regalia. Upon analysis, Ministry found two root causes for this, he said. One was an inadequate process of updating the PBM with changes in patients’ phone numbers and addresses. The second cause was failing to give it alternative phone numbers for patients, when possible.

As a result of the audit, Ministry now gets a bi-weekly report from its PBM on member contact information and conducts a more in-depth internal MTM audit process.

by Diana Manos

Does New CVS Health White Paper Muddy Drug Rebate Controversy?

Who is best suited to manage the savings from a prescription drug rebate? Is it the patient, the health insurance company or the health plan’s PBM? When it comes to prescriptions drugs, manufacturers, PBMs and health plans all say they are looking out for a patient’s best interest, yet critics continue to question whether that’s true.

Amid this controversy, CVS Health released a June 7 white paper suggesting that rebates should go directly to consumers. In “Consumer Transparency: Helping Members with High-Cost Drugs at the Point of Sale,” the Woonsocket, R.I.-based PBM says the point-of-sale (POS) model, which directly pays the rebate to consumers, shifts the high cost of pharmaceuticals away from consumers and onto health plans.

According to Jon Roberts, executive vice president and chief operating officer at CVS Health and author of the paper, several of CVS Health’s PBM clients have implemented POS rebates so far, and CVS Health offers it to its own employees.

CVS Health says in a typical scenario, POS rebates are applied directly at the point of sale, bringing down the cost to consumers by the amount of the rebate. When rebates are paid to insurers, consumers still pay the full amount at point of sale, and they don’t receive any of the rebate.

Health plans that adopt a POS strategy could offset the loss of rebates to their bottom line by altering benefit designs, according to Roberts. Under his proposal, plans would “assume greater cost share and may adjust overall member benefit costs to compensate,” and he suggests using deductibles, premiums and copays.

The white paper offers this example of how that arrangement could work: For an 180,000-member plan,
with POS rebates, the member’s cost share would decrease by 8%, while payer cost share would go up by the same amount. CVS Health estimates that rebates to the payer would decline by approximately $7.5 million. A 3% increase in the employee premium would help to offset the rebate reduction, CVS Health says.

In his June 15 Drug Channels blog, Adam Fein, Ph.D., says this may not be such a good deal for the consumer. “CVS Health’s white paper implies that a switch to POS rebates will require only a few actuarial math tweaks,” he says. “But the reality is more complex.”

The growing spread between the list price for a drug and the net price to a third-party payer — known as the gross-to-net bubble — is a significant burden to consumers. This is especially difficult for patients with high-deductible health plans (HDHPs), since they must pay full price for drugs until they satisfy their deductible, says Fein, president of Pembroke Consulting, Inc.

The POS model is also a problem because health plans and employers “have baked ever-growing rebate dollars into their health care economics,” Fein says. Making matters worse, he suspects these rebate dollars are now concentrated into “a relatively small number of products and therapeutic categories.”

Health plans have recently become more vocal in questioning the value of rebates, period. At a June 8 session of America’s Health Insurance Plans’ annual conference in Austin, Texas, Eric Schultz, president and CEO of Harvard Pilgrim Health Care, Inc., called rebates “completely meaningless” with the runaway drug prices. “Until we can negotiate prices differently...we are going to have a continuing challenge,” he said.

Christine Cramer, a spokesperson for CVS Health, says average increase in drug trend for CVS Health PBM clients in 2016 was 3.2%, compared with 11% without PBM strategies in place. In addition, 38% of CVS Health clients in 2016 was 3.2%, compared with 11% without POS rebates, which also brings with it unique financial and operations

Will Deal Help Amazon in Pharmacy?

CNBC was not the first to mention this potential area of expansion for Amazon. Evercore ISI analyst Ross Muken addressed the possibility of Amazon moving into the pharmacy space in a March 20 research note following a conversation with company management. To the issue of Amazon being “interested in distributing prescription drugs,” Muken pointed out that the company “traditionally...has not had a major presence in heavily regulated areas.” And while it “can deal with state sales taxes,” Amazon prefers to have control over its interests, he wrote, so for that reason, the company is “less interested in strategic partnerships because doing it in house allows for more control.”

Following the publication of the CNBC article, in a May 17 research note Muken maintained that “while moving into pharmacy could be an incremental adjacency for the company, we are somewhat skeptical that the company is definitively moving in to pharmacy given the highly regulated nature of pharmacy distribution and their seeming lack of desire to work with current PBMs/payers.”

In his Drug Channels blog, Adam Fein, Ph.D., president of Pembroke Consulting, Inc., said May 23 that “strategies that would likely be unsuccessful for Amazon” include (1) building or purchasing a PBM, (2) serving as a “central-fill mail pharmacy in a third-party payer’s network,” and (3) building or purchasing a specialty pharmacy.

More likely, according to Fein — who noted his thoughts were “pure speculation” due to the lack of details in the CNBC article — would be Amazon serving people who pay cash for prescription drugs or getting into the discount card program market.

“I would never underestimate Amazon,” wrote Fein. “However, I believe that Amazon has limited feasible options for disrupting pharmacy and PBM markets.”

Pharmacy Has ‘High Barriers to Entry’

“Health care has been becoming more localized and more consumer oriented over the past decade, which may be a reason why a company like Amazon is newly exploring this sector,” Stephen Cichy, founder and managing director of Monarch Specialty Group, LLC, tells AIS Health. “However, the challenge with pharmacy is that it’s not a commodity business like other consumer categories, and there are high barriers to entry including complex regulations, among other factors. The pharmacy industry is also highly integrated with the activities of payers, physicians and pharmaceutical manufacturers, which also brings with it unique financial and operations
challenges. Approximately 95% of industry scripts have some type of insurance associated with it, which means that if Amazon were to compete in this space it would require relationships with health insurance plans and plan sponsors for contracting, billing and collections. Also, only about 15% of traditional scripts in today’s market flow through a mail-order delivery model, and this continues to decline. Depending on how Amazon may be looking at these issues, the prescription-drug business is either complex and challenged, or ripe for a new option.”

A month after the CNBC report, on June 16, Amazon unveiled its plans to acquire Whole Foods. So how would this deal change Amazon’s prospects in the pharmacy and/or PBM space, as well as those of other companies?

In a June 18 research note, Citi Research analyst Garen Sarafian noted that the Whole Foods acquisition would give Amazon more than 450 physical locations across the U.S. “In the past, the grocery store chain has

Ruling Likely Will Speed Up Launch Dates for Biosimilars

The U.S. Supreme Court recently issued a ruling in a closely watched case over the first biosimilar drug to launch in the U.S. While the court did not fully resolve the case, remanding one aspect to the U.S. Court of Appeals for the Federal Circuit, it did clarify that the Biologics Price Competition and Innovation Act (BPCIA) did not intend to force biosimilar manufacturers to wait until the FDA approves their product to give 180 days’ notice of commercial marketing to the reference drug manufacturer. This should promote competition and potentially bring down prices of some costly biologics sooner than a lower court had ruled — potentially as soon as a drug is approved, assuming appropriate notice of marketing is given.

The ruling came on June 12, almost three years after Amgen Inc. filed the original lawsuit (No. 15-1309) against Sandoz Inc. and its drug Zarxio (filgrastim-sndz), a biosimilar version of Amgen’s Neupogen (filgrastim). In addition to when the six-month marketing notice could be given, the issue of whether a biosimilar company needed to follow the so-called “patent dance” detailed in the BPCIA by which biosimilar and brand companies exchanged information on their products also was contested. The Supreme Court ruled that the process was not mandatory, noting that the BPCIA spells out patent-infringement remedies available to reference drug sponsors. But the court did not rule on whether companies had options under state laws, leaving that to the Federal Circuit to decide.

Amgen did not respond to an AIS Health request for comment on the ruling.

“Biosimilars offer significant value to patients, providers and payers, increasing the number of treatment options available to patients across many disease areas at a reduced cost to the healthcare system. The Justices’ unanimous ruling on the notice of commercial marketing will help expedite patient access to life-enhancing treatments. We also appreciate the clarity provided on the patent dance, which will help the biosimilars industry move forward,” said Carol Lynch, global head of biopharmaceuticals at Sandoz.

“Today’s unanimous Supreme Court ruling opens the door wider to more affordable access to medicines,” says Jennifer Luddy, a spokesperson for Express Scripts Holding Co. She points to the PBM’s estimate of $250 billion in savings over the next decade if biosimilars of 11 biologics are approved. The two biosimilars on the market already — Zarxio and Inflectra (infliximab-dyyb) — are for two of those reference drugs for which savings are estimated, Neupogen and Remicade (infliximab), respectively. The FDA has approved a second biosimilar Remicade, Renfleix (infliximab-abda), which has yet to launch. Express Scripts estimates that Neupogen biosimilars could provide $5.7 billion of those savings, while Remicade biosimilars could bring $17 billion in savings.

by Angela Maas
A typical market entry point might include building or acquiring a mail pharmacy, but there could also be other approaches such as acquiring a prescription drug wholesaler, PBM or plan sponsor with pharmacy assets and building from there,” among other options.

It’s likely that at least initially, a company such as Amazon would need to get prescription drugs through a distributor. That would be “an interesting selection process,” said Sarafian, considering that each of the three big distributors is aligned with a major retail chain: AmerisourceBergen Corp. with Walgreen Boots Alliance, Inc.; Cardinal Health with CVS Health; and McKesson Corp. with Wal-Mart Stores Inc.

“Longer term, should Amazon enter the retail pharmacy market and source generic Rx direct, it would unfavorably impact distributors to the extent it took market share from existing distributor clients, indirectly reducing their volumes and ultimately profits,” said Sarafian. PBMs, he said, “should also be on guard” although not immediately due to the deep skill set required of these companies. “To the contrary, we think there could be some interesting opportunities for PBMs to work with Amazon, collaborating on consumer-facing technology that is generally not a payor skill-set, and/or including Amazon as part of a pharmacy network, which could include any future Amazon-owned retail locations.”

Ultimately, said Sarafian, the Whole Foods deal “inevitably changes the [pharmacy] landscape on multiple fronts, but also creates certain opportunities.”

Contact Cichy at scichy@monarchsp.com, Muken at Ross.Muken@evercoreisi.com and Sarafian at garen.sarafian@citi.com. ∗

by Angela Maas

---

**NEWS BRIEFS**

♦ The Trump administration is preparing an executive order targeting drug prices, according to The New York Times, which obtained a draft copy of the order on June 20. According to the article published that same day, many of the proposals “have long been championed by the [pharma] industry,” such as “scaling back” the 340B Drug Pricing Program and reviewing international trade agreements that could be revised “to promote greater intellectual property protection and competition in the global market.” Also mentioned were easing “regulatory or administrative actions” resulting in Medicare beneficiaries paying more for drugs than PBMs do, as well as regulations “that inappropriately or unfairly contribute to higher prices or cost-sharing for medical products for American patients.” View the Times article at http://tinyurl.com/y8d6bpkc.

♦ CMS lifted Medicare Advantage marketing and enrollment sanctions on Cigna Corp. on June 16, according to a Form 8-K filed with the U.S. Securities and Exchange Commission the same day. The agency imposed the sanctions on Jan. 21, 2016 (DBN 10/21/16, p. 3). Cigna immediately can resume marketing of its Medicare Advantage Prescription Drug and Part D plans and enroll beneficiaries with effective dates beginning July 1. View the 8-K at http://tinyurl.com/yc8gvzuc.

♦ Medication abandonment rates by new patients are 266% higher for brand-name drugs than they are for generics, according to a new report commissioned by the Association for Accessible Medicines (AAM). The report, titled Generic Drug Access & Savings in the U.S. and prepared by the QuintilesIMS Institute, says that 90% of copays for generic drugs are less than $20, but only 39% of branded drugs have similar copays. While generics represent almost 90% of prescriptions, costs for those drugs decreased to 26% of overall spending on medications last year, making it the second year in a row that the percentage of costs have come down. In addition, generics saved the U.S. health care system $253 billion in 2016, with overall savings of $1.67 trillion in the last decade. Download the report at http://RxAccessReport.us.

♦ Members of the U.S. Senate Health, Education, Labor, & Pensions Committee questioned four witnesses about prescription drug costs during a June 13 hearing. Titled The Cost of Prescription Drugs: How the Drug Delivery System Affects What Patients Pay, the hearing was the first of three on drug pricing. While the health care reform process was a dominant theme, much of the discussion also focused on value-based pricing and the difference between drugs’ list prices and net prices. Watch a video of the hearing at http://tinyurl.com/yaour66o.

♦ PERSON ON THE MOVE: Express Scripts Holding Co. named Bradley Phillips vice president, controller and chief accounting officer effective July 3. Prior to this, he was senior vice president and chief accounting officer for Peabody Energy.
If You Don’t Already Subscribe to the Newsletter, Here Are Three Easy Ways to Sign Up:

1. Return to any Web page that linked you to this issue
2. Go to the MarketPlace at www.AISHealth.com and click on “Newsletters.”
3. Call Customer Service at 800-521-4323

If you are a subscriber and want to provide regular access to the newsletter — and other subscriber-only resources at AISHealth.com — to others in your organization:

Call Customer Service at 800-521-4323 to discuss AIS’s very reasonable rates for your on-site distribution of each issue. (Please don’t forward these PDF editions without prior authorization from AIS, since strict copyright restrictions apply.)