How can the pharma value chain be more efficient?

Building a better working world

Emerging importance of an efficient pharma value chain

The pharmaceutical value chain has experienced increased scrutiny in recent years, as reflected most recently through President Trump's proposed American Patients First plan that seeks to lower drug costs and reduce out-of-pocket expenses. There also is now a greater media focus on drug pricing set by the manufacturers and/or the transparency around financial transactions between manufacturers, plan sponsors and the intermediaries such as pharmacy benefit managers (PBMs). These factors, as well as an increase in the number of high-cost therapies, are incentivizing employers, PBMs, manufacturers and other stakeholders to reassess their business models and contracting arrangements for distribution and reimbursement.

Many employers and pharmaceutical manufacturers are exploring disintermediation strategies that would exclude or limit the role of the PBM in the pharmaceutical value chain. By disintermediating the PBM:

- Employers/plan sponsors hypothesize they can reduce overall spend on high-cost therapies
- Manufacturers expect improved net prices through elimination of rebates and other fees paid to PBMs

These strategies are taking several forms and are likely to serve as a basis for a new paradigm for how high-cost therapies are valued and reimbursed in the future.

Streamlining the pharmacy value chain offers opportunity to lower costs, preserve value and help patients.

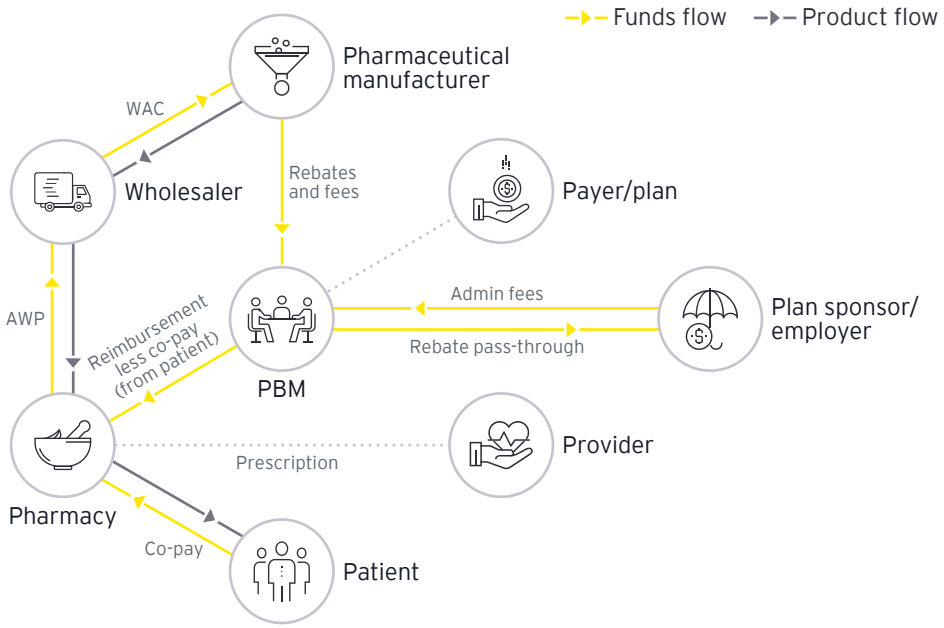
A complex network

PBMs sit at the nexus of many stakeholders across the pharmaceutical value chain due to their financial arrangements with nearly all stakeholders. Employers and plan sponsors, which are the primary customers of PBMs, pay PBMs to manage prescription drug benefit claims processing, formulary design, network access, prior authorizations and other prescription drug benefit design elements. This provides value to employers that do not have prescription drug benefits management as a core competency.

PBMs receive payments, in the form of discounts, rebates and other fees, from manufacturers to secure market access on a formulary (the list of approved drugs that a plan sponsor will cover). A conflict of interest arises if PBMs are being paid both by manufacturers and by employers/plan sponsors. These payments may create a dynamic in which the PBM could prioritize access to drugs that have greater rebates and fees from manufacturers at the expense of employers and plan sponsors. While PBMs indicate that most, if not all, rebates are passed through to employers and plan sponsors, employers are skeptical of that assertion. This skepticism has given rise to transparent PBMs that provide greater details of their dealings with manufacturers and several employer coalitions that are attempting to disrupt the model.

Going a step beyond demanding transparency, some employers/plan sponsors and other stakeholders have begun to explore models that fully or partially disintermediate a PBM. The following describes the various models that are being tested in the market.

Pharmaceutical value chain



AWP = average wholesale price; WAC = wholesale acquisition cost
Source: EY-Parthenon

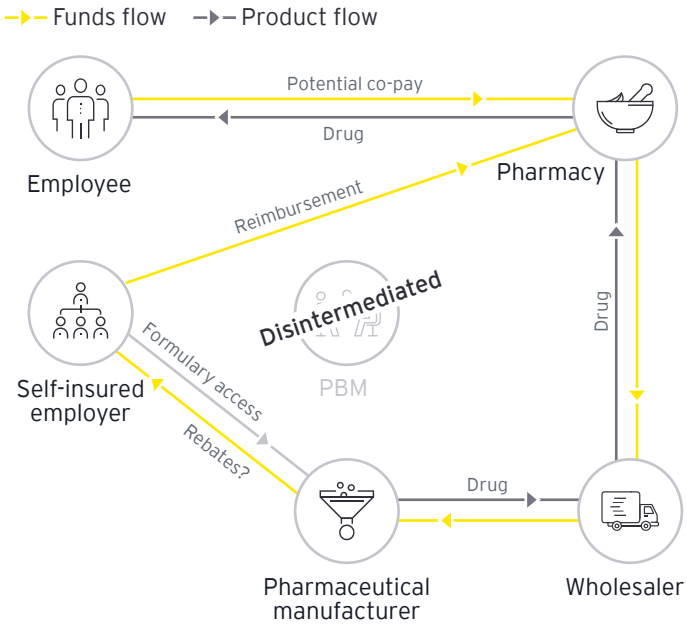
Opportunities for intervention

Trend 1: Direct contracting — complete disintermediation

Employers and other plan sponsors may bypass a PBM by contracting directly with pharmacies and manufacturers to provide their employees with their pharmaceutical needs. In such an arrangement, pharmacies submit claims either to the employers directly or to a third-party administrator for adjudication before direct payment from the employer. This model requires an employer to develop and maintain its own formulary and contracts directly with pharma manufacturers to capture all pricing credits and rebates. This type of complete disintermediation has yet to take hold in the market, but it is an option being explored by large employers.

This contracting paradigm has the potential to reduce employers' spend on their prescription drug benefit by eliminating the fees and costs associated with PBMs. Drug manufacturers and pharmacies will need to prepare for entering these types of agreements with employers, which may require new organizational infrastructure to support new solution providers that are performing the duties of a single PBM.

Complete PBM disintermediation



Source: EY-Parthenon

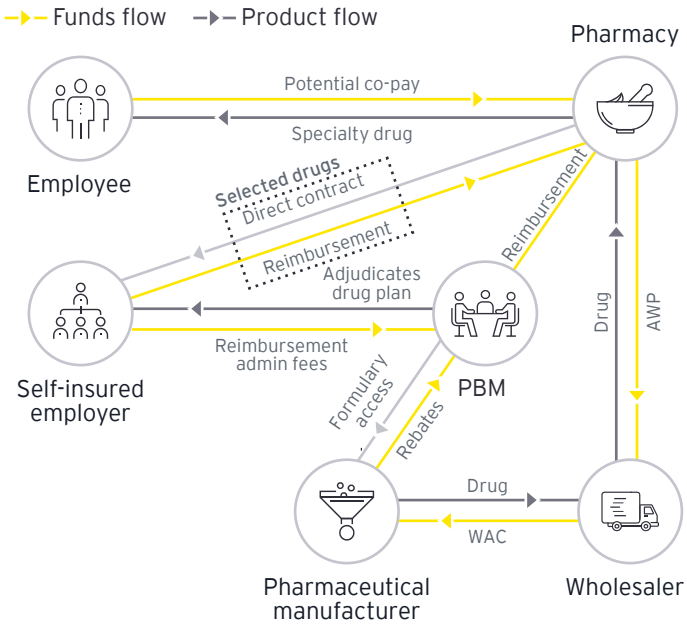
Trend 2: Limited contracting — partial disintermediation

In a hybrid model, PBMs may be used for a limited subset of pharmaceutical products or for treating certain conditions. For example, with some new high-cost gene therapies that may exceed $1m for a one-time treatment, employers are bypassing PBMs and directly paying either the manufacturer or a specialty pharmacy for the drug — often through milestone-based payment schedules, such as those in place for some gene therapies. For other employers, the complete medical treatment of employees who have high-cost chronic diseases, such as diabetes or heart disease, has been transitioned to a value-based payment system in which a partner with health care systems can offer a holistic approach to disease management.

These examples show a carve-out for only a single therapy or condition, but with the increased focus of employers on high-cost therapies and patients, this type of contracting may expand to include common biologics like insulin or other therapy classes.

All members of the value chain can be disrupted by this type of contracting, and those that are willing to embrace increasing disintermediation and have properly planned to engage in these creative arrangements may benefit through a redistribution of dollars that are potentially not being used for patient care.

Partial PBM disintermediation



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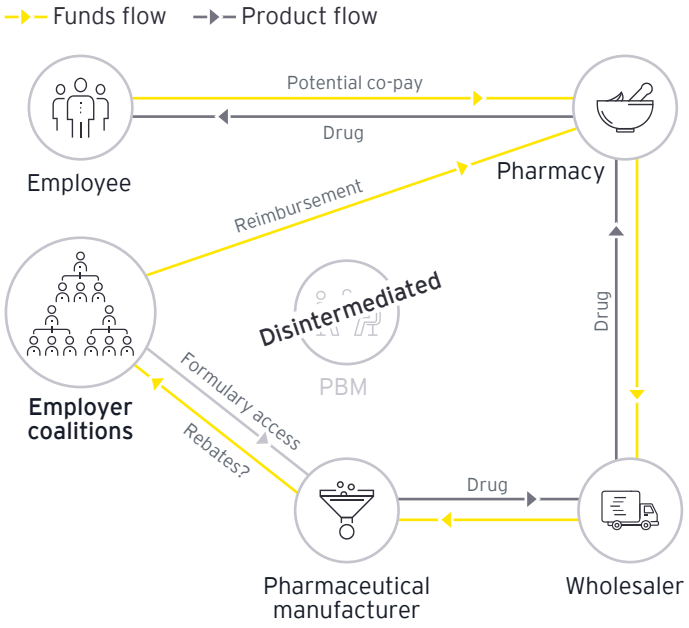
Trend 3: Employer coalitions — enabling disintermediation

The previously mentioned models are most easily implemented with the involvement of large employers that have the resources and purchasing power to negotiate and direct these arrangements. Such contracts may become more accessible to smaller employers if they are members of employer health purchasing coalitions that bring together resources and purchasing power. This combined power allows midsize and small businesses to obtain more favorable terms and potentially creative contracts. With these creative contracts enabled for smaller businesses, the possibility of disintermediation for PBMs may become more widespread.

The coalitions offer an alternative market for unique contracting, which could include PBM disintermediation, with pharmaceutical manufacturers and pharmacies looking to explore and test these new models. Coalitions stand to benefit from adopting emerging models to provide cost savings and improved returns for their members, as well as increasing the value provided to plan sponsors.

Employer coalitions



Source: EY-Parthenon

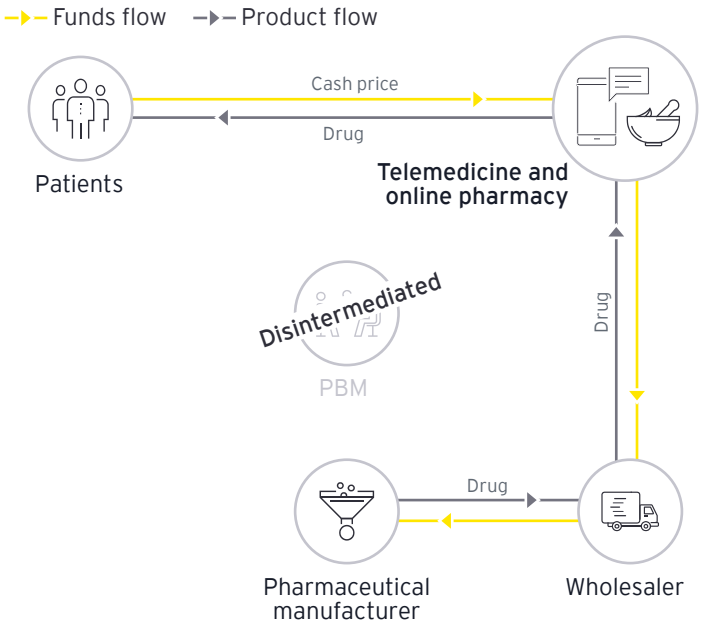
Trend 4: Direct-to-consumer self-pay e-commerce — consumer-driven disintermediation

E-commerce sales of prescriptions directly to consumers through online platforms, where the full costs are paid by consumers (cash/self-pay), have also emerged as a new model that disintermediates PBMs and potentially other stakeholders. This is most common for "lifestyle" drugs, such as sexual health, dermatology, hair loss or other low-cost generics that insurance may not cover or that result in lower costs for patients.

While online pharmacies have existed for some time, they have garnered new attention. Now, large tech companies are making investments in the pharmacy business and combining — on one platform — telemedicine for prescription writing and online drug purchasing.

As the significant use of telemedicine appears to be here to stay, even after the current COVID-19 crisis abates, it is possible that more consumers will be looking to purchase their prescriptions online. Partnerships between telemedicine providers and pharmacies could become more important and may lead to increased profitability for both parties.

Self-pay DTC



Source: EY-Parthenon

Conclusion

As the pharmaceutical value chain evolves with these new models, stakeholders across the entire value chain will be faced with critical strategic questions:

Manufacturers

- What organizational infrastructure and capabilities do I need to contract directly with employers/plan sponsors?
- How will my relationships with PBMs be impacted by pursuing these disintermediation strategies?
- What therapeutic areas or specific drugs would be most applicable for pilot programs of these models?
- How will my pricing strategy change by employing a variety of disintermediation strategies?
- How can I maintain profitability in a limited- or no-rebate environment?

Employers/plan sponsors

- What technology or process requirements will be required to operationalize these new models?
- What therapeutic areas or classes of drugs would be best for a pilot program?
- How do I need to change my financial planning processes to account for limited- or no-rebate conditions?
- How can I confirm that the member experience is not negatively impacted by transitioning patients to a new contracting model?
- What services do I need to continue to outsource to PBMs or other third parties?
- How will these new models change how I utilize benefits consultants as part of plan design?

Pharmacy benefit managers

- What set of diversified services can be provided to manufacturers and plan sponsors to retain their business and relationships?
- How can I transition to a more transparent model or full pass-through model to reduce the risk of being disintermediated?
- How will my manufacturers' and plan sponsors' account managers need to evolve in these new models?
- How can I maintain a consistent member experience in an environment where plan sponsors may have therapeutic area carve-outs?

The role of PBMs has been changing rapidly, and the impact of COVID-19 is likely to accelerate these changes as more employers, pharmacies and pharmaceutical manufacturers invest in exploring and implementing innovative solutions within the pharmaceutical value chain. Gaining a better understanding of the opportunities and challenges that come with these new models will be imperative for stakeholders to adapt successfully to this evolving pharmaceutical landscape.

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