Evaluate Vantage

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Vantage point – US insurer mergers shrink drug buyer pool

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First came the eye-watering pharma bills; now payers and providers are flexing their muscles. The US healthcare market is undergoing swift consolidation as the effects of reforms implemented under the Affordable Care Act are felt across the country.

The upshot is that insurers, hospitals and physician practices are reorganising to align themselves towards lowered costs and quality assurance systems that can fit some of the requirements of the law. Big insurers are getting bigger, while hospitals and physicians are organising themselves into local plans.

“In order to bolster bargaining power in the setting of rising costs, merger-mania is furiously under way among all key stakeholders, including health sciences companies, health insurers, and providers in the US,” says Mark Fendrick, director of the University of Michigan Centre for Value-Based Insurance Design.

Big fish get bigger

Two transactions proposed last month would transform the competition at the top of the US health insurance market. First, Aetna proposed buying Humana to create a company that would cover 33 million people, making it America’s second-largest health insurer after UnitedHealth Group, which insures 42 million.

That move was followed by Anthem’s deal for Cigna, which would create the very largest insurer at nearly 43 million people covered, and push Aetna-Humana into third place.

Both deals were enabled by the US Supreme Court’s decision in King vs Burwell, which confirmed that there would be no legally mandated changes to the structure of the federal health insurance exchanges established under the Affordable Care Act, commonly known as “Obamacare".

Essentially, the insurers were waiting for confirmation that the framework of the law would stand before committing themselves to consolidation, Dan Mendelson, chief executive of the Washington-based consultancy Avalere Health, explains. “The decision created operating stability for the large companies that invested in the new marketplace. They could rest assured, at least for the next couple of years, that this structure is going to stay in place.”

These transactions are primarily about building scale in health insurance exchanges made possible by the Affordable Care Act – however, in the long term they signal a marketplace with a shrinking number of buyers, a trend that could give payers more leverage in negotiations with drugmakers.

One of the more immediate consequences of the consolidation could be increased buying leverage for the pharmacy benefit manager (PBM) CVS Health. Humana uses its own in-house PBM, but Aetna contracts with CVS, suggesting that the Humana population could come under CVS management. A report from Moody's Investors Service commenting on the transaction says the standard CVS formulary excludes 97 branded drugs, although not every plan uses that standard formulary.

“Insurers’ strengthening market share will escalate reimbursement pressure over time, which will reduce the use of some pharmaceutical products and depress pricing on others,” the report states.

Both CVS and its competitor at the top of the PBM world, Express Scripts, have in recent days announced formulary exclusions for 2016 – casualties have included the diabetes pill Onglyza and constipation drug Amitiza – showing the already substantial market power of these organisations.

These exclusion announcements are an annual event that has taken on greater weight as the number of newly approved agents has grown and their cost has increased. Word on PBMs’ view of expensive new cholesterol drugs from Sanofi, Regeneron and Amgen will be watched closely as they are launched this year.

CVS executives have written a commentary urging physicians to revise cholesterol management guidelines to emphasise high-dose statin use and target-based treatment approaches because of the potential for the new agents to bust budgets.

Transformed hospital market

Insurers are not the only players consolidating – hospitals are merging and buying physician practices, sometimes to organise themselves into local health plans to offer an alternative to traditional insurers in state marketplaces. The hospital consulting firm Kaufman Hall reported 95 hospital mergers or acquisitions in 2014, the third consecutive year they have been at that level or above – in 2010, the year the Affordable Care Act was passed, the number was 66.

“These mergers are really intended to help accomplish the same objectives that the administration has for the US healthcare system. They want a more quality-oriented system that lowers cost for the consumer, and one of the ways to get that is through scale,” Mr Mendelson says. “There is undoubtedly going to be more consolidation in this market because there are returns to scale.”

The consolidation by hospitals is partly pushback against the growing power of the insurers, but is also a bid to control their own costs by increasing their purchasing muscle. When multiple hospitals merge, this puts more power in the hands of a single pharmacy and therapeutics committee. This is amplified further when those consolidated health systems buy up the practices of their top admitting specialist physicians.

The power to control which drugs are prescribed takes on greater significance when providers and pharma companies are competing for the same finite flow of dollars.

“As we come to market with more expensive therapies, the [pharma] industry is going to have to answer the question of where the funding is coming from,” says Kevin Schulman, a professor of medicine, business administration and global health at Duke University.

“It’s going to be a competition not between the pharma industry and the health insurance industry, but between the pharma industry and providers, because the providers have leverage and write the scripts. Providers aren’t necessarily going to sign up for lower reimbursement so that a hep C therapy can come to market for $100,000.”

At its core, larger healthcare organisations ought to enable better evaluation of which treatments yield the best outcomes, be they pharmaceutical or interventional. The University of Michigan’s Mr Fendrick says, however, that consolidation alone does not achieve higher quality healthcare, and can be just an exercise in cost-cutting.

“While consolidation may impact the flow of dollars this does not directly address a fundamental inefficiency regarding American healthcare spending,” he says. “Solutions are necessary to better allocate health expenditures on the clinical benefit achieved – not the price or profitability of clinical services provided.”

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