Consolidation in US health care negatively impacts cancer care

Consolidation in the US health-care sector has been rising over the past two decades, with mergers and acquisitions of national players occurring at multiple levels of the supply chain, including pharmacies. The pharmacy marketplace has undergone substantial changes, with vertical and horizontal consolidation, independent pharmacies facing increasing challenges, the growth of specialty pharmacies, and the exponential presence and influence of pharmacy benefit managers (PBMs). The landscape is complex, with conflicting views and theories on the impact of these market changes, and whether they are driving up cost and out-of-pocket expenses for patients with cancer.

The major chains have expanded from simply being pharmacies to incorporating retail health-care clinics into their locations, as well as investing in related businesses. Chain pharmacies, such as Walgreens and CVS Health, line the streets of neighbourhoods nationwide, and together, these two companies account for roughly 40% of the prescription market. In 2015, CVS acquired Target's 1672 pharmacies across 47 states and is operating them through a store-within-a-store format (Target is the seventh largest retailer in the country), and also acquired Omnicare, the leading provider of pharmacy services to long-term care facilities. 2 years later, CVS announced its acquisition of health insurer Aetna, making it the largest health-care merger in US history. The American Medical Association had opposed the merger, citing that it violated federal antitrust law and would possibly harm patients by reducing competition in certain pharmaceutical benefit markets, leading to higher premiums and lower-quality insurance products. The acquisition passed federal scrutiny in 2018, and in September, 2022, CVS has sought to expand into the home health market by acquiring Signify, a company that offers analytics and technology to help a network of 10 000 doctors provide in-home health care to 2·5 million patients.

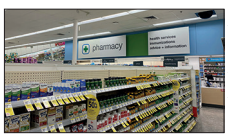
By contrast, Walgreens has also expanded, but stayed primarily in the pharmacy market alone. The second largest pharmacy store chain in the US behind CVS Health, Walgreens has been busy eliminating its competition by consolidating other chains and related e-commerce into its brand. During the past decade, Walgreens acquired New York City-area chain Duane Reade; Drugstore.com and Beauty.com; Alliance Boots; the mid-south drug store chain operating under USA Drug, Super D Drug, May's Drug, Med-X, and Drug Warehouse banners; and, finally, the drug store chain Rite-Aid.

However, some argue that these acquisitions might have little effect on patients with cancer. "Although retail pharmacy consolidation might create some inconveniences for patients, the consolidation of pharmacies is not expected to have much of an impact on cancer care in the community setting", says Ann Johnson (Pharmacy Healthcare Solutions, Pittsburgh, PA, USA). "The costs that patients pay for drugs, such as their copays, are set by the health plans and PBMs, not the pharmacies themselves, so pharmacy consolidation will not lead to higher prices for consumers. Likewise, from the pharmacy's perspective, the amount that the pharmacy is reimbursed is established in their PBM network agreements."

Oncology drugs were traditionally administered in health-care settings, but the advent of oral anticancer agents has changed that dynamic. Although some patients do get their medications at a retail pharmacy, most use a specialty pharmacy or receive them by mail order. Additionally, a model known as medically integrated dispensing allows oncologists to dispense oral anticancer drugs at their practices in on-site pharmacies. Far more threatening to the integrity of cancer care are the other types of consolidations, where the insurer, physician, and PBM are all connected, says Nicolas Ferreyros (Community Oncology Alliance, Washington, DC, USA).

One area of concern is the vertical integration of insurers and physicians, in which the insurance companies provide their own practitioners, says Ferreyros. One example is UnitedHealthcare, the largest health insurer in the USA and also the largest single employer of doctors in the country. UnitedHealth Group's subsidiary, OptumCare, has approximately 43 000 affiliated or employed physicians; the Optum health-care subsidiary also includes MedExpress urgent care facilities, Surgical Care Affiliates ambulatory surgery centres, HouseCalls home visits, behavioural health, care management, and Rally Health wellness and digital consumer engagement. "They can control primary care referrals and they can control prescriptions and being a fully integrated entity, keep everything in their network", says Ferreyros. "Decisions are not always made in best interest of patients or the best value."

Another major concern is PBM consolidation, which dramatically affects cancer care in terms of prescription drugs. Although PBMs have been around since the 1980s, they have faced growing scrutiny as to their lack of transparency and role in escalating prescription drug costs and spending. In simple terms, PBMs are companies that manage prescription drug benefits on behalf of health insurers, government programmes, such as Medicare drug plans, large employers, and other payers. Since PBMs negotiate directly with drug manufacturers and pharmacies to



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For more on **PBM's role in drug pricing** see https://www.commonwealthfund.org/publications/explainer/2019/apr/pharmacy-benefit-managers-and-their-role-drug-spending, *JCO Oncol Pract* 2020; **16:** 276–84, and https://www.marketwatch.com/story/cignas-latest-deal-could-spell-trouble-for-consumers-2018-03-09

For more on the **increasing number of mergers** see https://www.pharmacytimes.com/view/pharmacy-wars-an-era-of-acquisition-mergers-and-losses

For more on **Community Oncology Alliance concerns regarding PBM integration** see https://communityoncology.org/reports-and-publications/comment-letters/coa-formal-comments-to-ftc-on-harm-of-pharmacy-benefit-manager-integration/

For more on the **Community Oncology Alliance in 2020** see https://communityoncology.org/reports-and-publications/studies-and-reports/2020-community-oncology-alliance-practice-impact-report/

For more on the **costs for patients in a hospital setting** see *J Oncol Pract* 2018; **12:** e729–38 and https://communityoncology.org/reports-and-publications/studies-and-reports/the-value-of-community-oncology-site-of-care-cost-analysis/

control drug spending, they can have a substantial impact in determining total drug costs for insurers, patient access to medications, and how much pharmacies are paid.

Ferreyros explained that PBMs are more likely to push for branded drugs, as opposed to generics or biosimilars, since they might have an incentive to favour high-priced drugs. Since PBMs often receive rebates that are calculated as a percentage of the manufacturer's list price, they receive a larger rebate for the higher cost drugs, as opposed to drugs that provide better value at a lower cost. "Patients with high deductibles or copays based on a drug's list price can end up paying more out of pocket", Ferreyros said.

Consolidation of PBMs is even more concerning as it has left a small number of corporations with an unwieldy level of control and influence in the health-care system. Although dozens of PBMs exist, the three largest ones by market share are all vertically integrated with a large downstream insurer: Caremark with CVS/Aetna, Express Scripts with Cigna, and OptumRx with United. The largest PBM not owned by a single health insurer is Prime Therapeutics, which is owned by 14 Blue Cross and Blue Shield health plans.

"This is not good for any patients", says Matthew Seiler (National Community Pharmacists Association, Alexandria, VA, USA). "PBMs integrate upstream with the insurer and downstream with pharma, and this creates an issue of access."

Seiler notes that patients might be unable to use the pharmacy of their choice because it is "not in network," and instead are steered to the integrated pharmacies. "They might have to use mail order instead, for example", said Seiler. "This creates delays in getting the medication, prices might be higher, and so on. Patients are not given a choice and there is no transparency in the cost."

Consolidation in this space is not new, as pharmaceutical companies tried to buy PBMs during the 1990s, but were blocked by the Federal Trade Commission (FTC). The situation changed during the 2000s and onward, which saw a huge uptick in assorted mergers. However, the FTC has now launched a new formal study into PBMs that will require the six largest (CVS Caremark, Express Scripts, OptumRx, Humana, Prime Therapeutics, and MedImpact Healthcare Systems) to hand over information on PBM business practices, including fees and clawbacks charged to unaffiliated pharmacies, patient steering, audits of independent pharmacies, and reimbursement. Since its launch on Feb 24, 2022, the FTC has received more than 24 000 public comments. The agency notes that many of the functions of PBMs "depend on highly complicated, opaque contractual relationships that are difficult or impossible to understand for patients and independent businesses across the prescription drug system."

"Although many people have never heard of pharmacy benefit managers, these powerful middlemen have enormous influence over the US prescription drug system", said Lina M Khan (FTC, Washington, DC, USA) in a statement. "This study will shine a light on these companies' practices and their impact on pharmacies, payers, doctors, and patients."

But an even more concerning trend in health-care consolidation is the disappearance of independent oncology practices. During the past 12 years, 1748 community oncology clinics and practices have closed, been acquired by hospitals, undergone corporate mergers, or reported that they are struggling financially. Community Oncology Alliance has been tracking the changing landscape of community cancer care since 2008, with their latest report issued in 2020. Their results showed that, since 2018, there has been a 20·8% increase in practices merging with, or being acquired by, another community oncology practice or acquired by a corporate entity. This large increase in mergers is most likely due to practices seeking protection from hospital merger pressures, although the rate of practices being acquired by hospitals continued to rise at a steady pace, with a nearly 10% increase from 2018 to 2020.

Community Oncology Alliance notes that the two major issues with the loss of community practices are access and cost. When rural clinics are closed, for example, this creates an access problem, as patients might have to travel much further for care. This access problem can cause particular hardship if patients have transport or mobility challenges.

"Cost is an important issue, as studies have shown that cancer care in the hospital setting is more expensive", says Ferreyros. A study showed that the total cost of care for patients who received chemotherapy in hospital outpatient facilities was almost 60% higher than the same treatment at independent practices. These findings are consistent with ten previous studies done between 2011 and 2016 that also showed hospital outpatient costs were 38% higher on average. The larger difference seen in Community Oncology Alliance's study might reflect the increased costs of new biological drugs, more expensive radiology, and higher hospital fees.

Increased PBM and pharmacy consolidation, along with the steady disappearance of independent oncology practices, might be placing more barriers to accessible and affordable cancer care. Health-care mergers and acquisitions are continuing at a steady pace, but might negatively effect cost, quality, and accessibility of cancer care.

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