

# Market Intelligence Report for Q2 2016

July 15, 2016

\*Sources:

- EverCore ISI Research Analyst Reports
- MedImpact Marketplace Monitor Reports
- AIS Health/Drug Benefit News
- Cleveland Research
- JP Morgan Investor Relations
- Goldman Sachs Investor Relations
- Barclay's Investor Relations
- Kaiser Health News
- Drug Channels Blog
- Modern Healthcare
- Various newswire services

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Note: items deemed to be highly relevant by MedImpact Market Intelligence team have been **highlighted** below. Primary topic category is in parentheses following article title; topics include Competitors, Supply Chain (pharmacies, wholesalers), Payers & Plan Sponsors, and Market Trends.

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## Upcoming Industry Events

### **ACAP CEO Summit**

June 28-29, 2016 in Washington, D.C.

[Conference Website](#)

### **Michigan Association of Health Plans Conference**

Jul. 20-22, 2016 in Acme, MI

[Conference Website](#)

### **NACDS Total Store Expo**

Aug. 6-9, 2016 in Boston, MA

[Conference Website](#)

### **Florida Association of Health Plans Annual Conference**

Sept. 14-16, 2016 in Orlando, FL

[Conference Website](#)

### **PCMA Annual Meeting**

Sept. 19-20, 2016 in Scottsdale, AZ

[Conference Website](#)

### **Medicaid Health Plans of America Conference**

Sept. 21-23, 2016 in Washington, D.C.

[Conference Website](#)

**March 2016****3/25 – Nearly All U.S. Doctors 'Overprescribe' Addictive Narcotic Painkillers: Survey (Market Trends)**

When American doctors give their patients narcotic painkillers, 99 percent of them hand out prescriptions that exceed the federally recommended three-day dosage limit, new research suggests. And some doctors exceeded that limit by a lot: Nearly one-quarter gave out month-long dosages, despite the fact that research has shown that a month's use of prescription narcotic painkillers can cause brain changes, the National Safety Council survey found.

The problem has reached the point where these highly addictive painkillers, which include commonly prescribed drugs such as Oxycontin, Percocet and Vicodin, now account for more drug overdose deaths than heroin and cocaine combined, according to the report. The survey results, conducted in early March and released Thursday, come at a time when drug overdoses have reached record highs in the United States. Just this month, two federal agencies proposed measures to try to curb the narcotic painkiller abuse epidemic.

Source: <http://consumer.healthday.com/bone-and-joint-information-4/oxycontin-news-861/nearly-all-u-s-doctors-overprescribe-addictive-narcotic-painkillers-709352.html>

**3/28 – Obama tackles heroin and prescription drugs addiction in new initiative (Market Trends)**

President Barack Obama will announce a series of new public and private sector initiatives Tuesday designed to expand treatment, funding and education to combat the nation's prescription opioid and heroin abuse problem.

The President will announce plans to require Medicaid and the Children's Health Insurance Program to provide mental health and substance abuse services for clients on par with both programs' medical and surgical benefits. If the Department of Health and Human Services adopts the proposal, it would improve access to counseling and drug services for more than 23 million people enrolled in Medicaid and CHIP.

Obama also will announce a new interagency task force, chaired by the Domestic Policy Council, that will be charged with ensuring implementation of the parity protections by Oct. 31. President Obama's 2017 budget proposal calls for \$1.1 billion in new federal money to combat the growing abuse of heroin and prescription painkillers in the United States.

Source: <http://www.kansascity.com/news/politics-government/article68711237.html>

**3/28 – AMA, other groups urge CMS to modify accountable care organization benchmarking (Market Trends)**

Twenty physician organizations and other healthcare groups, including the [American Medical Association](#), have submitted joint comments to the Centers for Medicare and Medicaid Services praising the agency for some of its changes but say there is room for improvement in a proposed rule regarding [Accountable Care](#) Organizations in the Medicare Shared Savings Program.

The groups want CMS to honor the current policy that accounts for savings in rebased benchmarks, rather than punishing ACOs that worked hard to earn savings in previous agreements. They asked CMS to enhance the proposal and reopen ACO determinations to include greater opportunities, especially when CMS errors are the cause. They also proposed shortening the timeframe from four to two years.

Source: <http://www.healthcarefinancenews.com/news/ama-other-organizations-urge-cms-modify-accountable-care-organization-benchmarking-methodology>

April 2016

#### 4/1 – ADVI Aware Health Policy Update (Market Trends)

ADVI Aware is a snapshot of March's key health policy topics. News items are available for viewing by clicking on the hyperlink in the "Source" section below. This month's issue includes:

##### Actions and Activities of Key Governmental Agencies

###### CMS

- CMS Reveals New CMMI Initiative in Notice of Information Collection Request
- CMS Releases CY 2017 Final Notice of Benefit and Payment Parameters and Final Letter to Issuers in the FFEs
- CMS Announces Next Generation Accountable Care Organization Model Second Application Cycle
- CMS Releases 2016 Value Modifier Results and Upward Payment Adjustment Factor
- Medicare Part B Drug Payment Model Proposed Rule
- Medicare Pilot Program for Diabetes Prevention Could Save Lives and Money
- CMS Released DMEPOS Competitive Bidding Payment Amounts for Round 2 Recompete & National Mail-Order Recompete and Begins Sending Contract Offers
- CMS Releases White Paper and Holds Public Hearing to Discuss Potential ACA Risk Adjustment Changes
- CMS Implements Transition Period Before Enforcing AMP Provisions for 5i Drugs for Drug Manufacturers Participating in MDR Program

##### Important Announcements, Web Events, Publications, and Upcoming Meetings

- MedPAC Meeting March 2016
- ICER Releases Final Reports on Diabetes and Asthma Drugs
- ICER Releases White Paper on Indication-specific Pricing for Drugs
- Highmark Unveils Bundled Payment Model for Cancer Care
- ICER Releases Obeticholic Acid Draft Scoping Document
- National Health Council Announces Patient-Centered Value Model

Source:

[https://na2.salesforce.com/sfc/p/30000000062Y/a/40000000bmaB/wd6Zv.W9aj4impzd\\_IW8nvJ2k0vs5sGKpSeS8w65ACU](https://na2.salesforce.com/sfc/p/30000000062Y/a/40000000bmaB/wd6Zv.W9aj4impzd_IW8nvJ2k0vs5sGKpSeS8w65ACU)

#### 4/3 – CVS, Express Scripts plan value-based drug pricing (Competitors)

Recently [CVS](#) and [Express Scripts](#) announced they are rolling out plans to determine the price and access to cancer drugs based on the value per indication.

The approaches reflect a growing number of initiatives meant to tie drug prices to value, such as an analytic tool deployed by a Memorial Sloan Kettering doctor in 2015.

Peter Bach, MD, director of Memorial Sloan Kettering's Center for Health Policy and Outcomes, released the tool called the "DrugAbacus," which allows users to modify a number of parameters and compare a given drug's actual price versus the calculated value-based price derived from the parameters.

Health plans are using the abacus to determine what drugs to pay for when setting up one size fits all pathways.

"There are a broad spectrum of options for implementing value-based contracting," says Christine Cramer, spokesperson for CVS Health. "These include contracting with drug manufacturers as well as with providers in ways to ensure both cost effectiveness and improved outcomes. At CVS Health, we are in the process of exploring various options and developing new capabilities in this area."

For example, says Cramer, CVS is currently developing value-based contracting approaches within its exclusion formularies, which align discounts to specific indications rather than at the level of broad therapeutic categories.

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“For many drugs, particularly oncology agents and drugs for autoimmune diseases, one drug may have several different indications and the number of competitive drugs or the clinical utility may vary by indication,” she explains. “By negotiating formulary positions based on the specific indications we are able to create greater competition, lower costs and improve value for our clients.

“Keep in mind that overall, these types of contracts are very complex and are often influenced by government regulations and are dependent on process and infrastructure,” Cramer says.

According to [DrugWonks.com](http://DrugWonks.com), at a recent National Business Coalition on Health panel discussion, CVS vice president and head of specialty client solutions Surya Singh, MD, said: “I think we want to pay more for drugs that work better ... to push [manufacturers] to think about pricing things that have a better impact on survival at a higher price point and pricing things that don't have as much impact on survival at a lower price point.”

Singh went on to say: “Herceptin has gotten a lot of attention for being very good in breast cancer. It's very well studied and has great benefits. ...It's also used in gastric cancer. The benefit in gastric cancer is minimal, but [the indication] is on label. Should we pay the same for the drug on a unit cost basis when it's used for something where it doesn't work as well? I don't think so.”

Robert Goldberg, PhD, vice president and cofounder, Center for Medicine in the Public Interest, said in a recent DrugWonks blog post: “Except that prior to Herceptin, people with advanced gastric cancer had no other treatment options. It was originally given to the 15% of gastric cancer patients that had ERBB2 overexpression and/or amplification. Overall survival was modest [2.7 months] but significant because of dearth of other therapies to keep people alive. Now there are large initiatives to identify subsets of gastroesophageal cancer based on patterns of immune response. That's how innovation evolves. Cutting the price of taking on the most challenging tumor types cheapens the lives of those seeking to survive.”

Source: <http://managedhealthcareexecutive.modernmedicine.com/managed-healthcare-executive/news/cvs-express-scripts-plan-value-based-drug-pricing>

#### **4/3 – Navitus Health Solutions expands in Appleton, WI (Competitors)**

Construction is underway now on a second Navitus building next door with a price tag of more than \$13 million. It's 70 percent larger, at 120,000 square feet, than the first building and will be able to house up to 500 employees when it's ready in October.

The Madison-based Navitus is a pharmacy benefits company formed in 2003. It creates and administers pharmacy plans for government entities, self-funded employers and health plans, and today serves more than 400 companies nationwide. Besides Madison and Appleton, it has smaller offices in Phoenix and Austin.

The full article is available here: <http://www.postcrescent.com/story/money/companies/2016/04/03/navitus-health-solutions-expands-appleton/82439680/>

#### **4/4 – Walgreens likely to be satisfied with PBM partnerships after Rite Aid acquisition (Supply Chain)**

Walgreens Boots Alliance aims to acquire competitor Rite Aid, which acquired the small pharmacy benefit manager EnvisionRx last year. Walgreens is unlikely to make the substantial investments that would be needed to turn the PBM into a major force, writes Bruce Japsen of Forbes.

Source: <http://www.forbes.com/sites/brucejapsen/2016/04/06/walgreens-unlikely-to-make-rite-aids-pbm-a-priority/#5083ec2544a6>

#### **4/5 – Revenue up, prescriptions down for top 10 best-selling drugs (Market Trends)**

Prices for four of the 10 top-selling drugs in the US have risen by more than 100% since 2011, and prices for the other six rose by more than 50%. Revenue for the 10 rose by 44% while the number of prescriptions dropped 22%, according to data from IMS Health.

Source: <http://www.reuters.com/article/us-usa-healthcare-drugpricing-idUSKCN0X10TH>

#### 4/6 – Walgreens Unlikely To Make Rite Aid's PBM A Priority (Competitors)

Walgreens Boots Alliance will inherit a pharmacy benefit manager once its deal with Rite Aid closes in the second half of this year, but don't look for the drugstore giant to make big investments in the PBM's growth even if it decides to keep it.

Rite Aid [last year spent \\$2 billion acquiring EnvisionRx](#), which is a minor player in the pharmacy benefit management industry. PBMs like Express Scripts, the OptumRx unit of UnitedHealth Group and the Caremark PBM subsidiary of CVS Health are several times the size with each processing more than one billion prescriptions annually.

Walgreens CEO Stefano Pessina acknowledged the uphill climb that would be needed to grow EnvisionRx into a player that could compete with the nation's top three PBMs in response to Wall Street analysts' questions during the company's second-quarter earnings call.

"We cannot be considered a true competitor, a competitor at the point that we cannot collaborate in the most important element of the business, which is to allow the PBM to give us a very good service to the customers," Pessina said Tuesday.

To be sure, [EnvisionRx has about \\$5 billion in annual revenues](#) while the likes of Express Scripts had north of \$100 billion in sales last year. And the bigger PBMs are growing even faster as employers and other clients look for leverage against rising drug costs.

Read the full article from Forbes here: <http://www.forbes.com/sites/brucejapsen/2016/04/06/walgreens-unlikely-to-make-rite-aids-pbm-a-priority/#4d0dba7044a6>

#### 4/7 – PCMA applauds FDA approval of 2nd biosimilar (Market Trends)

The FDA's approval of Pfizer and Celltrion's Inflectra as a biosimilar to Johnson & Johnson's Remicade will increase competition, which is key to lowering drug prices, said Pharmaceutical Care Management Association President and CEO Mark Merritt in a statement. "Increasing competition through the approval of brand and generic drug competitors is the key to lowering prescription drug costs for consumers, employers, government programs and others. To further advance the use of biosimilars, the FDA should finalize an interchangeability policy that will allow for greater patient access to these important drugs," Merritt said.

Source: <http://americanpharmacynews.com/stories/510711403-fda-approves-inflectra-for-iv-infusion>

#### 4/8 – UnitedHealth exiting Ga., Ark. insurance exchanges (Payers & Plan Sponsors)

UnitedHealth Group will not sell 2017 health insurance plans in Georgia and Arkansas through the Affordable Care Act exchange, a spokesman said.

Source: <http://www.bloomberg.com/news/articles/2016-04-08/unitedhealth-quitting-obamacare-markets-in-georgia-arkansas>

#### 4/11 – Calif. bill would require advance notice of drug-price hikes (Market Trends)

California lawmakers will consider a bill that would require drug makers to notify the state of plans to increase drugs' list prices by more than 10% during any 12-month period. Price increases on drugs with list prices already higher than \$10,000 would have to be explained within 30 days of the price hike, and insurers would be required to give regulators spending data on prescription drugs.

Source: <https://www.statnews.com/pharmalot/2016/04/11/drug-prices-drug-costs-california/>

#### 4/14 – IMS Report: U.S. prescription drug spending to hit \$400 billion a year by 2020 (Market Trends)

Prescription drug spending in the US is projected to increase 22%, reaching up to \$400 billion, over the coming five years, according to a report from IMS Health. Researchers accounted for rebates and other commonly used discounts, and they say national drug spending calculated with wholesale prices may reach up to \$640 billion by 2020. Spending on cancer medications alone reached \$39.1 billion last year, while spending on autoimmune diseases reached \$30.2 billion.

Source: <http://www.reuters.com/article/us-health-usa-drugspending-idUSKCN0XB08Q>



Read Dr. Adam Fein's analysis of the IMS report on his Drug Channels blog here:

<http://www.drugchannels.net/2016/04/key-insights-on-drug-prices-and.html>

#### 4/14 – As Drugstores and PBMs Debate MAC Pricing Updates, Is More Clarity Needed From CMS? (Market Trends)

In the latest squabble between drugstores and PBMs, the National Community Pharmacists Association (NCPA) on April 1 issued a [letter](#) to CMS Deputy Director Cynthia Tudor asserting that Medicare Part D plans and PBMs are not complying with a federal requirement to use drug pricing standards that “accurately reflect the market price of acquiring the drug” when reimbursing pharmacies for dispensing covered outpatient drugs to Medicare beneficiaries. But the Pharmaceutical Care Management Association (PCMA), the trade group representing PBMs, says this is all a “backdoor attempt to undermine preferred pharmacy networks,” which are used by three out of four Medicare Part D enrollees.

Section 173 of The Medicare Improvements for Patients and Providers Act (MIPPA) requires that CMS's contracts with Part D sponsors include a provision mandating that sponsors update any standard they use to reimburse network pharmacies based on the cost of the drug to “accurately reflect the market price of acquiring the drug.” These updates must occur not less frequently than once every seven days, and were extended to maximum allowable cost (MAC) pricing methodologies through a provision in the 2015 Final Part D Rule that took effect on Jan. 1, 2016. CMS explained in the rule that it was requiring the actual MAC prices to be disclosed in advance so that pharmacies can use the updates “as a reference against which they can check their reimbursements.”

While NCPA does not suggest that plans aren't complying with the timeliness of the updates, it charges that “multiple” Part D plans and PBMs have been using MAC drug pricing values “that are far below what would be considered to be reasonably approaching the ‘market price of acquiring the drug,’” thus putting pharmacies “significantly underwater.” NCPA said that further guidance from CMS is needed on “what exactly is meant by ‘the market price of acquiring the drug.’”

PCMA President and CEO Mark Merritt, however, says the complaint is really about independent pharmacies that participate in preferred pharmacy networks wanting to “have their cake and eat it, too.” He tells AIS's [Drug Benefit News](#), “What we're having right now is the independent drugstore or the PSAO [pharmacy services administrative organization that negotiates network participation on behalf of the drugstore] signs up and agrees to accept discounted reimbursements in exchange for more foot traffic, but now they are demanding the higher reimbursements while still getting that extra foot traffic.” And, he says PCMA has been hearing anecdotal information that drugstores are “balance billing” by demanding the patients themselves pay more rather than going through a coverage appeal.

Source: <http://aishealth.com/blog/pharmacy-benefit-management/drugstores-and-pbms-debate-mac-pricing-updates-more-clarity-needed->

#### 4/20 – Express Scripts returns fire with lawsuit against Anthem (Competitors)

Less than a month after Anthem filed a lawsuit against Express Scripts, the pharmacy benefits manager (PBM) has returned fire with a countersuit, accusing the insurer of violating the terms of their contract, according to the *Wall Street Journal*.

Anthem filed a lawsuit last month following public accusations that Express Scripts owed as much as \$3 billion per year from prescription drug savings that it never passed on to the insurer. In its lawsuit, Anthem is seeking “damages related operational issues” and the right to terminate its contract with the PBM, which is set to expire in 2019.

Express Scripts has denied the allegations publicly, but in its countersuit filed on Tuesday, the PBM doubled-down, demanding unspecified damages for “improperly attempting to rewrite” the contract. Express Scripts also outlined a more pointed denial of Anthem's allegations, claiming it made five separate repricing proposals over the last 10 months that included savings of \$2-2.8 billion through the end of the contract, according to the *WSJ*.

Last year, Anthem CEO Joe Swedish said the proposed merger with Cigna would bring “significant value and opportunity for the combined company and our customers from a better pharmacy contract,” reflecting a notable shift toward internal PBMs. Last year, UnitedHealth acquired Catamaran for \$12.8 billion, which positioned the insurer to negotiate better drug prices through OptumRx.

To learn more, read the *WSJ* article: <http://www.wsj.com/articles/express-scripts-countersues-anthem-in-contract-dispute-1461103836>

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## 4/26 – Cleveland Research Key Insights from ESI 1Q Results (Competitors)

### Top 5 Insights From ESI 1Q16 Results

1. ESI now has 27-28mm lives using national preferred formulary, up several million over the last 12-24 months, seeing interest from health plans as well
2. At employer outcome conference this week will discuss new programs for autoimmune. Believe there will be additional opportunities within PCSK9s after indication data comes out and in HCV.
3. Expects retention rate to be 95%-98% for the 2017 selling season; off to good start to this year's selling season, Anthem situation is not impacting selling season
4. After filing the counterclaim to Antheims initial response, it is now in the hands of the court – open to conversation/negotiation if reasonable, but will have nothing to do with Anthem's \$3bb claim
5. EBITDA per adjusted script was \$4.51, down -8.0% in 1Q – pressure was due to renewal of DoD last May, lost Coventry Med D contract, and Catamaran brining formulary and rebate contracting inside OptumRx

### ESI 1Q16 Conference Call Notes|4.26.16

#### 2017 Selling Season

- Expect retention rate to be 95%-98% - ex Coventry. Goal is to be at high-end of this range.
  - Normal year in terms of mix of business
  - As it relates to new business opportunities, we see a little more opportunity than last year, but it is early
  - We have had already had some successes
- Still early, but anticipate another strong year

#### Formulary

- Now have 27-28mm lives using exclusion list, has increased by a few million over the last 12-24 months
  - Seeing interest from health plans as well
  - Very few clients have exited the program, retention is high
- PCSK9 – we remain very disciplined and continue to prefer generics
  - Utilization has been low
  - Currently preparing for new data to come out on indications
- Expect to see increased activity in HCV with new products entering the market
- We are currently watching and working on anti-inflammatory category – there has been a lot of new activity in that class and plan to discuss some ideas on this at our outcomes conference this week
- Compounds is a daily battle to stay ahead of market to innovate

#### Mail

- When we were looking to revamp our mail offering a couple years ago, our focus was on the member experience along with the clinical advantages
  - Have an app that is ranked with 4 stars compared to 2 when we first launched
  - Our mail strategy looks to integrate our entire organization and retail partners
- Also seeing interest from health plans to do more with mail
- We are growing share in mail with our existing book
  - We are improving experience
  - We have had several large health plans that are more supportive of mail

#### Anthem

- We filed a counter claim 1 week ago
  - We would have preferred that this did not reach this point
  - Our legal case is strong
- We value Anthem as a client, believe we are their best PBM option
  - Collaborating to implement solutions and proud of the results we have achieved
- We did not want to see it get to lawsuit
  - We have upheld our service agreements
  - We countered and is now in hands of courts
  - This will be a long drawn-out process which is unfortunate
- Always open to conversations with them, but we will have nothing to do with \$3bb – those numbers are ludicrous, but will have discussions if it is reasonable

- Continue to bring solutions and hope they will implement, they could be saving billions if they implement our solutions
- The situation is a head-scratcher
- This situation has the full attention of our full board

#### **Anthem Impact on customer relationships/selling season**

- Anthem comes up in some conversations this selling season, but not frequently
  - Not a distraction
- We have had several CEO to CEO conversations with our customers, more of them just wanting to know what happened and how it got to this point
  - Rarely does a customer situation go to this level which is why people want to discuss
  - What is going on, we scratch our heads and would have liked to have solved this in a back-room

#### **Curascript Distribution and UBC**

- Seeing new client growth and new products –both are fueling specialty distribution and UBC growth

#### **Retail-90 Programs**

- We offer two 90-day programs, one is with Walgreens
  - These programs are adopted for certain clients
  - We see opportunity to partner with retail and together manage the patients and coordinate to best manage the patient

#### **ABC Distribution Contract**

- Contract is up this year
- ABC has continued to provide us value, would expect this to continue

#### **Price Increases/Pharma Contracting**

- Seeing a little change in terms of the timing of increases, but everything we see is tracking in line with expectations
- We have seen a slight decrease in specialty price increases, but expect it to normalize as we move throughout the year
- Believe we can get manufacturers to price products in a reasonable way, but we also have to work with physicians to make sure that they are prescribing the right products
- Have seen a growing number of manufacturers looking to do creative and responsible pricing/contracting – in addition to share we offer data capture which gives them confidence they are pricing their products in a way that is fair and positions them well in the market
- We continue to work to provide access for all products at fair prices
- Seeing pharma come to the table and making the right choices to best position their products
- IMS data shows a large gap between gross to net
  - PBMs that have been willing to take bold actions are going to be able to provide their customers with the biggest gross to net savings and cost savings
- The real focus and leverage is not just gross to net prices, but gross to net on total patient costs – this is the key metric we are focused on

#### **1Q16 Financial Results**

- Performance in line with expectations
- 1Q EPS was \$1.22, up 11%
- EBITDA was \$1,460, down -3%
- Adjusted claims were up 5% to 323.5 million, in line with ESRX expectations
- EBITDA per adjusted script was \$4.51, down -8.0%
  - EBITDA per script down due to Catamaran formulary and rebate management moving to OptumRx at the end of 2015 and early 2016, DoD renewal, and the lost Coventry Med D contract, ramp up costs for 1/1 benefit renewals
- Revenue per adjusted script was \$76.51, down -3%.
  - For the most part increases have been in line

**FY16 Guidance**

- EBITDA still expected to be \$7.2-7.4bb up 3-5% despite being down -3.0% in 1Q
- Drivers to 2H acceleration in EBITDA
  - There are new generic drug launches that are expected to come out, this will be a driver – Crestor is the key drug going generic
  - Implementing cost saving initiatives
    - Very focused on fulfillment process and looking at ways to improve – initiatives to improve and reduce costs (will come out in 2H)
    - Taking out costs in calls centers through digital innovation –these changes should bring down cost around call volumes
    - SGA reduction initiatives are on-going
- EBITDA growth will also benefit from new generics and higher mail growth in 2H
- EPS now expected to be \$6.31-\$6.43 up from \$6.10-\$6.28
- Share count now expected to be 635-645mm

**2Q Guidance**

- Adj EPS 1.55-1.59, up 8-10%
- Anticipate revenue from large customer will be realized in 2Q as in past years

*Source: Cleveland Research investment analyst notes from Q1 ESI conference call*

**4/29 - Express Scripts plans fiercer fight against sudden drug price hikes (Competitors)**

NEW YORK, April 28 (Reuters) — Express Scripts Holding Co. plans to introduce several benefit programs aimed at fighting high drug costs, including speeding up how quickly it moves insurer and employer customers to cheaper medicines after sudden price hikes, its chief medical officer said.

Express Scripts, the nation's largest pharmacy benefit manager, is discussing the changes with its customers at an annual meeting in Florida today, Chief Medical Officer Steve Miller said in an interview.

Last year, the sudden 5000% price hike by Turing Pharmaceuticals for Daraprim, an anti-infective treatment for a rare disease, caught hospitals and patients by surprise and spurred investigations and hearings in Congress. Drug pricing has since become a national issue, taken up by Presidential candidates Hillary Clinton and Donald Trump.

After that, Express Scripts and its next largest competitor CVS Health found cheaper alternatives for patients, but Express said the new program will make it easier for customers to switch plans quickly.

Express and CVS began several years ago trying to cut spending for customers by narrowing coverage choices and being tougher about patient authorization. This year, CVS also started a specific program to try to limit patient use of expensive dermatology drugs, like Valeant Pharmaceuticals' pricey Jublia toe fungus cream.

Mr. Miller said Express Scripts planned to expand a new pricing scheme in which it pays for cancer drugs based on how well studies show they work for a particular disease. He said it was looking at other therapeutic areas, such as arthritis and inflammatory diseases for 2017.

Rheumatoid arthritis drugs like AbbVie's Humira, Amgen Inc.'s Enbrel and Johnson & Johnson's Remicade are among the top selling drugs in this category and have had large price increases over the years.

Another therapeutic area Express Scripts is watching closely is dermatitis, with two new highly-effective drugs potentially hitting the market this year, one from Regeneron Pharmaceuticals. It is also working on diabetes, where it is expecting cheaper treatments to hit the market by the end of the year.

*Source: <http://www.businessinsurance.com/article/20160429/NEWS03/160429765/express-scripts-plans-fiercer-fight-against-sudden-drug-price-hikes>*

**May 2016****5/2 – Express Scripts looks for retail partners to reduce diabetes costs (Competitors)**

Express Scripts plans to team up with community pharmacies that excel at keeping diabetic customers on track. According to chief medical officer Steve Miller, MD, the initiative aims to rein in costs for big employers by helping patients get healthier. "It's such a rapidly growing problem," he said.

Express Scripts plans to team up with community pharmacies that excel at keeping diabetic customers on track. According to chief medical officer Steve Miller, MD, the initiative aims to rein in costs for big employers by helping patients get healthier. "It's such a rapidly growing problem," he said. "We have got to change the paradigm, and we think pharmacies are the way to do that." The new partnerships, which Miller hopes to start locking in by year end, also would go a long way toward demonstrating the value and savings that Express Scripts offers its customers. "We think this is going to be huge in the marketplace, because you're going to be able to get millions of patients higher quality care and lower cost on diabetes," Miller noted.

View full article from CNBC here: <http://www.cnbc.com/2016/04/28/express-scripts-looks-for-retail-partners-to-reduce-diabetes-costs.html>

**5/3 – Cleveland Research Key Insights from CVS 1Q Results (Competitors)****Top Insights From 1Q CVS Conference Call**

1. 1Q PBM profit growth was reported up 6.6% year/year, ahead of up 0-4% guidance. Retail profit growth was in-line at up 6%.
2. Retail comp was 4.2%, a bit below CVS' 4.5-6.0% range on soft underlying front-end (down 1.0% excluding leap day and early Easter versus 4Q down 0.5%) and some modest improvement in Rx comp (5.5% versus 4Q up 5.0%).
  - a. CVS has pulled back on FE promotional activity in edibles and consumer merchandise
3. CVS is working to roll out indication based management programs for both auto-immune and oncology
4. CVS raised 2016 PBM revenue and profit guidance
  - a. Revenue guidance by 150bps on the PBM to range of 21.75-23.25%
  - b. Midpoint of PBM profit guidance raised by 125bps to 11-13%
5. 2016 net new business now \$400mm higher to \$13.1bb; 2016 retention rate was 97%
6. Plan sponsor plan design for 2017
  - a. Seeing increased interest for specialty drug management services, including infusion services and medical benefit management
  - b. Top concerns for plan sponsors are cost management and service levels
7. Average revenue per brand script is slightly below expectations
  - a. This is not due to lower brand inflation
  - b. Believe it is the result of more consumer orientated plan designs – until patient hits deductible, they are opting for lower cost brand products
8. Specialty revenue was up 23% in 1Q, down from 32% in 4Q.
9. Have remodeled 50% of Target pharmacies, will have other half done by end of summer
10. Omnicare integration is going well; have piloted and rolled out use of CVS pharmacies as an extension of the Omnicare pharmacies to speed delivery of first fills
11. 30% of CVS customers represent 80% of the spend in the drug store

**CVS Caremark 1Q16 Conference Call Notes | 5.3.16****PBM**

- PBM segment net revenues increased 20.5% to \$28.8bb
  - Growth driven by increased volume and pharmacy network claims, as well as growth in specialty pharmacy
  - PBM adjusted claims grew 19.4%
  - 170bps increase in generic dispensing rate to 85.2% partially offset sales growth
- 2016 PBM selling season
  - Have won additional business for 2016
    - Net new business of \$13.1bb, which is up \$400mm over the last 90 days
    - Much of this increase relates to new health plan client which will increase revenues in 2016 and 2017
  - Retention rate was 97.3% retention rate

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- Almost half of new business adopted on Maintenance Choice programs
  - Life cycle with clients that adopt maintenance choice is longer because we have to sell those programs through the sales systems
  - Have started to see health plans adopt this – still slower than we expected
- 2017 selling season
  - Off to a good start
  - Completed over a third of client renewals – typical for this time of year
  - Integrated business model continues to resonate with customers
  - See more RFPs and potential revenues in the marketplace than last year – some of that could just be timing
- Plan Design/Customer Demands
  - Clients top concerns continue to be cost management and service
    - We have been able to deliver on both fronts
  - Clients looking for proactive cost management solutions
  - They are adapting more aggressive strategies in formulary design and specialty management to mitigate trend drivers
  - Specialty drug management has been emphasized in plan design elections for 2017
  - Seeing growing interest in infusion and site of care services as well as medical claims management services
- Indication Based Strategies
  - Have shown we can move share based on access, started back in 2012 when we introduced our exclusion list. This has created significant value for customers
  - In addition to exclusions, we evolved our strategy to include price protection which a portion of that comes back to clients in the form of a rebate
  - Now we are started to contract based on indication. Autoimmune category is the best example
    - In RA there are 13 drugs that can treat the condition and less for Crohn's
    - So we may have different rates for each indication based on competition and the effectiveness of all the products in the class
    - Oncology is another opportunity
    - Will continue to see these types of negotiations and opportunities evolve
    - We believe we are leading the industry with these programs

### Specialty

- Specialty revenues increased 23% in 1Q vs. 32% in 4Q.

### Target

- Integration efforts have been successful and are on track
- All planned store conversions will be completed by the end of the summer
- Launching additional core pharmacy offerings as stores are converted and rebranded
- Include specialty connect, Extra Care pharmacy rewards, and digital tools
- About half way through heavy lifting with rebranding, system conversion, look and feel, etc.
- Won't be done until end of summer but pleased so far
- Retention of TGT employees has been 98%
- Too soon to see impact on script trends
- Won't see broad-based marketing until integration complete

### Omnicare

- Long-Term Care pharmacy business performed in-line with expectations
- Working to combine operational infrastructures and further develop programs to improve work streams and enhance service delivery
- Have piloted and rolled out use of CVS pharmacies as an extension of the Omnicare pharmacies to speed delivery of first fills
- Currently developing integrated service offering to enhance medication delivery options based on preference and acuity level

### Retail Pharmacy 1Q Results

- Total comps increased 4.2%
  - Positively 125bps of impact from additional day from leap year

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- Pharmacy comps up 5.5%
  - Negative 360bps impact from generic introductions and 50bps from softer flu season
  - This was offset by positive 130bps impact from extra day and increase of 5.9% in same store prescription volumes on a 30-day equivalent basis
- Retail pharmacy mkt. share was 23.9% in 1Q on a 30-day equivalent basis (up 245bps y/y)
  - Primary driver is addition of Target pharmacies
  - Experiencing strong organic share growth as well
- A recent pharmacy innovation has been Script Sync
  - More than 2/3 of patients offered the service have adopted
  - Have nearly 359k patients enrolled during 1Q (over 1mm total since launch in 3Q15)
- Front-end comps increased 0.7%
  - Includes 105bps positive benefits from extra day and 80bps from shift in Easter holiday
  - Continue to pull back on broad-based promotions
    - Margins increased benefiting from these efforts, along with increased emphasis on health and beauty businesses
  - Continue to balance strategies between traffic and profitable growth
  - Extra Care continues to provide more relevant and personalized communication
  - Know our top customers drive disproportionate amount of sales and margin
  - Store brands represented 21.9% of front-ends sales in the quarter (up 100bps y/y)
    - Significant opportunity remains to build on core equities in health and beauty and seek other areas that offer value/growth
- Recently announced partnership with Curb Side
  - Customers can make mobile in-app purchases from CVS and have products delivered to them when they pull up to the store
  - Service currently available in select mkts. (San Francisco, Charlotte, and Atlanta)
  - Goal is to roll out full program later this year
- 19 net new stores in 1Q
  - Expect about 100 net openings for the year
- Expect all Minute Clinics to be converted by the end of the summer
  - Now operating 1,136 clinics across 33 states
  - Minute Clinic revenues increased 17.7% y/y
- Longer-term front-end strategy
  - Spend a lot of time thinking about
  - See front-end as door into the pharmacy
- Health and Beauty
  - Why we are shifting more towards health and beauty
    - Customers think of health and beauty when they think of our stores
  - Pleased with where we are
    - Growing share in health and beauty
- Promotional Strategy
  - Pulling back on promotional business – edibles, consumer merchandise, etc.
  - 30% of customers drive 80% of profit
    - Focusing on this group
  - Looking hard at digital strategy
    - Excited about curbside
    - Don't need to out-Amazon Amazon
    - We are the convenient location for those looking to pick up a few items quickly
    - Still in early stages
- FE represents 11% of revenues
  - Allows us to think about it in a differentiated way
- Front-end margins
  - Seeing pretty rational marketplace
  - No major moves in last 6 months
  - Allows us to focus on driving profitable growth – focusing on the right 30% of customers
  - We know who our best customers are and how to target them

**1Q16 Financial Results**

- Adjusted eps was \$1.18 in 1Q, \$0.01 above guidance (up 4% y/y)
- Retail Long-Term Care segment performed in-line, while PBM posted profit growth above high-end of guidance
  - Outperformance driven by stronger-than-expected volumes and better purchasing economics within PBM
- Revenues increased 18.9% to 43.2bb
- PBM segment net revenues increased 20.5% to \$28.8bb
  - Growth driven by increased volume and pharmacy network claims, as well as growth in specialty pharmacy
  - PBM adjusted claims grew 19.4%
  - 170bps increase in generic dispensing rate to 85.2% partially offset sales growth
- Average revenue per brand script was slightly below our expectations
  - Not seeing anything out of norm
  - Patient is becoming more of a payer which is part of the issue
    - As more high-deductible health plans are adopted by consumers, seeing consumers chose lower cost options until their deductible is reached
    - Driving patients to lower-cost branded options
  - Impact on revenue but not on growth or profitability
- Retail long-term care revenues increased 19.6% to 20.1bb
  - Driven by addition of Omnicare and pharmacies
  - Revenue growth was just below our guidance range
  - Script growth remains strong but mix of branded drugs differed slightly from plan resulting in lower ASP
  - Haven't seen change in level of branded drug inflation, simply a mix-shift that impacted price
  - Front-end revenues impacted by promotional strategies
  - Gave up some lower-value customer traffic to drive increasingly profitable front-end sales mix
- GDR increased by 125bps to 85.7
- Gross margin was 15.6% (down 135bps y/y)
  - Gross profit dollars increased 9.5%, in-line with expectations
  - Within PBM segment, gross margins contracted 45bps to 3.8%
    - Driven by mix of new business and price compression, partially offset by GDR improvement and favorable purchasing economics
    - Gross profit dollars increased 7.4% y/y driven by strong volumes
  - Gross profit dollars increased 10% y/y in Retail Long-Term Care segment
    - Gross margin declined 225bps to 29%
    - 40% of the decline in gross margin rates was mix driven by inclusion of Omnicare and Target business
    - Remainder is largely reimbursement
- Operating expenses were 10.4% of revenue in 1Q
  - PBM SG&A rate improved 10bps to 1.1%
  - SG&A as % of sales improved by 120bps to 19.9% in retail long-term care segment
- Corporate expenses were up \$20mm to \$209mm, slightly better than expectations
  - Company operating margin decreased 70bps to 5.2%
  - PBM operating margin decreased by 35bps to 2.7%
  - Retail Long-Term care decreased 105bps to 9.1%
- Operating profit for each segment was in-line or better than expectations
  - PBM increased 6.6%
  - Retail long-term increased 6.4%
- Net interest expense increased \$149mm y/y to \$183mm
  - Due to debt associated with acquisitions
- Effective tax rate was 39.3%
- Weighted average share count was 1.1bb

**2016 Guidance**

- Confirming 2016 adjusted EPS guidance of \$5.73-5.88
  - Reflects y/y growth to 11-14%
- Increasing revenue guidance by 150bps on the PBM to range of 21.75-23.25%
  - Takes into account lower-than-anticipated volumes of Hep C and PCSK9 therapies
  - Narrowing and raising midpoint of PBM's operating profit guidance by taking lower-end up 125bps
    - New range is 11-13%

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- In Retail Long-Term, lowering revenue growth guidance and maintaining operating profit growth guidance
  - Reduction in revenue growth expectations reflects discontinuation of certain Rx cross road programs
  - Also reflects mix of branded drugs along with earlier-than-anticipated launch of generic Nasonex as well as slightly weaker front-end sales trends due to shift in promotional strategies
  - Now expect retail long-term are revenue growth of 13-14.25% (reduction of 125bps on both ends)
  - Expect total comps of 1.75-3% while continuing to expect scrips comps of 3.5-4.5%
- Consolidated net revenue growth is expected to be 17.5-19%
- Intercompany revenue eliminations are expected to be 11.4% of segment revenues
  - Expect higher eliminations as mix of generics increases within Maintenance Choice
  - Offsets improvement in PBM operating profits

#### 2Q16 guidance

- Adjusted EPS of \$1.28-1.31
  - Represents y/y growth of 4.75-7.5%
- GAAP diluted EPS of \$1.17-1.20
- Factors that will affect cadence of profit delivery though the year:
  - Introduction in timing of break-open generics
  - Timing of profitability in or Medicare Part D business
  - Timing of benefits of share repurchases
  - Certain tax benefits
- Cadence of profit growth still expected to be 2H-weighted
- Expect retail segment revenues to increase 15.5-17% y/y
- Adjusted script comps expected to increase in the range of 3-4%
- Total comp sales up 1.25-2.5%
- PBM revenue growth of 22-23.5% driven by continued growth in volumes and specialty
- Consolidated revenues expected to grow 18.5-20%
- Retail operating profit to increase 5-7 and PBM operating profit to increase 4-8
- Consolidated operating profit expected to grow 3.75-6.5%

Source: Cleveland Research investment analyst notes from Q1 CVS conference call

### 5/3 – Shortages Of Essential Emergency Care Drugs Increase, Study Finds (Market Trends)

At some hospitals, posters on the wall in the emergency department list the drugs that are in short supply or unavailable, along with recommended alternatives. The low-tech visual aid can save time with critically ill patients, allowing doctors to focus on caring for them rather than doing research on the fly, said Dr. Jesse Pines, a professor of emergency medicine and director of the Office for Clinical Practice Innovation at the George Washington University School of Medicine and Health Sciences, who has studied the problems with shortages.

The need for such workarounds probably won't end anytime soon. According to a new study, shortages of many drugs that are essential in emergency care have increased in both number and duration in recent years even as shortages for drugs for non-acute or chronic care have eased somewhat. The shortages have persisted despite a federal law enacted in 2012 that gave the Food and Drug Administration regulatory powers to respond to drug shortages, the study found.

For this report, which was published in the May issue of Health Affairs, researchers analyzed drug shortage data between 2001 and 2014 from the University of Utah's Drug Information Service, which contains all confirmed national drug shortages, according to the study. They divided the drugs into acute and non-acute categories. Acute-care drugs were those used in the emergency department for many of the urgent and severe conditions handled there and include remedies such as pain medications, heart drugs, and saline and electrolyte products.

Overall, the study found that 52 percent of the 1,929 shortages during the time period studied were for acute-care drugs. Following passage of the federal law in 2012, the number of active shortages of non-acute care drugs began to decline for the first time since 2004, but there was no corresponding dropoff in shortages of drugs that emergency departments and intensive care units rely on, the researchers reported..

Click here for the full KHN article: <http://khn.org/news/shortages-of-essential-emergency-care-drugs-increase-study-finds/>

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### 5/3 – IMS Health to Buy Quintiles in \$9 Billion Pharma Data Deal (Market Trends)

IMS Health Holdings Inc. will buy Quintiles Transnational Holdings Inc. in an all-stock transaction for about \$9 billion, bringing together two of the biggest providers of data and services for the pharmaceutical industry.

IMS Health shareholders will receive 0.384 share of Quintiles common stock for each of their shares, and they will own about 51.4 percent of the combined business, according to a statement Tuesday. The transaction offers no premium compared with Monday's close. Both stocks declined in New York trading.

The combination will create an expanded pool of information for drugmakers, which are under pressure to limit costs and improve the efficiency of their research. IMS Health tracks prescriptions, medical claims and electronic records and sells the data, while Quintiles offers a range of services focused on product development, including advice on clinical-trial design -- a business called a contract research organization, or CRO.

Source: <http://www.bloomberg.com/news/articles/2016-05-03/ims-health-to-merge-with-quintiles-in-deal-valued-at-23-billion>

### 5/4 – Wentworth replaces Paz as CEO of Express Scripts (Competitors)

George Paz has officially retired from his role as CEO of Express Scripts Holding Co., the St. Louis region's largest public company, passing the reins on to Tim Wentworth. Express Scripts had announced in September that Paz, 60, would step down and Wentworth, the company's president, would add the title of CEO, a move that became effective Wednesday. The company also held its annual shareholders meeting Wednesday.

Paz continues to serve as chairman of the pharmacy benefits manager's board. He will remain a company employee through June 1, according to a Wednesday regulatory filing by Express Scripts.

Wentworth, 55, was named president of the company in February 2014, having previously served as president of sales and account management. He joined Express Scripts in 2012 when the company merged with Medco Health Solutions.

As of Wednesday, Wentworth's base salary is \$1.4 million and his annual bonus target is 175 percent of his base salary, according to the filing. In connection with his appointment as CEO, he also received a one-time equity grant valued at \$5.25 million, split evenly between non-qualified stock options, restricted stock units and performance share units. The company entered into a new employment agreement Wednesday with Wentworth that runs through March 31, 2019, and can be extended by written agreement, according to the filing.

Express Scripts Holding Co. (NASDAQ: ESRX) reported a profit of \$2.5 billion on revenue of \$101.8 billion in 2015, up from \$2 billion in earnings on revenue of \$100.9 billion in 2014.

Source: <http://www.bizjournals.com/stlouis/blog/2016/05/it-s-official-wentworth-is-ceo-of-express-scripts.html>

### 5/9 – Evercore ISI Takeaways from Asembia (formerly Armada) Specialty Pharmacy Summit (Market Trends)

#### **Key Takeaways**

- Specialty drug spending forecasts are rising with **\$400 Bn of spend estimated by 2020** (half under the pharmacy benefit and half under medical)
  - Current spending is estimated to be ~\$176 Bn, with \$93 Bn under medical benefits and \$86 Bn under pharmacy
- There is no silver bullet to managing spend. Cost savings will likely come from an amalgamation of site of care management, prior authorization, biosimilars, and narrow provider networks
  - Comparative effectiveness will also become increasingly important for formulary placement and coverage decisions
- Although **biosimilars** bring the prospect of savings to specialty drugs, **much still needs to be decided** to facilitate this process, including labeling, interchangeability, education, naming, and coding
  - Several manufacturers we spoke to noted that **biosimilar discounts will likely have to be north of the oft-stated 20%** (off of net not gross) discount to promote wide adoption given switching costs to providers, patients, and other pharma supply chain participants

- The increase in specialty drugs will require payers, providers, and specialty pharmacies to ‘up their game’ regarding their knowledge and comfort with **genetic testing** as many new drugs only work with certain genotypes/mutations, and correct usage will be important in managing costs
- **Anthem** seems increasingly interested in **in-sourcing its pharmacy benefits** as it emphasized the lower cost of care (vs. outsourced benefits) if it can properly manage the site of patient care
  - In addition, this can produce savings for members (fewer payers to potentially bicker over payments), which can also be **attractive** in an environment where **member cost sharing is generally rising**
  - However, **smaller managed care players** appear to be struggling with managing drug costs (on both the pharmacy and medical sides), and thus will likely to **continue to rely on PBMs** to help manage these costs

### Full Notes – Evercore ISI has highlighted sections in red particularly of interest

#### Managing Specialty Pharmaceuticals: A Payer’s Point of View

##### *Lisa Morris, Anthem, VP, Clinical & Specialty Pharmacy*

- 14 MM pharmacy lives, not just through ESRX
- Specialty Drug Spending
  - 2014: Pharmacy \$60 Bn, Medical \$67 Bn
  - 2016: medical \$93 Bn, pharmacy \$86 Bn
  - 2020: \$200 Bn pharmacy, \$200 Bn medical
  - 50% spend on medical benefit
- Biosimilar pipeline
  - 54 biotech products with patent expiries through 2020
  - 2016: Humira, Elitek, ReoPro, Benefix, Remicade
  - 2017: Lemtrada
  - 2018: Xolair, Erbitux
  - 2019: Avastin, Herceptin, Orenicia, Actemra, Advate
  - 2020: Lucentis, Tysabri, Pegasys, Vectibix, Peg-Intron, Kineret
  - Given testing and marketing requirements, it’s going to take a while for doctors to start prescribing them and prices won’t be as low as for oral solid generics
- How people take specialty drugs is very complex
  - E.g. self-administered vs. medical-provider administered
    - pharmacy vs medical benefit
    - Specialty pharmacy vs. retail pharmacy
    - Physicians’ offices (specialty pharmacy or buy and bill), ambulatory infusion center, home infusion, outpatient hospital
  - **Retail pharmacies and outpatient hospitals are highest cost sites**
  - ESRX is “only 50% of my problem” as half of spending under medical benefit
  - **ANTM excludes in-patient drug spend**
  - **Don’t have an issue with buy and bill as long as physicians bill under contract guidelines**
- Managing spend
  - Clinical management
    - Clinical edits
      - Prior authorization and precertification programs
      - Align criteria across medical and pharmacy benefits
        - Clinical appropriateness review of specialty drugs
        - Physician drug guidance
        - Dosing and frequency management
        - Preferred medical specialty providers
    - Clinical pathways
      - Oncology
        - Built pathways based on evidence-based programs
        - Doesn’t penalize those who don’t follow, but rather incentivizes providers (additional monthly fee)
      - Medication adherence
  - Coordinating patient care
    - Specialty pharmacy

- Health plan
- Coordination of care
- Steering benefits and lower-cost sites of care
  - Site of care redirection
  - Right drug right channel
- Managing cost and negotiating discounts
  - Preferred products
  - Reimbursement
  - Network management
    - Incentivize physicians to keep drug administration in office where appropriate
    - Re-contract outpatient hospital percent of charge rates to specialty drug fee schedules resulting standardized rates
      - Most challenging areas
      - Need to be careful that costs don't balloon elsewhere
    - Provide "incentive" codes to physicians when leveraging lower cost drugs
    - Drug management – easier on the pharmacy side
      - Establish preferred specialty providers with aggressive contract rates
      - Create narrow networks for certain high touch/profile disease states – e.g. specialized hemophilia treatment centers
      - Negotiate rebate contracts for preferred products
- Are specialty drugs really cheaper under the pharmacy benefit?
  - Many times no (if can keep at outpatient)
    - About 12% savings
    - Also prevents problems where a drug is denied under the medical benefit and is not covered under the patient's pharmacy benefit (problem with delayed billing) – can result in high bills for members (e.g. \$16,000)
  - Site of care – average claim
    - Outpatient hospital: \$7,254
    - Home or infusion suite: \$3,620
    - Doctor's office: \$3,063
    - Drugs that clinically belong in outpatient hospital will be left there, others should be moved
    - ANTM works with patients to move them (5-10% conversion rate as members are often scared to move)
- Specialty pharmacies bring value, especially for patients with comorbidities
  - Improved adherence and outcomes
  - ANTM promotes specialty pharmacy use for members
  - Working to connect specialty pharmacies and medical case managers
- Future initiatives
  - Pipeline management
  - Implementing specialty narrow networks
  - Creating strategies for biosimilar drugs
  - Reimbursement strategies
  - Focus on rare condition management

### **Biosimilars on the Horizon: Opportunities & Challenges in the US**

*Cheryl Schwartz, Pfizer*

- Why biosimilars are important
  - Eight of the 15 highest expenditure drugs were biologics, accounting for ~\$29 Bn in spending (2014)
    - Sofosbuvir, Aripiprazole, Insulin glargine, Adalimumab, Esomeprazole were top 5
  - 24% of pharmaceutical products approved in 2015 were biologics
  - Healthcare spending rising ~1.1% faster than GDP (projected 2014-2024)
  - Many products facing patent expiry in years to 2020
- The FDA has developed guidance for the regulatory approval of biosimilars as part of the ACA
  - The objective of a biosimilar development program is to demonstrate that there are no clinically meaningful differences based on totality of evidence
    - Not to reestablish the benefit

- Opportunities & challenges in US market
  - How will the FDA manage specific biosimilar issues (i.e. extrapolation, labeling, naming)?
    - Extrapolation: The sponsor will need to provide sufficient scientific justification to support a determination of biosimilarity for each condition of use
      - European rules
        - Clinical experience with reference product
        - Route of administration
        - Function/MOA/active sites
        - Difference in the safety/immunogenicity profile between indications
          - Patient and disease related factors
    - Labeling
      - Upfront statement that it is a biosimilar
      - Largely similar to reference product except anything unique to product (e.g. handling/storage)
      - No Phase III data in the label (will be a change for physicians used to looking at Phase III data)
    - Naming
      - FDA rules in line with WHO ones
      - Biologics and biosimilars will bear a nonproprietary name that includes a FDA-designated, unique suffix of 4 lowercase letters
      - There is a need to clearly identify biological products to improve pharmacovigilance and differentiate among biological products that have not been determined to be interchangeable
  - How will the FDA address interchangeability? What may be the potential impact on automatic substitution?
    - Must be expected to produce the same clinical result as the reference product in any given patient
      - Similar safety profile
    - FDA has not released interchangeability guidelines
    - Automatic substitution done at the state level and have already started weighing in
  - How will key stakeholder groups be educated about biosimilars?
    - Education takes time – even within the provider community, let alone patients
    - It's a shift away from clinical data focused evaluation/education
  - How will reimbursement be managed (i.e. coding, CMS policy, payor implementation)?
    - Use of J codes – reimbursement would be ASP + 6%
      - All biosimilars would share a J code with blended ASP reimbursement except for the innovator biologic, which will get a separate J code
    - Biosimilars are supposed to produce savings
  - How will the needs of specialty products be managed in an off patent landscape?
    - Need to support products, but they need to provide savings
    - Support needs vary by therapeutic area
      - Specialty services (e.g. reimbursement, patient training, etc.)
      - Supply needs (e.g. supply reliability, inventory management, etc.)
      - Provider support

#### **Exploring the Impact of ACOs & Payment Reform on the Specialty Pharmacy Business Model**

- ACOs have the triple goal of improved patient experience, reduced cost, and improved population health
  - 477 Medicare ACOs exist today
  - 300+ commercial Cos
- 90% of health plans say automating the exchange of new information types is critical to success, yet only 5% of plans describe their information exchange capabilities to be fully automated and 46% had real time automation in place
- Who does disease management is an area for debate – ACO, provider, PBM, specialty pharmacy, etc.
- ~57% of ACOs contract with pharmacies
- Cancer represents less than 1% of the population, yet drives over 8% of the total cost of care
- Some commercial payers looking to do a narrow network for certain conditions (e.g. Walmart and Cleveland Clinic)

#### **The Specialty Pharmacy Pipeline: A Panel Review**

Ray Tancredi, WBA; Michael Einodshofer, WBA; Brett Furchner, Acro Pharmaceutical Services; Saira Jan, Horizon BCBS; Tom Woller, Aurora

- New Molecular Entity Pipeline
  - 2,769 Filed (in Phase I-III)
  - More specialty drugs approved last year vs. seven years prior
- Recent approvals
  - Zepatier (Merck) – HCV in January
    - Now 8 competing HCV therapies
    - Harvoni, Sovaldi, Olysio, Daklinza, Technivie, Viekiera Pak, etc.
    - Dealing with state regulations such as NY state’s decision regarding universal HCV coverage
  - Pulmonary Hypertension
    - Upravi (Vertex) – no competing therapies currently
      - Approved in July 2015
  - Hypercholesterolemia
    - Praluent/Repatha
    - Limited indication right now, will accessibility improve?
      - Limited indications could impact pricing negatively
  - Duchenne Muscular Dystrophy (DMD)
    - Recent pipeline issues
    - ~2-3K lives in the US
    - Naïve patient group means that specialty pharmacy, payers, and patient/caregivers need to work together to promote adherence
- Products to watch
  - Nuplazid (PDP)
  - Ocaliva (PBC), often accompanied by comorbidities related to being overweight, so needs a lot of diseases/lifestyle management
  - Sofosbuvir/velpatasvir (HCV) – pangenomic (1-6)
  - Atezolizumab (bladder cancer)
  - ITCA 650 (exenatide) (diabetes)
    - Large potential patient population
  - Payers overwhelmed by onslaught of new drugs and running to keep up
    - Depending on specialty pharmacies to help sort through deluge
  - Oncology – move from tumor reduction to survival (and for how long/quality of life)
    - Rocelitinib (NSCLC)
    - Abemo (breast)
    - Buparlisib (breast)
    - Niraparib (ovarian)
    - Binimetinib (melanoma)
    - Neratinib (breast)
    - Rucaparib (ovarian)
  - **Oncology – things to watch**
    - CMS will have a big impact here and will push comparative effectiveness
    - Payers will have to become more involved in new areas such as end of life discussions
    - All of the below are oral solids, which will impact providers/payers
    - Divide between patient care providers and specialty pharmacy management can negatively impact care
      - Particularly problematic with oral solids as patients take them at home and may go 30 days between appointments vs. infused drugs where immediate help is more available regarding managing side effects, etc.
      - IDNs will have to act increasingly like specialty pharmacies
    - Pharmacists and doctors will have to up their game regarding genetic testing as many of these drugs have genetic testing components
  - Rare diseases - pipeline
    - Obeticholic acid (PBC)
    - Austedo (Huntington’s)
    - Firdapse(LEMS)

- Reveglucosidase alfa (Pompe Disease)
- Galafold (Fabry Disease)
- Zorblisa (EB)
- Patisiran (Amyloidosis)
- Huntexil (Huntington's)
- Valbenzine (Tardive Dyskinesia; Tourette Syndrome)
- **Payers are increasingly doing comparative analysis when deciding whether to approve/formulary status**
  - o So being the only drug is no longer enough to guarantee pricing/coverage
  - o Employers are driving these decisions as smid-sized employers can see huge upticks in specialty spend depending on if they have an employee/member with a rare disease

### **The US Specialty Pharmaceutical Market: What's In, What's Out & What's Ahead?**

- Specialty innovation has driven spending
  - o \$24.5 Bn in 2015
  - o Mostly due to HCV
- **Spending on medicines in 2015 increased by 8.5% on a net price basis to \$309.5**
  - o Net price is up MSD in 2016 vs. HSD gross price
  - o Gap getting wider
- Spending on specialty medicines in 2015 increased 21.5% to \$150 Bn on average invoice price
  - o Diabetes, autoimmune, hepatitis, and oncology driving spending
  - o HCV went from 1<sup>st</sup> to 3<sup>rd</sup> largest driver of growth as we have finished lapping launch
  - o Harvoni, Humira, Enbrel, Remicade were largest
- **2016 all about politics and drug costs**
  - o AMP finally arrives
  - o New FDA?DEA guidelines on controlled substances
  - o CMS experiment on Part B
  - o PD1s/PDL1s and PCSK9s
  - o New HCV drug from Merck
  - o Another biosimilar approval
  - o Turing and Valeant
  - o Pfizer-Allergan merger fails
  - o Anthem-Express Scripts
  - o Merger mania continues
- **Generics are driving 8% of sales growth in 2016 vs. >40% in 2011**
- Oncology drugs are becoming increasingly targeted
  - o e.g. PD1s
- 1% of the patient population consumes 26% of healthcare costs
- Pharma/biotech a lot less concentrated than the rest of the pharma supply chain
  - o e.g. distributors, PBMs, and managed care
- **Payers are increasingly excluding launches from coverage**
  - o Protects them until they have more data and the category is potentially more competitive
  - o Important to be proactive with actuaries and clinical departments to understand new launches and prior authorization criteria
- **Norway pushing biosimilar discounts to the 70%+ range, makes it hard to push for further development if that's what the pricing structure looks like**
  - o Costs \$100-\$300 MM to launch a biosimilar

### **Medical Benefit Specialty Pharmacy Management**

- Community oncologists accept management from payers and generally expect that now
  - o The days of "cowboy medicine" with doctors operating independently are over
- Treatments have become fairly standardized and the role of value has even crept into academic journals
- The average oncologist spends \$2-3 MM on drugs
  - o They need reimbursement certainty to continue ordering
  - o Reimbursement delays can cause cash flow issues
- **Managed care is very reactionary to problems, e.g. rising costs – "put prior auth on it!"**
  - o Change in focus to thinking proactively and holistically about problems

- White bagging – use depends on reimbursement rates in ASP vs. buy and bill
  - o Need tight claims management to avoid paying twice

#### Practice Based Oral Oncology Specialty Pharmacy Model

- Community oncologists are often much better versed in medical benefit plan requirements vs. pharmacy plan requirements
- There is a lot of waste in brown/white bagging, so some practices don't allow it
- There are often long delays in patients gaining access to oral prescriptions with clinical consequences

#### Medical Benefit

- Smaller managed care organizations appear to be struggling to cope with rising specialty drug costs, both on the pharmacy and medical sides
  - o Desperately trying to reduce spend mostly via PA
  - o Don't appear to be out in front of managing drug costs, more reactionary
  - o Combined payor/provider organizations able to better take advantage of ways to reduce costs
- 92% of payors have product preferencing in place on the medical side
  - o Autoimmune drugs had the highest amount of product preferencing
  - o Product preferencing
    - Varies by therapeutic class and how drug is administered
- Oncology practices more likely to be purchased vs. other areas such as rheumatology
- Magellan Rx Medical Pharmacy Trend Report
- Site of Service
  - o Hospitals are setting up home infusion centers as they are starting to realize that some hospital outreach businesses are unsustainable

### 5/9 – CVS Health receives NCQA Certification in Utilization Management (Competitors)

CVS Health recently announced that CVS Caremark received its NCQA Certification in Utilization Management. NCQA Utilization Management Certification is a quality assessment program that focuses on consumer protection and customer service improvement.

The CVS Caremark Utilization Management Program is designed to encourage the effective use of medications, identify optimal drug use, and promote cost-effective drug benefit plan designs for its clients. "Utilization management programs help ensure that members access clinically appropriate and cost-effective therapies and as a result, are integral in helping our clients manage costs while improving health outcomes for their members," said Jonathan Roberts, president of CVS Caremark.

Source: <http://cvshealth.com/newsroom/press-releases/cvs-health-receives-ncqa-certification-utilization-management>

### 5/13 – State of Wisconsin ETF PBM RFI memorandum (Competitors)

MedImpact client WEA Trust in WI shared the below PBM comparison summary document with us. In addition to the business they have with us, they also manage the medical for some of the State of WI employees which are currently with Navitus and managed through the State of WI contract. The State of WI will be going to RFP in November. In preparation they completed an RFI to gather info on PBMs to help them structure the RFP. WEA shared this summary document to help us succeed in the November RFP.

**State of Wisconsin, Department of Employee Trust Funds**  
**Robert J. Conlin, Secretary**

#### **Correspondence Memorandum**

**Date:** April 21, 2016

**To:** Group Insurance Board

**From:** Jeff Bogardus, Manager of Pharmacy Benefit Programs Office of Strategic Health Policy

**Subject:** Pharmacy Benefit Management Request for Information

**This memo is for informational purposes only. No Board action is required.**

#### **Background**

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In November 2015, the Group Insurance Board (Board) exercised the final contract extension option with Navitus Health Solutions, the Board's pharmacy benefit manager (PBM). The contract with Navitus will expire December 31, 2017. At the February 17, 2016 Board meeting, the Board approved the development and release of a PBM Request for Proposals (RFP) to be issued in November 2016, to procure a new PBM administrative services contract effective January 1, 2018.

In late 2015, ETF issued a Request for Information (RFI) to get feedback from the PBM industry regarding recommendations made by the Board's benefit consultant, Segal Consulting (Segal), and to learn more about innovative pharmacy benefit concepts. RFI responses will assist in the development of the RFP scheduled to be released later this year.

There were 14 responses to the RFI that represented the full range of PBMs currently operating in the market.

### RFI Results

The major categories of questions asked in the RFI and a summary of responses are below.

**1. Formulary Concepts and Design** – All responding PBMs have formularies with tiering and customization capabilities, including value-based plan designs. Pharmacy and Therapeutics (P&T) committees are also used by all vendors to evaluate clinical effectiveness of various drugs. Some of the more innovative programs include:

- Provider engagement strategies encouraging adherence to formulary design. These include developing prescriber profiles; pay for performance programs and shared savings agreements with prescribers; messaging programs through e-prescribing and electronic health record (EHR) channels.
- Member engagement strategies encouraging adherence to formulary design, which include medication review programs and wellness programs.

**2. Pharmacy Network Concepts and Design** – Network design is intended to direct more members to pharmacies where the PBM can obtain the best reimbursement terms. Concepts that are widely adopted include the exclusion of one or more national pharmacies, closed specialty pharmacies, mail order services, and longer refills (90 day) for maintenance prescriptions. Among the innovative concepts in network design, PBMs offer:

- Live video consultations with a pharmacist for patients, as well as communication between pharmacists and providers.
- Home infusion therapy.
- Mobile Apps available to members for formulary access and to determine pharmacy locations, drug costs at competing pharmacies, and drug alternatives/equivalents that can be substituted for brand name drugs.

**3. Specialty Drug Management** – All potential vendors are looking to better manage specialty drugs. While individual prescriptions are often costly, the total cost of treatment for some conditions may be lower with appropriate drug regimens. Widely adopted specialty drug management programs include site of care restrictions; split fill or short cycle dispensing programs that allow for a short trial period of a new, generally costly medication; and tighter prior authorization programs. Innovations currently under consideration by the market include:

- Separate formularies for specialty drugs and separate P&T committees to evaluate specialty drugs for coverage.
- Integrating manufacturer-sponsored programs that assist with member cost sharing requirements.
- Negotiating contracts with drug manufacturers based on value, risk, indications and efficacy. For conditions that require high-cost therapies, if the therapy fails to achieve the expected/desired outcomes, the drug manufacturer covers the cost of the medication.
- Specialty networks that require the pharmacies to competitively bid against each other to dispense approved specialty drugs so the most cost effective specialty pharmacy in the network is dispensing the drug.
- Review coverage for compounded medications (two or more drugs that are normally separately dispensed combined into one medication) for further restrictions.

**4. Fully Transparent Revenue and Cost Models** – This question produced the widest variety of responses from potential vendors. Current ETF experience with a full transparency model allows audit rights to all contracts, including drug manufacturer and pharmacy contracts. Other pricing transparency issues include:

- Referenced based pricing strategy, which establishes the cost the plan will cover for a set of drugs at specific dosages that have therapeutically equivalent outcomes. The member pays the difference between the defined benefit amount and the negotiated cost of the drug.
- Many PBMs feel reference based pricing strategies do not benefit the plan as greatly as other generic and low-cost drug utilization strategies.

**5. Performance Guarantees** – Most performance standards are comparable across the industry and include guarantees in the following categories:

- Claims processing
- Implementation and system changes
- Mail-order dispensing
- Prior authorizations
- Grievances/appeals
- Customer service
- Reporting
- Guarantees specific to clinical outcomes, generic dispensing rate (GDR) targets and cost trends all require:
  - o Extensive historical data,
  - o Clearly measurable and reportable parameters that are agreed upon, and
  - o A perspective that the guarantees are seen as rewards and are the result of a partnership between the PBM and the client striving for the same goals.
- Guarantees for clinical outcomes vary by PBM, with some PBMs not considering them at all, to other PBMs requiring clients to participate in all clinical programs available, which comes at a cost.
- Guarantees for GDR rate targets are currently available from some PBMs but only for overall GDR and not for specific disease states.
- Guarantees for cost trends vary by PBM, with some PBMs not considering them at all, to other PBMs requiring claims data from multiple years to analyze.
- Most PBMs are willing to discuss and consider guarantees to determine if a mutual agreement can be made between parties.

**6. Integration of Pharmacy and Medical Data and Member Adherence** – Integration of medical, lab and pharmacy data is readily available, and can be structured with the PBM providing data to another entity or having the PBM serve as the accumulator of the data. Most data is available for daily feeds but hourly feeds are available as well. Data analytics strategies include:

- Proactive programs for drug non-adherence and tailored proactive intervention.
- Targeted communications for various situations or conditions.
- Retrospective claims analysis to identify members for adherence or non-adherence using metrics such as Medication Possession Ratio, Gaps in Therapy, Proportion of Days Covered.
- Remote patient monitoring for asthma and diabetes.
- Methods for members to improve adherence to their prescription and over-the-counter drugs (e.g., mobile apps, putting all drugs to be taken at the same time in one package, coordinating refills).
- Integrated authorization systems that connect medical and pharmacy decisions.
- Daily Retrospective Drug Utilization Reviews.
- Medication Therapy Management (MTM) programs for most appropriate disease states, utilizing various means of communication.

**7. Other Innovative PBM Strategies** – Several of these concepts would require significant resources to implement.

- Digital tools for members that include wearable monitoring devices; two-way texting communications; video conferencing via mobile devices; refill reminders and other communications.
- Targeted messaging to members, prescribers and pharmacies via multiple communication channels.
- Better coordination between patient EHR/EMR and ePrescribing to include electronic prior authorizations.
- International delivery channels via an international prescription fulfillment entity.
- Web-based analytical tools that allow clients to identify and manage cost trends; measure and monitor benefit design effectiveness, utilization management edits, formulary tier placement, and utilization patterns.
- Using patient genetic testing to assist in identifying the best possible treatment regimen.
- Establishing fixed costs for high price therapy treatment programs and negotiated caps on inflation with the Pharmaceutical Manufacturers.

## Conclusions

Many widely used cost management techniques are part of the current benefit plan. However, the RFI provided new information that could potentially improve the management of pharmacy costs in the future, plus information to better coordinate care and work towards better health outcomes for our members.

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Questions for the RFI were designed to be very broadly interpreted to invite responses that would identify innovative methods, designs or practices.

### 5/17 – Why Walmart Is Finally Joining McKesson for Generic Purchasing (Supply Chain)

Yesterday, Walmart announced that it will jointly source generic drugs to McKesson, its long-time brand-name drug supplier. [Read the press release.](#)

Below, I outline why this long-expected deal makes sense for both companies. Walmart finally bowed to the inexorable economics of generic purchasing, while McKesson captured a much-needed partner that it had been aggressively chasing.

The deal also formalizes an intriguing alignment between the three largest wholesalers, the three largest pharmacy benefit managers (PBMs), and the four (soon to be three) largest retail chains. See what you think about my summary chart.

Here are four key points to understand about yesterday's Walmart-McKesson announcement.

1. Walmart lacked the scale of the new generic power buyers.
2. Walmart is finally surrendering to the new realities of drug wholesaling.
3. McKesson partially solves its M&A-driven scale problems.
4. The deal finalizes an intriguing industry channel alignment.

Read the full article on Drug Channels here: <http://www.drugchannels.net/2016/05/why-walmart-is-finally-joining-mckesson.html>

### 5/17 – Most employers plan to continue offering health coverage (Market Trends)

Most employers continue to offer employer-sponsored health insurance, despite questions about whether they would move workers to Affordable Care Act exchanges. A report from Mercer shows that only 5% of large employers said they were likely to stop offering coverage in the coming five years, while among businesses with 50 to 499 employees, 7% said they were likely to stop offering coverage, down from 21% in 2013.

Read the full article here: <http://www.startribune.com/are-employers-dropping-health-insurance/379797771/>

### 5/18 – OptumRx wins CalPERS from CVS - 480k lives, 5 year contract starts 1/1/17 (Competitors)

Calpers announced today they are moving their PBM business from CVS to Optum starting Jan 1, 2017. It is a 5 year deal and around \$5bb over the 5 years and will cover 486k lives. Optum was the lowest bidder followed by CVS and ESI.

Other interesting data points from the articles below:

- Article says Calpers trend was up 8% in 2014 and up 9-12% in 2015
- CalPERS said one of its goals was more "transparency" into the PBM-pharmaceutical manufacturer agreements.

Overall it appears Optum is gaining some momentum in the market after struggling last year (lost Wellcare, Wellmark, state of IL, state of SC). They are retaining well (outside of losing BCBS of RI) and now has won a marquee account in addition to have some success in the middle market.

The growing traction in the market is being driven by more aggressive pricing, increased flexibility/transparency, and new offerings (Walgreens 90-day offering).

Below is the press release on the contract.

#### May 18, 2016 -- CalPERS Picks OptumRx as New Pharmacy Benefits Manager

**SACRAMENTO, CA** - The California Public Employees' Retirement System (CalPERS) today announced that it selected OptumRX as its new Pharmacy Benefits Manager (PBM). The company will administer prescription drug benefits for nearly 486,000 members and their dependents enrolled in all of CalPERS' health plans with the exception of the Kaiser and Blue Shield of California Health Maintenance Organization (HMO) plans.

The five-year contract – worth an estimated \$4.9 billion – takes effect January 1, 2017, and ends December 31, 2021. It will cover pharmacy benefits for members enrolled in CalPERS' self-funded PERS Select, PERS Choice, and PERSCare Preferred

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Provider Organization health plans, as well as for those enrolled in the Anthem Blue Cross, HealthNet, Sharp, and UnitedHealthcare HMO plans.

OptumRx, a subsidiary of UnitedHealth Group, is headquartered in Eden Prairie, Minnesota, and has connections to more than 67,000 pharmacies nationwide. It will replace CalPERS' current PBM, CVS Caremark, whose contract expires December 21, 2016. CVS has held the PBM contract since January 1, 2012.

OptumRx was one of three finalists in a competitive bid process for the PBM contract. In addition to CVS, the other bidder was Express Scripts, Inc.

The CalPERS Board of Administration awarded the PBM contract to OptumRx based on the results of its final bid submission.

"The finalists and their bid responses went through a thorough vetting during the review, from their customer service and mail order processes to their pricing and cost-control measures," said CalPERS Board of Administration President Rob Feckner. "OptumRx had the strongest bid submission. We are confident that the company will successfully meet the needs of our members and our staff will work with OptumRx and CVS Caremark to ensure that the transition for our members and physicians will be as smooth as possible."

This is the first time CalPERS has negotiated and secured contractual agreements before the PBM contract was awarded, and the first time it has negotiated a full five-year PBM contract at one time.

"We placed a lot of emphasis in this solicitation on the company's ability to deal with the increasingly high cost of prescription drugs, and OptumRx presented a very strong proposal," said Priya Mathur, chair of the CalPERS Pension and Health Benefits Committee. "In addition to being concerned about the health and safety of our members, we wanted to ensure the company we selected would be as committed as we are to continually develop strategies to mitigate the impact of those rapidly rising costs on our members."

Contract terms require that the PBM provide drugs of the highest quality and value, based on sound clinical evidence. It also requires transparency and full disclosure of the financial relationships between the PBM and drug manufacturers.

All of the bidders for the PBM contract were evaluated on their strategies for price controls, sustained affordability, pricing, innovation, mail order networks, formularies, drug utilization programs, utilization management, and customer service.

For more than eight decades, CalPERS has built retirement and health security for state, school, and public agency members who invest their lifework in public service. Our pension fund serves more than 1.8 million members in the CalPERS retirement system and administers benefits for more than 1.4 million members and their families in our health program, making us the largest defined-benefit public pension in the U.S. CalPERS' total fund market value currently stands at approximately \$291 billion. For more information, visit [www.calpers.ca.gov](http://www.calpers.ca.gov).

Source: <https://www.calpers.ca.gov/page/newsroom/calpers-news/2016/optumrx-pharmacy-benefits-manager>

## 5/18 – Evercore ISI PBM Selling Season Expert Webinar Key Takeaways (Competitors)

On Monday, May 16<sup>th</sup>, Evercore ISI held a call with a well-regarded pharmacy benefit expert on the key topics of the current PBM selling season.

### Key Takeaways from the Call

- **RFP volumes are ~2x those of last year** within his book of business as many clients are particularly **unhappy with their specialty trend**
  - PBMs are not providing many tools for dealing with high levels of inflation
  - Specialty trend is also causing more clients to be open to changing PBMs
  - However, there does not seem to be much differentiation in terms of offerings across the PBMs
- Pricing renegotiations have been driving **savings of up to 15-20% this year** (across AWP discounts, rebates, and fees)
  - 20% is usually for larger clients, with mid-sized clients receiving less

- Average **generic discount off of AWP** is now **~74% for smaller accounts vs. 80%+ for larger accounts** (brand is stagnant at 16% off)
- Clients will usually change PBMs once discounts reach 6-7%
  - **Discounts** this selling season have been **between 8-14% on average** as the PBMs fight for business
- For mid-sized clients, PBMs started sharing more rebates 2-3 years ago
  - Specialty rebates average \$100-\$225/Rx
  - **PBMs seem to be keeping >50% of rebates for some smaller clients (passing back as little as ~10% for some), and using cushion to give higher discounts on brand/generic**
- Pass through pricing hasn't gained much traction as the best pricing model continues to be from the traditional PBM model
- **Combined pharmacy/MCO benefits make a lot of sense, but are not likely to happen soon** because that would require a much higher service level and more data integration / evidence
- Our expert has seen the **best pricing from CVS**, with **Optum continuing to lose some legacy CTRX business**, and ESRX seems focused on the larger employers
  - Many clients have called with questions about ESRX-ANTM, and he believes **ANTM is trying to leave**

### Full Notes

- Background
  - Worked for 3 PBMs focused on employers
  - Now works for employer-focused consulting firm
- Focus in selling season
  - Pricing
    - Focused on trying to save clients money for the past 7 years
    - Many clients debating between fully/self-funded
  - Specialty
    - Many benefit managers don't have tools to manage high cost drugs
      - PBMs don't initially limit many and aren't providing pro-active tools
      - More needs to be done across specialty given high levels of inflation
      - Need to start clinical management at/before launch
    - Many PBMs won't allow specialty carve outs
  - Technology Tools
    - Get data in the hands of HR
    - Helps to manage service issues and review data
  - Seeing more groups changing PBMs this year
    - People unhappy with specialty trend
    - 2x level of activity vs. last year
- Don't see much differentiation across PBM complex (PA + formulary modestly)
- Optum/MedImpact will be a bit more creative on specialty (open to other vendors)
- Therapeutic areas
  - PCSK-9 still a bit controversial
  - Oncology remains key focus area (employers not reacting)
- Most restrictive specialty formularies drive best cost savings
- Pricing renegotiations
  - Can drive 20% savings (across AWP, rebates, fees, etc.)
    - Typically for larger clients who are threatening to leave
  - Shrinks up for mid-sized clients
- Rebates started being shared with clients starting 2-3 years ago
  - Brand only (except 1 client)
    - At retail, mail
  - Specialty rebate
    - On average, see \$100-\$225 per Rx
  - ESRX/CVS/Optum get largest rebates given volume advantage
  - Consultant believes PBMs keeping >50% of rebates and passing back 10%
    - Then using some savings to give discounts on brands/generics
  - Rebates ex-specialty have stagnated
  - Generic retail discount today is ~80% vs. 68% 5-10 years ago on a higher #

- Average discount is ~ 74%
  - Average generic AWP is \$50
  - Average brand is ~\$125
- ESRX/CVS not in pass-through world
  - 95% of the time, the best pricing is from traditional PBM model
    - Bc they can't control member spend as well
    - High risk means lower rebate \$ guarantees
  - Admin fee on transparent model is typically \$2-4
  - Does not see any material change in rebate/pricing model long term bc of industry lobbying
- Combined medical/pharmacy benefits
  - Idea makes sense but there has been very little discussion of it in the employer market
  - Would require that PBMs provide a higher service level
- Biosimilars are still in wait and see mode
  - PBMs haven't shown cards yet
  - More to come over next 2-3 years
- Players
  - CVS
    - Seeing best pricing
  - Optum not being as aggressive on pricing
    - Seeing some service issues
    - Has lost some CTRX business
  - ESRX
    - More focused on larger clients
    - Not playing as much in smaller client space
    - Focused above 10k lives
    - Consultant's office is 15 miles from ESRX
    - Has never seen a focus on the 5-15k lives market
    - MHS had a strong offering, but not there now
- ESRX-ANTM dispute
  - Has received a lot of client questions
  - Believes ANTM is going to go out on its own
  - PBM contract between ESRX-ANTM could have up to 4 price checks (if traditional)
- WBA
  - Likely wishes they had not exited marketplace
- Smaller PBMs
  - Magellan
    - Have had positive employer feedback
    - A little more visible than in the past
    - More flexible around specialty
  - MedImpact
    - Do a little bit of business
    - Not much change
  - Prime
    - Not much change
  - Small-mid-sized PBMs – not much change overall
- RFPs
  - Generic pricing better
    - 80% discount better than last contract round
    - More generic players is increasing competition
  - In order to recommend a move, need to see 6-7% price improvement
    - Seeing ~14% discounts as PBMs fight for business
  - Incumbent isn't always given the chance to respond if pricing is so much better or if client is unhappy with current PBM
  - Price checks more important in long-term contracts
    - Consultant does not believe in long-term contracts (90% are 2 years, 10% are 3 years with price check half way through)

- LT contracts help PBMs more than clients
  - Large clients almost always do a price check
- IT
  - Have improved internal modeling/IT capabilities to better help on managing costs
  - Only require a data feed now
  - Enhancements in auditing data has improved positive points of access for HR to view
  - PBMs don't really want smid clients to have access bc then their customer service people will become overwhelmed
    - Don't have that service infrastructure built
- Medium term outlook
  - Top players likely to continue to dominate
    - Will continue to get best pricing
  - Wouldn't be shocked to see changes in large health plans
  - Don't see new PBMs coming into the market place that would do things much differently
  - Could see more industry consolidation
  - Inflation likely to continue over the medium term
    - Particularly as branded players have bought generic manufacturers
  - Employers will have to start to limit formularies and networks

### 5/19 – Evercore ISI Rx Supply Chain Monthly Publication (Market Trends)

Please find a link to the latest edition of the **Evercore ISI Monthly Overdose** (our monthly pharma supply chain publication) below. We are also including a few high level takeaways from the report beneath, which focuses on drug volumes, distribution channels (mail vs. retail), pricing trends (incl. generic inflation), and key contract changes within the chain (PBM and wholesaler). Additionally, we have included this month a schematic to better understand how money flows for the dispensing of a brand drug.

**Link to FULL slide deck and relevant disclosures:** [Rx Supply Chain - April IMO - Rx Demand Decelerated; Inflation Subdued](#)

#### **Key Takeaways from April IMO:**

- Total Rx volumes down ~1% y-o-y in Apr. vs. up ~2.5% in 1Q. (down ~7% m-o-m) - **DECLINED**
- Generic TRx were up ~0.1% y-o-y in Apr. vs. up ~3% in 1Q. (down ~6% m-o-m) - **DECLINED**
- Specialty growth was ~0.5% y-o-y in Apr. vs. up ~4% in 1Q. (down ~8% m-o-m) - **DECLINED**
- Composite inflation up ~32 bps in Apr, with TTM now ~10% - FLATTISH
- Branded inflation up ~45 bps in Apr, with TTM now ~14% - FLATTISH
- Specialty inflation up ~28 bps in Apr, with TTM now ~10% - **DECELERATION**
- Generic inflation up 3 bps in Apr, with TTM now ~2% – FLATTISH

**Conclusion:** After witnessing improved demand over the prior two months, utilization again decelerated in April. This was generally broad based with little to no growth in specialty nor generics, and a modest decline in brand. On the inflation side we also continue to see a mixed bag, with composite inflation flattish on a TTM basis but below prior year levels YTD, specialty inflation modestly below recent trend and generic inflation basically non-existent (would be modest deflation including launches / break-open). In terms of contract news, we recently got affirmation from ABC with respect to extensions / renewals from ESRX/WBA (still awaiting Kaiser), while yesterday also brought a reasonably sized contract shift in the PBM world w/ CVS losing CalPERS to Optum (nearly \$1Bn in annual spend). The CalPERS news bucks the trend of much of what we have seen/heard so far during the selling season, where CVS appears the big winner (notably in health plans / small employers). From a stock standpoint (in the Rx Supply Chain) our bias remains to **own both of the large-cap drug stores** (aid from generic deflation / capital allocation), with an increasingly positive skew toward the wholesalers given underperformance (and a negative bias toward ESRX/RAD). However, we would **prefer to see an improved volume / inflation dynamic prior** to becoming more constructive in the complex broadly. For now our sole buy-rated distributor remains MCK.

**Supply Chain Top Picks:** MCK & WBA

## 5/20 – Doctor Evidence to Provide CVS with Evidence Analyses to Support Formulary Decisions (Competitors)

SANTA MONICA, Calif., May 20, 2016 /PRNewswire/ -- Doctor Evidence, a global medical evidence software and services company, announced this week that the company will be working with CVS Health to help support evidence gathering for the formulary decision-making process. As part of an ongoing effort to provide the greatest value to its clients and their members, CVS Health has identified Doctor Evidence as an organization whose adherence to the highest methodological criteria will bring increased agility to its formulary process.

With the rapid advancement of health technologies and specialty therapies, Pharmacy and Therapeutics Committees are faced with a deluge of evidence, and short time frames for synthesis and review when considering coverage for expanded indications or introducing new therapies. Doctor Evidence's best-in-class tools help ensure the highest quality and most current evidence is available for these committees. Through GROWTH (Guidelines & Research Organizations Worldwide for Transparency & Harmonization, [GROWThevidence.com](http://GROWThevidence.com)), Doctor Evidence will provide the CVS Caremark National Pharmacy and Therapeutics (P&T) Committee with digital data and tools to efficiently perform comparative effectiveness research using the highly sophisticated analytics available within the Doctor Evidence platforms.

"Doctor Evidence is pleased to be working with CVS Health to support their efforts to ensure the most current and relevant data is readily available to their P&T Committee," affirmed Robert Battista, MBA, co-founder and Chief Executive Officer of Doctor Evidence. "Doctor Evidence will bring the highest quality research evidence to bear and we strongly encourage manufacturers of new or modified treatments to ensure their published studies are represented in the Doctor Evidence library."

### About Doctor Evidence

Doctor Evidence, LLC, founded in 2004, is a leader in technological solutions for evidence-based medicine reviews and analysis with a mission to provide stakeholders across the healthcare ecosystem with the most timely and relevant medical evidence and related analytics to make and inform the best clinical decisions. Doctor Evidence is best known for its proprietary Digital Outcome Conversion (DOC™) platform and its rigorous methodology of extracting clinical data from static, unstructured sources, including published studies, epidemiological databases, drug label and creating dynamic, scientifically-curated data hubs. The digitized data can be pooled and analyzed to support the development of evidence-based clinical practice guideline recommendations, systematic reviews, and health technology assessments, regulatory and policy submissions. The company's goal is to support efforts of healthcare providers, healthcare professionals and patients to gain access to important evidence-based knowledge and to improve the health and wellbeing of patients worldwide. Doctor Evidence is a global company headquartered in Santa Monica, California. For more information on Doctor Evidence innovations, please visit <http://www.drevidence.com> and <http://growthevidence.com/>.

Source: <http://www.prnewswire.com/news-releases/doctor-evidence-to-provide-cvs-health-with-reliable-evidence-analyses-to-support-formulary-decisions-and-policies-300272661.html>

## 5/23 – Evercore ISI: Insights from ESI investor presentation on diabetes and autoimmune safeguard Rx programs (Competitors)

Below are notes from a presentation Everett Neville gave at an investor conference last week. They provided a lot of good insight on the new Safeguard Rx programs (Diabetes, Autoimmune, and Market Events).

### ESI Investor Conference Notes | May 11, 2016

1. Criteria for areas were are focused on with Safeguard Rx
  - a. Focused on areas where clients are felling a lot of pain – drug classes where the cost is accelerating and increasing much faster than the overall book
  - b. Improve patient care
  - c. ESI can deliver substantial cost savings through better pricing at pharmacy, higher rebates, better pricing, lower cost or lower utilization
  - d. ESI is taking some risk themselves (performance risk)
    - i. Hep C – ESI is at risk for compliance levels
  - e. There is a lot of unfinished business, significant opportunities
2. 3 New SafeGuard Rx Programs For 2017
  - a. Diabetes – spend is expected to grow 50% over the next three years – several drivers:

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- i. Prevalence of diabetes is increasing
    - ii. Pipeline is strong - a lot of new drugs on the market that is driving an increase in unit costs
    - iii. Doctors are treating diabetic patients with 3 or 4 therapies as opposed to 1 or 2
    - iv. Expect to have a biosimilar to Lantus (basal insulin) which we currently support on our formulary – this opportunity will drive some substantial savings
    - v. Program will have a very tight formulary management, a network approach
    - vi. The patient population is too large to bring it all into mail so we are going to wrap the diabetes program with mail as well as with a small network of pharmacies
      - 1. The retail network we put together will be limited and will be based on cost and quality metrics.
    - vii. We will roll this out in 4Q and implement in 1Q
  - b. Inflammatory Conditions
    - i. Trend is increasing about 25% annually
    - ii. Trend is driven by unit cost inflation on both existing products and new classes
    - iii. A lot of the trend is not being driven by new patient populations – they key driver is unit cost inflation
      - 1. The cost increases are coming from existing manufacturers taking price or new products like IL-6 which are being priced at premiums to the previous regimes
    - iv. ESI will manage this class by diagnosis code
    - v. This is the number one specialty spend for a lot of clients and it has been tough to manage based on the multiple disease states that are in their
      - 1. The drugs are not clinically the same for all the disease states
    - vi. Now at the point where we can manage certain classes by diagnosis code
    - vii. Similar to oncology – we have selected certain indications to manage separately both from a formulary and quality point of view and will also use PAs and other UM tools
      - 1. We will manage RA, Psoriasis, and Ulcerative Colitis separately for example
    - viii. ESI will share some of the for performance and patient outcomes
    - ix. Similar to diabetes will include a risk sharing for certain metrics and performance and patient outcomes
  - c. Market Events
    - i. Not disease state specific, deals with activities or situations that have increased over the last year or so that is driving trend
    - ii. This programs allows ESI to move much quicker for customers and save them money
    - iii. Compounding drugs is one example
    - iv. New generic launches that have no competition
    - v. This is programs is focused on drugs that are getting around the system
    - vi. ESI can remove a generic product from the formulary if that generic product is not clinically superior to other generic products or is priced at a considerable premium
    - vii. ESI can move a patient from the retail channel to a mail channel if the price differential between the two expands
    - viii. ESI can eliminate pharmacies from their networks
- 3. Safeguard Rx Enrollment
  - a. Every program has over 10mm members enrolled
  - b. The largest program has over 40mm members
  - c. The majority of programs have over 20mm lives
  - d. Expect solid uptake for both Diabetes and Autoimmune programs
- 4. ANTM Dispute
  - a. Expect ANTM to respond to ESI's legal response soon
  - b. We continue to work with them to help them be more competitive utilizing tools like mail, formulary management etc
- 5. Selling Season
  - a. Confident in the 95-98% retention rate
  - b. There is fairly a robust supply of new opportunities that we are waiting to hear back on – in the next month we should hear back on the bigger opportunities
- 6. EBITDA/Claim – sustainability of industry leading rate
  - a. Expect EBITDA/Claim to continue to grow

- b. One of the reasons for the premium is that our direct formulary (aggregating rebates for other payers) doesn't have an associated claim that goes with it. By default, its going to be higher because you have EBITDA with no associated claim, so the mix is different
7. Generic Pricing
    - a. ESI defines generic inflation or brand inflation as the top line price increases – the price increases manufacturers purposely take (their WAC or AWP going up)
    - b. Historically, generic price increases were 1-2%, maybe 2.5%, on gross prices
    - c. This year, ESI is seeing lower than the 2% rate (around 1%, or a little less)
    - d. Generic pricing has a big impact on distributors and manufacturers, but very little impact on ESI because ESI does not buy generic drugs based on their AWP or WAC, instead ESI participates in a bidding process
    - e. ESI continues to pay less for generics for its mail facility

## 5/24 – PCMA Press Release Announcing New National Campaign Promoting PBMs, Downplaying Drugstore Lobbying (Market Trends)

### The Independent Drugstore Lobby Agenda: Higher Drug Prices, Fewer Choices in Medicare

#### *New National Campaign Highlights How PBMs Reduce Costs, Improve Pharmacy Benefits*

May 24, 2016 (Washington, D.C.) — As the independent drugstore lobby descends on Capitol Hill this week to push an agenda that would increase costs and reduce access for Medicare enrollees, the **Pharmaceutical Care Management Association (PCMA)** is promoting a national campaign, called [That's What PBMs Do](#), to highlight how pharmacy benefit managers (PBMs) reduce prescription drug costs and improve benefits for consumers, employers, unions, and government programs.

"PBMs will save consumers, employers, unions, and government programs \$654 billion over the next decade," said **PCMA President and CEO Mark Merritt**. "Unfortunately, the independent drugstore lobby agenda would raise costs for seniors, employers, and programs like Medicare Part D."

PBMs reduce drug costs by:

- Offering Amazon-style home delivery of medications;
- Creating discount pharmacy networks;
- Promoting generics and less expensive brand options;
- Negotiating discounts, rebates and other price concessions from drugmakers and drugstores; and
- Managing high-cost specialty medications.

Click [here](#) to learn more about PCMA's *That's What PBMs Do* campaign.

The independent drugstore lobby wants Congress to pursue so-called "Any Willing Pharmacy" mandates (H.R. 793/S. 1190) that would eliminate the popular "preferred pharmacy" plans in Medicare. These mandates would increase spending by \$21 billion over 10 years, according to [research](#) from The Moran Company examining the same legislation introduced previously.

Research and polling highlight the value of preferred pharmacies in Medicare, including:

- A [survey](#) of seniors in preferred pharmacy plans shows that nine out of 10 seniors from urban, suburban, small town and rural areas have convenient access to these preferred pharmacies in Part D.
- An [analysis](#) of CMS Part D 2016 enrollment data found that 75 percent of Medicare beneficiaries chose preferred pharmacy plans that offer convenient access and extra discounts at certain pharmacies.
- The [Federal Trade Commission](#) (FTC) wrote a letter to Centers for Medicare and Medicaid Services on "Any Willing Pharmacy" provisions included in the agency's proposed Medicare Part D rule and warned that: "*Requiring prescription drug plans to contract with any willing pharmacy would reduce the ability of plans to obtain price discounts based on the prospect of increased patient volume and thus impair the ability of prescription drug plans to negotiate the best prices with pharmacies.*"

Another drugstore lobby mandate (HR 244) would gut a key cost-control tool—the use of Maximum Allowable Cost (MAC) lists—which ensure payers aren't overpaying pharmacies for generic drugs. Forty-five state Medicaid programs now use MAC lists to reduce costs.

The Health and Human Services Office of Inspector General (OIG) touted "the significant value MAC programs have in containing Medicaid drug costs." The OIG also recommended that states strengthen MAC programs, not weaken them. Likewise, a [white paper](#) authored by David Hyman, a former Special Counsel at the FTC, notes that "legislative or regulatory

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measures that limit, restrict, or interfere with MACs are likely to have several unintended adverse consequences,” including higher prices and tacit collusion among pharmacies.

The independent drugstore lobby also opposes patient safety legislation to curb prescription drug abuse in Medicare, known as “Safe Pharmacy” or “Lock-In.” Creating this program in Part D for controlled substances would allow health plans to require at-risk beneficiaries to work with their plans to choose a single pharmacy to dispense controlled substances.

The independent drugstore lobby’s argument for new mandates is undermined by their own research. According to a [Drug Channels](#) analysis of the 2015 National Community Pharmacists Association (NCPA) Digest, the number of independent pharmacies continues to hold steady and profit margins remain stable.

###

*PCMA is the national association representing America’s pharmacy benefit managers (PBMs). PBMs administer prescription drug plans for more 266 million Americans who have health insurance from a variety of sponsors including: commercial health plans, self-insured employer plans, union plans, Medicare Part D plans, the Federal Employees Health Benefits Program (FEHBP), state government employee plans, managed Medicaid plans, and others.*

## 5/24 – CalPERS Bidder Comparison Analysis, courtesy of Specialty Pharmacy Solutions (Competitors)

**Specialty Pharmacy Solutions** - Client Alert - CalPERS Smacks Down CVS and ESI in PBM Runoff

The California Public Employees' Retirement System (CalPERS) announced recently that it had selected OptumRx – owned by UnitedHealth Group - as its new pharmacy benefit manager (PBM). That is stunning for two reasons.

First, this selection ices Optum as a major player in the PBM pantheon. Optum (*the PBM formerly known as Prescription Solutions*) needed to expand rapidly to shoulder United’s own PBM business being offloaded from Medco/ESI. Optum now seems ready to bring on even more business with big accounts like CalPERS (486K members)..... and a few weeks earlier nabbing the Texas employee Retirement System from Caremark.

Second, CalPERS released (as a public document) the “Comparison of Solicitation Proposals” which used a rudimentary star system to rank CVS, ESI and Optum across five major categories and up to as many as 15 sub-categories – *a total of 72 rankings by my count....*

I’ve attached the full Comparison report and highlighted the key variances – red being the lowest ranking and yellow the highest relative ranking. (*if all rankings were the same we skipped them*). [View comparison report with comments here](#)

The Summary page (1) doesn’t tell us much since the averages muted the variances in the rest of the pages. However, even here CVS begins to show red...a trend that continues throughout. *In fact, there is so much red it has got to have heads rolling at CVS.*

Here are the hard facts across the five major categories:

- Firm’s Capabilities - Lots of 5 Stars here with the exception of CVS with two red marks (3 stars) in Strategic Vision and External Factors (*whatever those are*).
- Management Plan - Not many 5 stars here, but Optum begins to accumulate more 5s than its competitors. However, CVS limps in with fully 7 red marks (3 stars) in key sub-categories like Pricing, Payments, Fraud/Waste, Claims Administration.... and more. By comparison to ESI and Optum, they are now bleeding badly.
- Work Plan - CVS is again battered in this category with fully 9 red marks (including a dreaded 2 Star for Medical Management Services – *ouch!!!*) ESI is tagged with 4 red marks and Optum with 2; however, Optum is the only one to shine in this category with two 5 star ratings.
- Staffing Plan – Once again CVS is crushed with 8 red marks, ESI gets tagged with 3, but Optum does well with only 1 red mark while holding its own on 4s and 5s.
- Financial Plan - All plans were pretty much on par here except for CVS with 2 red marks on Pricing and Generic Drug Dispensing Guarantees.

So here’s my Summary....Optum clearly outpaces ESI on many sub-categories – but it would be a horserace. Clearly, Optum will be using the CalPERS Summary as a selling piece for the next year to win more business – it is a compelling document. CVS, however, does so poorly comparatively as to be embarrassing. It will be interesting to watch the fallout from CVS’ painfully public experience with CalPERS.

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OptumRx winning bid and other evaluation documents are available here:

[G:\Marketing \(775\)\z\\_Public\\_Dropbox\Market Research\FOIA Documents\CalPERS - OptumRx - Jun2016](G:\Marketing (775)\z_Public_Dropbox\Market Research\FOIA Documents\CalPERS - OptumRx - Jun2016)

## 5/24 – Notes from CVS Management Meeting and Anthem Investor Presentation (Competitors)

### CVS Management Meeting Notes | 5.24.16

1. PBM Selling Season
  - a. CVS is pleased with the selling season so far which includes a couple of wins
  - b. Despite Calpers and Texas Retirement System (TRS), CVS is still confident and expects another good selling season
    - i. These losses are not the result of the Optum-WBA relationship. These RFPs started in 2015
    - ii. Combined represent \$2bb in lost revenue
  - c. CVS never budgets 100% retention (97% retention last year)
  - d. The integrated model continues to resonate with plan sponsors
  - e. Biggest difference today versus 6-8 years ago is that there are three distinct models. Back then, ESRX, Medco and Caremark were competing with the same model. Today, there are now three different value propositions
  - f. Pricing is competitive, but rationale. Similar to previous years
  - g. Caremark's pricing is competitive, but not the lowest in the market
  - h. Once you are competitive in pricing and offer good service, the suite of services are what wins new business
  - i. There has been no fundamental change in the business
  - j. Maintenance Choice cannot be replicated with a partnership on a widespread basis, perhaps it can be for a customer or two
    - i. A partnership cannot create scale because in a partnership someone will win and someone will lose
  - k. CVS does not think the Optum model is best or worst for government accounts. Calpers and TRS was a bid process with no best in finals
  - l. Clients continue to be focused on specialty and cost trends. There is more interest in adopting tools that will bend the cost curve
  - m. Caremark has \$22bb up for renewal; FEP is not part of this – the contract is not up for renewal
2. Pharmacy Reimbursement
  - a. Do not expect this pressure to abate anytime soon
  - b. CVS is seeing higher growth within Medicare and Medicaid – both of these customers are good for revenue growth, but negatively impact margins
  - c. Offsets to margin pressure
    - i. Generics although this is less of an offset than in the past
    - ii. Biosimilars – still a lot of unanswered questions. These will behave more like branded drugs however, they will bring competition to the market which should create value from a rebate and discount perspective
    - iii. Specialty
    - iv. Acquisitions
3. Health Plans
  - a. Some regulations do not allow PBMs to implement certain programs for health plans. For example, Medicare plans cannot adopt mandatory mail
  - b. Consequently, Caremark has to target each individual member. For example, Caremark is trying to utilize Specialty Connect as a way to drive Medicare members to their stores with the hopes of bringing the specialty scripts but also the acute and chronic scripts too.
  - c. Caremark is just starting to try to upsell its recent health plan wins – too early to tell how successful it will be
    - i. 80% of 2016 wins were health plans
4. Rebates
  - a. A significant percentage of rebates go back to the clients
  - b. More competition in specific classes creates an opportunity for additional rebates
  - c. Rebate yield is increasing, however, most go back to clients
5. Indication-based Pricing
  - a. This is not applicable to all therapeutic classes
  - b. Caremark is applying it to Autoimmune
6. Aetna
  - a. Contract goes through 2022 with an early termination in 2020
  - b. If AET leaves, CVS still has a significant size/scale advantage

- c. Overall, the PBM optionality to bring it in-house results in sub-optimal scale
- 7. Walgreens- Rite Aid
  - a. CVS cannot comment on potential divestitures
  - b. CVS would be interested in divestitures if it makes from both a geographic and price standpoint
- 8. Generic Conversion Trends Being Lower
  - a. The lack of conversion of some brands to generic is not something new. This has been going on for a while but it's really an exception
  - b. Some brand manufacturers will give a significant rebate that makes the branded drug the lowest net cost
  - c. Caremark's objective is to get the lowest net price for their customers
  - d. This only occurs during the exclusivity period
  - e. Overall, typically this is better for CVS but it happens so infrequent that it does not really have a significant impact
- 9. Retail Network Contracting
  - a. CVS wants to be a player in Med-D but will only participate where it makes sense
  - b. There is always a step down in the rates; however, not all Med-D is the same – depends on co-pay differentials
- 10. Omnicare
  - a. Integration is going very well although it's mostly back-office integration. This will be done by year-end
  - b. The procurement integration is essentially done
  - c. CVS is now working on revenue synergies – piloting several programs within the assisted living and skilled nursing space
  - d. Don't expect much revenue synergies in 2016
  - e. CVS hopes to gain share in skilled nursing and assisted living beds
- 11. Target Integration
  - a. Integration is going very well
  - b. The system and store conversions will be done by the end of the summer
  - c. Once this is done, CVS will start to do broad-based marketing in an effort to drive incremental business to TGT pharmacies
- 12. Red-Oak Generic GPO
  - a. This is in the 3<sup>rd</sup> year of operation and continues to do well
  - b. Generic manufacturer consolidation has not impacted the market or Red-Oak
  - c. Red-Oak's volume is 50% higher today versus when it started
  - d. CVS is hitting its milestones for Cardinal Health
  - e. Red-Oak is working on developing more sophisticated sourcing programs
- 13. Retail Business
  - a. The front-end represents less than 11% of revenue; Business revolves around the pharmacy
  - b. CVS continues to do well from a margin standpoint
    - i. Same-store gross profits is growing while same-store traffic is declining
  - c. CVS is ok with losing the one-off customers who would show up for a promotion – CVS didn't make any money off of these customers
  - d. CVS continues to have success with its loyalty customers
  - e. CVS is doing less promotions and advertisements
    - i. Used to have 62mm circulars in Sunday papers; now has around 40mm
- 14. Amazon And Curbside Pick-Up
  - a. CVS's exposure to AMZN's business is very small today
  - b. CVS would consider shipping product to consumer's home if it made sense

View the full CVS Health presentation here:

[https://na2.salesforce.com/sfc/p/3000000062Y/a/40000000bmaf/AmLIAQpRqndgIgTYsbB1nU\\_c8mK5NZZCHM66Pla3JI](https://na2.salesforce.com/sfc/p/3000000062Y/a/40000000bmaf/AmLIAQpRqndgIgTYsbB1nU_c8mK5NZZCHM66Pla3JI)

#### **Anthem Investor Presentation | 5.24.16**

- 1. ESI Dispute
  - a. We are in typical lifetime of a standard litigation – they filed a counterclaim in the federal court in New York, we moved to dismiss 2 of those counts. That hearing is June 3<sup>rd</sup>.
    - i. After that, we will move forward with discovery, which we will file shortly. After that will come the deposition phase.
  - b. There was just another class action suit filed against ESI on behalf of ANTM members.

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- c. Plaintiffs have moved to have this termed a related action, ESI opposes this, ANTM supports this.
    - i. If it is deemed related action discovery will be more efficient.
  - d. \$5bb paid by ESRX to WLP at onset of the deal - how should this factor in?
    - i. ESRX has consistently taken this position that this payment means that ANTM cannot do a market check, but our position is that nothing in the agreement supports this.
    - ii. More compelling – accounting treatment that ESI took with SEC at the time of the deal is inconsistent with what they are saying now.
    - iii. Contract says that market check is an entitlement, not related to the price that ESI paid.
2. Strategic Rationale for CI Deal
- a. Back to the beginning – believe that deal will enable 1+1 to equal 3
  - b. Sense is that we have two strong portfolios with minimal overlap and significant synergies that will improve members, customers, the marketplace, and shareholders.
  - c. Analytics uncovered at least \$2bb in synergies – everything has affirmed that is still a likely number.
  - d. Regulatory review has a very long tale to it. Knew it would be a hill to climb until we got DOJ determination, which we believe is in the not too distant future.
  - e. 700-800 employees working on integration teams
  - f. Everything is progressing extremely well, notwithstanding all the noise and media releases
  - g. General Counsel is with us today to provide greater clarity around this
  - h. This is playing out as expected with minimal surprises thus far.
  - i. Going into deal, there was expectation that the deal would pass muster.
  - j. Knew that DOJ had never taken position that national accounts was a national market. We have always felt that it is a local/regional market.
  - k. Last precedent transaction of any scale is at least 10 years old. Marketplace has changed significantly, particularly in national accounts space.
  - l. There is a lot of slice business done at the local and regional level.
  - m. If you do a win loss analysis of National Accounts business, there is still a lot of competition in regional pockets – overlap between ANTM and CI was not as significant as we would have thought.
    - i. Post close, 75% of membership will be ASO, those employers will directly benefit from our ability to negotiate lower medical rates.
    - ii. Move to value based reimbursement will change the cost curve, which benefits consumers in consumer oriented marketplace.
3. Media Noise Over The Last Week On The Deal
- a. What came out in the press is unfortunate, but a lot of it is old news. Would discount a lot of the commentary and highlight that we are marching forward.
  - b. Two teams are working extremely well together, meeting deadlines on submissions (have met virtually all deadlines at this point).
  - c. Think that we are incredibly well aligned, still marching towards a due date for the deal to be approved.
  - d. At the most senior level there is an active steering committee and it is going very well.
  - e. Cigna management and legal team has been at the table with us, we have worked through differences of opinion, it has been a collaborative process, even more so than other transactions we have been involved in in the past.
    - i. Collaboration brings through differences of opinion, but is no difference than any lawyer's day at work.
    - ii. Some of the correspondence that was released was due to legal need to document everything. We are working together as business partners rather than opposing legal teams.
      1. Once we work through this it will be viewed as a non-event.
    - iii. In any deal this size you are going to have bumps in the road, this is very typical and we are not distracted by it.
4. Submission to the DOJ
- a. In the process of submitting white papers, which the DOJ requested. They want to see our input and analysis of the potential impact of the deal. We view this as SOP for a deal of this size.
  - b. To their credit they are trying to gain a detailed understanding of our business, which we view as a good and healthy thing.
5. Remedy to the national account issue

- a. Still feel very comfortable that we will be able to demonstrate that there is not a national market for national accounts.
  - b. If on the off chance that we need a remediation plan, we will have an answer for that.
6. MLR during 1Q
- a. Coming out of 1Q, we have a conservative balance sheet and feel we have been prudent in how we closed the books for 1Q.
  - b. Exchange business grew more than expected because we are a safe brand in a shaky industry
    - i. As a result, we do not have much background on these individuals because of churn and need to reserve more for this population until we have more clarity.
    - ii. Our price strategy is not market leading...still implementing medical management and expect to hit target efficiency next year or year after.
    - iii. Leap Day caused an 80bp increase in MLR
      1. Assume 25bps work down in MLR each of the next 3 quarters.
7. Exchange Participation
- a. Deeply embedded in 14 states, not making any changes. Believe it will be sustainable market in the long run, nothing to suggest that we should exit in any way shape or form.
  - b. CI is expanding exchange offerings, so we will certainly be there with them in that after the deal closes.

## 5/25 – Fox Business: 15 Numbers from CVS Health That Blew Me Away (Competitors)

CVS's PBM client retention rate (97.3%) for "last quarter" and other interesting numbers...

### 15 Numbers From CVS Health That Blew Me Away

By Brian Feroldi Published May 24, 2016 Markets Fool.com

CVS Health is on a roll. After it rang up more than \$153 billion in total sales last year -- making it one of the largest retail operations in the world -- industry watchers expect the company's top-line to surpass \$181 billion this year. That represents double-digit growth off of an enormous base, which is an impressive accomplishment for a company of CVS Health's size.

I've been digging deep into CVS Health's recent financial results and have been blown away by just how big this company has become. Below is a list of 15 numbers that amazed me and might help you put this behemoth's size into perspective.

That's the approximate number of pharmacies that are currently in CVS Health's retail empire. This number took a sizable step forward last year when the company ponied up \$1.9 billion to take over Target's pharmacy and clinic business, and the company continues to grow organically, too. Management has plans to net a total of 100 new store openings during 2016.

1,136: This is the number of in-store clinics (called MinuteClinics) that the company currently operates. These quick-service clinics are a big hit with CVS Health's customers -- revenue from MinuteClinics jumped 17.7% year over year last quarter, despite the company stating that traffic was moderate from a slow flu season. Management continues to see opportunity for MinuteClinic expansion and has already announced plans to get to 1,500 clinics within the next few years.

240,000: That's the size of the company's work force at year-end. CVS Health also retained 98% of the former Target employees that came to the company through the acquisition.

23.9%: That is CVS Health's retail pharmacy market share during the first quarter of 2016. That's up 245 basis points versus the same quarter a year ago, mostly because of inclusion of its Target acquisition -- but the company believes that it grew organically, too. **That's a healthy lead over the 19.5% market share that Walgreens Boots Alliance boasted over the same period.**

**80 million: That's about how many members are covered by CVS Health's pharmacy benefits management (PBM) business. That's the second-largest network in the country, behind only Express Scripts.**

**97.3%: This was CVS Health's retention rate for its PBM customers last quarter. It's a remarkably high number that demonstrates just how much its services are valued by customers.**

**85.2%:** This is the percentage of dispensed drugs from its PBM business that were generics in the first quarter. It was up 170 basis points versus the same period last year, and with more drugs losing patent protection each year and the rise of biosimilars, it is likely to keep climbing.

**\$40 billion:** That's how much revenue CVS Health pulled in from its specialty drug business in 2015, which was up 32% percent over the prior year.

19 million: This is the number of CVS Health's customers that have signed up to receive text alerts regarding clinic appointments and prescriptions. Management credits the company's continued fast growth with its investments in creating a better consumer experience and is in the process of rolling out curbside pickup, too.

**1 million:** That's the number of patients who have enrolled in ScriptSync, a program designed for patients with multiple prescriptions. Patients who utilize ScriptSync can pick up multiple monthly refills at the same time, thereby eliminating the need to make several different trips to the store. The program appears to be a big hit with customers as more than two-thirds of patients who have been offered ScriptSync have signed up. That's a pretty impressive results for a program that hasn't even been available for a full year.

21.9%: This is the percentage of front-store sales that were from CVS Health's store-branded products. This category was up 100 basis points year over year, and management is seeing so much success with its store brands that it has plans to enter a number of new product categories over time.

21%: This was how much the company's dividend was recently raised. Even with the payout bump, CVS Health sports a payout ratio of only 31.9%, which is a bit below its long-term target of 35%. That hints that investors should see another dividend boost next year.

**\$2.1 billion:** That's how much the company spent on repurchasing its own shares during the first quarter. In total, 22.4 million shares were retired for an average price of \$98.52 per share, and management has plans to buy back another \$1.8 billion worth by year-end. That should ensure that the company's share count continues to decline at a rapid rate.

**\$5 billion:** That's how much total capital will be returned to shareholders in 2016 through a combination of dividends and buybacks. Still, the company's cash balance is expected to grow this year, as management plans to throw off at least \$5.3 billion in total cash flow for the year.

17.5% to 19%: That's how much total revenue growth CVS Health expects to show for the full year. Acquisition-related costs and slightly lower margins are going to curtail profit growth, but management is still guiding for adjusted earnings to fall in the range of \$5.73 to \$5.88. That's growth of at least 11% versus the prior year.

Shares of CVS Health are currently trading for about \$100 each, which implies a forward price-to-earnings multiple of about 17. With the company preparing to have another solid year, I think that's a great entry price into this healthcare giant.

Brian Feroldi has no position in any stocks mentioned.

Source: <http://www.foxbusiness.com/markets/2016/05/24/15-numbers-from-cvs-health-that-blew-me-away.html>

### **5/30 – Unencrypted OptumRx Laptops Expose Over 400,000 Patients' Medical Data (Competitors)** **Far too many unencrypted laptops containing vast amounts of sensitive data are still being left in employees' vehicles.**

In three separate incidents, the thefts of unencrypted laptops from healthcare providers potentially exposed more than 400,000 patients' personal and protected health information (PHI).

Home prescription delivery provider OptumRx recently began notifying 6,229 people that their personal information may have been exposed when an unencrypted laptop belonging to an OptumRx vendor was stolen from an employee's vehicle in Indianapolis on March 16, [SC Magazine](#) reports.



The laptop held customer names, addresses, health plan names, prescription drug information, prescribing provider information and in some cases, birthdates. All those affected are being offered one free year of access to LifeLock identity theft protection services.

In a [notification letter](#) [PDF] to those affected, OptumRx chief privacy officer Mitchell W. Granberg stated that the company is working with the vendor in question to put additional protections in place to prevent a similar incident from occurring in the future.

"These measures include additional security requirements on laptops they use for OptumRx work, training and reinforcement of existing policies and practices, and further evaluation of additional safeguards," Granberg wrote.

California's Imperial Valley Family Medical Care Group recently stated that an undisclosed number of patients' personal information may have been exposed when a laptop was stolen from a physician's office on March 21, [HealthITSecurity](#) reports.

The information that may have been exposed includes names, addresses, birthdates, personal health information, Social Security numbers, driver's license information and California identification card information.

"Please be assured that we have taken every step necessary to address the incident, and that we are committed to fully protecting all of the information that has been entrusted to us," chief strategic officer Donald G. Caudill wrote in a [notification letter](#) [PDF] to those affected.

And California Correctional Health Care Services (CCHCS) recently acknowledged that as many as 400,000 people's personally identifiable information (PII) and PHI may have been exposed when an unencrypted laptop was stolen from a staff member's personal vehicle on February 25, [DataBreaches.net](#) reports.

All those potentially affected were patients incarcerated within the California Department of Corrections and Rehabilitation (CDCR) between 1996 and 2014.

"Appropriate actions were immediately implemented and shall continue to occur," CCHCS director of communications and legislation Joyce Hayhoe said in a [statement](#) [PDF]. "This includes, but is not limited to, corrective discipline, information security training, procedural amendments, process changes and technology controls and safeguards. As necessary, policies, risk assessments and contracts shall be reviewed and updated."

A recent *eSecurity Planet* article looked at [7 full disk encryption solutions to check out](#).

Source: <http://www.esecurityplanet.com/network-security/unencrypted-laptops-expose-over-400000-patients-medical-data.html>

June 2016

## 6/7 – Premier Announced the Acquisition of the National Specialty Pharmacy Business of Lincare (Supply Chain)

*Evercore ISI analysis of Premier acquisition of Lincare specialty pharmacy*

**Announcement:** Premier announced the acquisition of the national specialty pharmacy business of Lincare for \$75MM, funding the transaction primarily from available cash / existing borrowings. The **business generated ~\$200MM in prior year revenue** and we would assume **OMs in the 2-4% range** (margins can range from LSD to MSD dependent on therapeutic focus). The two main assets within the business include Acro Pharma Services and Community Pharma Services. Furthermore, the company noted that the acquisition brings access to limited distribution drugs in the areas of oncology, MS and respiratory as well as a notable footprint in Medicaid.

**Financial Implications:** The purchase price implies **~0.4x sales (in-line w/ prior transactions and public comparables)** as well as ~10-12x EBITDA, at the low end of specialty pharmacy sales; however, we would note that the margin mix and size are likely driving factors. With respect to accretion, the unit is likely similar in scope to the PINC core from a revenue growth standpoint (LDD to teens), while we estimate **accretion to be in the range of \$0.05 to \$0.08** (dependent on funding bias + synergy assumption).

**Our Take:** The asset purchase continues PINC's run of tuck-in transactions, bringing **critical mass to the specialty pharmacy effort** (revenues up materially). Specialty is an area with appealing growth (double digits) in addition to offering a plethora of future roll-up opportunities cementing the strategic rationale. From a P&L perspective it also aids FY17 consensus revenue estimates (which implied ~10% growth prior), while also providing cushion to forward year EPS estimates (much needed post a challenging Q). Of note this transaction is clearly dilutive to margins and should continue the de-rating trend that has been of modest concern (we tend to focus more on EBITDA \$ growth). Additionally, we would remind investors that our above ST forecast for next year already contemplated a healthy amount of M&A (full deployment of FCF), albeit we had anticipated the assets to fall within the Performance Services unit. All-in we see the Lincare deal as a solid transaction that should help to **somewhat de-risk impending out-year guidance**, where questions have arisen after mixed recent growth momentum in certain key segments of the business (PS).

Link to Evercore note: [PINC - Specialty Pharmacy deal helps to de-risk FY17 guide](#)

Analysis by Drug Channels: <http://www.drugchannels.net/2016/06/premiers-latest-acquisition-shows.html>

## 6/8 – How Much Does OptumRx Contribute To UnitedHealth Group's Revenues & Growth? (Competitors)

UnitedHealth's Optum division has three primary businesses – OptumHealth, OptumInsight and OptumRx. OptumRx specializes in pharmacy care services, catering to more than 66 million people in the U.S. through its network of over 67,000 retail pharmacies and home delivery centers. OptumRx has been the primary contributor to Optum's revenues and growth over the last five years and delivered excellent results in the first quarter this year as well.

Going forward, we expect OptumRx to contribute about 71% of Optum division's revenue growth over the next five years, accounting for about 30% of UnitedHealth group's overall revenues in 2021 from an estimated 24% in 2016. However, its

contribution to EBITDA is likely to be slightly lower at 50%.

UnitedHealth Revenue Breakdown	Units	2011	2016E	2021E
+ UnitedHealthCare Group	%	77%	66%	58%
+ Optum Group	%	23%	34%	42%
Optum Health	%	5.4%	7.2%	8.8%
Optum Insight	%	2.2%	3.1%	3.3%
<b>Optum RX</b>	%	<b>15.5%</b>	<b>23.9%</b>	<b>29.6%</b>
= Total	%	100%	100%	100%

Optum Revenue Composition	Units	Q1 2016	CY 2015
OptumHealth		20%	21%
OptumInsight		9%	6%
<b>OptumRx</b>		<b>72%</b>	<b>73%</b>

Optum's 5 Year Growth Components	Units	Value	Contribution To Growth
Optum's 2016E Revenue	\$ Bil	80	
+ Optum Group	\$ Bil	59	
Optum Health	\$ Bil	13	22%
Optum Insight	\$ Bil	4	7%
<b>Optum RX</b>	\$ Bil	<b>42</b>	<b>71%</b>
= Optum's 2021E Revenues	\$ Bil	139	

Optum Segment Breakdown	Units	Q1 2016	Y-O-Y Growth	CY 2015	Y-O-Y Growth
<b>OptumHealth</b>					
Revenue	\$ Bil	4.0	22%	14.0	26.2%
Consumers Served	Mil	79	11%	78	11%
<b>OptumInsight</b>					
Revenue	\$ Bil	1.7	20%	4.0	22%
Contract Backlog	\$ Bil	11	21%	10.4	21%
Contract Backlog Expected To Be Realized In 2016	\$ Bil			5.8	
<b>OptumRx</b>					
Revenue	\$ Bil	14.3	<b>72%</b>	48.3	51%

In the first quarter this year, OptumRx's revenues grew 72% year-over-year driven by the acquisition of pharmacy benefit management firm Catamaran for \$12.8 billion last year. The acquisition has made UnitedHealth one of the largest players in the PBM market, with about a 20% market share.

The company's progress with respect to its strategy of delivering holistic health care solutions through Optum is reflected in its performance results for the last several quarters. One of the key drivers has been the company's focus on five key areas of health care services – clinical care, pharmacy care services, information and technology solutions, government services and international business. In addition to an increase in revenues, the company continues to add more clients – individuals as well as enterprises. We believe that strong fundamentals, a comprehensive approach and a greater number of market opportunities should keep the division's growth momentum strong going forward.

Source: <http://www.forbes.com/sites/greatspeculations/2016/06/08/how-much-does-optumrx-contribute-to-unitedhealth-groups-revenues-growth/#215b208a7398>

### **6/10 – Express Scripts makes list of 'worst' employers, per 24/7 Wall St. (Competitors)**

Jun 10, 2016--The St. Louis area has many companies that make [lists of best places to work](#). There's one major employer, though, that's garnered a different kind of distinction. Express Scripts, the nation's largest pharmacy benefit manager, was [ranked the second-worst place to work for](#), according to 24/7 Wall St., [a financial news and opinion website](#). The ranking is based on an analysis of "thousands of employee reviews from jobs and career website Glassdoor," 24/7 Wall St. said in its online posting Friday.

According to the site, employees at the north St. Louis County-based company commonly cite "incompetent management, difficulty maintaining work-life balance, and long hours as major drawbacks for working at the company. Many employees report working 10-hour days."

But there's a sign that the company may be turning things around with the elevation of Tim Wentworth as the new CEO, 24/7 Wall St. says. Express Scripts spokesman Brian Henry, in an emailed statement Friday to the Post-Dispatch, said:

"Although we disagree with the methodology of ranking companies based on anonymous online comments, we know no company is perfect and we can always be better. We take all feedback seriously and it helps us to constantly improve. All of us at Express Scripts show up every day focused on putting medicine within reach of patients who need it. We have a diverse, inclusive culture rooted in mutual respect and collaboration. We know Express Scripts is a great place to build a career.

"We continuously look for ways to improve our culture — whether it's in the form of development programs, flexible work schedules or employee recognitions. The feedback we receive from employees through our engagement survey and other channels tells us we are on the right path. Many of our employees find Express Scripts to be a rewarding place to work because of what we do to help make medicine more affordable and accessible.

"Over the past year, our rankings on [Glassdoor.com](#) have been improving and our CEO, Tim Wentworth, has an approval rating of around 80 percent, well above the average rating on Glassdoor.

"And, as you know, we've been a proud donor to many deserving organizations in the St. Louis area. We are proud to have been born, raised and growing in St. Louis."

According to 24/7 Wall St., retailers Forever 21 and Family Dollar were ranked the worst and third-worst, respectively.

Other "worst" employers were Sears (No. 4), Xerox (No. 5), Kmart (No. 6), DISH (No. 7), RadioShack (No. 8), Dillards (No. 9) and Kraft Heinz (No. 10).

Source: [http://www.stltoday.com/business/local/express-scripts-makes-list-of-worst-employers/article\\_26b0d975-2126-560f-a2d9-98bd58ff6009.html](http://www.stltoday.com/business/local/express-scripts-makes-list-of-worst-employers/article_26b0d975-2126-560f-a2d9-98bd58ff6009.html)

## 6/10 – Sen. Grassley urges U.S. 3rd Circuit Appeals Court to revive fraud case against Caremark (Competitors)

Republican Senate Judiciary Committee Chairman Chuck Grassley of Iowa is urging a federal appeals court to revive a whistleblower lawsuit accusing pharmacy benefit manager CVS Caremark Corp of defrauding Medicare, saying a lower court decision dismissing the case could undermine the goals of the federal False Claims Act.

In an amicus brief accepted by the 3rd U.S. Circuit Court of Appeals on Thursday, Grassley said the lower court wrongly inferred that the federal government knew of Caremark's billing practices based on federal employees' testimony that those practices were widespread. He also said those employees were testifying as individuals, not speaking for the government.

To read the full story on Westlaw Practitioner Insights, click here: [bit.ly/1Ua9IRw](http://bit.ly/1Ua9IRw)

## 6/13 – OptumRx ousts CVS as PBM for General Electric, per Barron's Report (Competitors)

### United Health: With General Electric Win, is PBM Rethinking in Order?

Mizuho's Sheryl Skolnick notes that UnitedHealth Group's (UNH) pharmacy benefits manager OptumRx won a contract with General Electric (GE), replacing CVS Health (CVS). She considers the implications:

UnitedHealth confirmed to us in a call that OptumRx has been selected, once again, to replace CVS in a major PBM contract. The General Electric win (300k lives, 1/1/17 start) is important not just for the \$300mm in revs it represents, but more because General Electric is widely regarded as one of the most sophisticated HC buyers in the commercial market and not just on price. Optum now has at least \$2.3B in major competitive wins across all customer types, with & without UnitedHealthcare coverage...

The knock on OptumRx has been that it could either only win government/quasi-government contracts (i.e., price buyers) or only if there was synchronicity with UHC's coverage. In the last month, OptumRx has won contracts with and without UHC, government/quasi-government and commercial and with some of the most sophisticated buyers of HC coverage in the country. Moreover, these are major contracts that UnitedHealth couldn't have won if it didn't have broker/consultant support; if the integration of Catamaran hadn't gone smoothly and if the suite of innovative clinical-technology services didn't prove out in testing as well as in concept. In short, we think buyers understand that it's not just PBM services replacing PBM services that is the compelling value, but it is the moving forward of PBM functions into more clinical and customer-facing functions that drives future improvement in outcome and value, i.e., the Optum part of OptumRx, that is helping Optum to win this business. We think this win, given General Electric's historic innovation and sophistication in health care benefits, is an especially important proof of concept for OptumRx and potentially troubling for legacy PBM businesses that are more geared toward scale-driven efficiencies for price competitiveness...Perhaps some PBM rethinking is in order. Buy \$156PT.

Shares of UnitedHealth Group are unchanged at \$139.24 at 10:23 a.m. today, while General Electric has ticked up 0.2% to \$30.09, and CVS Health has fallen 0.7% to \$96.01.

Source: <http://blogs.barrons.com/stockstowatchtoday/2016/06/13/united-health-with-general-electric-win-is-pbm-rethinking-in-order/>

## 6/15 – Judge OKs \$310 million settlement in MedPartners (CVS) investor fraud lawsuit (Competitors)

A Jefferson County judge has given preliminary approval to a \$310 million settlement of a lawsuit that claims MedPartners, a health care company once led by former HealthSouth CEO Richard Scrushy, lied to investors about how much the company could pay under a 1990s settlement.

Jefferson County Circuit Judge Pat Ballard issued an order June 1 granting preliminary approval of the settlement. He has set an Aug. 8 hearing to determine, among other things, whether the settlement is "fair, reasonable, and adequate" and if he should grant final approval.

After fees and other administrative costs are deducted, the remainder of the \$310 million will be doled out to the investors filing approved claims, according to the settlement.

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The lawsuit against [CVS Caremark Corp.](#), the company that ended up owning the former MedPartners, is a class-action litigation representing about 70,000 investors who claim they lost \$3.2 billion in a 1990s securities fraud.

View the full article here: [http://www.al.com/news/birmingham/index.ssf/2016/06/judge\\_gives\\_preliminary\\_okay\\_t.html](http://www.al.com/news/birmingham/index.ssf/2016/06/judge_gives_preliminary_okay_t.html)

### 6/21 – PCMA on New PwC Report: PBMs Driving Competition to Reduce Drug Costs (Market Trends)

June 21, 2016 (Washington, D.C.) — The new PwC Health Research Institute (HRI) annual report (*“Medical Cost Trend: Behind the Numbers 2017”*) highlights how pharmacy benefit managers (PBMs) help reduce drug cost trend, specifically noting that: *“With increased appetite from employers to narrow their formularies to one treatment option, PBMs are using competition between products to more aggressively negotiate drug costs. This is putting a downward pressure on the growth rate of total healthcare spending. Reflecting the demand for value, the future of PBM contracting points toward paying for results and cures, not fee-for-service, around drug costs.”*

**Pharmaceutical Care Management Association (PCMA) President and CEO Mark Merritt** released the following statement on the new report:

“This report underscores how PBMs are driving competition and in turn reducing costs for consumers, employers, government programs, and unions. Policymakers should embrace greater use of proven PBM tools and reject drugmaker and drugstore lobby mandates that would increase prescription drug costs.”

PBMs are projected to save employers, unions, government programs, and consumers \$654 billion — up to 30 percent — on drug benefit costs over the next decade. Learn how PBMs reduce prescription drug costs and improve convenience and safety for consumers, employers, unions, and government programs at [That’s What PBMs Do](#).

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PCMA is the national association representing America’s pharmacy benefit managers (PBMs). PBMs administer prescription drug plans for more than 266 million Americans who have health insurance from a variety of sponsors including: commercial health plans, self-insured employer plans, union plans, Medicare Part D plans, the Federal Employees Health Benefits Program (FEHBP), state government employee plans, managed Medicaid plans, and others.

View PwC report here: <https://www.pwc.com/us/en/health-industries/health-research-institute/behind-the-numbers.html>

Download a PDF here: <http://pwchealth.com/cgi-local/hregister.cgi/reg/pwc-hri-medical-cost-trend-2017.pdf>

### 6/21 – PBM hardball, specialty med slowdown to curb 2017 healthcare spending jump (Market Trends)

Blockbuster drug launches have strained health systems budgets in recent years by driving sizable spending hikes. But that trend may be nearing a lull. Specialty drugs are “loosening their grip” on health spending growth, a new PwC report says.

Issued Tuesday, the report predicts steady healthcare spending expansion in 2017 at 6.5%, the same figure as 2016, and a number that PBM negotiations are helping to moderate, the analysts said. PwC’s Health Research Institute suspects that political pricing pressure and their clients’ needs for narrow formularies will drive PBMs to negotiate even more, offsetting areas anticipated to drive growth such as greater access to behavioral health.

But it’s not only PBM negotiations that will limit healthcare spending increases next year, the team said. They expect no new blockbusters in 2017, and they predict the tidal wave of hep C spending may be less of a factor in the big picture moving forward. That’s because hep C meds face different competitive dynamics now, while all of the prescriptions issued to this point have “shrunk the remaining population still living with hep C.”

Gilead’s Sovaldi first launched in late 2013 with an \$84,000 price tag, but the California-based Big Biotech has since seen rivals from AbbVie and Merck & Co. enter the fray. Upon the introduction of Viekira Pak by AbbVie, leading PBM Express Scripts struck a deal with the Illinois drugmaker in exchange for a “significant discount,” leaving Gilead out of the loop for millions of patients. For its part, Merck took an “aggressive” approach to pricing its hep C entrant Zepatier, AbbVie CEO Richard Gonzalez recently said, helping the New Jersey drugmaker to steal market share.

Even still, the upcoming year represents an “inflection point,” PwC said, adding that employers--worried about a potential return of sky-high cost jumps--will “demand more value from the health industry.”

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Also to play a part in the future of healthcare spending are PBM contracts structured around drug performance rather than volume, PwC says, a trend that has so far seen limited uptake but may be catching on. Novartis, with its heart failure med Entresto, was able to strike pay-for-performance deals with Cigna and Aetna, while PCSK9 competitors Amgen and Sanofi entered deals under similar terms for Praluent and Repatha, respectively. Industry watchers anticipate more of those to come.

Read the PwC [report here](#).

Source: <http://www.fiercepharma.com/pharma/specialty-drugs-loosening-their-grip-as-healthcare-spending-growth-expected-to-flatten>

## 6/22 – Express Scripts Investor Presentation Analyst Update (Competitors)

### ESI Investor Presentation | June, 2016

1. Selling Season
  - a. Confident in the 95-98% retention rate
  - b. Pricing is rational but competitive
  - c. ESI has won some accounts and has helped their health plans win accounts
2. Industry Growth Drivers
  - a. Historically, the drivers were inflation, generics, the generic pipeline
  - b. Today, the pipeline is largely specialty, biosimilars are an opportunity
  - c. New formulary opportunities that save clients' money – when the client saves, ESI makes more money
  - d. A key driver to growing EBITDA is managing the supply chain and negotiating discounts/rebates – this is not impacted by Anthem which does not use ESI's National Preferred Formulary
3. Anthem
  - a. ESI continues to provide good service to Anthem and is helping them grow both through acquisition or commercially
  - b. The discovery process for the lawsuit has just begun – this could take until the end of next year
  - c. Nothing new to report on the conversations with Anthem
  - d. Anthem – Potential Outcomes
    - i. ESI has started analyzing and preparing for a variety of potential outcomes with Anthem
      1. Extend the contract beyond 2020 – in this situation, Anthem would become a more traditional commercial contract with lower pricing/margin
      2. Lose the contract in 2020
  - e. ESI is evaluating its cost structure to prepare for these potential changes – want to me more automated
4. Managed Care Bringing PBM back in-house
  - a. Most MCO's are heavily invested on the medical side – going forward, the question is where will they invest their time and money
  - b. Pharmacy represents 15-25% of total healthcare costs - ESI invests 100% of capital in staying regulatory compliant and creating patient access programs
  - c. It's unclear how much effort managed care wants to spend to provide best in class pharmacy benefit
5. Specialty Opportunity
  - a. Big opportunity to create competition in specific drug classes (step therapy, tightly managed formularies, plan designs, etc)
  - b. We are implementing both indication outcome pricing (Hep C for example)
  - c. UBC business helps pharma companies with commercialization and R&D
6. WAG-RAD Deal
  - a. ESI embraces the transaction
  - b. WAG is doing a good job leveraging their cost model down – they can continue to be increasingly competitive with rates and the services they provide to payers and patients
  - c. RAD deal is another opportunity for WAG to drive out costs and drive out wastes in their model
  - d. Given the bigger footprint and lower costs, ESI can work with WAG on giving them access to patients they want
  - e. WAG is in ESI's Med-D plan, they are in one of ESI's Retail 90 products
  - f. ESI is constantly in dialogue with WAG and other players to explore opportunities to do broader things
7. 90-day at retail
  - a. Going forward, the focus is on optimizing patient outcomes and choice

- b. ESI wants mail, patients want mail, payers want mail; however, ESI is willing to work with those that want a retail focus
  - c. ESI would welcome retail partnerships to help ensure chronic patients are taken care of
8. ABC Contract
- a. Happy with ABC distribution contract – recently extended the contract a year
9. Generic Purchasing
- a. Wentworth wants to challenge Econdisc to improve their generic pricing and make sure ESI is getting the best rates and discounts
  - b. ESI is not married to their GPO as the only way to do generic purchasing
  - c. ESI's net pricing (which includes fees they collect in GPO) is within 1-2 basis points of the other super large purchasers. This is not compelling enough to switch to another entity

### 6/28 – Express Scripts, Anthem Face ERISA Lawsuit Over Drug Pricing (Competitors)

Express Scripts Inc. and Anthem Inc. are accused in a proposed class action of breaching their ERISA fiduciary duties by entering into a 10-year, multibillion-dollar prescription-drug agreement that caused plan participants to overpay for benefits ( *Burnett v. Express Scripts, Inc.* , S.D.N.Y., No. 1:16-cv-04948, complaint filed 6/24/16 ).

The lawsuit is the latest development in the \$15 billion battle between Anthem and Express Scripts. In March, Anthem [sued](#) Express Scripts for allegedly overcharging for prescription drugs in violation of the parties' agreement. Two months later, two health plan participants [sued](#) both companies under the Employee Retirement Income Security Act challenging Express Scripts' alleged overbilling.

The latest lawsuit, filed June 24 in the U.S. District Court for the Southern District of New York, is brought by participants in three medical plans sponsored by Verizon Communications Inc., AmTrust Financial Services Inc., and LG&E and KU Energy LLC. The plans have more than 26,000 participants combined.

View the full article from Bloomberg here: <http://www.bna.com/express-scripts-anthem-n57982076060/>

### 6/28 – McKesson to separate IT segment in venture with Blackstone (Supply Chain)

Health-care giant McKesson Corp. on Tuesday said it plans to form a health-care information-technology joint venture that it expects to take public later in an initial public offering. The planned company will combine most of McKesson's technology segment with the bulk of Change Healthcare Holdings Inc., which is majority owned by Blackstone Group LP. McKesson MCK, -0.45% would own 70% of the new company, with the rest owned by Change Healthcare's shareholders, including Blackstone and Hellman & Friedman LLC.

View the full article here: <http://www.marketwatch.com/story/mckesson-to-separate-it-segment-in-venture-with-blackstone-2016-06-28-10103529>

### 6/28 – FDA approves Eplclusa, first pill to treat all forms of hepatitis C (Market Trends)

Federal health officials have approved the first pill to treat all major forms of hepatitis C, the latest in a series of drug approvals that have reshaped treatment of the liver-destroying virus. The Food and Drug Administration approved the combination pill from Gilead Sciences Inc. for patients with and without liver damage. The agency has approved a number of hepatitis C drugs in the last three years, but all were targeted to specific strains of the virus or patients with various stages of liver disease.

Eplclusa, the new pill from Gilead, combines the Foster City, Calif., company's first hepatitis drug, Sovaldi, with a new drug that attacks the virus using a different mechanism. Gilead's hepatitis pills have raked in billions of dollars by replacing an older approach that involved a grueling pill-and-injection cocktail.

View the full article here: <http://www.latimes.com/business/la-fi-gilead-hepatitis-c-20160628-snap-story.html>

### 6/30 – Catholic Health Initiatives to divest health plan operations, a.k.a QualChoice (Payers & Plan Sponsors)

Hospital system Catholic Health Initiatives' experiment with health insurance has hit the end of the road after a couple years of heavy losses. CHI is "exploring options to sell" its health plan subsidiary, executives said in new financial documents. CHI executives "decided to exit the health insurance business" in May after undergoing a strategic review in

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March. CHI's consolidated insurance division, QualChoice Health, formerly known as Prominence Health, has hemorrhaged money since its inception. QualChoice sells Medicare Advantage plans and commercial plans to employers in six states.

In the first nine months of CHI's fiscal 2016, which ended March 31, QualChoice lost \$97 million from operations compared with \$19 million in the same nine-month period last year. QualChoice collected \$377 million in premiums during the first nine months of this fiscal year, a 41% increase from \$268 million last year, according to the financial statements.

CHI, based in Englewood, Colo., did not immediately respond to an interview request. As of March 31, the company had about 33,000 Medicare Advantage members and about 150,000 commercial covered lives.

It's unclear what kind of price tag CHI could fetch for its insurance division. But based on the subsidiary's revenue and industry valuation metrics, CHI could receive several hundred million dollars from potential buyers, which would help offset the system's growing net losses.

Source: <http://www.modernhealthcare.com/article/20160630/NEWS/160639998>

July 2016

## 7/5 – Healthcare Lawsuits: UnitedHealth Alleges Fraud and Anthem, Express Scripts Accused of Overcharging (Competitors)

UnitedHealth Group is suing American Renal Associates Holdings for fraudulent behavior, and Anthem and Express Scripts are facing a lawsuit for overcharging on prescription drugs.

UnitedHealth Group has filed a lawsuit against American Renal Associates Holdings for fraudulent behavior. Three affiliates of the health insurer are alleging that American Renal Associates convinced patients to sign up for coverage under one of United's Affordable Care Act plans instead of Medicare or Medicaid plans that the patients were eligible for.

[The Wall Street Journal reported](#) that the dialysis centers run by American Renal Associates received larger reimbursement payments for treatments under UnitedHealth plans compared with Medicare or Medicaid. In a statement with its [SEC filing](#), American Renal Associates said that it plans to "vigorously defend itself" against a lawsuit it says "is without merit." The lawsuit stems from complaints filed by 3 UnitedHealth affiliates in Florida regarding 27 patients who received dialysis at 12 facilities run by American Renal Associates in Florida and Ohio.

Meanwhile, Anthem and Express Scripts, the insurer's pharmacy benefits manager (PBM), are facing a lawsuit that alleges they overcharged patients for prescription drugs. The lawsuit could cover tens of thousands of Americans in a class action case. The lawsuit claims that Express Scripts violated its fiduciary duties to act prudently and in the best interests of participants under the Employee Retirement Income Security Act when it charged for prescription at prices higher than competitive pricing levels.

"Furthermore, Anthem breached its fiduciary duties by entering into a contract with Express Scripts that allowed Express Scripts to overcharge for prescriptions, and by failing to adequately monitor Express Scripts' activities to the detriment of Plaintiffs and the Class," [the lawsuit also alleged](#).

The plaintiffs believe that based on a market analysis from Health Strategy, a third-party consultant, that the prices being charged were higher than competitive benchmark prices.

"Based on Health Strategy's analysis, [Express Scripts]'s pricing exceeded competitive benchmark pricing by more than \$3 billion annually, which projected forward indicated additional overcharges of approximately \$13 billion over the remaining term of the PBM Agreement," according to the lawsuit.

Source: <http://www.ajmc.com/newsroom/healthcare-lawsuits-unitedhealth-alleges-fraud-and-anthem-express-scripts-accused-of-overcharging>

## 7/6 – Evercore ISI: WBA's Stefano has "a lot of ideas" on how to inflect EPS; BUY WEAKNESS (Supply Chain)

### What has changed?

#### Rating:

- Reiterate Buy

#### Estimates:

- FY16 EPS – **Lowered** from \$4.55 to \$4.50 given impact from dollar strengthening as well as a more conservative view of GMs (partially offset by tax)
- FY17 EPS – **Lowered** from \$5.60 to \$5.25 due to a material headwind from the pound, as well as a more conservative view of RAD accretion
- FY18 EPS – **Lowered** from \$6.40 to \$6.10 based on the knock-on effect from prior changes as well as less EBITDA contribution from RAD (OM miss)

#### Price Target:

- **Raised** from \$93.00 to \$94.00 primarily due to improved market multiples despite more conservative estimates (9% premium to S&P on forward basis)
  - Valuation Methodology: PT equates to ~17x forward CY EPS (in-line with 5-year avg; equates to ~10.5x forward EBITDA) and a DCF TGR of ~0.5%

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- Key Risks: 1) Challenges associated with improving front end merchandising and profitability given poor industry-wide traffic, 2) Accelerated pressure from reimbursement cuts both in the US and abroad (particularly the UK) 3) Inability to solve PBM / MCO partnership over medium-term negatively influencing share dynamic

Link to FULL notes (and important disclosures): [07-06lswba2](#)

**WBA Thesis update:** WBA's first fully comparable quarter post Step 2 has engendered mixed commentary as **core metrics were a touch light**, though EPS beat thanks to favorable non-operating items (namely tax). Although the quarter was certainly not perfect, our underlying thesis regarding the multi-year EPS growth trajectory of mid-to-upper teens remains generally unchanged (despite a notable Fx headwind). **We see green shoots starting to emerge that could drive a stabilization in gross margins on the front end (with the beauty roll out looming), and in the pharmacy through generic deflation and further vertical integration (Optum partnership),** with operating margins further aided via increased leverage (restructuring pull through). On the capital deployment front, management remains enthusiastic about the Rite Aid deal closure (>\$0.25 of accretion to FY17 with run-rate >\$0.75), though the deal is not crucial to the medium-term thesis on WBA given the plethora of other capital deployment opportunities (buy-back + other mid-sized deals). Overall, WBA shares offer superior growth at an attractive valuation (especially for such a large cap name) versus peers in both the healthcare services and consumer staples complex. **We would therefore view any weakness today as a buying opportunity.**

#### **Key Takeaways from Conference Call**

- **RAD is progressing as planned, with management noting that their lawyers have seen nothing negative so far**
  - The final divestiture package is still TBD. WBA has an idea of how many/which stores, but not the exact required divestiture package
- The full year tax rate for FY16 is expected to be ~27.2% though it will rise post the pending RAD acquisition given a more US-focused profit mix
- **WBA's US front end transition is underway with a mix shift towards more health & wellness and photo vs. certain convenience categories**
  - The company is working to create a beauty destination as well as help with fill in shopping
  - In stores with new beauty format, WBA is seeing bigger beauty baskets and more repeat customers, particularly with No 7
  - Comps should generally improve quarter by quarter and margins should improve
- Management noted that "we would have a lot of ideas" in terms of what to do with its capital if the RAD transaction does not close
- WBA has an option to purchase 36.6 in 5 years post the sale of its wholesaling businesses and taking of a 15% stake

#### **7/11 – Cleveland Research: Notes from ESI Investor Presentation (Competitors)**

##### **1. Selling Season**

- a. Confident in the 95-98% retention rate
- b. Pricing is rational but competitive
- c. ESI has won some accounts and has helped their health plans win accounts

##### **2. Industry Growth Drivers**

- a. Historically, the drivers were inflation, generics, the generic pipeline
- b. Today, the pipeline is largely specialty, biosimilars are an opportunity
- c. New formulary opportunities that save clients' money – when the client saves, ESI makes more money
- d. A key driver to growing EBITDA is managing the supply chain and negotiating discounts/rebates – this is not impacted by Anthem which does not use ESI's National Preferred Formulary

##### **3. Anthem**

- a. ESI continues to provide good service to Anthem and is helping them grow both through acquisition or commercially
- b. The discovery process for the lawsuit has just begun – this could take until the end of next year
- c. Nothing new to report on the conversations with Anthem
- d. Anthem – Potential Outcomes
  - i. ESI has started analyzing and preparing for a variety of potential outcomes with Anthem
    1. Extend the contract beyond 2020 – in this situation, Anthem would become a more traditional commercial contract with lower pricing/margin

2. Lose the contract in 2020
  - e. ESI is evaluating its cost structure to prepare for these potential changes – want to me more automated
4. Managed Care Bringing PBM back in-house
  - a. Most MCO's are heavily invested on the medical side – going forward, the question is where will they invest their time and money
  - b. Pharmacy represents 15-25% of total healthcare costs - ESI invests 100% of capital in staying regulatory compliant and creating patient access programs
  - c. It's unclear how much effort managed care wants to spend to provide best in class pharmacy benefit
5. Specialty Opportunity
  - a. Big opportunity to create competition in specific drug classes (step therapy, tightly managed formularies, plan designs, etc)
  - b. We are implementing both indication outcome pricing (Hep C for example)
  - c. UBC business helps pharma companies with commercialization and R&D
6. WAG-RAD Deal
  - a. ESI embraces the transaction
  - b. WAG is doing a good job leveraging their cost model down – they can continue to be increasingly competitive with rates and the services they provide to payers and patients
  - c. RAD deal is another opportunity for WAG to drive out costs and drive out wastes in their model
  - d. Given the bigger footprint and lower costs, ESI can work with WAG on giving them access to patients they want
  - e. WAG is in ESI's Med-D plan, they are in one of ESI's Retail 90 products
  - f. ESI is constantly in dialogue with WAG and other players to explore opportunities to do broader things
7. 90-day at retail
  - a. Going forward, the focus is on optimizing patient outcomes and choice
  - b. ESI wants mail, patients want mail, payers want mail; however, ESI is willing to work with those that want a retail focus
  - c. ESI would welcome retail partnerships to help ensure chronic patients are taken care of
8. ABC Contract
  - a. Happy with ABC distribution contract – recently extended the contract a year
9. Generic Purchasing
  - a. Wentworth wants to challenge Econdisc to improve their generic pricing and make sure ESI is getting the best rates and discounts
  - b. ESI is not married to their GPO as the only way to do generic purchasing
  - c. ESI's net pricing (which includes fees they collect in GPO) is within 1-2 basis points of the other super large purchasers. This is not compelling enough to switch to another entity

## 7/11 – Barclays Investment Report for Diplomat Pharmacy (Supply Chain)

The following is an excerpt from a Barclay's Equity Research report on the financial performance and outlook of Diplomat Pharmacy published in July 2016. To view the report in its entirety, click the link below:

[https://na2.salesforce.com/sfc/p/30000000062Y/a/40000000bmdP/qWLE9bGPx8NDPpey1R\\_pV\\_zf5.cbyZFtj1PDeHz5IGq](https://na2.salesforce.com/sfc/p/30000000062Y/a/40000000bmdP/qWLE9bGPx8NDPpey1R_pV_zf5.cbyZFtj1PDeHz5IGq)

**Earlier this week, we had the pleasure of hosting investor meetings with Diplomat's CEO Phil Hagerman and CFO Sean Whelan.** We observe that DPLO occupies a unique position as the largest independent specialty pharmacy (SP) in a highly consolidated and highly complex industry. As such, it falls to DPLO management to help investors understand the macro trends impacting the SP space and the value of an independent model. Management scored well on both accounts, in our view, while conveying confidence in the core business and excitement around recent M&A activity.

**From acquisition, organic growth opportunities emerge.** Beyond financial accretion from TNH, DPLO will drive organic growth/synergy by making limited distribution (LD) products available to TNH's cadre of oncologists. Further growth will be derived from the opportunistic purchase of a TX pharmacy, which will enable DPLO/TNH to pursue the sizable open market TX Medicaid population.

**The pipeline is strong and success begets success in limited distribution.** Recently launched LD products should continue to power growth and management made clear that the ongoing expansion of ltd dist will enable DPLO to grow well in excess of the market. Management's commentary (and our discussions with commercialization consultants) suggests that

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once DPLO has established expertise in a therapeutic class, manufacturers of follow on products are likely to seek to leverage this expertise.

**Deconstructing DPLO's limited distribution portfolio.** Our updated analysis of 80 of DPLO's LD drugs included in our *Specialty Market Model 2016 Update (1/6/2016)*, finds that the LD portfolio will grow 57% 2015 to 2016, contributing 63% of modeled 2016 revenue growth of \$1 .27bn (prior to share gains). On a dollars basis, our model finds DPLO's LD portfolio will grow to -\$2.2bn+ in 2016 from -\$1.5bn in 2015.

**We reiterate our Overweight rating and raise our price target to \$41 (21x CY2016 EBITDA) from \$37 (19x previously) given increased confidence in the LD portfolio.**

## DPLO: Quarterly and Annual EPS (USD)

FY Dec	2015		2016			2017		Change y/y	
	Actual	Old	New	Cons	Old	New	Cons	2016	2017
Q1	0.09A	0.23A	0.23A	0.18E	0.29E	0.29E	0.25E	156%	26%
Q2	0.16A	0.21E	0.21E	0.22E	0.24E	0.24E	0.26E	31%	14%
Q3	0.27A	0.21E	0.21E	0.24E	0.22E	0.22E	0.28E	-22%	5%
Q4	0.21A	0.24E	0.24E	0.24E	0.24E	0.24E	0.29E	14%	0%
Year	0.74A	0.89E	0.89E	0.88E	0.98E	0.98E	1.07E	20%	10%
P/E	47.3		39.2			35.6			

Source: Barclays Research.

Consensus numbers are from Thomson Reuters

## 7/13 – CMS Releases 2015-2025 Projections of National Health Expenditures Data (Market Trends)

Total health care spending growth is expected to average 5.8 percent annually over 2015-2025, according to a report published today as a 'Web First' by Health Affairs and authored by the Centers for Medicare & Medicaid Services' (CMS) Office of the Actuary (OACT). Projected national health spending growth remains lower than the average over previous two decades before 2008 (nearly 8 percent).

"The Affordable Care Act continues to help keep overall health spending growth at a modest level and at a lower growth rate than the previous two decades. This progress is occurring while also helping more Americans get coverage, often for the first time," said CMS Acting Administrator Andy Slavitt. "Per-capita spending and medical inflation also remain at historically very modest levels, demonstrating the importance of continuing to reform our delivery systems. As we look to the future we must continue our efforts that keep people healthy, providing access to affordable, quality care, while spending smarter across all categories of care delivery."

In 2015, medical price growth is estimated to continue to be very low, helping to restrain overall health spending growth. In addition, the Medicare program is testing various alternative payment approaches, which may provide some relief to long-term spending growth, even as a record number of people age into Medicare. Overall, national health expenditures are estimated to have reached \$3.2 trillion in 2015.

Health spending is projected to grow 1.3 percentage points faster than Gross Domestic Product (GDP) per year over 2015-2025; as a result, the health share of GDP is expected to rise from 17.5 percent in 2014 to 20.1 percent by 2025. Federal, state and local governments are projected to finance 47 percent of national health spending (up from 45 percent in 2014).

Other findings from the report:

- **National health spending** growth is estimated to have been 5.5 percent in 2015. By 2016, slower growth in health spending of 4.8 percent is projected as the enrollment in Medicaid and Marketplace plans slows and the associated declines in the number of the uninsured decreases. Total annual health care spending growth is expected to average 5.8 percent over 2015-2025.
- In 2015, **medical price inflation** slowed to 0.8 percent, down from 1.4 percent in 2014. Hospital prices increased by 0.9 percent while price growth in physician services fell by 1.1 percent.

- The **share of health expenses that Americans pay out-of-pocket** is projected to decline from 10.9 percent in 2014 to 9.9 percent in 2025.
- The **insured share of the population** is expected to continue to rise from 89 percent in 2014 to 92 percent by 2025.
- **Private health insurance expenditures** are estimated to have increased by 5.1 percent from 2014 to 2015, reaching \$1.0 trillion. Thereafter, average annual growth through 2025 is expected to be similar (5.4 percent).
- **Medicaid spending growth** is slowing significantly in 2016, to 5.3 percent, which the report attributes to slower enrollment growth and stronger utilization management. Spending growth is expected to average 5.6 percent for 2017-19, lower than in 2014-15.
- In 2015, **Medicare expenditures** are expected to have been \$647.3 billion, a 4.6-percent increase from 2014, driven partly by increased enrollment. However, per-enrollee costs are estimated to have increased by only 2.4 percent, the same as the previous year, continuing the recent trend of low per-enrollee cost increases.
- **Prescription drug spending** is projected to grow an average of 6.7 percent per year for 2016 through 2025. This follows growth of 12.2 percent in 2014 and 8.1 percent in 2015 when spending growth was influenced by the introduction of expensive new specialty drugs such as those used to treat Hepatitis C.

The OACT report will appear at: <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html>

An article about the study was published by Health Affairs and is available here: <http://content.healthaffairs.org/lookup/doi/10.1377/hlthaff.2016.0459>.