June 21, 2023 Testimony
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Testimony for House Committee on Education and the Workforce; Subcommittee on Health, Employment, Labor and Pensions

"Competition and Transparency: The Pathway Forward for a Stronger Health Care Market"

Chairman Good, Ranking Member DeSaulnier, distinguished members of the House Committee on Education and the Workforce, ladies and gentlemen;

Thank you for the opportunity to appear before this esteemed committee today. My name is Dr. Gloria Sachdev, and I serve as the President and CEO of the Employers' Forum of Indiana. My testimony and comments represent my own views, not that of Forum members or organizations. Indiana employers, large and small, are deeply invested in the wellbeing of their employees and their ability to receive the highest quality health care for the best price. Employers provide health insurance coverage to retain and recruit talented employees, and they understand that a healthy workforce is a productive workforce. I appreciate this committee's purview and interest in helping working families and their employers.

These challenges are not unique to Indiana employers. Nationally, employer-sponsored health insurance covers 179 million people representing 55% of the U.S population. Health insurance premium contributions for employees and employers have been increasing every year over the past 2 decades. The Kaiser Family Foundation (KFF) 2022 Annual Employee Benefits Survey finds that the average family health insurance premium was an astonishing $22,463 (whereas 20 years ago it was $8,003), and the average single person premium in 2022 was $7,911 (whereas 20 years ago, it was $3,083). During open enrollment, employees select the insurance coverage from options provided by their employer. At this time, employees see how much money will be withheld from each paycheck representing their share of the insurance premium. For the same average family insurance plan in 2022, the average worker contributed over $500 per month just to have health insurance. Thus, workers paid an average of $6,106 annually and employers paid the balance, $16,357 annually (see Appendix A).

The majority of healthcare dollars are spent on hospitals, followed by physician services. Numerous price transparency studies, including those conducted by RAND Corp, have found that employers are paying about 2.5 times what Medicare pays for the exact same service at the same hospital. While drug costs not the largest slice of the employer cost pie, it is the fastest growing slice, and thus also deserves our attention.

The Impact of High Healthcare Prices is Harmful to Workers

In addition to paying a portion of their insurance premium from their paycheck, most workers also pay other out-of-pocket healthcare expenses such as deductibles and coinsurance required by their health insurance plan. The result of high healthcare costs to workers is they have less money to spend on other aspects of their lives such as housing, food, and transportation. The Urban Institute has a free online web tool that shows what percent of adults in each state, and by every county, are in collections for medical debt using February 2022 data. Shockingly, the national average is 13%, meaning 13% of U.S. adults are in collections for medical debt. In Indiana the average is 16%, representing 1 in 6 adults. Medical debt and putting people in collections causes generational harm. An analysis of 528 hospitals in 2022 found that 2/3 of hospitals sued patients or took other legal action against them, such as garnishing wages or placing liens on property. A similar share of hospitals reported patients with outstanding bills to credit rating agencies, putting patients' credit scores and their ability to rent an apartment, buy a car, or get a job at risk. Sadly, about 1 in 5 denied emergency care to people

with outstanding debt. Thankfully, states such as New York and New Mexico have begun to protect Americans from these abhorrent practices.

When we compare the rate at which health insurance premiums have increased compared to inflation, and salary growth, the problem becomes crystal clear. From 1999 to 2022, family premiums increased 296% and worker contributions increased 288%, but overall workers' earnings only increased 103%. Inflation does not explain the increase in health insurance premiums as inflation increased by 73% over the same period (see Appendix B). I appreciate the committee working to lower healthcare costs for working families.

The Impact of High Healthcare Prices is Harmful to Employers

After paying employee salaries, healthcare expenses are typically the second largest line item expense for employers. Employers pay the majority of health insurance premiums for their workers. Per KFF, on average, employers pay 74% of a workers' family insurance premium and 83% of a single person's insurance coverage. Thus, high health insurance premiums are also harmful to employers resulting in having less money to offer raises to employees, less money to hire the best talent, and less money to expand their business footprint. With fewer resources, it is challenging to stay competitive in local and global markets. To manage their healthcare spending, many employers have established onsite/near-site provider clinics and offer a menu of preventative services, among other strategies. Most employers share growing healthcare cost burdens with employees by offering high deductible health plans (HDHPs) and limiting coverage of health services and medications.

Healthcare affordability is a non-partisan issue that impacts all of us. The root cause of our healthcare system being sick is a lack of competition and transparency. PBMs and insurance companies sit in the middle between employers/workers who pay for healthcare, and workers who receive healthcare. Employers contract with PBMs and insurers to help operationalize high value care. However, consolidation among these middlemen has resulted in detrimental practices, such as refusing to provide employers with requested price and quality data about their own employees so they can make evidence based decisions. With transparency, purchasers can shop for more affordable care and policy makers will have additional data to inform development of evidence-based policy.

SUGGESTED OPPORTUNITIES FOR POLICY IMPROVEMENT

Healthcare price transparency is foundational to lowering healthcare prices. The information has to be available in a useable, understandable, and accessible format to allow employers, policy makers and the public to make evidence-based purchasing and policy decisions.

1. Establish Honest Billing – amend Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185 et seq.), ERISA

Typically, hospital systems that purchase independent physician clinics tack on a hospital facility fee even though nothing has changed about the location, physician, staff, or service provided. The only difference is now the hospital owns this clinic. Adding a hospital facility fee in addition to a doctor professional fee results in a much higher total price for the exact same service. The Healthcare Cost Institute has a wonderful new tool that illustrates the average price difference by state for an office visit and an ultrasound at hospital-owned outpatient clinics vs independent clinics. In Indiana, the price difference is 79% higher for an office visit and 219% higher for an ultrasound at a hospital-owned clinic. This means that because the hospital now owns the clinic, Hoosiers are paying more than double for the same ultrasound. Prohibiting hospitals from adding unwarranted facility fees is also helpful in creating competition because it removes a key incentive for hospitals wanting to buy independent clinics. We know from numerous studies that increased market consolidation leads to higher prices. Requiring hospital outpatient clinics that are far away from a hospital (off-

campus) to bill as an independent clinic will result in an immediate lowering of healthcare costs paid by workers and employers. The bottom line is that the healthcare service is the same so the price should be the same. There is strong bipartisan support for this policy. Indiana and Colorado recently passed laws prohibiting unwarranted hospital facility fees. Connecticut, Maine, Massachusetts, and North Carolina have bills currently in progress. Texas' had a bill, but it died. Recently, H.R. 3561, the PATIENT Act, passed the U.S. House Energy and Commerce Committee (summary), and a bipartisan SITE ACT authored by U.S. Senators Braun, Hassan, and Kennedy was introduced.

Policy ideas for consideration:

a. Correct Billing Form: All hospital services, medications, and products provided at a hospital off-campus site, defined by CMS as greater than 250 yards from a hospital, shall bill on a professional form (namely CMS-1500 form, HCFA-1500 form, or HIPAA X12 837P electronic claims transaction form for professional services or their successor forms). Hospitals shall not bill for any off-campus services, medications, or products on a hospital institutional form (namely, CMS-1450 form, the UB-04 form, or HIPAA X12 837I institutional electronic claims transaction form or their successor forms).
b. Correct Billing Address: Establish that the correct address of where a service, medication, or product was actually provided be noted on the billing claim.
    - This is important as some hospitals currently note the main hospital billing address instead of the address of where the service was provided on the bill claim field. Thus, if a service was provided at a physician clinic off-campus, but the address on the claim is the hospital's billing address, payers would assume that this service was provided within a hospital and mistakenly pay a higher amount.
    - CMS issued a clarification document, MLN Matters SE #19007 which was not about a new rule, but rather to clarify the intent of existing rule regarding proper billing. It noted that hospitals were to note the actual address of where a patient received the service on the hospital billing claim field titled "service facility address" beginning April 1, 2020. Due to COVID-19, in March 2020, hospitals asked CMS for this implementation to be placed on hold. The hold on was granted as noted in MLN Matters SE #19007-Revised, but now the hold should be lifted for CMS. Requiring that hospitals bill on a provider form only, eliminates the noted hospital form address shenanigans.
c. Correct Building Identification: Require that hospital systems establish and bill using a unique National Provider Identifier (NPI) number for each and every off-campus outpatient department. Direct HHS to treat outpatient departments as subparts of the parent organization and to issue these subparts unique NPIs.
    - This, too, is important as currently some hospital systems have multiple hospitals and/or off-campus physician office clinics billing for services all under a single NPI. This is a problem as it does not permit payers to discern hospital services provided on-campus or off-campus, and it makes it very difficult to separate price and quality transparency data by site. Importantly, having separate NPIs permits regulators to monitor for appropriate billing.
d. Office Visits: Consideration may wish to be given to require all on-campus hospital outpatient office visits designated by CPT billing codes 99201-99205 (new patient office visits) and 99211-99215 (follow-up patient office visits), as well as telehealth visits, to be billed on an individual provider form, namely the CMS-1500 form, HCFA-1500 form, or HIPAA X12 837P electronic claims transaction form for professional services or their successor forms.
    - In person office clinic visits and telehealth visits on-campus of a hospital do not use additional hospital resources beyond the services provided at off-campus provider office visits, thus they should not be permitted to tack on a hospital facility fee.
    - If hospitals are prohibited from adding hospital facility fees for off-campus office visits, a concern is that they may bring off-campus services on-campus. By paying office visits at the same rate

whether they are on-campus or off-campus, the incentive for moving off-campus clinic services (which are more convenient to access) to on-campus will dissipate.

- If payment parity for on-campus and off-campus existed, hospitals may decide that it is in their financial best interest not to employ as many physicians to staff their outpatient clinics. This unwinding of hospital consolidation of physician services would be welcomed as it would result in opportunities for physicians to be employed elsewhere or stand up an independent practice. The latter option, in particular, would create more competition in local markets.

e. Accountability: Add a penalty for noncompliance and note claims do not need to be paid by payers if billed incorrectly on a hospital claim form.

f. Background: America's working population should have the same benefit afforded to Medicare patients by not having to pay more for hospital-owned off campus services. CMS references:

- Medicare began paying new off-campus hospital-owned physician clinics lower hospital facility fee payments to equal independent physician office services per a Medicare program with site-neutral payment reform in the Bipartisan Budget Act of 2015; however, the BBA excepted, e.g. grandfathered, established off-campus clinics and on-campus clinics. In 2019, by administrative policy, CMS removed the grandfathering exception. The American Hospital Association sued CMS and eventually the case landed at the U.S. Supreme Court. In 2021, the Supreme Court decided not to hear this case, thus the immediate lower court's decision became final.
- CMS Outpatient Clinic Visit Services at Excepted Off-Campus Provider-Based Departments: Payment Update, Sept 9, 2019 notes, "By November 1, 2021, CMS will begin reprocessing claims for outpatient clinic visit services provided at excepted *[grandfathered]* off-campus Provider-Based Departments (PBDs) so they're paid at the same rate as non-excepted *[not grandfathered]* off-campus PBDs for those services under the Physician Fee Schedule (PFS)."
- Thus, CMS now pays the same amount to all hospital off-campus clinics for all services the same rate whether the hospital owns the off-campus clinic or if it is independently owned.
- In 2023, CMS noted one off-campus exception in 2023 CMS new outpatient prospective payment system (OPPS) Rule: "We're exempting rural sole community hospitals from the site-specific Medicare Physician Fee Schedule-equivalent payment for the clinic visit service when an off-campus provider-based department provides the service."
- 2022 MedPAC report to Congress recommends expansion of CMS site neutral payments.

2. Require PBM Transparency - by amending it into Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185 et seq.), ERISA

Drug price transparency is desperately needed in the entire drug supply chain. The large PBMs sit in the middle and operate in secrecy, negotiating prices from drug manufacturers on behalf of employers and insurers, yet not telling them what the actual discounts, known as rebates, were that they negotiated per drug. Typically, PBMs provide aggregate drug rebate data, but this is not helpful in determining how best an employer should design their drug benefit plan for workers. Drug prices are soaring and, in an effort to bring relief, Indiana legislators passed SEA 8 in 2023 requiring at least 85% of each drug rebate, which is broadly defined to include fees and other remuneration, be given to certain patients at the point of sale at the pharmacy counter, or for 100% of rebates to be given to ERISA-exempt employers. Without additional transparency policies, we have no way of auditing PBMs to determine if they did provide 85%-100% of rebate to patients and employers, respectively. In general, we must have full transparency in order to follow the money in the drug supply chain.

Policy ideas for consideration include:

a. Prohibit gag clauses

- Gag clauses between PBMs and all entities they have business and agreements with result in employers not having the information to develop the drug benefit plan design that is in the best interest of their employees. PBMs have partnerships with drug manufacturers, wholesalers, distributors, pharmacies, hospitals, physician groups, and importantly, Group Purchasing Organizations (GPOs). It is important to include GPOs and all other partnerships PBMs have.

b. Full Drug Price Transparency on all drugs dispensed and administered
   - Full price transparency is needed to understand drug prices PBMs have negotiated with drug manufactures at the drug level to include wholesale acquisition (WAC) cost; net price; rebates, fees, or other remuneration; co-pay assistance; out-of-pocket spending; and other pricing metrics.
   - While most drugs are "dispensed" to patients at the pharmacy counter, employers often have injections and other drugs that are "administered" that flow through their PBM, so these drugs should also be included.

c. Prohibit Spread Pricing
   - A terrible practice conducted by some PBMs is when they pay the pharmacy a lower price for an employee's drug claim but bill the employer a higher price for that drug claim, thus keeping the spread. This practice should be prohibited. To ensure that this practice is not occurring, employers need PBM data to conduct payment due diligence.

d. Require Insurers and PBMs to Report Companies that they have Full and Partial Ownership in and Contracts With.
   - Mergers and acquisitions are rampant (see Appendix C).
   - Insurers, PBMs, pharmacies, physician groups, home health agencies, and more are now often owned by a single parent company but have different business names, so ownership is not transparent. For example, a single physician group may be partially owned by numerous companies including a physician, a hospital, and an insurance company.

e. Prohibit Self-Dealing
   - Some insurers and PBMs mandate self-dealing, meaning they mandate their employers use the PBM and pharmacy owned or contracted by the insurer/PBM, and because all insurer payments are 100% passed through to the employers/workers, these entities could easily provide higher payment to their own company affiliates and pass this prices to employers/workers. This behavior leads to decreased competition and further consolidation. It is important for all to know where potential conflicts of interest exist and monitor payment flow.

f. Prohibit Insurers and PBMs from requiring employers to choose or to pay fees for services not rendered.
   - Unbelievably, some insurers charge employers a huge penalty fee if they opt not to use the insurers' PBM or pharmacy. This anti-competitive practice results in greater consolidation, making it challenging for innovators to break into a market. Due to existing insurer/PBM consolidation, many employers, especially small employers, have no choice but to sign a contract using an insurers' entire suite of businesses.
   - Prohibiting insurers/PBMs from limiting or charging fees to employers who wish to carve out any aspect of the plan offerings is important.

g. Monitor Competition Adequacy - Require Insurers/PBMs to report Merger and Acquisition information within a designated time period of them occurring and/or before they occur.
   - To better understand who is contributing to consolidation, where it is geographically occurring, and to be able to analyze the impact of mergers and acquisitions on prices and quality, merger and acquisition information should be made publicly available, allowing researchers, purchasers, and policy makers to have the facts.
   - This will allow regulators to be more effective at monitoring for increased consolidation, reduced market competition, and intervene more quickly.

3. **Codify the Transparency in Coverage (TiC) Rule and strengthen it**- by amending it into Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185 et seq.), ERISA

The TiC rule enacted by HHS in 2020 requires group health plans and health insurance issuers in the individual and group markets to disclose pricing data by making it publicly available on their own business websites. The intent is terrific: all people and purchasers have price transparency allowing them to shop for more affordable care.

Policies for consideration:

a. Standardize Insurer Machine Readable File (MRF) - Develop a standardized method and uniform format.
   - Researchers from Georgetown University published a report titled, Transparency in Coverage: Recommendations for Improving Access to and Usability of Health Plan Price Data which notes numerous recommendations identified by a group of national data experts.

b. Ensure monitoring and compliance – To increase transparency compliance, require that a copy of each insurer's MRF be uploaded to a secure federal website.
   - Having all MRFs will make monitoring substantially easier for federal regulators and likely increase compliance.

c. Codify the TiC rule to include prescription drug price transparency.
   - Codifying this rule would allow employers to have the transparency they need to shop for which insurer and PBM have the best negotiated prices.
   - This level of transparency will eventually create drug price competition in the market if purchasers use this information to make purchasing and benefit design decisions.

d. Require Provider Quality Transparency - add new language for CMS to display on their existing CMS Compare website, provider quality data by procedure, or at least by clinical categories.
   - Currently, CMS Compare includes quality data resources including Hospital Compare, Physician Compare and 6 other useful quality resources/datasets. While this data is useful, people and employers do not shop for hospital quality in the manner in which quality information is presented, i.e., hospital readmission rates, mortality rate, etc. People and employers seek healthcare services by either individual procedure or by clinical category, i.e., X-ray of wrist or imaging, colonoscopy or GI procedures, heart failure or cardiac procedures.
   - Using existing CMS clinical categories is an easy first step is to bring forward Shoppable Hospital and Physician Quality Transparency. This is important as we all want to go to the best quality at the best price….not necessarily the to the place with the cheapest price.

e. Increase Access to Transparency Data – require insurers to not only post their MRFs on their own websites, but also send a copy to HHS. HHS shall in turn place all of this data into one federal database freely accessible to the public, researchers, and policy makers. This database may be managed by a contractor.
   - It is very challenging to find all MRF on each insurer's website. Also, most of these MRF are so large that they are unable to be downloaded by the average person/organization.
   - An organization such as the Employers' Forum of Indiana has no choice but to pay third party data contractors, who have big data storage capabilities and data expertise, to download and merge the MRFs from hospital and insurer websites. My hospital data contractors provide me with a cleaned up Excel document that I use to upload into Sage Transparency, a free, online, hospital price and quality transparency tool. While I am grateful to have these restricted use data sets, I am not able to make available to the public all that I want, even though the raw data in the MRF have what I wish to display and is available in a publicly. Requiring summary reports could be useful as the resulting data file will be smaller, thus in a format that I can use to incorporate this important data.

- If the federal government maintained a data warehouse with insurer MRFs, policy makers, employers, consultants, and innovators would have access to single dataset or subsets to make evidence-based decisions.
- Importantly, this database would easily allow regulators to monitor insurers for transparency compliance.

f. Create of a federal All-Payer-Claims-Database (APCD)
- Developing a national user-friendly, customizable, interactive online tool would be transformational as all people and employers could easily shop for services, and policy makers could assess the impact of their policies.
- The USE of transparency data by purchasers and policy makers is key to competition increasing.
- Insurer MRFs have much of the data included to create a robust federal APCD, and to this CMS Medicaid and Medicare price and quality data files could be added. Thus, this single, easy-to-use database would not only have comparable pricing data, but also include comparable quality data across all payers in public tool that would allow Americans to shop for services by state, insurance plan (or cash paying), procedure, and radius from zip code. Innovators could develop phone apps to make this data even more accessible.
- Numerous State APCDs exist and much can be learned from them.
- A CBO report published in 2022 notes a favorable assessment for a federal APCD.
- It creates competition within the insurer and provider industries as people will see and go to insurers and providers that have the best quality at the best price.
- This federal data would also be useful to states who have or are building APCDs, such as Indiana. States could download data for their state and build upon it with other state-level data.

4. Consolidated Appropriations Act (CAA) Improvements

ERISA establishes that employers have fiduciary duty if they manage and control their health plan. This includes self-funded employers who must follow minimum ERISA standards for managing health benefit plans. CAA Section II requires that the plan fiduciary attest in writing that all facets of the CAA have been applied to the applicable plans, that the guidelines have been adhered to, and that the plan has made a good faith effort to expend plan assets in a PRUDENT manner on behalf of the plan participants and their beneficiaries. At present, the CAA attestation format for self-funded employers remains unclear. As self-funded employers are plan fiduciaries, in order for them to meet this CAA requirement and use plan funds in a prudent manner, employers must have timely access to price, quality, and utilization data, as well as the full cooperation of all of their contracted healthcare partners. Otherwise, how can they make evidence-based decisions that are in the best interest of their employees? A concern is that employees will sue employers over not managing their benefit plan in their best interest. We need government support, so employers have unfettered, timely, and accurate access to their data. The alternate is that employers, in an effort to minimize their legal risk, consider alternatives to being the benefit plan administrator.

Policies for consideration:

a. Gag Clauses noted in CAA Title II - Section 201
- Problems for employers is that many of their insurer and PBM partners do not provide requested price and quality data or it takes months to get it.
- The current law prohibits plans and issuers from entering into an agreement with a provider, network or association of providers, third-party administrator, or other service provider offering access to a network of providers that would directly or indirectly restrict the plan or issuer from: (1) providing provider-specific cost or quality of care information or data to referring providers, the plan sponsor, participants, beneficiaries, or enrollees, or individuals eligible to become participants, beneficiaries, or enrollees of the plan or coverage; (2) electronically accessing de-

identified claims and encounter data for each participant, beneficiary, or enrollee; and (3) sharing such information, consistent with applicable privacy regulations. In addition, plans and issuers must annually submit an attestation of compliance with these requirements. These provisions are effective December 27, 2020 (the date of enactment of the CAA).

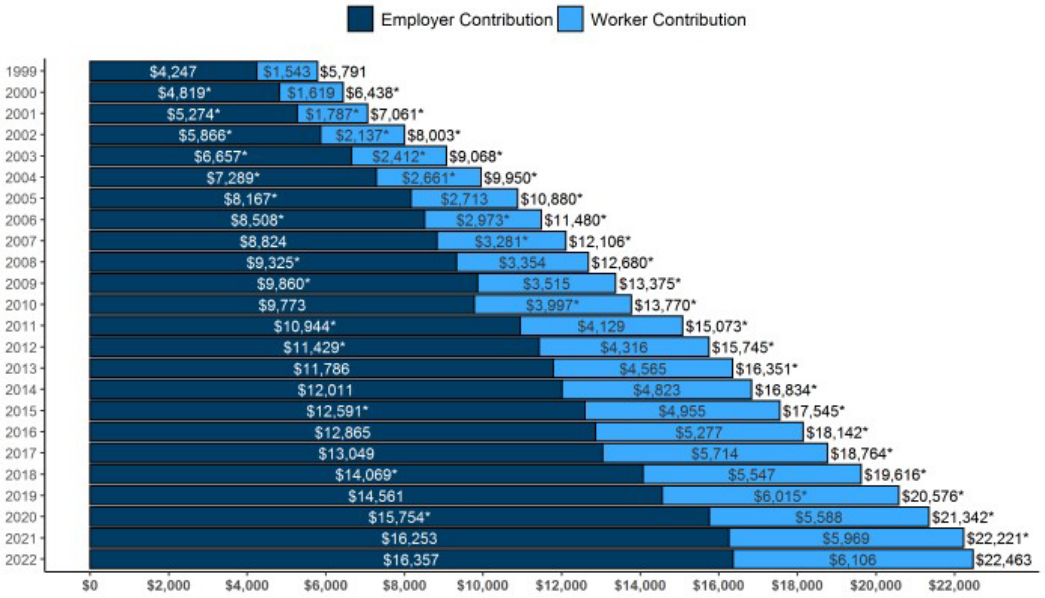
b. Claims data ownership – establish that employers own their covered lives claims data, not their insurer partner, PBM partner, or other organization.
   - Ownership of the data must be made clear that it belongs to the employer. This includes their insurer/PBM partner sending it to a third party of the employers choosing for analysis.
c. Unfettered Employer Auditing privileges
   - Some insurers and PBMs note auditing restrictions in their employer contracts. These may include who the independent auditor is, approval required of the independent auditor the employer selects, what data can be audited, frequency of audits, depth of audits, etc. With significant insurer and PBM consolidation in Indiana and across the country, most employers have little choice but to sign these contracts.
d. Reasonable Fees to Supplying Data for Audits
   - To obstruct employer access to their own claims data, insurers and PBMs may charge employers high fees, thus a maximum fee, i.e. $1,000, should be established for their efforts to send the employer claims data file to an auditor or any designee of the employers' choice.
e. Responsiveness for Requests: Add a specified timeline by which all requested data must be provided.
   - In Indiana in HEA1004, we added a 15 business day turnaround time for insurers to provide employers with their claims data upon request.
   - It is important that data that is "requested" is provided and not just a "response" as a response could may not yield the requested data.
f. Prohibit anti-steering/anti-tiering, all-or-none, and most favored nation clauses.
   - Gag clauses were prohibited because they are anti-competitive. Additional anticompetitive clauses were initially in the CAA, but they did not make the final cut.

As we explore the pathway forward for a stronger healthcare market, let us not forget the human impact of our decisions. Every American deserves access to affordable, high-quality healthcare that meets their unique needs. By embracing competition and transparency as guiding principles, we can create a healthcare system that fulfills this promise and ensures a healthier, more prosperous future for our nation.

Thank you Chairman Good and members of the committee for your attention and commitment to this vital issue. I look forward to engaging in a productive dialogue on these policy matters and more.

APPENDIX A

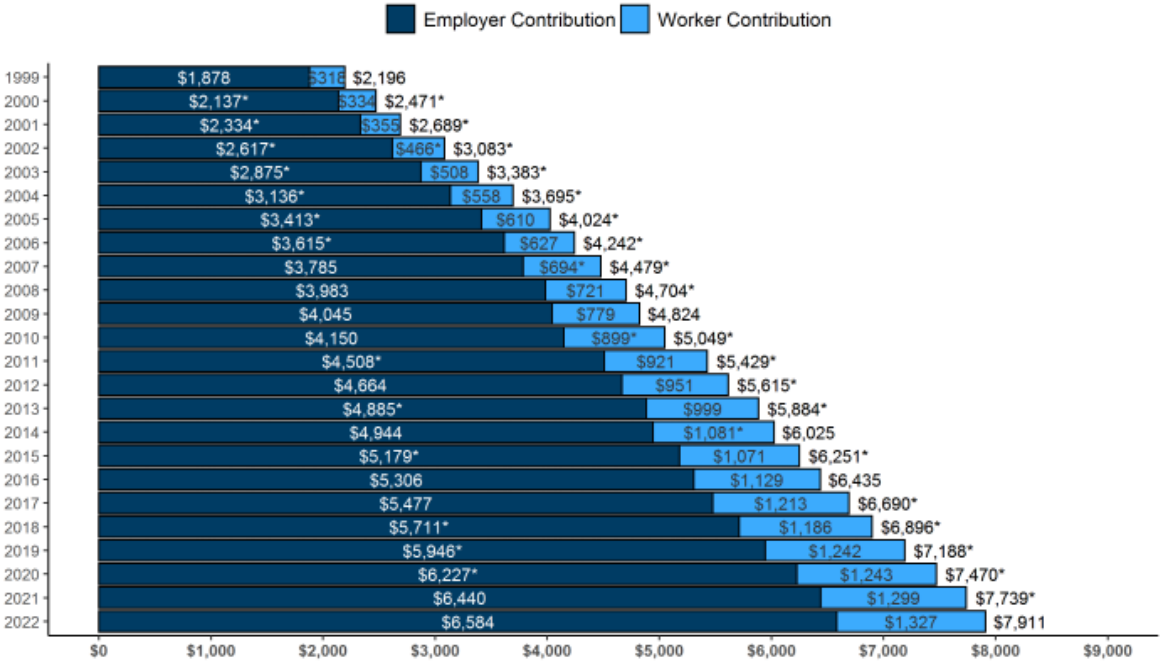
Average Annual Worker and Employer Contributions to Premiums and Total Premiums for Family Coverage, 1999-2022



* Estimate is statistically different from estimate for the previous year shown (p < .05).
SOURCE: KFF Employer Health Benefits Survey, 2018-2022; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

KFF

Average Annual Worker and Employer Contributions to Premiums and Total Premiums for Single Coverage, 1999-2022

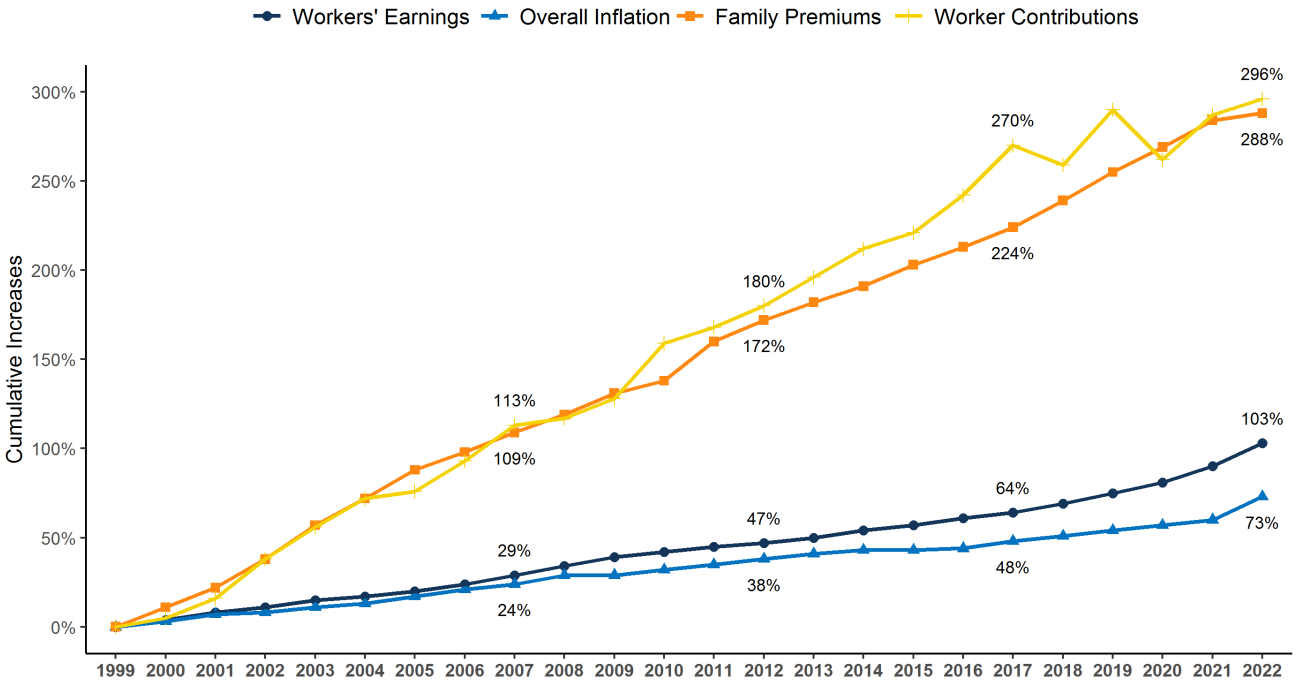


* Estimate is statistically different from estimate for the previous year shown (p < .05).
SOURCE: KFF Employer Health Benefits Survey, 2018-2022; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Reference: [Section 6: Worker and Employer Contributions for Premiums – 10020 | KFF]

APPENDIX B

Cumulative Increases in Family Premiums, Worker Contributions to Family Premiums, Inflation, and Workers' Earnings, 1999-2022



SOURCE: KFF Employer Health Benefits Survey, 2018-2022; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation, 1999-2022; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1999-2022.

Reference: https://www.kff.org/slideshow/2022-employer-health-benefits-chart-pack/

APPENDIX C

Vertical Business Relationships Among Insurers, PBMs, Specialty Pharmacies, and Providers, 2023

1. Since 2021, Prime's Blue Cross and Blue Shield plans have had the option to use Express Scripts or AllianceRx Walgreens Pharmacy for mail/specialty pharmacy services. IN Dec. 2021, Walgreens purchased Prime Therapeutics' 45% ownership interest, so this business had no PBM ownership as of 2022. Effective June 2022, the company was rebranded as AllianceRx Walgreens Pharmacy.
2. Centene has announced that it would outsource its PBM operations to Express Scripts in 2024. In 2023, Centene rebranded its pharmacy benefit subsidiary as Centene Pharmacy Services.
3. In 2021, Centene sold a majority stake in its U.S. Medical Management to a group of private equity firms.
4. Since 2020, Prime has sourced formulary rebates via Ascent Health Services. In 2021, Humana began sourcing formulary rebates via Ascent Health Services for its commercial plans.
5. Previously known as Evernorth Care Group and Cigna Medical Group.
6. In 2021, Cigna's Evernorth business acquired MDLive.
7. In 2022, Cigna invested $2.7 billion for an estimated 14% ownership stake in VillageMD. Walgreens owns a majority of VillageMD.
8. In September 2022, CVS Health announced its acquisition of Signify Health. In February 2023, CVS announced its acquisition of Oak Street Health. Both transactions closed in 2023.
9. Previously known as IngenioRx.
10. In 2021, Partners in Primary Care and Family Physicians Group businesses were rebranded as Centerwell Senior Primary Care.
11. In 2022, Kindred at Home was rebranded as CenterWell Home Health. In 2022, Humana announced an agreement to divest its majority interest in Kindred at Home's Hospice and Personal Care Divisions to Clayton, Dubilier & Rice. Humana also announced plans to close a majority of its SeniorBridge home care locations.

Source: *The 2023 Economic Report on U.S. Pharmacies and Pharmacy Benefit Managers*, Exhibit 234. Companies are listed alphabetically by corporate name.

DRUG CHANNELS INSTITUTE

May 2023

Reference: https://www.drugchannels.net/2023/05/mapping-vertical-integration-of.html