

The Pharma/Payer Relationship— Strategies for the Next Two Years

by
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The power to determine what pharmaceutical products are bought and at what price has shifted dramatically in the past decade from physicians to institutional customers. For pharmaceutical executives, who have long allocated 80 percent of their spending on sales and marketing toward prescribers, while basing their relationships with institutional customers almost entirely on unit price, this change is a wake up call.

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It isn't easy to develop new strategies for dealing with health plans, PBMs, CMS, state Medicaid agencies, and emerging customers such as retailers. These segments face their own challenges in securing a position in the healthcare system of tomorrow, and it is not clear how long it will take for that system to evolve. The anticipated shift to outcomes-based contracting, for example, is taking place much more slowly than anticipated: Only a handful of deals are in place today, rather than the several hundred many observers expected.

In time that will change, possibly spurred by healthcare reform. In the meantime, however, it is difficult to create the aligned incentives and support capabilities between payers and pharmaceutical companies to make outcomes-based deals work. Equally important, it is difficult to discern when and how that situation will change. The pharmaceutical industry doesn't just have to hit a moving target; it has to figure out when to pick up the gun and shoot.

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That said, nobody believes pharma can approach the next ten years using the methods of the last ten. Change is imperative, and a new approach to institutional customers needs to be part of that change. Today's unit price-based relationships are not only adversarial, but less and less able to produce useful results for either side. But in trying to go beyond them, the industry has continually been frustrated by regulatory constraints. Marketing has plenty of great ideas on how to partner with payers to create value. The trick is to get any of them through legal.

In the short run, Oliver Wyman believes the challenge is to develop customer strategies that work in today's market but create a pathway toward a model based on patient outcomes. As a starting point, consider four key questions:

1. What are the **key trends that got us here** and are we ever going back?
2. **Which trends require immediate response**, and which trends are evolving?
3. What is the **role of PBMs** (and other intermediaries) in the value delivery chain over the next few years?
4. What will be the **domino effect of reform** on our customers—where are the opportunities and challenges?

This article will delve into these questions and provide suggestions on how pharma should respond to the likely market dynamics of 2010-11, with an eye toward 2013 and beyond.

1. ***What are the key trends that got us here, and are we ever going back?***

It is tough not to see a link between the growing influence of payers and the dramatic drop-off of new product approvals in the past ten years. When products are not strongly differentiated, formulary choices don't really deprive patients of choices. The converse is true as well: Where differentiation and need are high, physicians are largely free from stringent prescribing guidelines, and manufacturers continue to enjoy tremendous margins.

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Today, perhaps the best example of a marketplace with strongly differentiated products and great unmet patient need is oncology. As a result, oncology products command great access, and oncologists have the latitude to prescribe the right product for the right patient in the right quantity. Other similar areas, where unmet need is high, include rheumatoid arthritis (RA) and multiple sclerosis (MS). Many therapies in these areas are physician-administered biologics with unique supply-chain requirements. These factors also enable physician leverage.

But areas like these are scarce. Many therapeutic areas—cardiovascular disease, ulcer treatment, allergy and asthma, even diabetes—have had few recent breakthroughs and are becoming commoditized. Overall, 70 percent of prescriptions written today are for generics rather than brand products.

2. ***Which trends require immediate response, and which trends are evolving?***

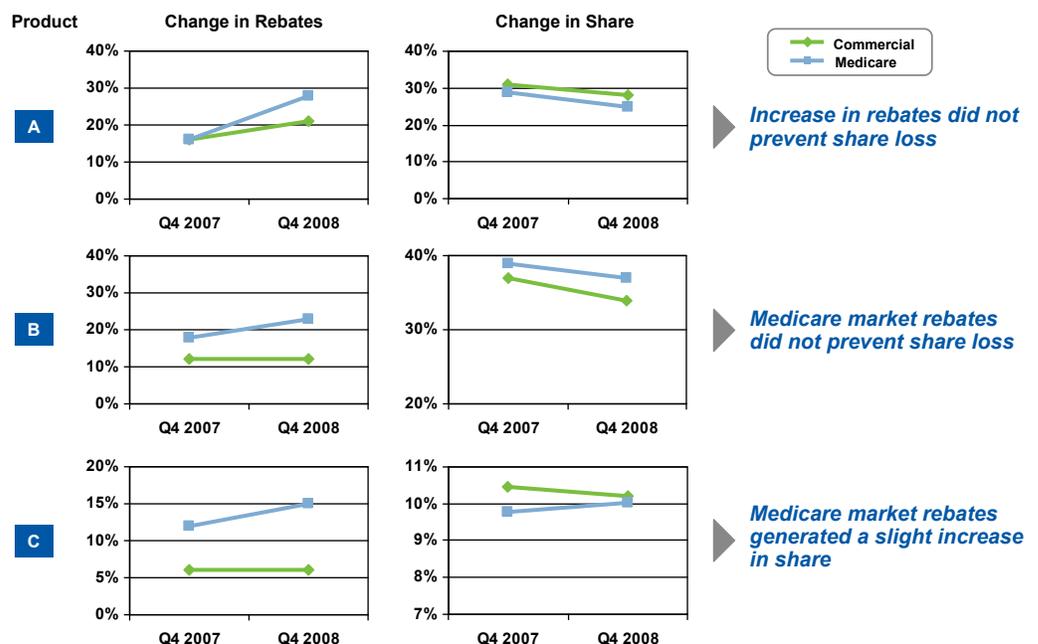
Many aspects of reform will not be implemented until 2013. We still do not know what impact they will have or what strategies payers will employ to rein in costs. For the next few years, companies need to be on the lookout for clues to help answer the questions reform raises: How can pharmaceuticals help manage disease costs? (The alternative, of course, is to be regarded as a source of excess spending.) What aspects of comparative economics will be most significant in the near term, and how should development and marketing functions respond? What role will employers and consumers play?

But reform is just one trend reshaping the pharmaceutical marketplace. Several others are already considerably advanced, and companies should be taking action to respond to them:

The industry is becoming commoditized, which means that companies should revisit the practice of rebating. The idea of rebates is to gain preferential formulary position with reduced patient co-pays in order to boost sales volume. But that logic falls apart when generics enter the picture. With generics, patients have low co-pays, the plan pays low prices, and the clinical benefit is similar if not identical to the branded alternative. Pharma companies spend 12 to 15 percent of gross sales on managed-care rebates, but our analysis shows that their marginal value is decreasing (see Exhibit 1 below). Cuts to rebates in selected markets or products could free up money that could be invested elsewhere to produce higher returns.

Stakeholders are demanding more evidence of comparative or cost effectiveness for new drugs. This is especially true in heavily genericized indications or for high-cost therapies. FDA has in some cases deprioritized review of new drugs that did not offer significant improvement over available therapies. Forward-thinking companies are already integrating economic and comparative measures into their clinical programs. This will help them be more persuasive with the FDA and better prepared for possible future regulations extending these requirements into the promotional realm.

Exhibit 1 Increasing Rebates Does Not Always Drive Share



Source: Oliver Wyman analysis

Most companies reach only a small share of the potential market.

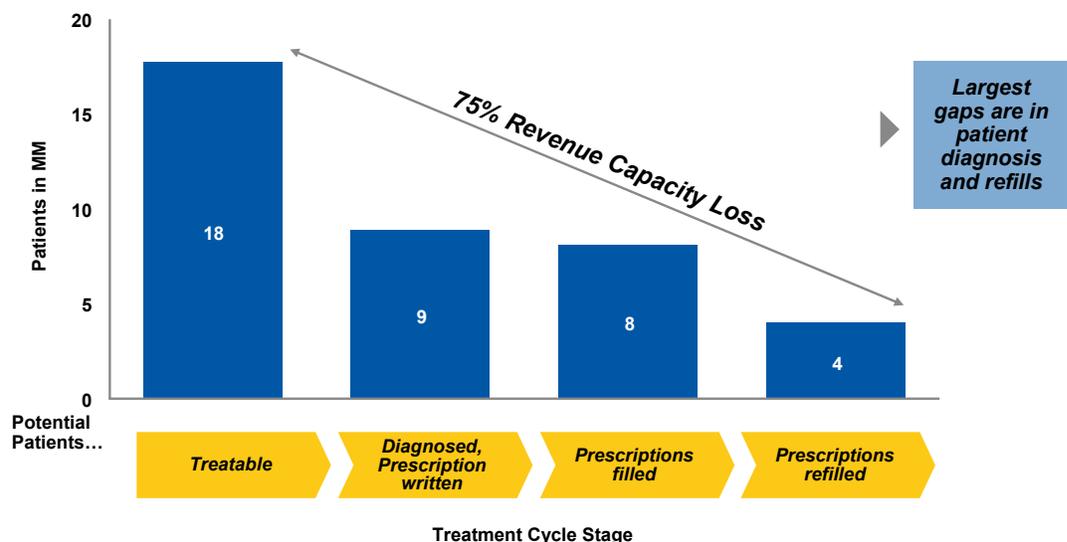
In an Oliver Wyman analysis of a wide variety of therapeutic areas and products, typically only 20 to 50 percent of the value of a product market was realized (see example in Exhibit 2). The causes are many: failure to diagnose, failure to treat a diagnosed condition, or poor patient compliance with a treatment regime.

Compliance is a complex issue. The best approaches require segmentation, high-touch interventions, and multi-channel strategies. Results to date have often been mixed, with many programs being suspended after 6 to 12 months. That said, improved treatment and compliance rates would have tremendous value to pharma companies and payers alike. We believe companies should give a high priority to the following efforts:

- Leverage the pharma company’s disease-based skills to develop ideas for partnering with payers. The challenge here is to provide value while staying within regulatory and legal requirements.
- Understand your customers’ motivations. Different health plans have different exposure to short-term and long-term disease costs. For example, a state Medicaid program has a different horizon than an employer covering a high-turnover group of employees.
- Begin to understand what you can do independent of payers to invest in partnerships and programs to maximize market potential.

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Exhibit 2 Patient Yield Through Treatment Cycle
Depression Market Example



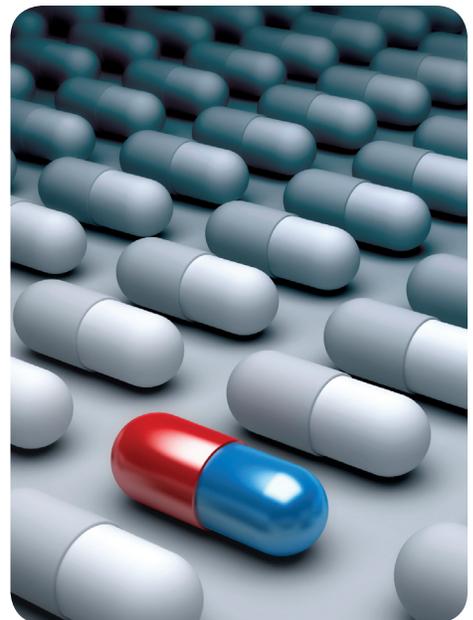
Sources: Oliver Wyman analysis based on statistics from the US Census, NMHA, NHPF, and AJPH; estimates were taken from academic studies, www.dbsalliance.org, and www.nyt.com.

3. **What is the role of PBMs (and other intermediaries) in the value delivery chain over the next few years?**

Prescription Benefit Managers have tremendous influence on the pricing and prescribing of pharmaceuticals. They command significant relationships with employers (who pay most of the health-care bill for about 180 million Americans). PBMs have interesting strategic advantages relative to pharma. Many have evolved into mega-pharmacies. They are substantially free from regulatory constraints that keep pharmaceutical companies from extending their relationships with patients: They maintain patient-level data and can realize value for providing clinical service in compliance, lifestyle management, and other forms of clinical intervention.

Pharma needs to embrace the current reality and seek ways to guide the PBMs' agenda toward patient outcomes.

Like pharmaceutical manufacturers, PBMs are threatened by the commoditization of pharma, which could ultimately render formularies obsolete. Moreover, just as pharma companies have endured their “patent cliff” of branded products losing exclusivity in the U.S., the generics industry will face its own cliff—a sharp decline in the number of products going off patent, starting in about 2013. This is bad news for PBMs, which create value partly by shifting patients from branded to generic drugs. Also, larger retailers such as Wal-Mart and Target, and traditional retail pharmacy giants like Walgreens, are looking to enhance pharmacy sales by expanding their health and wellness offerings. These big players have already encroached on the employer market and in a few cases disintermediated PBMs. The most notable example: Wal-Mart's arrangement with Caterpillar, which established a price list and co-pay policy on commonly used generic and branded drugs.



PBMs for their part have been fighting back. They have built mail order businesses, focused on specialty pharmacy offerings, and in the case of CVS/Caremark, played a role in the retailization of healthcare. They are ready to capitalize on other healthcare trends and find new ways to leverage their assets. Large PBMs such as Medco, CVS/Caremark, and Express Scripts have tremendous reach to individual patients via mail order, resource centers, and retail outlets that cover a growing percentage of the United States. These assets, combined with a growing set of relationships with employers, may well help PBMs survive their current challenges and remain a force in the marketplace for years to come.

The fact is that pharma is unlikely to win if it attempts to compete with PBMs for the attention of payers and employers; pharma's regulatory disadvantages and lack of infrastructure are almost impossible to overcome in the near to medium term. Pharma needs to embrace the current reality and seek ways to guide the PBMs' agenda toward patient outcomes. For example, PBMs want to drive prescription volume and compliance. Pharma should support those efforts, directly or indirectly, in areas where both sides' interests are aligned.

Pharma's priority in the post reform world will be to define a new method of engagement with payers and providers.

4. ***What will be the domino effect of reform on our customers—where are the opportunities and challenges?***

The Obama administration is having difficulties in passing its health-care bill, but it still seems likely that we will see some sort of reform in the near future. The sooner it happens, the sooner health plans, patients, providers, and government entities will begin to understand their new roles and needs. Meanwhile, pharma's priority in a post reform world will be to define a new method of engagement with payers and providers. A good first step for companies will be to map stakeholder needs to product portfolios and the opportunities they afford. For example, if reform brings a more intense focus on the disease costs of the Medicare population, there may be areas of a pharma company's portfolio that could produce new partnering opportunities. If FDA policy becomes even more focused on the economic value of new products, that could have implications for pharma over a broad range of therapeutic areas. The goal is to assess and respond to challenges and opportunities in a proactive manner.

Summary

While there is much we do not know about how the pharma/payer relationship will evolve over the next ten years, we do know that the market forces enabled by healthcare reform will dictate change. There are clear opportunities today to engage institutional customers in new and productive ways—revising contracting strategies, challenging how pharma engages PBMs and retailers, and understanding the reform-based needs of customers. Efforts in these areas won't just lay the groundwork for the new marketplace that will begin to emerge over the next few years; they can also drive value in the short term.

Oliver Wyman has experience on both sides of the pharma/payer relationship as we assist health plans and pharmaceutical and biotech companies navigate these changes toward the similar aim that needs to be the centerpiece of the new paradigm—improved outcomes for patients.

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