WHITE PAPER

Delivering the Value Message in the Language of Payers

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INTRODUCTION

The healthcare environment is complex and ever-evolving, but in recent years we have experienced a sea change in the regulations, infrastructure, players and priorities in every discipline. The customer landscape for pharmaceutical companies is changing too, and we need to change the way we communicate if we are to effectively reach these stakeholders.

We can't lay all the change at the feet of the Affordable Care Act, but it has dominated the narrative and significantly impacted the way healthcare business is conducted. The ACA was promoted as a way to insure 40 million uninsured Americans, but it is a more far-reaching program which fundamentally seeks to shift the reward system from paying for services to paying for better health outcomes.

At the heart of this change are the payers, private and public, who are increasingly empowered to make decisions affecting which drugs and treatments are prescribed. The payer community itself is changing, requiring us to adapt our marketing approaches for pharmaceutical therapies, devices and interventions. The decision-makers' heightened focus on value demands an overhaul of traditional marketing and messages.

SHIFTS IN THE INDUSTRY

The United States spends more on healthcare than any other country in the world, with inferior results. The U.S. population is aging, increasingly obese, suffers from scores of preventable diseases and shares a consensus that the system is failing them. Each year, preventable chronic diseases add a $1.3 trillion burden to the system and medication non-adherence adds another $300 billion in avoidable medical spending.

To address these issues and many others, the healthcare system is attempting to shift from a fee-for-service to a value-based model that centers on the patient and compensates healthcare stakeholders for better patient outcomes. The ACA has not been fully implemented, but the mandate for better health outcomes is clear, and incentives and rewards for medication and care compliance initiatives are significantly altering the way pharmaceutical companies, payer organizations and healthcare professionals do business.

The ACA mandate seeks the best health outcome at the lowest cost. When talking to payers, that means the intersection of the clinical benefit and the dollar impact of a healthcare product. Sometimes we take the long view, because outcomes for some therapies are measured in years. A treatment prescribed today can minimize treatments and health complications down the road, resulting in better health outcomes at a lower cost. But there are challenges to communicating this ultimate benefit to payers in today's environment.

In the past, payers only needed to know that a drug was effective to add it to their formulary. Today, we have to convince them of the short-term and long-term health benefits in a way that delivers value. That's a much more complicated formula than it seems, but Comparative Effectiveness research can help. Payers tell us they want this type of analysis, but are not receiving it from manufacturers.

Payers today are less interested in results from a sterile clinical environment and more focused on comparative data, such as head-to-head studies and real-world results.

We can pair Comparative Effectiveness data with budget impact models when we show payers a drug's effectiveness and how will it affect their budget. Payers today are less interested in results from a sterile clinical environment and more focused on comparative data, such as head-to-head studies and real-world results.

Comparative Effectiveness research is not new. Most companies have a health economics department, but the researchers often have little interaction with the customer-facing side of the business. Some research is conducted by government agencies, and we should work to make that data available to the industry.

But to best demonstrate ultimate effectiveness and cost in a value equation, we should do the research ourselves. In countries like England and Germany, with single-payer systems, this research is done routinely. In the U.S., payers press us for discounts because that is the shortest path to cost savings and historically we haven't delivered the research that shows the ultimate value of our therapies.

We need to change the way we conduct research to include value outcomes in clinical studies. If we develop a drug that will decrease hospitalization, we have to include this in the pivotal trial. Adding value outcomes to approval trials makes

those messages easier to deliver to payers, which in turn will allow a more holistic formulary decision.

Some companies are investing heavily in payer research groups and building risk models in the quest for the sweet spot. Success depends on knowing the decision makers for a product and what tactics will work with them.

Transformation of the Payer Community

A key element in this environment is the transformation of the payer community and its expanded role in deciding which drugs are prescribed. Payers are still public and private organizations, employers and individuals who buy healthcare products and services, but the types of payers influencing healthcare access is evolving. And, they are making decisions in a rapidly changing system with shifting priorities.

Further, we have a new set of customers – organizations like accountable care organizations, medical home plans, integrated delivery networks, and new risk-sharing HMOs. These customers are pooling people together for a common goal. Payers are offering them bonuses for improved outcomes and reduced payments for poor outcomes. Payers have assumed more power and control, and their coverage, support or opposition can dramatically impact the success of a pharmaceutical product. The pressure on them to deliver value has never been greater.

New customers – accountable care organizations, medical home plans, integrated delivery networks, and new risk-sharing HMOs – are pooling people together for a common goal: improved outcomes.

Each department in a payer organization has its own goals and objectives, so it's not always possible for the individuals making formulary decisions to balance benefit and cost for value. They often focus only on their department's bottom-line objective, further complicating our ability to communicate value. When payers have options, they can threaten to place a drug into a more expensive tier class, leaving the burden on a patient, who has no voice in the argument and is the least qualified to determine the best therapy.

Payers are pressured to decrease spending as costs outgrow their ability into increase premiums. The argument for long-term benefits of a therapy isn't new. We have historically tried to convince payers that good drugs, taken properly, would reduce their costs overall. But often we made these arguments without sufficient data and research to back them up. And sometimes the benefits occur beyond the engagement timeframe during which the member is with the plan.

Some of these new providers, like ACOs, encourage teams of physicians and hospitals to coordinate their efforts on behalf of health consumers. That's why the physician's opinion remains important. Great drugs succeed, but there are relatively few launched. Most are only slightly different from those already available. Now we have to demonstrate a dramatic improvement, or we have a tough sell.

How do you tell a value story when the environment and rules have changed so drastically?

SHOWING PAYERS THE DIFFERENCE

We can help payers make good decisions for members, but we have to go to them with more than just a drug and a price. We have to be able to demonstrate the overall cost impact on the system. Armed with years of cumulative data, we can now tell them exactly what a drug should cost, because we can show how much it saves in other healthcare costs.

For example, we can use results-based data to show that a particular drug or therapy results in less invasive surgery for a patient. Or we can deliver data that shows how a particular drug resulted in fewer complications of a chronic condition. These are bottom-line savings with better health outcomes.

We have to be able to illustrate how much needs to be spent for a beneficial outcome. But in doing so, we are trying to transform something very dynamic and variable into something finite.

FDAMA114:

- Acknowledges that discussions about drugs are different with payers than with healthcare professionals.
- Allows for conversations about the broader impact of a drug; the data needs to be competent and reliable, but it can make direct comparisons.
- Is not a license to talk off label, but it is a license to talk about value and that is the word we want to emphasize.

Cost is about price and discount. Clinical is about the effect a drug has on an outcome. Value is delivered when the clinical research shows that a drug accomplishes a desired effect with a favorable cost impact.

Pharmaceutical companies need to use real-world research findings in their marketing and dialogues with payers. Success today depends not only on changing your marketing but changing the way you talk to payers. We have to speak in the language of payers – and that language is intricately tied to value.

The days of flashing pretty pictures of people on a beach to drive positive brand images are gone. We need to demonstrate our deep understanding of the system and how the variables interact.

When we talk to a payer, we need to demonstrate cost-value models and be ready to show them how they can calculate the outcomes. This helps us tell the value story and package our data to demonstrate value for each type of payer. Many pharmaceutical marketing and advertising approaches speak to the payer in healthcare professional language. To be successful in today's environment, we must talk to payers in their own language.

ABOUT INVENTIV HEALTH

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