Guest perspective

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The myth of "the payer"

Biopharmas now routinely talk about "the payer." But as the failures of recent, theoretically "payer friendly" launches make clear, there are many different kinds of payers, with very different incentives and very different buying criteria.

In the last two years, it's been the rare drug that has achieved an unequivocally successful launch – despite often unarguable value. Novartis's heart failure drug Entresto, Merck's Hepatitis C drug Zepatier, and the radically LDL-lowering PCSK9 inhibitors produced by Amgen and the Regeneron/Sanofi partnership have all underperformed their owners' expectations, not to mention Wall Street's.

In certain cases, the drugs simply haven't appealed much to physicians. But the real roadblock has been payers. There is no need to rehearse their growing power: we've witnessed the increases in formulary exclusions, the expanding rebates, and the ever-stricter requirements a patient needs to meet before he or she can get a new drug prescribed, let alone reimbursed.

So, absent some governmental deus ex machina mandating payers cover these new drugs, or the equally fond hope that complaining loudly enough about payers will shame them into generosity, most people in the pharma world have realized that drug companies need to show they can meet the needs of payers, not just patients.

That means doing some, or all, of the following: proving lower costs; providing real-world evidence; conducting head-to-head trials; and offering pay-for-performance contracts.

These are all good ideas. Or good ideas sometimes, as compellingly noted by Ernst & Young LLP's Ellen Licking and Susan Garfield in a recent IN VIVO article. They argue that not all drugs fill the bill, for example, for outcomes-based contracting.

But it's also true that even a drug that does fill the bill doesn't fill the bill for all payers. That's because different kinds of payers have different economic incentives.

We all recognize that payers are increasingly the new powerbrokers. Now it's time to understand that these powerbrokers don't all make their decisions the same way.

Needed now: payer segmentation strategies

In the United States, a Medicare Prescription Drug Plan (PDP) operates under different financial assumptions than a commercial plan that's fully at risk. Though both businesses may be owned by the same insurer, the former has no incentive to save on nondrug medical costs and every incentive to use the cheapest drug available. The latter might be willing to use a more expensive drug if it can save money related to other medical expenses, making arguments around medical cost offsets more attractive.

Meanwhile, pharmacy benefit managers can often make more money on an expensive drug than a cheaper one, through rebates and specialty pharmacy charges. Sometimes, so can a commercial administrative services only (ASO) plan — one that passes drug and, usually, other medical costs on directly to the sponsor-client. On the other hand, a Medicaid plan, or most individual exchange plans, can't; these plans need additional reasons to justify the widespread use of a costlier drug.

Take Entresto. If ever a drug seemed a no-brainer for "the payer," this is it. It's been proven to reduce cardiovascular events, and thus one big cost driver. The Institute for Clinical and Economic Review (ICER), a US-focused cost-effectiveness watchdog, rarely finds a drug that it believes is appropriately priced. But ICER actually thinks Entresto delivers value for money, more or less at its list price. And Novartis has obligingly offered up outcomes-based reimbursement: if Entresto doesn't reduce cardiovascular events, its effective price drops.

What's not to like?

Problem is, many — probably most — of the likely Entresto patients are in Medicare, and most of those in PDPs. And PDPs don't benefit from reductions in nondrug costs. Indeed, PDPs don't want heart failure patients, who tend to bring with them lots of co-morbidities and thus higher drug expenditures, reducing profit for these kinds of payers. So making it easy for their beneficiaries to get Entresto only encourages enrollment from the kinds of patients they don't want. Is it therefore any wonder that pharmacy departments at many of these PDPs are making it hard to prescribe Entresto and, thus, that Novartis has struggled to sell a drug otherwise perfect for this specific patient population?

With the rise of value frameworks such as ICER's Evidence Reports or Real Endpoints' RxScorecard, and CMS's proposal to actually use value frameworks in its Part B pilot, pharmas are increasingly aware that they need to understand how these frameworks assess their products and product candidates, so they know how their customers will view them and can take steps to improve their data profiles.

But they'll also need to do something else: assess the value of their drugs not from the point of view of a mythical, unitary insurer but by the often very different perspectives of the managers who run the different lines of that payer's businesses.

Smart payer segmentation strategies, in short, will soon be as important to successful biopharmas as smart physician and patient segmentation. We all recognize that payers are increasingly the new powerbrokers. Now it's time to understand that these powerbrokers don't all make their decisions the same way.

Real Endpoints is a healthcare information company that defines and forecasts the relative value to payers of existing and pipeline therapies and their likely budget impact.

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