Marc Iskowitz

PAYERS, CATS, DOGS, AND KUMBAYA

THE TOUGHENING market access climate of the last several years has led to a collective anxiety within the drug industry. However, this month's *MM&M* suggests a pathway out, or at least a payer-pharma relationship that is somewhat less fraught.

Payers' increasing use of formulary controls, such as prior authorization and high patient co-pays, has often put them at odds with the pharma industry, whose use of co-pay cards and other promotional efforts, along with price hikes, has at times been the bane of payers.

"Will outcomes-based deals become just as important to payers as the value story?"

Where is it heading? Price-gouging and pricing increases have forced payers to clamp down in more disease states, and to do so even when the price hikes are less than astronomical.

But today, the game is changing. To quote Peter Venkman (Bill Murray) in *Ghostbusters*, the new examples of pharma and payers recasting their relationship seem like "Dogs and cats living together! Mass hysteria!"

In actuality, "It's a very rational place for us to go together," said Merck's Robert McMahon in our February cover story, to describe the contract the drugmaker inked with Aetna. One facet of the deals assures Aetna a rebate if diabetes drug Januvia doesn't deliver agreed upon outcomes.

The idea is that each gets some of what it needs. Payers gain some control over cost, and pharma may get to stay on formulary. Moreover, a recent survey of payers by the research firm inVibe, with help from payer recruitment firm Interactive Forums, suggests the appetite exists for further rational negotiation.

"We negotiated an outcome-based contract on cardiovascular events and readmissions related to [a] drug compared to its competitors," a PBM-based pharmacy director told inVibe. "It was very favorable on all sides." (See this month's Go Figure on p. 10 for more.)

However, contracting is not without challenges. As Jaimy Lee writes, there are a number of "lingering questions" — from whether the pacts invoke anti-trust rules to how to structure the tie-ups. Earlier deals reportedly stumbled due to inadequate measurement ability.

Indeed, payers need the right data to assess real-world performance, define the parameters of success, and measure those within a 12-month time frame.

It seems odd to speak of their most recent wave as a coming kumbaya moment, or any sort of rapprochement between pharma and payers, when "payer pressure" has consistently ranked among pharma and device manufacturers' biggest challenges.

But faced with exclusion lists becoming the norm, pharma needs to use all tools at its disposal. Might we be seeing the point when advances in real-world evidence generate the right comparative data in order for performance-based bargaining to become just as important to payers as pharmacoeconomic value stories and payer access communication?

Industry should, where it makes sense, pursue such contracting, not only with insurers, but with health systems, IDNs, and ACOs, all of whom may be willing to consider performance deals on drugs.

There will be cases where dealing doesn't work. Only through further experimentation by those brave enough to partner will the two be able to prove whether this approach is but a nostrum that doesn't do enough to control healthcare costs, or a novel move toward getting more for the healthcare dollar.

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BPA WORLDWIDE haymarket

PAYER NAYSAYERS?

PBMs and health-plan executives haven't always been vocal about the changes set in motion by the shift to outcomes-based pricing. InVibe, with help from Interactive Forums, polled 13 medical or pharmacy directors. Here are their takes on several formulary-related issues.

Source: InVibe

1 HOW DOES YOUR HEALTH PLAN USE OUTCOMES DATA TO EVALUATE AND MANAGE NEW DRUGS?

"We want to see outcomes of a new therapy that are better than what is currently available, so we're expecting a lot of comparative data. It needs to show the product has better outcomes than what's already available, or a new product is going to help address unmet needs current therapies are unable to address."

— pharmacy director at a commercial health plan

"Outcomes data in the form of peer-reviewed published articles are always required before moving on to these new agents. There needs to be some review in addition to FDA approval of a drug."

— medical director at a commercial health plan

2 HOW HAS THE RECENT NEWS ABOUT PRICE-GOUGING IN THE PHARMA INDUSTRY CHANGED YOUR HEALTH PLAN'S APPROACH TO FORMULARY MANAGEMENT, IF AT ALL?

"We're seeing exclusions, where we simply will not cover a drug if it offers equal efficacy and safety at a much higher price point. Drug exclusion lists, as we're seeing from ESI, CVS, and closed formularies, are becoming the norm."

— medical director at a PBM

"If we notice a tremendous price increase, we will re-evaluate at formulary to determine whether we add restrictions. If it's preferred, maybe we make it non-preferred."

— pharmacy director at a commercial health plan

3 WHAT'S THE BEST EXAMPLE YOU'VE SEEN OF A SUSTAINABLE, VALUE-BASED CONTRACT YOUR HEALTH PLAN HAS IMPLEMENTED WITH A PHARMA COMPANY?

"There was a drug we contracted from an outcomes basis that had preferential outcomes around cardiovascular events. We negotiated an outcome-based contract on cardiovascular events and readmissions related to that drug compared to its competitors. We then allowed that drug on our formulary with no restrictions."

— pharmacy director, PBM

"We haven't had much success. Bisphosphonate use related to risk around fracture was the first true risk-based contract that we've seen. Usually the issue is defining the perimeters of success. Can those be easily measured within a 12-month time frame and do those truly impact cost and outcome?"

— medical director, PBM