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Pharma's Latest Challenge: What To Do About New Provider-Payer Business Models

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Many companies now are endeavoring to glean the implications of these emerging payer-provider collaborative models, endorsed by both the public and private sectors and a key element of U.S. health care reform.

These new models combine with independent but equally relentless health care cost pressures to facilitate a new commercial landscape that offers biopharma companies plenty of opportunities but also uncertainty and risks.

Under health reform, Medicare is to begin contracting with ACOs by January 2012, via the newly created Medicare Shared Savings Program. The Patient Protection and Affordable Care Act authorizes MSSP to reward those ACOs that achieve lower overall health care spending growth while meeting pre-defined performance standards for quality of care ("Physicians Have A Bigger Stake In Patients' Total Care Under Medicare ACOs," IN VIVO, April 2011).

ACOs must sign three-year Medicare contracts and cover 5,000 Medicare beneficiaries but CMS is still working out the myriad details of how it will evaluate ACOs and work with them ("ACOs Stakeholders Are 'Flying And Building The Plane At The Same Time,'" "The Pink Sheet," July 4, 2011).

Chief obstacles to implementation, according to a survey by AMN Healthcare Services, are physician alignment followed by worries about capital outlays, lack of integrated IT systems, and lack of evidence that models work as intended. Improving the traditionally tense relationships between hospitals and physicians is expected to be tough, given lack of clarity around who will lead these organizations, how participants will share risk, and how they will distribute reimbursement, the survey notes.

ZS Associates' Angela Bakker Lee discusses ACO implications

To gain insight into possible near-term and long-term implications of new models like ACOs for pharma, "The Pink Sheet" recently spoke with Angela Bakker Lee, Managing Principal at ZS Associates, a global consulting firm specializing in commercial effectiveness. Bakker Lee has worked with many pharmaceutical companies, helping to design their go-to-market strategies, and currently leads ZS' global health care service providers practice.

"The Pink Sheet": What are the most important changes impacting the health care market today, and how proactive is the pharma industry about responding to these changes?

Bakker Lee: There are three important ways that the health care market continues to shift: 1) increasing payer and provider controls to address the challenge of rising health care costs; 2) greater integration and coordination of patient care among payers and providers through emergence of new structures like ACOs; and 3) greater experimentation to blunt the cost curve and deliver better value in health care. These are not "new" trends impacting pharma, but momentum is building now in ways that signal more proactive steps by the pharmaceutical industry. In the past, the pharma industry has taken a "wait and see" approach to these trends, but that is starting to change.

"The Pink Sheet:" To what extent is the private sector following the govern-

ment's [Center for Medicare & Medicaid Services] lead and experimenting with shared savings models that could impact pharma commercial strategy and market access?

Bakker Lee: As the market evolves, the differences between the public (CMS) and private sector in health care in terms of actions taken by payers and providers to control and cut costs is immaterial. Both sectors face the same, overwhelming pressure to cut costs in order to simply remain viable and avoid an affordability crisis. Both sectors are exploring the same mechanisms to control costs. One illustration of this is the fact that ACOs and ACO-like organizations are being formed, endorsed and supported by organizations in both the public and private sector.

As one hospital executive expressed to me recently, "The incentives offered by CMS are a nice benefit for our ACO and it will help us a lot when these payments kick in for us in 2012, but the major motivator to take these actions now is simply survival."

"The Pink Sheet": ACOs represent only a small fraction of providers today. Will ACOs spread?

Bakker Lee: It's still early days, but results I've seen recently suggest that ACOs and ACO-like organizations (in which payers and providers coordinate their efforts to more efficiently and effectively care for a given population of patients) are likely to grow in popularity and very likely to spread far beyond the 5% to 10% share of providers they represent today.

In a recent survey [AMN Healthcare Services' "2011 Accountable Care Organization Survey," mailed to 105,000 health care facility administrators and doctors, with 882 responses], for example, 27% of providers reported that their organization was moving towards becoming an ACO now, and another 29% of providers said their organization was considering it. That's almost 60% of providers saying they feel they are now moving to become, or may soon be, a part of an ACO.

And some recent data we have seen indicates ACOs can be effective at controlling costs. For example, one ACO executive recently told us about the results his ACO achieved in 2010 saying that they "achieved most of our goals for our ~40,000 member population including exceeding our target of cutting costs by over $15 million." He attributed their success primarily to achieving reductions in inpatient utilization such as lower re-admission rates and fewer admissions to the hospital per thousand members.

This is only one example, but the implications are pretty clear. If ACOs work to control costs, without sacrificing quality of care, they will spread. It's still too early to be conclusive, but the signs are there. ACOs could become a very popular model, and one of the dominant payer-provider models, we see in the future.

"The Pink Sheet": What does this mean for pharma?

Bakker Lee: ACOs and ACO-like collaborations and joint ventures won't have a significant impact immediately. There are two reasons for this: today they still represent only a small fraction of providers, and prescription drug costs account for only roughly10% to 15% of total health care costs. If an ACO wants to achieve serious cost reduction, it must focus attention first on much bigger cost drivers like hospitalization rates, as in the example I mentioned earlier. The bang for the buck just isn't very big, relatively speaking, from controlling utilization of prescription drugs versus controlling hospitalization.

But, having said that, as ACOs exchange electronic health information, they can easily exert more control over prescribing decisions. With e-prescribing and instant access to formulary information at the point of care, ACOs can very easily enforce generic utilization policies for example, and this could have an impact on pharma as these systems come online. So one way to look at it is to ask whether ACOs will do first what is easy (as soon as the support systems are there), or do first what is going to have the most impact on costs, or do a combination of both. That will dictate how fast and how negative the impact of ACOs and ACO-like payer-provider collaboration will be on pharma.

"The Pink Sheet": What should the pharma industry be doing now to prepare?

Bakker Lee: Pharma companies need to work much more effectively with ACOs to have a seat at the table going forward, to be viewed as part of the solution and not simply as part of the problem contributing to escalating health care costs. In a way, the advent of ACOs offers a golden opportunity to the industry. Now is the time to get involved in the experiments, to innovate, to be a strategic supplier competing on your ability to bring solutions – not just lower prices.

ACO Points To Consider

- Sixty percent of providers surveyed are at least considering move to ACOs
- Initial pharma impact may be seen via HIT-enabled controls
- Pharma firms need to engage in solution-oriented ACO experiments
- Drugs can be positioned as a solution as ACOs initially target hospital costs
- Possibilities may arise for premium offerings combining a drug with services
- "Frequency driven" promotional models may have less payoff
- Tighter coordination between sales forces and market access departments is key

"The Pink Sheet": What are the longer-term implications for pharma?

Bakker Lee: There are some signals that a shift could happen in the health care marketplace, possibly creating a tiered system in the U.S. with a wider range of premium and standard health care offerings available for purchase by individuals and employers. Longer-term, this could drive the development of a more dramatic difference between the public and private sectors than we see today.

For example, if a large percentage of employers decide to no longer offer health insurance as a benefit to their employees when the public exchanges [created by health reform to select health coverage] become available, this could create a two-tier system. A [McKinsey] study recently predicted that among employers with a high awareness of health care reform, as many as 50% may stop offering health benefits to their employees after 2014. If this happens, we may see a greater effort on the part of payers and providers to segment the marketplace and to offer premium services to some customers (employers and individuals), who are willing to pay more, while others receive the standard no-frills service.

There are some interesting implications here for the pharma industry. A prescription drug product plus service solution could be part of a premium offering. It could be marketed to those desiring a premium health care experience (for themselves or for their employees), while the standard, no-frills offering could include more use of generics and the less expensive branded therapies, and no services.

If such a bifurcation happens, new marketing techniques, borrowed from the consumer goods industry, will be needed in pharma in order to successfully design offerings and build brands that are preferred by a segment of the population despite their higher price point. And a new, much higher level of service will need to be available for this premium or 'top tier' segment.

"The Pink Sheet": With some physicians now successfully marketing an exclusive product (a higher level of service at a higher price) to consumers, e.g. concierge medicine, does that signal that we are already starting to experience a two-tier system?

Bakker Lee: This is a great point. It would suggest that we are potentially moving in that direction. However, pharma executives I meet with regularly still say that they believe consumers simply don't care enough to spend more for a better health care experience that includes a better pharmaceutical product. But, can we change their view? Can more sophisticated marketing and branding change this? That's the question we should be asking.

"The Pink Sheet": How could ACOs and other new payer-provider business models impact the primary care promotion strategy that pharma uses today?

Bakker Lee: As payer-provider collaboration and cooperation increase (through ACOs and ACO-like partnerships), the degree of control payers and providers can exert will increase, making it harder for the pharma industry to reap the rewards that some still see from the old sales rep "frequency-driven" promotional model.

One top-tier pharma company with several popular primary care products analyzed this last year and found that the old commercial model still works fairly well for one of their products in the Southeast, where payers are more fragmented. However, it doesn't work well in areas where payer-provider collaboration is much stronger. To address these differences, the company adopted a differentially resourced, regionally customized, more agile promotional model for the primary care sales force, which many pharma companies already have done.

If payer-provider collaboration continues to increase, these "new" pharma commercial models, which employ leaner, more flexible, sales force designs (versus a one-size-fits-all national, centralized model), will become the norm. All pharma companies will need that flexibility to adapt their resource allocation plan in each region to more precisely fit the local payer environment in order to preserve profitability.

"The Pink Sheet": You mentioned that you attended an ACO Summit in Washington in June. Although that event did not focus on suppliers, were there takeaways for pharma ("Can Health IT Deliver What ACOs Need?" "The Pink Sheet," July 4, 2011)?

Bakker Lee: Many of the biggest pharma companies and biotechs were present at this summit, as were companies like Walmart. So suppliers are clearly taking note of the changes in how payers and providers are structured and how care is being delivered through ACO-style partnerships.

Although the focus of this summit was not on pharma, a clear message came through to pharma executives in the audience. Today, attention is being paid primarily to major cost drivers such as hospitalization rates. This is positive for pharma. Prescription drugs can be part of the solution, if they are used correctly, to keep people healthier and out of the hospital. That requires a change in thinking on the part of both pharma and payers, to not consider pharmaceutical products a cost that must be controlled but instead consider them a means to lower other costs by keeping patients healthier (e.g. if they are compliant with their medications, etc.).

In the future, pharma products will be a bigger target for cost cutting. Therefore, as one pharma executive said to me during the event in Washington, "Whether the pharma industry will be seen [by ACOs] as part of the solution to blunting the rising cost curve or merely as part of the problem, will be a direct result of how

engaged the pharma industry is now in this period of experimentation. We need to be here"

"The Pink Sheet": If pharma is seen as part of the problem, what will happen?

Bakker Lee: More strict controls over use of pharma products. As there is more real-time electronic data shared among payers and providers, that opens the door and enables many more and stricter controls. E-prescribing pilots, for example, provide instant feedback to doctors when they write prescriptions for patients. And results from these pilots clearly show that when the data are available, it influences what providers do.

"The Pink Sheet": What about product launches in pharma? Given the changes we have discussed in payer-provider business models, will the same techniques work in the future that have worked in the past or will that change?

Bakker Lee: A few pharma companies are beginning to explore launch plans that use in-house sales teams and account managers instead of traditional sales reps. But these models are not common yet. They are the rare exception.

"The Pink Sheet": How are companies organizing to manage these changes, especially Big Pharma, which is so segmented by function?

Bakker Lee: Many pharma companies have moved to a regionalized structure for their field organization. Some have also taken steps to align the boundaries of field personnel in different roles [managed markets and sales reps] so that coordination is easier in the field, enabling them to be more responsive and to deliver better service to key customers, especially payers and providers.

A key benefit of this change has been tighter coordination between the managed markets or market access function within pharma companies and the sales function. It's essential for these two teams to work from a common playbook in dealing with a customer and in the past they were too often disconnected, or worse, working at cross purposes.

For example, one top 10 pharma company took steps to align the boundaries of field personnel in these two functions by creating and then managing a common account plan – together implementing strategies for specific hospitals and health plans in their area (rather that at times working against each other, which had happened in the past and caused some hospitals to close their doors to the sales reps).

"The Pink Sheet": We've talked about the need for pharma to engage more with new payer-provider models like ACOs, and to bring solutions vs. just using the same old selling model of the past. But when it comes right down to it, no one's revenues currently depend on a solutions-based dialog, do they?

Bakker Lee: No, that's true. So the issue is easy to sweep under the rug. But, it's clear what the future will bring if they don't get more actively involved soon. Increasing payer-provider control can only restrict their options in the future. Some experimentation now may result in a silver lining down the road.

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