KEYS TO SUCCESS IN THE NEW WORLD OF THE VALUE-MINDED PATIENT

By Richard Palmer

With the ongoing implementation of the Affordable Care Act (ACA) and changes in the world of employer-provided health insurance, much ambiguity lies ahead. What seems fairly certain, however, is that as a result of these changes, the US system will become increasingly value-minded in its approach to delivering and paying for care. Not only will this change in philosophy apply to health plans and third-party payers, but also to physicians and, more importantly, patients, which may have a major impact on manufacturers of prescription medications.

No longer will it be sufficient to communicate a product's value only to third-party payers. In a world where the patient is both the consumer and the payer, the patient value proposition becomes a critical component of a product's success. This article will examine the four trends that are perpetuating the rise of the value-minded patient and will outline steps pharmaceutical manufacturers can take to succeed in the new world these patients will create.

Trend 1: Pay for What You Buy

According to the Employer Health Benefits 2013 Annual Survey conducted by The Kaiser Family Foundation, in 2013 approximately 20% of persons with employer-provided insurance were enrolled in high-deductible plans, up from 4% in 2005 (i.e., a greater percentage of individuals were responsible for a larger proportion of the healthcare costs they incurred). Also in 2013, of the 82% of commercial insurance members covered by three-tier or four-tier formularies, 21% were exposed to coinsurance on preferred drugs, 25% on nonpreferred drugs, and 48% on specialty drugs. Finally, one of the most notable trends highlighted in the Kaiser data is the percentage of commercial lives covered with four-tier prescription drug coverage, a number that has grown from just 4% in 2005 to 23% in 2013.

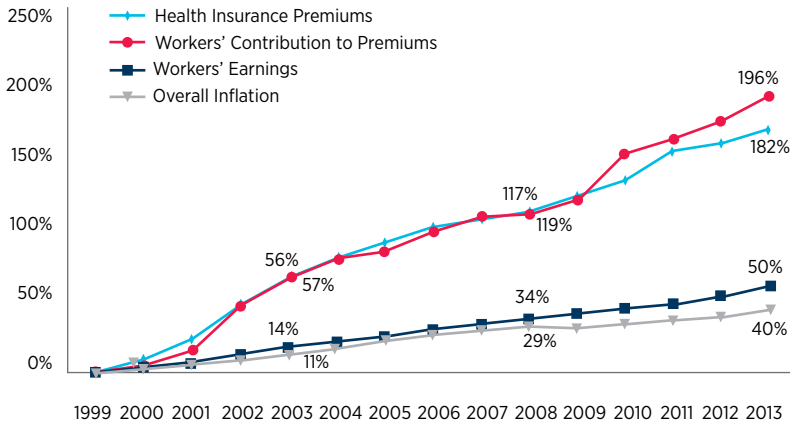
As patients are exposed to and incur a greater percentage of total healthcare costs, it is important to consider how the dollars they have available are allocated to different types of healthcare expenditures. "Share of wallet" is a concept used to capture this notion. It is grounded in the assumption that consumers of healthcare (i.e., patients) have limited financial resources available for health-related expenses that include insurance, preventative care, medical interventions, and pharmacotherapy. Each expense that a patient must incur ultimately captures a share of the total monies they have available for healthcare (i.e., their healthcare wallet). Items that account for a lower proportion of available monies have a lower share of wallet. Items that account for a higher proportion have a higher share of wallet.

There are two critical points here. First, as the share of wallet increases, it is more likely that the decisions associated with these high-share expenses will be influenced by cost. Second, as the share of one type of health-related expense increases (e.g., premiums on insurance), the amount of money left for other cost categories (e.g., out-of-pocket charges for medications) decreases.

Trend 2: Rising Premiums and a Less Favorable Risk Pool

The potential for an adverse selection problem lies on the horizon given the weakness of the ACA's coverage mandate and its prohibition of coverage denials for pre-existing conditions. On an individual basis, beginning in 2014, those forgoing coverage will face a penalty of $95. According to Kaiser's Employer Health Benefits 2012 Annual Survey, in 2012 the average portion of the annual premium paid by an employee for employer-provided insurance was approximately $950. Why pay $950 per year when you can pay $95? This same dynamic holds for family coverage and remains intact after adjusting for tax

Cumulative Increases in Health Insurance Premiums, Workers' Contributions to Premiums, Inflation, and Workers' Earnings, 1999-2013



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2013. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 1999-2013; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1999-2013 (April to April).

savings associated with employer-provided insurance. On health exchanges, where employers will not be around to foot the majority of the bill, the difference between the penalty and the annual premium will be even greater.

Other trends may exacerbate these dynamics, at least in the early years of health exchanges. CMS is eager to partner with manufacturers to drive enrollment into federal exchanges. In this regard, a convenient first step for manufacturers could be to facilitate the transition of patients in manufacturer-provided free-drug programs into an exchange-provided health plan likely subsidized by the federal government. Such a decision follows sound business logic but will add more risky and more costly patients into the risk pool. Coupled with the law's abolishment of coverage denials for pre-existing conditions, the weak mandate creates a perverse incentive to not purchase health insurance until it is needed, or to purchase scaled-down benefits until more robust coverage is needed.

These incentives will be priced into health plans by insurance companies. If only sick people are buying insurance, it's going to cost more. And, if the cost of insurance increases at a rate greater than the averages person's income, people will likely have fewer dollars to pay for their share of health-related expenses.

Trend 3: Disincentives to Offer a Lower-Cost Alternative

Currently, high-deductible health plans (HDHPs) paired with health savings accounts (HSAs) provide a lower-cost health insurance option and effectively incent younger and healthier individuals to purchase insurance and take ownership of their health—a potential reason as to why such plans have grown more popular. Indeed, HDHP enrollment accounted for only 4% of the commercial market in 2006; in 2012, this figure was 19%. Two pieces of ACA undermine this trend and the existence of high-deductible plans as an alternative to higher-cost insurance.

1. Actuarial Value (AV) Calculation—Actuarial value is defined as the percentage of total costs expected to be covered by the health plan in a given year. The higher the actuarial value, the greater the proportion of costs covered by the plan and the richer the insurance benefit. Individual (patient) contributions to HSA accounts are not included in the AV calculation as a covered expense. Intuitively, these contributions should not be included; actuarial value is the percentage of costs expected to be covered by the health plan, not by the health plan and the patient's savings. However, HDHPs are designed to do just this. That's why they have lower premiums. Understating covered expenses makes it harder for HDHPs to meet AV requirements set forth in the law without enhancing their benefits, which, in turn, will almost certainly lead to an increase in premiums.

2. Medical-Loss Ratio (MLR)—ACA requires health plans to spend 80% of revenue earned from premiums on its customer's medical expenses. The issue with the minimum MLR is that by offering an HDHP, health plans put themselves at greater risk of violating the rule in a given year, a consequence that would require them to pay rebates to their members. According to a report on the impact of MLR requirements on high-deductible plans from Milliman, an actuarial consultancy, health expenses for HDHP members tend to occur less regularly but at higher amounts than expenses for non-HDHP members. In other words, HDHP members may not have expenses that are "adequate" enough to achieve the 80% MLR in a given year. In theory, this could actually lower premiums for HDHPs, so that rebates do not have to be paid, but in practice, premiums will likely increase to offset any potential rebates—a less-risky alternative for the health plan.

Trend 4: Shopping for Health Insurance

Until recently, the notion of shopping for health insurance was somewhat of a misnomer. Since the days of wage controls imposed during World War II, you did not get health insurance by shopping around to compare and contrast different options—you got it by getting a job or by enrolling in a government-funded program. This all changed in 2006 with the introduction of Medicare Part D, at which point those eligible for Medicare could choose the insurance company from which they would purchase prescription drug coverage. Today, we now have an online marketplace where Medicare enrollees can go to assess the pros and cons of different prescription drug options offered by Humana, United, and many other plans participating in Part D.

When individuals need to shop for their own health insurance coverage, they have an incentive to be more inquisitive and to better understand what they are paying for, what they are receiving, and whether or not that tradeoff is acceptable. In other words, they become more value-oriented and cost-conscious. They also have a reason to understand how the system works.

With the launch of health exchanges in 2014, what started with Part D in 2006 will be expanded to include a much broader population. As more people grow accustomed to shopping for health insurance—or at least having the option to shop for health insurance—the basic tenets of free markets, consumerism, and cost-benefit tradeoffs should be able to establish roots in the healthcare marketplace, not only in the purchasing of insurance but also in the procurement of certain products and services, like prescription medications.

Life in the New World

In a market where these trends are at play, the patient value proposition becomes a key influencer of pharmacotherapy treatment decisions and, ultimately, a product's financial success. Key elements of this proposition include educational materials or programs that provide a thorough, more scientific disease-state understanding, establishing the rationale for a given medication and expectations on treatment results; information that allows patients to fully assess the benefits and risks of a given medication; and supportive services that will enhance a product's value.

Education, Explanation, and Expectations
Patients need to be better educated on what they are dealing with before they can understand the value of a given treatment intervention. To understand the clinical rationale behind a given intervention, patients need to have a better understanding of the basic science behind the disease. Furthermore, if patients do not understand the clinical rationale behind a given treatment intervention, they may be less likely to buy into said treatment and persist with whatever that intervention may be, especially if they are footing a good portion of the bill.

Once patients understand what they are dealing with, they then need an explanation of why a particular treatment intervention is being prescribed. Finally, patients need to have a realistic picture of what to expect as a result of taking a given medication. If these expectations are not met, the patients will likely be disappointed and may move on to an alternative medication or discontinue therapy altogether.

Data-Centric Communication
Value-minded patients will want to understand the benefits they should expect to receive and the risks to which they may be exposed when they pay for their prescription. Communications designed to provide this information may include product benefits that third-party payers typically eschew (e.g., convenience). In an ideal world, communications would also reach into the realm of patient behavior to touch the motives driving compliance and persistence, something that is admittedly hard to do given the regulatory environment.

With the ability of manufacturers to tap into patient psyche severely curtailed by The Office of Prescription Drug Promotion at FDA, a more objective, data-centric approach can be used to communicate the risks and benefits of a particular medication. Today, this is inherently hard to do in many disease states, as most patients lack the necessary scientific understanding of the disease and data points typically measured in clinical trials. In the future, when patients are faced with higher costs and more difficult decisions, this dynamic should change, especially with the implementation of more science-minded disease-state education programs as described above. Strong patient value propositions will ultimately be grounded in data-centric messages, similar to what is done today with physicians and third-party payers.

In a world where patients are both cost-conscious and value-minded, the communication of risks and benefits in a more objective and data-centric fashion is critical. Current approaches to patient communication are hindered by fair balance regulations. The problem is not with the regulation; it is with the binary nature in which adverse event information needs to be delivered, i.e., risks are disclosed but not quantified. By educating patients and packaging data appropriately, a manufacturer may be able to more accurately communicate risks and benefits to patients while still maintaining fair balance.

Without a clear understanding of risks and benefits, or in the absence of such information, treatment decisions made by the patients of tomorrow may be more heavily influenced by cost—a situation that could lead to an unfavorable pricing and revenue environment for manufacturers.

Supportive Services
In most instances, pharmacotherapy is only one aspect of comprehensive patient care. Medical interventions, diet, lifestyle, mindset, emotional state, and activities of daily living all represent areas around which services could be developed and marketed to patients. Again, the regulatory environment may pose challenges, but in a value-centric world in which products in a particular category struggle to differentiate on clinical profiles alone, programs that impact patients' lives (e.g., transportation services, meal-delivery programs, and personal training) could provide better care and build more durable patient-manufacturer relationships.

Conclusion

In a landscape where health insurance is more expensive and few, if any, lower-cost alternatives are available, the proportion of the consumer healthcare wallet available for out-of-pocket prescription drug costs may shrink. A perfect storm manifests when we layer in the expectation that out-of-pocket cost liabilities will grow due to the proliferation of coinsurance and more aggressive cost-sharing structures. Combine this with the emergence of a healthcare consumer that is better informed and more comfortable with the notion of analyzing cost-benefit tradeoffs, and we can foresee a potential future environment in which patients are more value-minded and cost conscious than they are today.

As we look to the future, the days in which the value-minded healthcare consumers represent a majority are likely several years out; however, when they arrive, those companies that understand patient value will be in a position of competitive advantage and ready to play by the rules of the new world.

Contact

Richard Palmer
Engagement Manager
Campbell Alliance
rpalmer@campbellalliance.com

Scan here to download an electronic version of this white paper.

RESULTS.

It's a pretty simple word that's used a lot in the business world, but what does it really mean?

When you cut through all the clutter, "results" means performing beyond expectations, eradicating challenges, and achieving your business goals. It means not just dreaming it. But actually doing it.

Campbell Alliance is purpose-built to help biopharmaceutical and medical technology companies achieve results. Whether it's seizing the leadership position in a new market, solving seemingly impossible challenges, or developing innovative approaches for success, we don't quit until the desired results are delivered.

We offer the insight to help leaders develop powerful strategies, as well as the knowledge to ensure they'll work in the real world. And through our relationship with inVentiv Health, we bring the global implementation capabilities needed to put even the most ambitious plans into action.

Delivering results is what we do. Let's get to it.

Campbell Alliance: Strategy. Results.

Campbell Alliance®

INVENTIV HEALTH

Campbell Alliance: Strategy. Results.
www.campbellalliance.com

Headquarters Address
370 Lexington Avenue, Suite 1100
New York, NY 10017
Telephone: 919.844.7100
Fax: 646.805.0351
Toll Free: 888.297.2001