

Executive Briefing

Reform and Pharma: It Goes Way Beyond the Bill

Healthcare reform will have a huge impact on the pharmaceutical industry. But much of it will come indirectly, as managed care organizations—pharma's most influential customers—are forced to change the way they do business. Here's what to expect.

The 900 pages of the healthcare reform act had only a handful of direct mandates for the pharmaceutical industry—an industry user fee, a discount for Medicare Part D members in the “doughnut hole,” larger rebates for Medicaid, and not much more. But no one should be deceived. Healthcare reform will transform managed care, pharma's most influential customer segment. And that transformation will ripple out to healthcare providers, pharma, and other stakeholders for years to come.

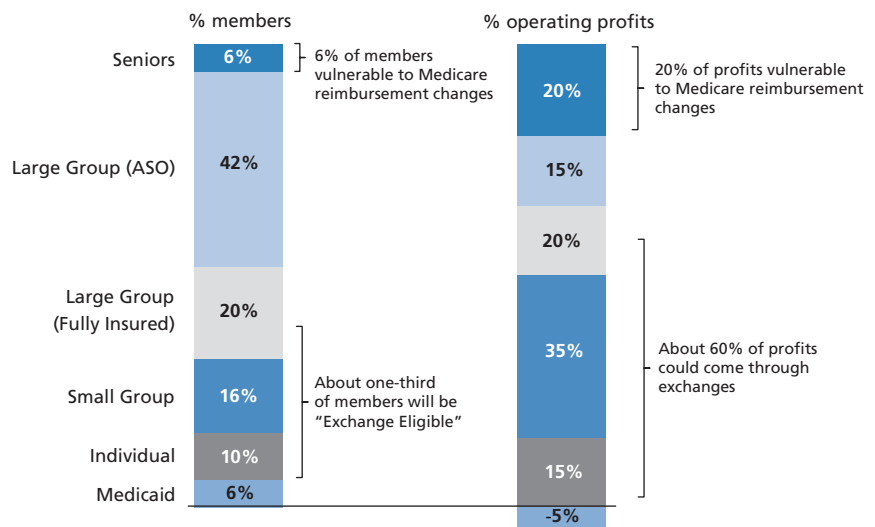
Consider:

- Traditionally, health insurance is a business of managing risk and processing claims. But the reform law throws a monkey wrench into risk management: Plans can no longer exclude customers with pre-existing conditions or undesirable risk profiles. For the most part, they can't even charge high-risk customers higher rates.
- The law restricts how health benefits in the individual market are designed, making it difficult for plans to differentiate themselves. And the soon-to-launch state and regional healthcare exchanges will give health insurance a solid push toward commoditization.
- Health insurance has never been a high-margin business, but the new law will make it even tougher to stay profitable by requiring plans to spend a fixed percentage of premium revenues on healthcare costs. Almost every plan will have to drastically cut administrative costs just to survive.

Pharma's most important customers are in difficult straits. To survive, payers need to spend less on care and deliver better outcomes.

For health plans, the reform era will be a time of severely constrained margins and unprecedented competition—and not just in the individual market, the corner of the industry where reform started. Several potentially expensive reform provisions, including the ban on annual and lifetime benefit limits, will apply to group as well as individual policies. By 2017 we expect that reform will have a serious impact on 40 percent or more of insurance policies, representing 80 percent of health plan profits (see Exhibit 1). Insurers have no choice but to become more efficient in their spending on care. They also need to deliver better outcomes to enable them to operate at a lower long-term cost structure. The business partners who can help them transition to a new way of doing business will be well positioned to thrive.

Exhibit 1: In a typical plan, reform could have an impact on 40% of members—and 80% of profits



Sources: MEPS Adjusted D&B Employer Data 2009, CMS Filings 2009, Kaiser State Health Facts 2008, United States Current Population Survey Data 2008, Oliver Wyman Health Reform Analysis, Congressional Budget Office

The pharmaceutical industry has long known that drugs can help reduce the overall cost of healthcare, an insight that has only rarely been put to practical use. That situation may finally be on the verge of changing. Your most important customers are in difficult straits. They need the benefits your medicines can provide—not just for their members, but for the survival of their businesses.

What Your Customers Need

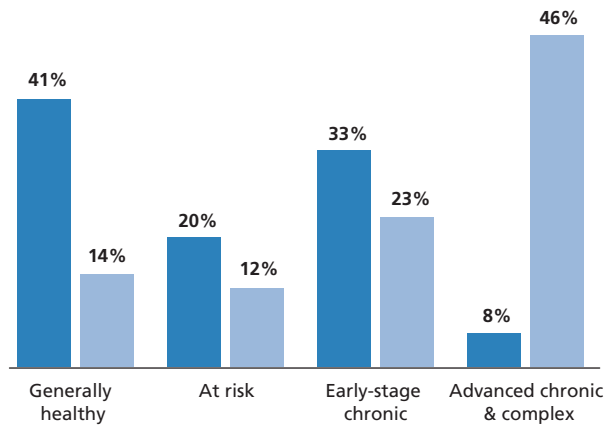
A next-generation strategy for a pharmaceutical company must be rooted in a detailed understanding of what payers need and what pharma can do in terms of portfolio, product profiles, ancillary support, and data to help provide it. Based on Oliver Wyman client work, payers' top priorities must include:

Slower progression from risk factors to chronic conditions and from chronic conditions to chronic disease. At an average health plan, almost half of medical costs are generated by about 8 percent of the members—many of them suffering from late-stage or multiple chronic diseases (see Exhibit 2).

Payers must keep early-stage patients from progressing to late stage, and patients merely with risk factors from progressing to chronic disease.

Exhibit 2: Targeting the sickest patients

In a typical commercial managed care organization, a small percentage of members (■) generate a high percentage of costs (■). One of pharma's great opportunities is to help control those costs.



Source: Oliver Wyman analysis

By comparison, the healthiest half of members generate less than 15 percent of medical costs. A key concern must be to keep early-stage patients from progressing to late stage, and patients who merely have risk factors from progressing to chronic disease. This is a job that drugs already do well and cost-effectively in many conditions, including asthma and hypertension. But there are still major opportunities for improvement both in areas with few treatments—such as nicotine addiction, Alzheimer's disease, or obesity—and in areas such as diabetes, where treatments are available but outcomes are often unsatisfactory. It is important to note that the slowing of disease is not just a matter of the availability of drugs, but in many cases the availability of services that lead to patient adherence and wellness.

Reduction in hospitalization and expensive procedures. Costs are concentrated not just in the sickest patients but in the most expensive treatments, especially hospitalization. Outpatient therapy, including the use of drugs, can be a powerful tool in keeping patients with chronic diseases out of the hospital, potentially generating enormous savings. In fact, the Agency for Healthcare Research and Quality's Healthcare Cost and Utilization Project estimated that in 2006 there were 4.4 million preventable hospital admissions in the United States,

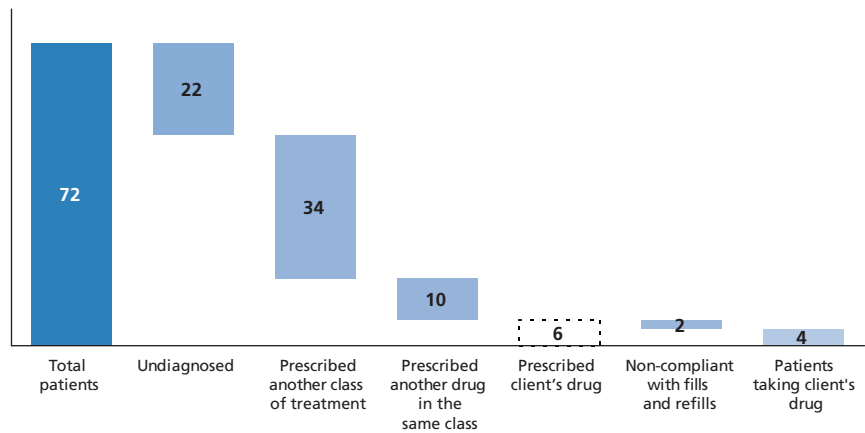
accounting for \$30.8 billion in costs—about 10 percent of total US hospital costs that year.

Better diagnosis and compliance represents a remarkable opportunity to improve the overall effectiveness of healthcare.

Better diagnosis and compliance. An enduring problem in healthcare is the failure of patients to make use of the drugs and treatments they have been prescribed. The exact numbers vary from case to case, but the pattern is all too familiar: Perhaps a third of patients with a given condition will never be diagnosed at all. But even those who are diagnosed end up largely untreated in the long run: If seven patients receive a prescription, six (or fewer) will fill it, and only four will make it to the first refill. By the fourth or fifth refill, only one remains compliant. This represents lost revenue for a pharmaceutical company, but also a remarkable opportunity to improve the overall effectiveness of healthcare (see Exhibit 3). While there are some legal and regulatory constraints on pharma, it is clear that companies have the opportunity to play a role in many of the factors that cause poor adherence.

Exhibit 3: Improving diagnosis and adherence

A typical case from a cardiovascular condition. For payers, poor diagnosis and adherence can lead to higher costs—but can pharma companies demonstrate that they can make an economic difference?



Sources: Oliver Wyman analysis based on statistics from the American Heart Association, US Census, NHLBI, MTF, and JABFM; estimates were taken from academic studies, www.americanheart.org, and www.healthaffairs.org.

Improved cost/benefit ratios for therapy. It seems unlikely that the United States will go so far as to create an agency like Britain's National Institute for Health and Clinical Excellence (NICE), which rules on the cost-effectiveness of therapies. But NICE's approach will inevitably become part of the thinking of insurers, who have already begun to push back against high-priced drugs that only minimally affect patient outcomes. There will be challenges for pharmaceutical companies and payers alike—understanding the full range of relevant economic and quality-of-life issues related to medical conditions, developing data, and learning to integrate clinical

and nonclinical information effectively. But as payers gradually become more comfortable with value calculations and value-based transactions, pharmaceutical companies will gain important new tools in negotiating for access.

Comparative effectiveness will provide new opportunities for pharma to differentiate products and win share.

Better predictive data for costs and outcomes. The Patient Protection and Affordable Care Act's rules on benefit design and Minimum Loss Ratios will have the effect of compressing the insurance industry's already-tight margins. The ability to model future disease progression and response to therapy will become crucial for insurers as they design products or argue their case for rate increases, giving a potential advantage to the pharmaceutical product that provides data enabling such prediction.

What Pharma Must Do: Addressing "Unmet Economic Need"

The idea of measuring the economic impact of drugs has been around for years but until recently has gained little traction in the United States. Reform may provide a tipping point: The law imposes economic constraints on health plans that leave them little choice but to aggressively attack medical costs, and it contains provisions to advance outcomes research and evidence-based medicine. As plans restructure to save administrative costs, there will be an impetus to build organizations that can look at costs holistically. Manufacturers that have been trying to make an economic argument for their products may finally find a willing audience.

Inevitably healthcare will shift toward a more integrated, value-driven model. But the transition will take place unevenly. Our research shows that if plans focus their care delivery improvements on the 10-15 percent of members with complex conditions—whose care is expensive partly because it is badly coordinated—they can lower medical inflation by five percentage points over the next five years, while holding quality steady or even improving it. A key goal for pharmaceutical companies now is to understand where they could help achieve savings of that scale. In some cases, the answer is clear. In a recent study by Oliver Wyman, plans overwhelmingly said that they need pharma's help to drive outcomes and compliance, and those contributions were most needed in the most costly disease areas.

Today, medical costs continue to rise faster than the Consumer Price Index, and there is no reason to think that reform on its own will curb them. That job rests in the hands of providers, insurers, pharmaceutical manufacturers, and medical device companies. If they fail, rationing and other limits on care are inevitable. In this context,

it's no exaggeration to say that a product or service that lowers the total cost of care is meeting an unmet economic need.

The road ahead will require pharma to:

Plans overwhelmingly said they need pharma's help to drive outcomes and compliance, particularly in the most costly disease states.

Embrace clinical and economic differentiation. In the past five to seven years, the pharma industry has had a hard time developing truly innovative drugs. Payers understand that not every product that comes to market is significantly better than the products that came before. And both payers and regulatory agencies are getting smarter, demanding products that are truly innovative, and not rewarding the industry for modest advances in dosing or convenience.

In this context, greater focus on the economic value of drugs will benefit pharma. Companies will need to build comparative economics into their drug development model and widen their view from a narrow clinical focus to a broader sense of how their products affect real-world outcomes and overall cost of care. In the past, comparative effectiveness studies have been a source of fear, with the risk of an unfavorable result outweighing any likely benefit. In today's crowded markets, however, regulators have begun to question the wisdom of even reviewing products without comparative data. Comparative effectiveness studies may well become a required element of a drug dossier. For companies that can make the right bets on the right claims, there are plenty of opportunities to thrive.

Focus on high-opportunity disease states. Some clinical areas offer little opportunity to improve their cost of care. Cholesterol control, for instance, is thoroughly commoditized, with plenty of relatively inexpensive drugs that work well, and the prospect of still lower prices once Pfizer's Lipitor goes off patent. In the primary-care arena, managed care organizations are focusing on conditions with unmet clinical need and expensive co-morbidities. Diabetes, obesity, pain, and smoking cessation are all good examples.

On the specialty side, cancer remains extraordinarily expensive to treat, and there is great opportunity in autoimmune diseases such as multiple sclerosis, Crohn's, lupus, and rheumatoid arthritis. These diseases are difficult to treat and are so debilitating that even a marginal improvement in quality of life can be significant.

Keep an eye on government. Managed care organizations have many reasons today to start measuring and managing the total cost of care, but government programs such as Medicare and Medicaid have even more. The government, unlike health plans, is a true payer—and not just for healthcare, but for disability and other expensive entitlements.

As pharma continues to test new ways of delivering value, our message is simple: Don't quit.

Government coverage tends to be longer-term than commercial coverage. It does not have the high level of churn that has traditionally dissuaded insurers from giving a high priority to total cost of care. Finally, the government has the buying power to bring about change in the way medicines and medical services are bought and paid for. The Affordable Care Act includes numerous pilot programs related to alternative delivery models. If Medicare, for instance, eventually implements any of them widely, it could represent an enormous change to the playing field.

Seizing the Opportunity

Oliver Wyman estimates that health plans have only about five years to deal with cost/quality issues. If they fail, the country will see runaway costs, further strain on the Medicare trust fund, and destructive effects on business as healthcare costs rise to roughly 20 percent of Gross Domestic Product—and ultimately a new round of healthcare reform that will probably end health insurance as we know it today.

To their credit, pharma companies have long experimented with programs to deal differently with their customers. In general, they have not had the hoped-for impact, even when pilots have demonstrated the soundness of the underlying strategies. The reason is simple: It is intrinsically difficult to align incentives, and until recently few stakeholders saw the project as worth the effort. Our message is equally simple: Don't quit. The motivation to work differently is growing for both pharma companies and payers. The road will continue to be bumpy, but for companies that see the journey through, there is the promise that pharma and managed care can change the adversarial relationship they have had in recent decades, and that both sides can finally assess the real value of medicines and build their businesses on that foundation.

About Oliver Wyman

With more than 2,900 professionals in over 40 cities around the globe, Oliver Wyman is an international management consulting firm that combines deep industry knowledge with specialized expertise in strategy, operations, risk management, organizational transformation, and leadership development. The firm helps clients optimize their businesses, improve their operations and risk profile, and accelerate their organizational performance to seize the most attractive opportunities. Oliver Wyman is part of Marsh & McLennan Companies [NYSE: MMC].

Oliver Wyman's Health & Life Science's practice serves clients in the pharmaceutical, biotechnology, medical devices, provider, and payer sectors with strategic, operational, and organizational advice. Deep healthcare knowledge and capabilities allow the practice to deliver fact-based solutions.

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