How Pharma Can Cope with Consumerism

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Summary:	Consumer−directed health plans have been less a boon for the drug industry than pharma executives expected because consumers, responsible for more of their own costs, are buying generics when they can and skimping on therapeutic regimens. Drug companies will have no choice but to reduce prices to patients in these plans−−but should provide the discounts in return for greater adherence, which could to a large degree offset the revenue losses.

Further Analysis:

Title	Magazine	Issue	Article ID
Leveraging Patient−Centric Information for Market Success	*IN VIVO*	Nov. 2005	2005800203
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Under managed care, consumerism has become a threat—when they have to pay, consumers generally choose the cheaper drug or just cut down on therapy. But there are some strategic solutions.

By Phyllis Yale and Elgar Peerschke

- Consumerism under managed care has been less a boon for the drug industry than pharma executives expected.
- Financially responsible for their own decisions, consumers are buying generics when they can and skimping on therapeutic regimens.
- Drug companies will have no choice but to reduce prices to patients in these plans—but should provide the discounts in return for greater adherence, which could to a large degree offset the revenue losses.
- Drug companies will have to work closely with managed care organizations to create these programs.

Given their success with consumer promotion in general, drug company marketers have been cautiously optimistic about their business prospects in a fast−growing corner of managed care: consumer−directed health plans (CDHPs). With consumers making more of their own choices in managed−care plans, drug marketers thought they might be able to get around some of the controls imposed by managed−care organizations and pharmaceutical benefits managers focused on containing the costs of medicines.

But there's another side to this story, recognized by many in the drug industry. Consumers in these plans have responded more to financial incentives than brand−based promotion. Patients enrolled in CDHPs have increased their use of generics, as well as reduced their adherence to prescribed regimens, in an attempt to save their own money. Bain & Company analysis shows that if current projections of CDHP enrollment are met by 2009, the pharmaceutical industry will lose $4−6 billion in revenues, with increased use of generics accounting for about one−quarter of the total, and reduced adherence accounting for the other three−quarters.

With so much at risk, some pharma companies are redoubling their efforts to reach consumers directly, with advertising and marketing campaigns designed to sell the benefits of their drugs. But if pharma firms overweight this strategy and go too far in trying to bypass managed care organizations (MCOs), they may wind up doing themselves more harm than good. A better approach for pharmacos is to use the spread of CDHPs and investments in direct−to−consumer marketing programs as levers to make progress on the big issue they can influence—improving adherence and appropriate use. For that, pharma companies need MCOs.

Because health care consumers' pocketbook issues are so important to them, pharma companies will have no choice but to reduce prices on some products in highly competitive disease areas. Given this necessity, the question becomes what pharma companies can buy with their discounts beyond market share. The answer: improved adherence and compliance. Giving consumers a price incentive on refills, for instance, becomes a loyalty strategy that uses discounts. In return for working with MCOs to structure discounts, pharma companies get repeat customers, in a cost−effective way.

In other words, working with MCOs becomes even more critical for pharma companies to succeed as CDHPs grow. And they will grow. While some pharma executives view CDHPs as a permanent feature of the industry's landscape, others shrug their shoulders and regard CDHPs as a temporary aberration that will fade

away. The latter course is dangerous. Adoption and enrollment in CDHPs is progressing faster than anticipated: consumerism in health care is here to stay. Pharma executives that ignore the trend now will have to play catch−up, expensively, later.

The Boom in Consumer−Directed Health Care

By the numbers, consumer−directed health care is off to a strong start. Since 2003, the number of people enrolled in CDHPs has matched even the most optimistic projections. America's Health Insurance Plans, a trade association of health insurers, and *Inside Consumer−Directed Care*, an industry newsletter, recently reported some six million enrollees in health savings accounts (HSAs) and health retirement accounts (HRAs). Meantime, forecasts from a joint DiamondCluster−Goldman Sachs study and the Bush administration anticipate more than 20 million CDHP members by 2010. The most rapid growth is occurring in large organizations, where the totals will add up quickly; 22% of all US employers with more than 20,000 workers offered CDHPs last year.

The expectations of strong continued growth reflect the early success of CDHC programs in reducing health care costs. While preferred provider organization costs are expected to rise 7−14% in 2006, CDHC costs are predicted to increase only 5−10%. And health care payers have started to see the impact. Insurers Aetna and CIGNA, with more than 40,000 CDHP enrollees each, report results on many fronts: Overall costs declined, driven by fewer inpatient days, decreased use of branded medications, and greater generic substitution.

Boom Meets Bust

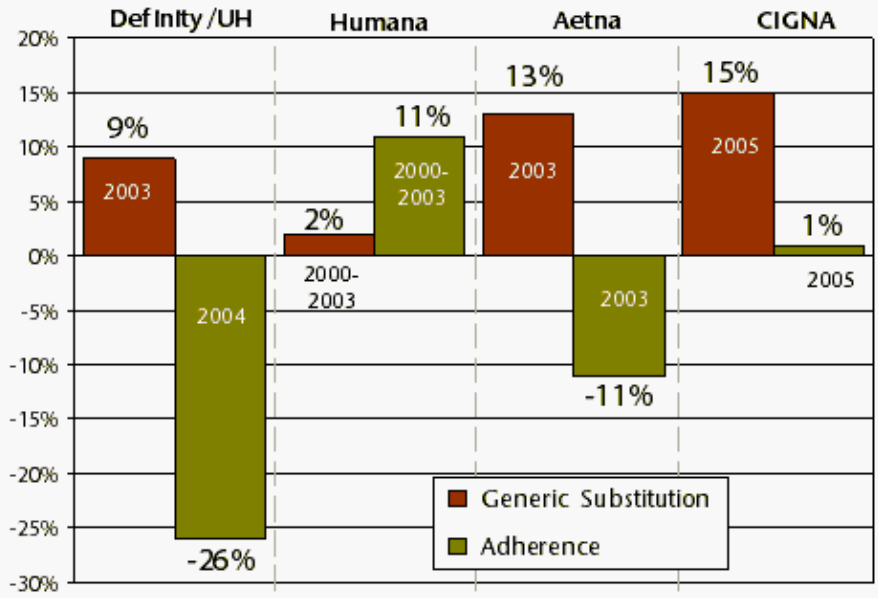
Simply put, CDHPs appear to be reducing health care costs, as intended. But for drug companies, exposing patients to the fully loaded cost of pharmaceuticals has had two major consequences: Generic use has gone up, with adherence and compliance down.

The evidence that pharmacy spending is down is widespread and growing. Aetna members experienced a 5.5% decrease in pharmacy costs driven by a 13% decline in overall prescriptions. Lumenos, a CDHP provider acquired by Wellpoint, has seen declines ranging from 8−15% in prescription drug spending, while CIGNA reported in September 2005 that its members enrolled in CDHPs spend 8−15% less on prescriptions, due in part to consumers shopping among brands and retailers.

At the same time, purchases of generic drugs are increasing. At CIGNA, for instance, members boosted their use of generics in 2005 by 15%, while at Aetna the increase in 2004 was 13% (s*ee Exhibit 1*).

Exhibit 1

Consumer Plans Increase Generic Substitution and Reduce Adherence



Years noted within bars refer to the years studied in which increases or decreases occurred.

SOURCE: Bain & Company

The data also point to an accompanying trend: Consumers fill and refill prescriptions less frequently when presented with the full cost of their medicines. A study of Humana members who switched from a conventional four−tiered pharmacy benefit to Humana's allowance−based RxImpact plan found a decrease of 11% in prescriptions filled from 2000 to 2003. Aetna registered decreases in adherence of 7% in 2003; adherence at Definity/UH dropped 25% in 2005. When the Employee Benefit Research Institute (EBRI) looked into the issue, it found that 26% of CDHP enrollees reported skipping a dose to make it last longer, compared with 15% of those enrolled in comprehensive plans.

Medical journals and academic researchers are sounding alarms about the health effects of lower adherence. Moreover, for certain chronic diseases like diabetes and asthma, lower adherence in filling and refilling prescriptions leads directly to an increase in the short− and long−term treatment costs.

Many CDHP enrollees already have a sense that all is not well: A separate EBRI study found that only about a third of CDHP members are very satisfied with their plans, and also revealed that only 34% of those in CDHPs would recommend their plans to friends or colleagues.

In short, while CDHPs are successfully holding down immediate costs, they aren't delivering better, more−targeted health care for consumers. Without accompanying information that clearly spells out the options and trade−offs, the financial incentives built into most CDHPs lead consumers to choose short−term monetary savings over their best interests, in terms of both treatment and overall savings.

Payers recognize the issue, and some are introducing innovative incentives for consumers to practice preventive care. Humana's venture with Virgin Life Care, for instance, rewards members with points every time they go to the gym. Unlike past programs, where MCOs partly covered the cost of a gym membership, Humana can actually track the activities of its members. By uploading data from their pedometers or getting their health assessed, for instance, members collect a certain number of points. Plans are also covering more

preventive services.

Some next−generation CDHP plans substantially increase the scope and the detail of information patients receive, and also refine the incentive structures to try to improve health outcomes. But the big challenge remains: how to create a plan that gives meaningful incentives to spend health care dollars wisely, while ensuring that patients make the right investments in their health.

The process of refining that formula will absorb a huge amount of time, energy and resources in the years ahead. For pharma companies, however, the message is already clear: The shift to consumer−directed health care will dramatically reduce spending on branded drugs over the next five years. Each patient covered by a CDHP spends about 15% less on drugs than those covered by traditional insurance, according to Bain analysis. Generic substitution accounts for about one−quarter of the impact, while lower adherence, reduced by about 1 scrip per person per year out of 10, accounts for the balance.

To make the best of a difficult situation, pharmaceutical firms need to find new ways to help consumers get their money's worth. Three tactics show promise as pharma companies try to cope with the impact of CDHPs.

Patient−Centered Innovation

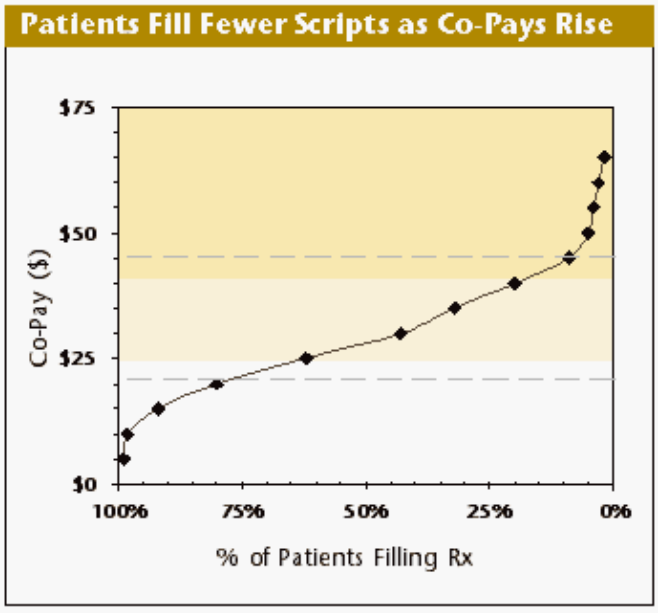
The first tactic is patient−centered innovation—making the needs of patients a focus for innovation rather than concentrating solely on clinical care. As patients enrolled in CDHPs become more involved in making decisions about their treatments, a number of disease areas are ripe for this type of patient−centered innovation. With gastroesophegeal reflux disease (GERD), for instance, the acid−reducing group of proton pump inhibitor medications (PPIs) have proven so effective that most payers and physicians regard GERD as a disease that's been conquered, with few if any unmet needs. But a significant number of patients still suffer from heartburn and acid reflux at night, when they lie down. Those patients may be willing to pay out of pocket for medications that address nocturnal GERD. In diabetes, inhaled insulin holds significant promise for many patients who would prefer to inhale rather than inject themselves, although products such as *Exubera* may still have too cumbersome a device to be convenient. Significant unmet needs also exist in obesity, where current drugs are effective in fewer than 1% of patients.

It's important to note that effective innovation does not have to rely on leading−edge mechanisms of action. **GlaxoSmithKline PLC** , United Health and Health Net collaborated to demonstrate the value of *Advair* over conventional therapies. *(See "Redefining Marketing and Development Innovation: GSK's Success with Advair,"* IN VIVO, *March 2003 [A#2003800059].*) They showed that benefits of increased compliance far outweighed the additional cost. "Though *Advair* is a more expensive product, it helps us to manage the medical spend, which is 90% of the cost," Rob Seidman, WellPoint's chief pharmacy officer, told *IN VIVO* in March 2003.

Pull the pricing lever

Some drugs don't lend themselves to patient−centered innovation and also lack meaningful differentiation from other medicines in the same therapeutic area. For these drugs, the right tactic may well be to pull the pricing lever and lower the cost to payers and patients. Bain analysis shows that 95% of prescriptions are filled in the first tier of formularies, where co−pays typically range from $6−12, compared with 58−95% of prescriptions filled for the second tier, with co−pays of $12−15, and fewer than 62% of prescriptions filled for the third tier, with co−pays of $26−45 *(See Exhibit 2).*

Exhibit 2



SOURCE: Christian Science Monitor (Dec. 2002); Hewitt Assoc.; Goldman Sachs; Bernstein Research (Feb. 2002); HSG; Private 3TCP Research (n=80), 2002

With CDHPs adding to the pressure on pharma companies to discount prices, the issue becomes not whether to discount but *how* to structure discounts most effectively. An important piece of the discounting strategy lies within adherence, through the financial incentives provided by pharma companies to boost adherence.

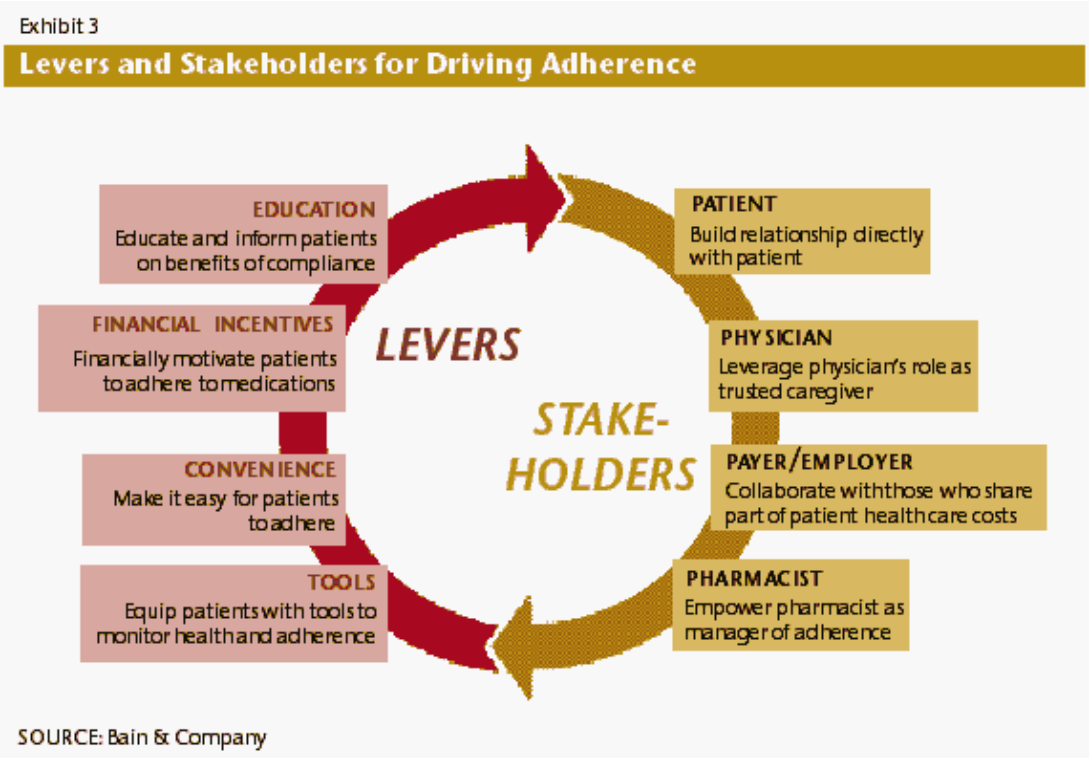
Focus on Adherence and Compliance

Adherence and compliance are not new problems. The World Health Organization estimates that only 50% of individuals in industrialized countries adhere to long−term therapy for chronic conditions. But CDHPs open up some new opportunities for pharmacos to promote adherence. CDHP members are more likely to respond to programs that promote the benefits of following prescription guidelines and explain the hidden costs of non−compliance, given their predisposition to take charge of their own health care.

A renewed focus on adherence and compliance targets the single biggest factor in lost sales: patients who don't take or refill their medicines as prescribed. Bain analysis indicates that a 10% increase in statin adherence results in $80 million in added revenue for every 1 million patients. That creates some options: At an average cost of treatment of $75 a month, for instance, a pharma company could reduce the price of their statin by 10% and still break even thanks to higher adherence.

The key for pharma companies is to move beyond the shotgun approach to adherence, with discrete programs that operate in isolation, and address the issue instead in a more coordinated and holistic way. Specifically, pharmacos can work more closely with MCOs to structure financial incentives for adherence and compliance for appropriate pharmaceutical use. Targeting the right patient cohort and providing discounted prices on refills to CDHP members, for instance, is an effective financial incentive for appropriate use and adherence. Since refills are the most profitable prescriptions, they can also absorb the most significant discounts. Approached this way, a pharma company's investments in adherence become a customer−loyalty strategy that uses discounts. At the same time, pharma firms need to educate and inform, equip patients with tools to monitor their progress, and make adherence easy. And they need to enlist the support of physicians, pharmacists and employers as well as payers to reinforce adherence *(See Exhibit 3)*.

Exhibit 3



Pharma companies are beginning to adopt this type of integrated approach, with encouraging results. The Ten City Challenge, for example, is sponsored by GSK and the American Pharmacists Association Foundation, with the twin goals of improving the health of diabetic patients and reducing employers' health care costs. The program uses financial incentives to encourage adherence: Participating employers in 10 cities across the US waive their workers' co−payments on diabetes prescription medicines.

Partner with MCOs to Put Consumers Front and Center

Education is another primary lever, through specially trained pharmacists who teach patients how to manage their diabetes more effectively, including setting goals, using medications properly and tracking their condition consistently through cholesterol tests, blood pressure, and foot and eye exams. The initiative also reaches beyond patients, convening collaborative care teams, including pharmacists, diabetes educators and physicians in participating communities, to educate them about the program and compensate them for their involvement.

Employers pay between $350−450 per patient for coaching by the pharmacists in the first year, but such costs generally decrease over time. Indeed, participating employers in a similar initiative focused in North Carolina have reported savings of about $900 per patient with diabetes in the first year of the initiative. In addition, employees save an average of $400−600 annually on co−pays.And early results suggest an 11% reduction in diabetes total cost of care.

These types of initiatives—combining the right kind of financial incentives with clear, well−documented information that consumers can understand, and making it easy to participate—will continue to spread. But they are only a first step. The big opportunity to increase adherence is to use the rise in CDHPs to build stronger alliances with third−party payers, with the common objective of seeing that patients take their medicines. Large MCOs remain the most relevant group of potential partners for the time being. With Medicare likely to become half of the total market for drugs, pharma companies should also be watchful of new entrants in the market for prescription drug plans.

This emphasis on building alliances may seem anathema to some pharma executives when the initial promise of rising consumerism in health care was the opportunity to reach consumers directly and adjust the balance of power, which many viewed as tilting in favor of MCOs. But a more coordinated approach to benefit design, with incentives and consumer education jointly developed by pharma companies and MCOs, so that both entities are pulling on the same levers systematically, will certainly yield higher results.

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