Value-based pricing: Hype or hope?

Value-based pricing looks like a win-win-win. Pharma companies can break through budgetary barriers. Payers secure more bang for their buck. Patients get the most appropriate whole-condition treatments. So why is it not commonplace? KPMG's Global Strategy Group has been looking at the obstacles – the opportunity, if they are overcome, is enormous.

Value-based pricing (VBP) of pharma products has the potential to help improve patient outcomes – at an affordable cost. That's a political imperative as global economies continue to struggle with the weight of patient expectations and, in particular, the cost of new treatments.

The beauty of a VBP arrangement is that risk is shared between pharma companies and payers. Meaning both parties should focus on appropriateness of use, rather than on efficacy scores and budgets. This is a shift from maximising sales to delivering patient outcomes.

Healthcare stakeholders are still grappling with what this shift means from a practical perspective and the risk that an unsuccessful VBP program fails all its stakeholders.

For instance, the patient does not have access to critical therapies, the pharma company loses crucial revenue to fund R&D, and the payer sees set-up investment wasted.

What do we mean by value?

"Value" is achieving the highest possible health gains (outcomes) for patients, measured against the total cost of care. The other key component of value is appropriateness, both in choice of product, and of care. Under or over-use of a treatment, or use in inappropriate conditions, can compromise the value.

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The deal-breakers

Functioning VBP programmes need to deliver from the outset measurable outcomes – accurate data on how actual patient results correlate with product use. If this condition is met, we have identified circumstances that would accelerate interest in VBP:

— Efficacy concerns. VBP enables pharma companies to demonstrate efficacy in a real-world setting, negating any concerns over product efficacy.

— Sales volumes. Proper VBP is relatively costly to administer. High revenues create headroom – for both pharma and payer – to spend on measuring efficacy. Starting with common conditions makes pilot schemes feasible ahead of a wider rollout.

The deep dive: barriers in detail

The two main issues are how we define the value of outcomes and how they are measured. Our analysis also showed there are additional legal and regulatory hurdles to overcome.

Positive outcomes are already described in medical literature and quality indicator repositories – such as the National Quality Forum indicators in the US, the NHS Outcome Framework in the UK or the International Consortium for Health Outcomes Measurement (ICHOM).

It is critical for pharma to collaborate with hospitals, doctors and professional societies to set specific parameters for a VBP scheme, as well as define inclusion and exclusion criteria for patients. Longer-term outcome measures (e.g. five-year survival rates) are often less useful when looking to crystallise value as a replacement for raw unit sales as a means of remuneration.

In an ideal situation, the infrastructure to deliver accurate outcome data will already be in place – or there is risk of driving up cost. Clinical registries or patient reported outcomes (PROMs) are already available in many therapeutic areas. Claims data can be useful in measuring or estimating outcomes like mortality, re-admissions or re-operations.

Certain markets are more geared towards providing VBP-applicable data. Italy's national health service Sistema Sanitario Nazionale (SSN), for example, has paid for data collection, making VBP significantly more attractive there.

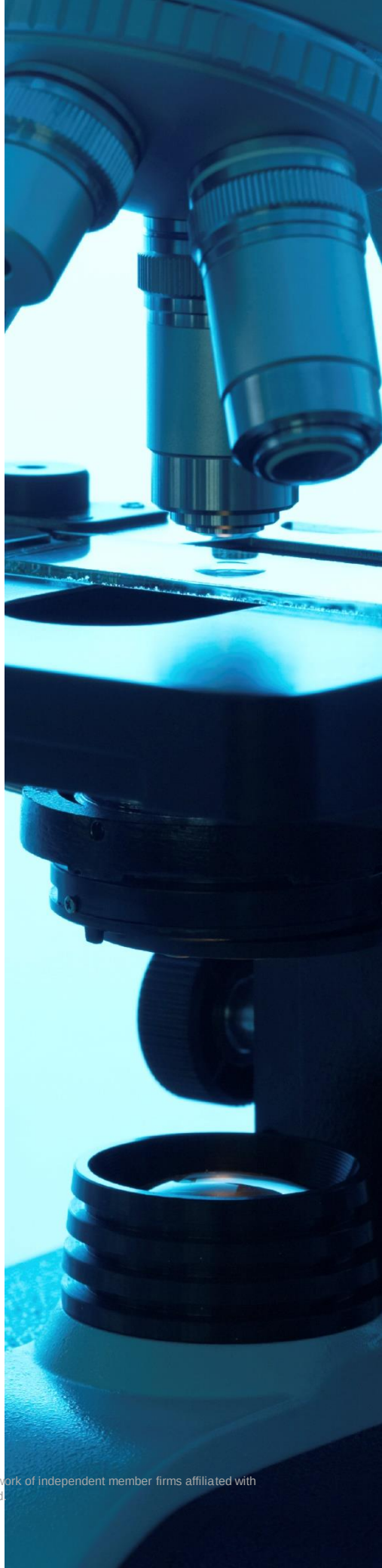
We recommend sticking to one data source with preferably two to three outcomes. This will provide a more robust baseline and simplify ongoing measurement.

Structural and regulatory challenges

Many countries set drug prices centrally to achieve greater buying power. For example in the UK, the NHS caps spending growth on drugs via the Pharmaceutical Price Regulation Scheme (PPRS). While in the US, certain Medicaid provisions make it unattractive for healthcare providers to reduce average drug prices – as might be the case with VBP. This may complicate the route for payers to negotiate separate VBP schemes.

Some health systems prohibit payments outside mandated reimbursement schemes, but there are examples of VBP arrangements that offer some guidance. According to Justin Senior, former Deputy Secretary for Medicaid at the Agency for Health Care Administration in Florida:

"States have been trying strategies like value-based purchasing to bring down their drug costs, but there are barriers to doing so, such as 'best price'



requirements. It becomes very difficult to calculate that when you're in a value-based purchasing arrangement. It's used as an excuse by pharmaceutical companies for getting out of those types of arrangements."

Pharma companies looking for ways around similar hurdles can learn from the recent VBP agreements in the US for a new class of cholesterol lowering drugs (PCSK9 inhibitors). The contracts (between Cigna; and Amgen and Sanofi/Regeneron) modify the cost of the Repatha and Praluent based on how well customers respond to them.

KPMG playbook: three tips for successful VBP

1. Keep it simple: VBP can be highly complex, so an emphasis on simplicity should help all parties more accurately measure the effectiveness of this approach.
2. Focus on appropriateness of care: choose the right drugs for the right patients at the right time to give a better chance of positive outcomes.
3. Keep transaction costs at reasonable levels. Both pharma companies and payers may have to invest significantly in VBP, so robust cost management can help deliver affordable treatment.

VBP in practice

Entresto is an innovative drug for treating chronic heart failure that was launched in the EU and US in 2015. A clinical trial showed a 21% reduction in heart failure hospitalisations.

In February 2016, Novartis signed VBP agreements with US-based health insurers Cigna and Aetna. Cigna's payments to Novartis depend on a reduction in the proportion of customers admitted to hospital for heart failure; Aetna's are based on the rate of deaths related to heart failure.

Novartis faced the following challenges:

- Developing metrics for 'reduced hospitalisation'. "One of the hardest things we had to do with Entresto was to agree with the FDA on the endpoints of the trial," said Novartis CEO Joe Jimenez. "How are we physically going to measure things like reduced hospitalisation? There was a lot of back and forth".
- Tracking and measuring outcomes – hindered by a lack of electronic medical records. Novartis planned to bundle Entresto with a remote monitoring device to help physicians trace early signs of deterioration, but the technology is still in its infancy. (Cigna tracks outcomes using claims data.)
- Cardiologists' reluctance to prescribe Entresto – in favour of effective, generic drugs.

Novartis is targeting annual sales of US$5 billion from 2022 to 2025, up from US$21 million in 2015. Getting VBP right is a crucial factor in this growth.

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