

Critical Issues for Pharmaceutical Executives Creating Performance-Based Contracts You Won't Regret

An article in the April 2008 issue of Pharmaceutical Executive describing innovative pricing tactics for pharmaceuticals¹ led to many interesting discussions about ways to improve payer contracting. But one option—performance-based pricing—seemed too risky for most companies to consider offering proactively. While Johnson & Johnson had already forged a precedent in 2007 by agreeing to refund the cost of Velcade, a chemotherapy drug, if a patient treated in the UK's National Institute of Health (NIH) failed to benefit adequately, that offer was made reactively to overcome a ruling that the drug was not cost-effective.²

Only a few companies “jumped the chasm” to make pay-for-performance a part of their value proposition. Positive publicity, favored formulary access to drugs, and good pricing associated with these deals is prompting pharmaceutical marketing and access teams to reconsider how they too might use more innovative contracting options, including performance-based rebates and guarantees, to win more sales without deep discounts. The right performance-based contract structure can overcome some barriers to quick and unencumbered access at a lower life-time cost to the manufacturer. But a mismatch between the barrier and the contract structure can expose a company to unnecessary risks. Before offering a performance-based contract, one should understand the payer access barrier one is trying to overcome, and then define contract parameters that mitigate the associated risks.

Performance-based contracting can drive more sales

There are three contracting challenges for which some form of performance-based pricing is potentially a cost-effective way to drive better market access and improve sales.

Challenge No. 1: Unproven “real-world” effectiveness.

Innovative new therapies often win approval based on their ability to show, under “controlled” conditions, improvement on some “marker” of a progressive disease state. Payers often try to delay paying for such therapies, or limit their availability, until they have more evidence that trial-based therapeutic claims will convert into clinical and economic benefits when used in real-world patient populations.



The right performance-based contract structure can overcome some barriers to quick and unencumbered access at a lower lifetime cost to the manufacturer.

Response: A performance-based rebate—such as the agreement with the UK's National Institute for Health and Care Excellence (NICE) to reimburse the cost of Velcade for cancer patients who do not show adequate improvement—or a performance-based penalty—takes away that risk and reason to delay access. For the drug company, a performance-based rebate can enable quicker adoption at a price premium. At worst, the company will have to rebate back the premium price if performance falls short, but it will still have benefited from additional sales volume at the net-of-rebate price. At best, the drug delivers the expected differential benefits and the higher price is sustained.

Challenge No. 2: Unsubstantiated economic benefits.

Although a drug's clinical benefits may be well documented, the corresponding economic benefits often are not. If a drug is twice as effective in halting a serious migraine headache, will patients given it make half as many emergency room visits? If true, the added value created may be huge for payers as well as patients, justifying a large premium. Payers, however, are likely to argue that other factors in addition to the drug affect emergency room visits. Even if the company has a study showing savings with one group, some payers may justifiably argue that their populations are different.

Response: A simple way to get past these arguments is to reimburse a price premium if cost reductions elsewhere in the system do not occur as expected.

As payers encourage clinicians to practice evidence-based medicine, performance-based pricing becomes an attractive option to meet demands for cost-effectiveness.

Challenge No. 3: Performance differences across patients and indications.

Clinical trials are designed to demonstrate performance for the most promising indications using subjects with the least confounding factors, such as other diseases or problems with patient compliance. Once approved, however, a drug is often used for treating disease states and patient populations for whom outcomes are unlikely to be as impressive. For expensive drugs, a payer may therefore impose a “step edit” or “prior authorization” requirement. Even patients themselves sometimes decline to try expensive treatments involving a high co-payment and an uncertain chance of success.

Response: A patient-specific, performance-based guarantee, entitling both the payer and co-paying patient to a full refund if the drug fails to deliver a pre-defined benefit, can overcome this reluctance. Although the contribution per unit of the drug will, after rebates, be less for patient segments with lower success rates, the incremental volume can still generate substantial incremental contribution. When the types of patients for whom success is less likely can be identified in advance, an automatic rebate can be built into a contract. Monitor Deloitte helped one client avoid step-edits in payer contracts by including a quarterly 20 percent rebate on scripts for patients less likely to benefit from the drug’s most differentiating claim.

Additional Risks Should be Mitigated

As more payers encourage clinicians to practice evidence-based medicine, performance-based pricing becomes an increasingly attractive option to meet demands for cost-effectiveness. But there are well documented risks to performance-based pricing that other industries have already discovered the hard way.

One of those risks is very familiar to the insurance industry: adverse selection. Clinicians are more likely to try a therapy that comes with a guarantee, and payers are more likely to pay for it, even on patients for whom the drug has a low chance of success. If the drug has a low variable cost of manufacture, the contribution generated by higher volumes of use may be more than enough to pay for more refunds and rebates. But drugs that have a high variable cost of manufacture, like some vaccines and biologics, could end up losing money, net of rebates, on the incremental volume that a guarantee would generate.

Another risk involves disagreements about performance tracking and measurement. Pfizer was a pioneer when it struck a performance-based contract with Florida Medicaid in 2001, promising to save the state at least \$37.5 million through more aggressive use of Pfizer’s drugs. Pfizer calculated that the program easily beat its goal more than a year in advance, but disagreements over how much of the savings resulted from the program led to years of acrimony and the ultimate discontinuation of the relationship. One solution, used in other industries such as consulting services and hedge funds, is to agree in advance on external benchmarks against which to measure performance or upon easily measurable proxies for performance. Defining verifiable performance measures in advance, that are related to economic outcomes, is part of the art of performance-based contracting.

For pharmaceutical executives, the need for prices that cover the rising cost of drug development is colliding with payers’ need to spend health care budgets more cost-effectively. A viable resolution to this dilemma is to align prices more closely with value, enabling innovative drugs to gain more market share sooner at prices commensurate with their promised benefits. Both payers and branded pharmaceutical companies are recognizing that pay-for-performance is sometimes the best way for both to achieve their goals.

¹ Nagle, Thomas, “Money-back Guarantee...and other ways you never thought to sell your drugs,” *Pharmaceutical Executive* April 2008.

² Whalen, Jeanne, “Europe’s Drug Insurers Try Pay-for-Performance”, *The Wall Street Journal* October 12, 2007. <http://online.wsj.com/news/articles/SB119214458748556634>

To learn more about Life Sciences at Deloitte, please visit:

www.deloitte.com/us/lifesciences.

For more information, contact:

Cameron C. McClearn
Principal, Monitor Deloitte
Deloitte Consulting LLP
cmcclearn@deloitte.com

About Deloitte

This publication contains general information only, and none of the member firms of Deloitte Touche Tohmatsu Limited, its member firms, or their related entities (collective, the “Deloitte Network”) is, by means of this publication, rendering professional advice or services. Before making any decision or taking any action that may affect your business, you should consult a qualified professional adviser. No entity in the Deloitte Network shall be responsible for any loss whatsoever sustained by any person who relies on this publication.

As used in this document, “Monitor Deloitte” means the Strategy practice of Deloitte Consulting LLP, a subsidiary of Deloitte LLP. Please see www.deloitte.com/us/about for a detailed description of the legal structure of Deloitte LLP and its subsidiaries. Certain services may not be available to attest clients under the rules and regulations of public accounting.

Copyright © 2014 Deloitte Development LLC. All rights reserved.

Member of Deloitte Touche Tohmatsu Limited