Launching into value:
Pharma’s quest to align drug prices with outcomes
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The heart of the matter

With intense pressure on drug prices, the pharmaceutical industry is turning to value-based contracts—which link the price of a prescription drug to its clinical or economic performance—to ease the tension. But insurer usage of these new drug pricing models remains limited despite an active minority of enthusiastic participants. Manufacturers that want to increase usage of these payment models may need a higher tolerance for financial risk, regulatory change, and the willingness and flexibility to collaborate closely with payers and providers.

For years biopharmaceutical companies have responded to criticism over drug prices with assertions about the innovation costs and the value new drugs bring to patients. The highly segmented US healthcare system, drugmakers argue, doesn’t adequately measure the downstream financial savings of drug therapy, or the clinical benefits to patients over time. The US drug payment system “needs to evolve to better recognize and reward value,” wrote Stephen Ubl, CEO of the Pharmaceutical Research and Manufacturers of America (PhRMA) on Forbes.com in June. He added that not all patients benefit equally from taking a specific drug. “We need to make sure our payment system for medicines reflects these differences,” he wrote.1

Value-based contracts are designed to tie prices to how a drug performs in the “real world,” as opposed to price based on data and evidence collected during the highly controlled clinical trial process. By collaborating with health insurers, providers and pharmacy benefits managers (PBMs), pharmaceutical companies can prove that a drug delivers a desired outcome in a specific patient population.2 But value-based contracts can also can reveal when a drug fails to produce an expected clinical or financial outcome, which can trigger a price reduction or refund. Value-based contracts can expand patient access to new therapies, which benefits manufacturers, and limit payers’ financial risk by guaranteeing a clinical or financial result, which benefits insurers.

An estimated 40 to 45 new medicines—representing new active substances or molecular entities—are expected to receive FDA approval for launch in 2017, with another 40 to 45 launching each year through 2021.3 Many of those drugs will feature new mechanisms of action or target rare diseases, and likely will launch with prices reflecting their novel characteristics and benefits. With pricing pressure coming from every direction, biopharmaceutical companies need pricing strategies and value-based approaches that work for different stakeholders and different value determinations.

Experimentation with new payment models in the US may also inform new commercialization approaches in global markets. PwC’s Health Research Institute (HRI) conducted surveys of 101 pharmaceutical executives and 100 health insurance executives, analyzed current and historical value-based contracts, and interviewed senior-level pharmaceutical, health insurer, and PBM executives to understand the strategic importance of value-based contracts for new drugs, how prevalent they are likely to become, and what challenges and opportunities exist. Despite public enthusiasm from many drugmakers, policymakers, insurers and other stakeholders, HRI’s findings suggest that value-based contracting remains limited in practice. Survey responses and industry interviews reveal that:

- Participation in value-based contracts of any kind is limited. Only a quarter of the pharmaceutical executives surveyed have participated in a value-based contract. Among those who have participated in value-based contracts, however, 80 percent describe the contracts as successful.
• **Pharmaceutical executives aren’t convinced that value-based contracts are worth the effort.** Just 38 percent of those surveyed believe that the potential rewards of a successful value-based contract are commensurate with the risks. But executives acknowledge the need for new drug pricing reform and payment models.

• **Most pharmaceutical executives believe value-based contracts are a win/win opportunity, in concept.** A majority (71 percent) of pharmaceutical executives surveyed agree that value-based contracts could improve patient outcomes and reward manufacturers for bringing innovative and effective products to market.

• **Support for value-based contracts among health insurers and PBMs varies.** All five of the largest US health insurers by market value have participated in at least one value-based contract, according to HRI survey data. Many insurers and health systems, such as Harvard Pilgrim Health Care and Advocate Health Care, and pharmacy benefits managers such as Express Scripts and Optum Rx, have entered into multiple value-based contracts. Other insurer and PBM executives, however, remain skeptical of such agreements. Most PBMs are not involved with an insurance plan’s medical benefits, which makes it difficult to assess a drug’s full impact on a patient population.

• **Value-based contracts may improve access in competitive therapeutic areas.** Value-based contracts may offer an alternative to traditional rebate practices and other drug utilization management tools that health insurers use. Linking unique product attributes to cost savings or improved patient outcomes—and testing those attributes against real world patients taking a competing product—may lead to better formulary placement and broader access.

• **Data sharing challenges and regulatory barriers remain, but neither are insurmountable.** Cloud-based technologies and third parties are improving clinical and financial data capture and analysis between partners. Regulatory agencies including the Centers for Medicare and Medicaid Services (CMS) and the US Department of Health and Human Services Office of Inspector General (HHS OIG) are considering new policies that would reduce the risks associated with value-based contracts.

• **Patient perspectives are still largely absent from drug pricing decisions.** Nearly half of the pharmaceutical executives surveyed agree that patient groups should be more involved in the FDA drug review and approval process, but only 25 percent say their company involves patients or patient advocacy groups in the drug price-setting process. Another 27 percent say they don’t involve patients now, but plan to in the future.

A number of factors complicate value-based contracts, and they may not be feasible in therapeutic areas that lack a clear, measurable outcome. Trust levels between stakeholders, differing degrees of technical and organizational capability among potential partners, lingering regulatory issues, disagreement over drug performance metrics, and the lack of a universal model for value-based contracting all inhibit such contracts’ proliferation in the market. Those challenges should not, however, automatically rule out their consideration. New examples outlined in this report demonstrate how certain products, combined with the right partners and the right patient population, can lead to successful clinical and financial outcomes. In some situations value-based contracts can improve insurance coverage and access to new prescription drugs, and deliver value as defined by customers such as insurers, PBMs and patients.
The vast majority of drugs continue to be sold on a price-per-dose basis, and only a handful of pharmaceutical and life sciences companies have established value-based contracts for their products. But those organizations that have participated in such a contract—healthcare’s activist minority—are having an outsized influence on trade industry messaging and new policy proposals (see Figure 1).

Value-based contracts can be tied to patient clinical outcomes, economic outcomes or both. Examples of clinical outcomes include virus eradication in hepatitis C, controlled Hba1c levels in diabetes, lowered LDL cholesterol rates in cardiology and survival rates and tumor size in oncology. Economic outcomes may include preventing costs associated with hospitalization or other medical interventions; limiting the use of additional medications; meeting a clinical endpoint at a lower cost than a competing product; or other financial outcomes.

Many value-based contracts are not announced publically, which makes it difficult to comprehensively measure participation. Drugmakers may withhold contractual details about drug prices, discounts or rebate schemes because those details may vary among customer groups. Other companies, such as Amgen, Sanofi,

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<tr>
<th>Does your organization currently use value-based drug contracts of any kind?</th>
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<tr>
<td>Yes</td>
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<th>If yes, when did your organization begin using value-based contracts?</th>
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<th>If yes, how many value-based contracts has your organization participated in?</th>
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Source: PwC Health Research Institute pharmaceutical executive survey, 2017
How successful have your value-based drug contracts been?

- Very successful 32%
- Somewhat successful 48%
- Not very successful 8%
- Do not know 12%

Will you seek to renew current value-based contracts or sign new ones, based on your past experiences?

- Very likely 50%
- Somewhat likely 36%
- Do not know 8%

Source: PwC Health Research Institute pharmaceutical executive survey, 2017

Eli Lilly, Novartis and Merck, have announced general details about value-based contracts, or their partners, such as Cigna, Aetna, Humana, Harvard Pilgrim, Express Scripts or OptumRx, have announced agreement outlines.

In the announcements, participating organizations speak to the benefits of value-based contracts. “When pharmaceutical companies stand behind the performance of their drugs through these kinds of contracts, we can deliver the most value to Cigna’s customers and clients for the money they are spending,” said Christopher Bradbury, senior vice president, integrated clinical and specialty drug solutions for Cigna Pharmacy Management, in a statement representative of such announcements.7

Other executives tend to be more doubtful. A value-based drug contract can make for a great press release, but it’s unclear whether such contracts can actually deliver additional value, said Mona Chitre, chief pharmacy officer and vice president of clinical operations and health innovation at Excellus BlueCross BlueShield, a New York-based nonprofit insurer covering 1.5 million people. “Pharmaceutical companies are facing intense pressure over drug prices, and are looking for new ways to demonstrate product value,” she told HRI. “It’s too soon to tell whether value-based drug contracts can actually deliver additional value.” Michael Ryan, senior vice president of US value, access and policy at Bristol-Myers Squibb (BMS), said his organization doesn’t advertise its value-based contracts. “I’m a major advocate of not doing value-based contracts just to say you’ve done it,” Ryan told HRI. “You do it because there’s an absolute need to do it.”

The 101 pharmaceutical executives surveyed by HRI come from 97 companies. Executives from 24 companies reported participating in at least one value-based contract;
executives from 73 companies had not participated in any value-based contracts. Of the executives from the 24 companies that had participated, seven report participating in more than 20 value-based contracts.

HRI’s surveys of other healthcare executives show that value-based contracts are widely distributed across insurers, integrated health systems and pharmacy benefits managers, including all of the five largest health insurers by market value. Eighty-percent of pharmaceutical executive respondents that have participated in value-based contracts say they were somewhat or very successful, and 92 percent said they are somewhat or very likely to renew current value-based contracts, based on past experience (see Figure 2). This relatively small but active minority of biopharmaceutical industry executives has counterparts in the health insurance, integrated health system and pharmacy benefits manager sectors. Dr. Michael Sherman, chief medical officer and senior vice president at Harvard Pilgrim Health Care, told attendees at the 2017 BIO International Convention in San Diego (a biopharmaceutical trade organization meeting) that his organization is involved in 11 value-based contracts.

Value-based contracts make sense for Harvard Pilgrim Health Care, for three main reasons, Sherman said. First, a majority of their physicians assume risk for their patient populations; second, data sharing and infrastructure costs are no longer expensive; and third, the industry has run out of cost-shifting options, leaving many patients with large out-of-pocket costs for new therapies. For Harvard Pilgrim Health Care, a Massachusetts-based health plan, value-based contracts help mitigate financial risks associated with a patient’s total cost of care. Rebates or refunds issued by drugmakers when a product doesn’t work as expected saves the health system money and offers relief to patients paying for drugs out-of-pocket.8

HRI’s survey of pharmaceutical executives found that value-based contracts span more than 15 therapeutic areas, although most of the contracts are concentrated in high cost, increasingly competitive therapeutic areas (see Figure 3).
New value-based contracts can be formed at different points in a drug’s lifecycle, but contracts are most often (34 percent) formed during the pre-commercial period, before a new drug launch. This activity is focused on ensuring that patients have access to new, unproven medications while limiting insurer’s or provider’s financial risk. Twenty-eight percent of respondents reported forming value-based contracts at the time of launch, after FDA regulatory approval, and 18 percent said value-based contracts are most often formed later in a product’s lifecycle, at least one year after launch (see Figure 4).

Survey results reflect different approaches to value-based contracts based on differences in product portfolio, target patient populations, risk tolerance and organizational capability. Although some organizations are expanding the use of value-based contracts, pharmaceutical executives don’t believe that most of their customers are adequately prepared to participant in such contracts (see Figure 5).
Why participate in a value-based contract?  
A big pharma perspective.

While preparing for the launch of a new cancer drug, one large pharmaceutical company faced a commercial environment dominated by a competing product, which was already being prescribed to a large portion of the new drug’s target patient population. In an effort to help convince insurers to cover the new drug, and to make it more accessible to patients, the company leveraged product insights collected during the clinical trial process, and used those insights as the foundation for creating new value-based contracts with health insurers.

During the clinical development of a new oncology drug, trial investigators noticed something interesting: the amount of active drug given to patients over a full course of therapy could be reduced over time, without compromising the drug’s efficacy. The results of that clinical finding could potentially lead to savings compared with a competing oncology drug, if the result held true with patients in the “real world,” or beyond the controlled clinical trial environment, according to an HRI pharmaceutical executive interview. By setting the new drug’s wholesale acquisition cost, or list price, at a slight discount to the competitor product, the company went out into the market with a clear value story to tell.

Some of the insurers approached by the pharma company thought the clinical result was interesting, but weren’t convinced that that the same dosage reduction observed in clinical trials would mirror real world patient outcomes. As a result, the pharmaceutical company offered to guarantee the dosage reduction and related savings; if the reduction and savings didn’t occur, the drugmaker would make incremental payments to the insurer, as part of the contract. For providers and health plans, guaranteeing the financial savings associated with a reduction in dosage helped bring pen to paper on at least one new value-based contract, and generated new interest from other insurers, the executive said.

Many pharmaceutical companies are beefing up their drug package inserts and written studies to include clinical trial data beyond safety and efficacy, to better elucidate health economic outcomes to customers. Although partnering with different organizations and customer segments remains challenging – and varies substantially from one organization to the next – the health insurance industry has made remarkable progress in terms of its ability to collect, aggregate and report medical and pharmacy data, according to several HRI interviews with pharmaceutical executives. Making it easier for companies to use real world evidence, and to contract with insurers and health systems on the basis of established clinical guidelines or surrogate outcomes not contained in a drug’s package insert, may lead to more value-based contracts for pharmaceutical drugs, executives said.
Collaborating to overcome regulatory and data-sharing challenges

An essential element of value-based contracts is the ability to capture and analyze a drug's clinical or economic impact on a patient population. But agreement on a clinical endpoint or financial metric for drug assessment can be challenging. Other challenges include regulatory risks associated with calculations that CMS uses to set prices and pay rebates to government health plans, and making sure not to run afoul of the Office of Inspector General's anti-kickback statute, surveyed pharmaceutical executives said (see Figure 6). Medicaid’s requirement that manufacturers offer a price equal to the best available commercial discount price also creates a barrier to wider adoption of value-based contracts.

And sharing and verifying data between stakeholders can be difficult. But the available tools are improving, and the costs are going down, executives told HRI.

Figure 6: Government pricing concerns, privacy issues and anti-kickback laws are among the top value-based contract regulatory barriers

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<th>Concern</th>
<th>Score</th>
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<tr>
<td>Anti trust laws</td>
<td>10</td>
</tr>
<tr>
<td>Product “best price” concerns</td>
<td>25</td>
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<tr>
<td>Communicating off-label information about drugs</td>
<td>15</td>
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<tr>
<td>Other legal or regulatory issues</td>
<td>20</td>
</tr>
<tr>
<td>Do not know</td>
<td>5</td>
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Source: PwC Health Research Institute pharmaceutical executive survey, 2017
Nearly a third of the pharmaceutical executives surveyed by HRI said that forging an agreement between partners on the metrics used to evaluate drug performance and patient outcomes in value-based contracts is the most significant operational hurdle (see Figure 7). Once that agreement is formed, data must be shared between organizations to adjudicate the findings.

Most pharmaceutical executives (71 percent) believe their companies would benefit from data-sharing partnerships with insurers. But insurance executives were less certain about the benefits of data-sharing partnerships with pharmaceutical companies, HRI survey results found (see Figure 8).

In July, America’s Health Insurance Plans (AHIP), a national health insurance trade association representing over 180 health plans, asked the FDA to work with CMS to expand outcomes-based payments for drugs in federal health plans such as Medicare. AHIP asked Congress in June to address existing regulatory requirements “that may inhibit the development of pay-for-indication and other value-based strategies in public programs.”

New guidance documents from FDA and CMS, and the passage of the 21st Century Cures Act in December 2016, make it easier for drugmakers to communicate the economic benefits associated with new drugs. But communicating off-label clinical information about a drug is a less flexible process, requiring “substantial context and an evidentiary basis as well as details on any adverse reactions,” said Jeffrey Handwerker, a partner at Arnold & Porter Kaye Scholer who leads the law firm’s government pricing practice and has worked on value-based contracts for biopharmaceutical clients.
It also can be difficult to contract around a clinical outcome if there is no clear biomarker or objective assessment metric to describe a given patient’s health outcome. Measuring a patient’s cholesterol levels, for example, is easier than measuring how much a patient’s pain has been reduced.

A drug’s label or package insert determines which kinds of value-based contracts are the most feasible, Handwerker said. From a regulatory perspective, contracting on an economic outcome may be simpler than contracting on a clinical endpoint, unless that end point is part of the drug label. A contract that aims to show a reduction in hospitalizations within a patient group, for example, may be more difficult to execute than a contract that aims to reduce the cost of hospitalizations in the same population. “The level of substantiation the FDA requires is lower for economic endpoints compared to clinical endpoints,” Handwerker said.

Still, new data-sharing models and using real-world evidence to examine clinical outcomes are expanding across the industry. In May 2017, Merck and Optum, a division of UnitedHealth Group, announced they were forming a joint “learning laboratory” to explore the potential for value-based contracts between insurers, PBMs and pharmaceutical companies. The multi-year collaboration will use real world data to co-develop and test advanced predictive models and co-
design outcomes-based risk sharing agreements to reduce clinical and financial uncertainty over payment for prescription drugs, according to a statement.¹⁴

Third parties also are contributing to the formation of new value-based contracts. Tapping into a cloud-based system is much simpler, less expensive, and more production-oriented than working to negotiate data transfers between third party health economics research companies, said BMS’ Michael Ryan. If drugmakers aren’t careful, they can end up “spending more than the value of a contract just analyzing the data,” he said.

For PBMs, value-based contracts are complicated by the fact that many aren’t involved with the medical benefits side of insurance plans. That makes it challenging to understand a drug’s full impact and whether a drug prevented additional costs associated with medical interventions. “It’s really difficult for a pure play PBM. They have to really set themselves up to be able to receive and understand everything that goes into the medical plan,” said Scott Wert, vice president, trade relations, at Envolve Pharmacy Solutions, a pharmacy benefits manager and specialty pharmacy. “It’s not an easy thing to do.”

Envolve Pharmacy Solutions is a division of Centene Corp., a health insurer based in Orlando, Fla., that covers over 12 million members in 28 states. John Sivori, president and chief operating officer, said the company is participating in three to four value-based contracts, including contracts for cardiovascular drugs. Other contracts—with Boehringer Ingelheim and Eli Lilly and Co. for Jardiance, a Type 2 diabetes drug, and Novartis’s Entresto—are being considered, Wert told HRI. Envolve’s value-based contracts have been mostly based on measurable outcomes in cardiology, he said. “We have not looked at neurological disorders or pain management, but it’s coming.”

Several large PBMs have started asking for indication-specific pricing for drugs that treat more than one disease.¹⁵ Indication-specific pricing, which puts a different price on the same drug according to the disease it’s prescribed to treat, has been the subject of much industry discussion.¹⁶¹⁷

HRI survey data found that only 10 percent of pharmaceutical executives surveyed said their organizations had participated in an indication-specific drug pricing contract. The degree to which a PBM can participate in a value-based contract remains largely determined by its incentive structure and the extent to which a patient’s overall health—as captured in pharmacy claims data and medical services—is factored into a drug’s performance.

“It’s really difficult for a pure play PBM, they have to really set themselves up to be able to receive and understand everything that goes into the medical plan.”

Scott Wert, vice president, Envolve Pharmacy Solutions
The Trump administration’s potential impacts on value-based contracts and drug pricing

At the 2017 BIO International Convention, Dr. Michael Sherman of Harvard Pilgrim said he has met with HHS Secretary Tom Price, and CMS Administrator Seema Verma about regulatory challenges that limit the use of value-based contracts. Price and Verma agreed to address the problem, Sherman told conference attendees. “I think they get it,” he said.

Pharmaceutical executives are unsure how the Trump administration will impact value-based contracts and drug pricing. HRI survey results show that 31 percent of pharmaceutical executives believe the Trump administration will accelerate the shift from volume-based payments to value-based payments, and 45 percent believe the Trump administration is likely to accelerate downward pressure on drug prices.

The pharmaceutical and life sciences industry recognizes the need for drug pricing reform and new payment models for innovative, but expensive, products. Several large drugmakers have taken steps to restrain drug price increases on an annual basis, or make their pricing decisions more transparent. But less than a quarter of pharmaceutical executives plan to impose new limits on their own drug prices next year, even if they believe that the industry should act to reduce drug prices (see Figure 9).

**Figure 9: Pharmaceutical executives recognize a need to control the growth of drug prices, but less than a quarter plan to limit price growth next year**

Is your organization considering limiting the growth of drug price during the next fiscal year?

- **Yes** 23%
- **No** 53%
- **Do not know** 24%

Do you think the industry should consider limiting the growth of drug prices during the next fiscal year?

- **Yes** 44%
- **No** 44%
- **Do not know** 12%

Source: PwC Health Research Institute pharmaceutical executive survey, 2017
A majority of the pharmaceutical executives surveyed do believe, however, that new price restrictions will be instituted at the state or federal level (see Figure 10).

The pipeline for new biopharmaceutical drugs is strong, and many companies will launch novel—and expensive—products targeting a broad range of diseases in the coming years. New competition will likely emerge in key therapeutic areas, such as oncology, cardiology, autoimmune disorders and neurological diseases, demanding new approaches to market access and insurance benefit design. Alternative payment models such as value-based contracts, which require closer collaboration between drugmakers and their customers, may help to clarify a given product’s unique value and put that value to the test among relevant patient populations. But for most drugmakers and products, value-based contracts haven’t definitively proven their value as a commercial strategy for innovative new medicines.

Figure 10: Over half of surveyed executives think new federal or state drug pricing laws are likely to be enacted

- Very likely 10%
- Somewhat likely 44%
- Somewhat unlikely 25%
- Very unlikely 11%
- Do not know 10%

Source: PwC Health Research Institute pharmaceutical executive survey, 2017
What this means for your business

**Pharmaceutical and life sciences**

- **Consider the benefits and risks of additional studies.** Committing additional resources to clinical development programs or post-market data collection can show how one drug differs from another, even for drugs in the same therapeutic class or with a similar mechanism of action. Capturing data beyond the strict safety and efficacy requirements needed for regulatory approval—such as comparative and cost effectiveness studies tested against competing products, patient-reported outcome studies, or other quality of life measures—may translate into a more robust package insert, drug label and commercial strategy. Drugmakers should analyze and understand the gaps or unmet needs associated with a current standard of care in relevant therapeutic categories. That assessment may help predict the potential return on additional studies conducted before or after a drug launch.

- **Design high performance value-based contracts.** Some insurers believe that pharmaceutical companies pushing value-based contracts are simply looking for ways to skirt drug utilization management tools, such as formulary exclusions and prior authorization, or sidestep traditional rebate and discount negotiations. Contracts that include meaningful risks, such as money-back guarantees tied to health outcomes or tangible savings desired by an insurance company, health system or PBM, can build trust between partners. Insurers are not likely to offer a premium price for a product based on an additional outcome they believe is a foregone conclusion, especially if they can choose a competing product with a proven track record and predictable cost structure.

- **Overcome data sharing challenges.** Value-based contracting models, by necessity, differ according to a product’s attributes and the customer’s needs. Drugmakers should understand the data capture and analysis capabilities needed to execute a value-based contract, and look for partners that are equipped to reliably assess a drug’s performance in the targeted patient population. A third-party intermediary may help to reduce both parties’ administrative burden and provide technologies useful in executing value-based contracts, such as cloud-based platforms, pharmacy and medical data repositories and analytical tools.

- **Advocate for regulatory reform.** PhRMA and other drug industry groups have requested policy changes from regulators including the HHS Office of the Inspector General, CMS and FDA on clarifying anti-kickback safe harbors, rewriting or creating exemptions to the Medicare average sales price and Medicaid best price reporting rules, and communicating off-label information, respectively. Understanding current regulatory risk areas allows partners to design contracts that avoid legal gray areas and may help identify policies that need reform. Trump administration leadership appointees at HHS, CMS and the FDA—all of whom have experience working in private sector healthcare—have spoken positively about value in healthcare. These officials may represent a sympathetic ear and a new opportunity for policies that protect or expand the use of value-based contracts.

- **Demand that patients share the benefits, if not the risks, of value-based contracts.** If insurers or PBMs receive money back due to patient nonresponses or noncompliance to therapy, a proportional share of those dollars should go to the patients who paid out-of-pocket for the drug. Press releases announcing value-based contracts aren’t likely to improve the public perception of drug pricing practices unless patients are in on the savings. Drugmakers should work with their partners to understand what counts as additional value to their patients, particularly if patients are being asked to pay a premium for it.
**Insurers, integrated health systems and PBMs**

- **Bring specific needs to the negotiating table.** Making determinations about which outcomes and assessment metrics are needed most for a particular drug class or patient population before engaging with drugmakers may improve the financial, clinical or quality upside in a value-based contract. Communicating covered members' specific needs, or the desired financial savings associated with a drug, may improve both partners' likelihood of success. Unique patient populations covered by specific insurers or health systems may help incentivize drugmaker participation.

- **Understand the resource commitment.** Collecting, aggregating and analyzing a drug's impact on patients requires specialized skills and infrastructure. If those capabilities don't exist, or need improvement, that cost should be included in the contract negotiation process. Integrated health systems may be best positioned to influence prescribing practices among providers, assess patient health outcomes and estimate financial impacts that span drug and medical benefits. PBMs wishing to form indication-specific contracts, for example, would need to access data that identifies which disease an individual prescription is targeting for each patient.

- **Work proactively with third party value assessment groups.** Third-party drug value assessment groups, such as the Institute for Clinical and Economic Review (ICER) and the National Comprehensive Cancer Network (NCCN) may help insurers, health systems and PBMs compare competing products or recognize new products' specific advantages or disadvantages. In oncology, NCCN guidelines may also help establish acceptable surrogate health outcomes so that value-based contract partners can assess a cancer drug’s performance over shorter periods of time. ICER has begun to review drug value associated with novel payment contracts, such as indication-specific pricing, which may help PBMs and other groups make decisions about entering new payment contracts.

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**Collecting, aggregating and analyzing a drug’s impact on patients requires specialized skills and infrastructure. If those capabilities don’t exist, or need improvement, that cost should be included in the contract negotiation process.**
Endnotes


Acknowledgments

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About this research

In May and June of 2017, PwC’s Health Research Institute (HRI) commissioned a telephone survey of 101 biopharmaceutical executives – ranging from director-level to C-suite – working at public and privately-held biopharmaceutical organizations. Executives represented biopharmaceutical organizations of varying sizes and annual revenues. Respondents were asked about their participation in and experience with value-based contracts; regulatory and data sharing challenges related to value-based contracts; organizational capabilities, and overall thoughts about drug pricing trends and the potential for policy changes under the Trump administration. In addition, HRI conducted phone interviews with biopharmaceutical executives, health insurance executives, pharmacy benefits manager executives, and other subject matter experts based in the United States.

This report is also based on insights from an HRI telephone survey of 101 insurance executives conducted in late November 2016 through January 2017, which included executives from commercial insurers, Medicaid managed care insurers, Medicare Advantage insurers, provider-owned health insurers, third party administrators, and consumer operated and oriented plans.

About PwC’s Health Research Institute

PwC’s Health Research Institute (HRI) provides new intelligence, perspectives and analysis on trends affecting all health-related industries. The Health Research Institute helps executive decision-makers navigate change through primary research and collaborative exchange. Our views are shaped by a network of professionals with executive and day-to-day experience in the health industry. HRI research is independent and not sponsored by businesses, government or other institutions.

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