(Re)Defining Value in Rare Disease Through Clinical and Commercial Insight
Innovation in Drug Development and Marketing Can Address Payer Concerns About the Cost of Rare Disease Treatments

With unprecedented candor, health insurers are questioning how drugs for rare diseases are defined, regulated and priced in the U.S. market. Their concerns, echoed in the media, the halls of government and other public forums, have profound implications for biopharmaceutical companies developing and marketing new medicines.

Yet, the issues payers raise are not intractable. In the pages that follow, we summarize the concerns and show how innovations in drug discovery, real world evidence, value-based contracts, and other business processes can address some of the most divisive issues.

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INTRODUCTION

How Insurers View Medicines for Rare Diseases

For years, health insurers have warned that rising price tags on certain classes of medicines threaten the stability of the U.S. health system. In the last two years, the sense of crisis among payers has reached a new pitch, especially regarding orphan drugs, which target populations of fewer than 200,000 patients in the U.S.

In a few cases, concern has translated to action. In the fall of 2016, several national health plans and pharmacy benefit managers declined to cover an expensive orphan drug on grounds the benefits patients derived didn’t justify the high cost. In effect, payers declared the safety and efficacy data provided by the manufacturer to the U.S. Food & Drug Administration (FDA) was insufficient—a claim that questioned the FDA’s authority to guarantee the efficacy of new drugs.

As criticism of orphan drug pricing mounted in 2017, Syneos Health™ conducted in-depth interviews with pharmacy and medical directors at 15 national and regional managed care organizations (MCOs) and integrated delivery networks (IDNs) representing 47.2 million covered lives. Topics ranged from how insurers manage products in the orphan drug space to the appropriate use of health economics outcomes research (HEOR). But it was drug pricing that occupied the greater part of each conversation.

Relatively few national health plans have refused to cover newly approved orphan medications. Still, all payers interviewed by Syneos Health said the combination of rising prices on orphan medicines and the increasing number of such products created an “unsustainable” cost environment. Many acknowledge that under the Orphan Drug Act of 1983, incentives such as longer market exclusivity and tax credits—some slated to be rolled back under tax reform—largely achieved their goal. The measures succeeded in spurring development of treatments for rare disease where few such medicines existed in the past. But, payers argued, manufacturers misconstrued the Act’s intent by pricing orphan drugs at “whatever the market would bear.”

The cost burden this trend imposes on the healthcare system, payers said, was exacerbated by the fast-rising number of requests for orphan drug designations, which more than doubled in five years, to 568 in 2016, according to the FDA. If orphan drug pricing trends continue, payers contended, health plans, as well as small and medium-sized employers who shoulder a portion of the costs, and self-funded employers, will find themselves in dire straits.
SUMMARY OF PAYER CONCERNS

In Candid, In-Depth Interviews With Syneos Health, Payers Said They...

... worry about a “tidal wave” of orphan treatments.
Funds available to insurers aren’t increasing, but outlays are growing quickly. The large number of expensive treatments in the pipeline, and the tendency to prescribe such drugs for both rare and non-rare illnesses, will push healthcare to the breaking point unless biopharma reforms its pricing practices, payers said. “Manufacturers are simply responding to the market place,” acknowledged one medical director of an integrated delivery network. “But payers are going to say ‘no.’”

... urge patient advocates not to carry the flag for manufacturers.
Many insurers said they recognize the critical work of advocacy groups focused on accelerating drug development. However, the groups should be more transparent about their financial ties to industry, payers said, and resist pressure when manufacturers ask them to push for better formulary placement. “Advocating to circumvent cost controls is really inappropriate,” said the pharmacy director of a national payer.

... want manufacturers to consider the “larger cost picture.”
Insurers are frustrated when manufacturers justify a high price tag as a “unique” case. Said a medical director at a national MCO: “I’ve had reps tell me, ‘this drug may be expensive, but there are only five people on your plan who have it.’ But behind him is another rep saying the same thing, and there are 30 more behind him.”

... want to see third-party corroboration of health economics outcomes research.
Manufacturers are pouring resources into health economics outcomes research, ignoring payer’s desire for third-party filtering or validation of the models. Said one pharmacy director at a regional affiliate: “There isn’t a model I’ve ever seen from a manufacturer for their product that doesn’t save me at least a million dollars.”
... desire more postmarketing surveillance data.

Payers said they understand there are hurdles in researching rare diseases. Patient populations are small, and broad knowledge of disease natural history or physiology may be limited. But there are other gaps researchers could help to fill. Rare disease drugs are rushed to market because they may address symptoms, payers say, but there’s little long-term data on outcomes or cost offsets, such as reduced hospitalizations. Payers crave this clarity, and postmarketing studies can help provide it, “but no one is doing that,” said one pharmacy director of a regional affiliate.

... intend to scrutinize clinical evidence—even after a drug is approved.

Insurers have always watched FDA advisory committees, but at arm’s length. Now, if a medicine is priced far above the average for specialty drugs, payers may use reports of disputes within an advisory committee as justification for denying coverage. With high-priced drugs that are approved based on scant data, payers say they must find new ways to limit the impact to their plans. For example, they may go back and examine clinical trial protocols more aggressively and write coverage policies that limit coverage only to the patient cohorts included in the clinical trials.

While it is still unusual to see U.S. national health plans declining to cover an FDA-approved rare disease treatment, there’s no question insurance plans have grown more restrictive. In a nationwide 2017 survey of hematologists, neurologists and pulmonologists by consultants from the Decision Resources Group, many physicians complained about prior authorizations and so-called step edits imposed by payers. These challenges will intensify over time, the doctors said.

As a professional services organization that helps biopharma develop and commercialize medicines, Syneos Health is working with clients to understand and assess payers’ concerns. In the pages that follow, Syneos Health executives responsible for clinical development, communications and advocacy relationships describe how biopharma can, in some cases, collaborate with payers, bringing resources and ingenuity to pricing conundrums and other challenges that lie ahead for orphan drugs.
In interviews with Syneos Health, many of the pricing concerns voiced by pharmacy and medical directors at leading health plans can be subsumed in one question: Where is the evidence to justify the high prices?

Invariably in such discussions, evidence is joined at the hip to value—the benefit a drug delivers relative to its price. But the word “evidence” is quickly taking on new meaning. Beyond just randomized controlled trial (RCT) data, many payers increasingly seek a panoramic view of how a drug performs in the real world. Among other things, they want to know how improvements in the patient’s condition in daily life will affect downstream medical or pharmacy costs.

The good news, for those of us in the business of developing rare disease treatments, is that our field is already a test bed for the kinds of evidence payers seek. We, too, need a panoramic view—precisely because there are so many research challenges and constraints.

Drug developers in rare diseases also crave a panoramic view—precisely because there are so many research challenges and constraints. These include small patient populations, scant medical literature on disease mechanisms, and few or no natural histories, biomarkers, or other surrogate endpoints for a study. And instead of running multiple Phase II and Phase III trials, we frequently get just one shot on goal.

These obstacles have forced researchers in orphan drugs to become early adopters of real world evidence, adaptive and pragmatic clinical trial designs, and other still-experimental approaches that yield valuable information. If a research approach holds the promise of speeding safe medicines to patients who have no treatment options, it is guaranteed to be part of our toolkit.

Real World Evidence (RWE) is an imperfect classification covering a myriad of data sets from diverse sources. Nonetheless, it captures the zeitgeist in drug development. Health data streaming from smart phones and other mobile devices make up one intriguing RWE category. Others include patients’ self-reported experience of their conditions, whether on message boards, or medical social media, or in structured formats such as patient registries and patient-reported outcome (PRO) measures. Electronic medical records, insurance claims and archives of lab results compose yet another RWE data source. With more common illnesses, researchers might compile data like these during postmarketing surveillance studies. The difference in the case of rare diseases is that some of these data sets may already be part of the trial design phase.

With today’s analytics, we can mine RWE repositories for insights on how patients taking a medicine feel at different times of day, whether these fluxes affect medication adherence, and how drug combinations perform vis-à-vis a single treatment. RWE data may also clarify the impact of lifestyle changes, the benefits of wellness programs and perhaps even how genomic variability affects disease progression under different treatment regimens.
Concurrently, we’re seeing broader implementation of pragmatic clinical trials. These are randomized studies comparing two or more active interventions where clinicians prescribe the drugs to real patients in conditions approximating real-world practice.

Why do we need these data types in the trial design phase? Because when you’re running just a few studies on minuscule numbers of patients, RWE enables you to design the trial around the patients, rather than forcing patients to fit the protocol, as has been the case historically in RCT for non-rare treatments.

This shift, fueled partly by industry’s desire to furnish payers with the insights they value, is bound to speed the evolution of clinical trials. In accelerated trials for rare disease treatments, developers often find themselves in an “adaptive” environment where the data themselves illuminate how to run the trial. In fact, the FDA has endorsed adaptive trial design in its Critical Path Initiative, providing a framework for companies to adjust sample size based on interim data, change dosing protocols and eliminate inferior treatment arms (“drop the loser” design). We are also seeing increased interest in so-called pragmatic clinical trials. These are studies that compare two or more drug regimens in routine clinical practice to inform decisions made by doctors and patients.

To be sure, RWE is likely to include unstructured data that doesn’t sit comfortably with RCT protocols or results. And RWE can be subject to bias and “confounding” when used to compare medical treatments, according to David Thompson, Syneos Health Senior Vice President, Real World Evidence & Insights. In a realworld setting, he notes, it’s not uncommon for doctors to use a new medical intervention only when treating the sickest patients. Those patients may seem to have poorer outcomes in a head-to-head comparison with existing therapies. In fact, the new treatment may be effective—but for these patients, it’s too late.

Ambiguities like these may slow adoption of RWE and novel trial designs in some regulatory settings. With regard to rare disease, however, these tools are already embedded in 21st Century Cures and PDUFA VI. In some cases, as we have seen, they also have the endorsement of payers, who ultimately determine whether patients gain access to these new therapies.

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Ensuring Orphan Drugs Live Up to Their Potential

By Meg Alexander

While the list price of an orphan medicine may look extravagant to an average American watching a TV news report, a pharmaceutical executive might find the number easy to justify. Rare disease patient populations are small and scattered, making these drugs difficult to develop and test. Once the medicines are approved, doctors will write fewer prescriptions than for mainstream medicines. What’s more, by the time coverage and formulary placement are negotiated, payers and patients will see costs far below what’s quoted in media reports.

In interviews with Syneos Health, payers acknowledged these and other hurdles. One insurer even sympathetically itemized the negative consequences of discounting for manufacturers. Nevertheless, pharmaceutical companies could avoid a significant quotient of dissonance in the orphan drug space by trying harder to understand the payers’ perspective and communicating the information payers and other stakeholders desire.

There are four precautionary steps you, as a developer or manufacturer, should take, particularly in advance of pricing decisions likely to spark controversy. These steps can minimize damage to new businesses initiatives and brands so your company can focus on what really matters: pursuing revolutionary treatments on behalf of very sick patients.

1. **In coverage and formulary negotiations with payers, it helps to acknowledge that payers face a growing cost burden**, particularly in the orphan drug space. It’s reasonable for payers to expect an accurate snapshot of a new drug’s impact on their budgets. They’re entitled to hear how many plan members are likely to receive prescriptions for the new medicine—even if it won’t entirely allay their concerns. Gone are the days when a drug rep would say, “You’ve got less than 10 members on your plan with this disease,” and the payer would reply, “You’re right. No problem.”

The need for straight talk may sound self-evident, but research Syneos Health conducted with payers suggests many orphan drug developers may not have gotten that memo. They continue to negotiate coverage and formulary placement as though their new treatments were the only rare-disease medicines the health plan will have to manage. This is despite well-publicized data showing drugs for rare diseases are proliferating at an unprecedented pace. Orphan medicines made up nearly half of all novel drugs the U.S. Food and Drug Administration (FDA) approved in each of the past three years.

From a payer’s perspective, the problem isn’t that more great drugs are coming out of the pipeline targeting rare diseases. Payers applaud the arrival of effective drugs, just like other healthcare stakeholders. What worries them, besides the high prices, is the advent of personalized medicines. The more we learn about the role of genes in rare diseases, the closer we come to an era when most treatments will be personalized to individuals or patient subpopulations. Yet no healthcare system can survive in an environment where every new drug commands a $140,000 price tag—the current average for orphan medicines, according to consultants EvaluatePharma.

Further complicating the pricing calculus is a phenomenon called “salami slicing,” in which manufacturers find new, rare indications for drugs that were first approved for common conditions. Payers cringe when developers working with non-rare diseases take advantage of orphan drug incentives to win accelerated approval of a treatment, gaining longer market exclusivity and the ability to price the treatment at parity with other orphans.
Make sure the price tag on a new medicine doesn’t sticker-shock your key audiences, which include patients, caregivers, physicians, investors, policymakers and the media. Seize control of the narrative surrounding the value and price of your medicine. Get the information to key stakeholders and provide the necessary context. Though high drug prices have been a flash point for years, surprisingly few journalists seem to report that insurers rarely pay the sticker price, known as the wholesale acquisition cost (WAC) or list price. Commercial plans often negotiate drug discounts. For state Medicaid programs, a quarter of the WAC comes back in rebates. And even when plans require high co-insurance, most patients never see a bill that looks like the WAC. In fact, companies are now introducing copayment programs that help offset high cost-sharing charges.

Show that your price reflects clinical value, including but not limited to clinical trial data. Payers are interested in comparative effectiveness research, real world evidence and health economic outcomes research—all good stuff your company may have developed in-house. But the window you provide on key data such as durability of response to a drug is of greater value to payers when paired with third-party validation. That might come from partners in academic institutions. But you should also pay attention to established “value frameworks” promulgated by the Institute for Clinical and Economic Review (ICER), the American Society of Clinical Oncology (ASCO), Memorial Sloan Kettering Cancer Center, and other bodies. Some of these frameworks may initiate cost-effectiveness assessments before an investigational drug is approved by the FDA—effectively pricing the drug before the manufacturer has a chance.

Perhaps most important, developers and manufacturers should start to look at payers as collaborators rather than hostile gatekeepers. Farsighted manufacturers are already entering into risk-sharing and value-based contracts—most recently, a string of partnerships between the Harvard Pilgrim health system in Massachusetts and Eli Lilly, Novartis, and others. But many of these models are still costly to administer relative to the small size of an orphan population. Such approaches must be refined so our society builds value-based contracts that actually work.

Ultimately, ideas formed through collaboration are building blocks for new structures the healthcare community desperately needs, especially in the area of rare diseases. These are the bridges that will one day connect the interests of drug developers, medical service providers, patients who depend on them and managed care organizations at the heart of the commercial model.

Meg Alexander, Head of Reputation and Risk Management at Syneos Health
Opportunities and Obstacles in Value-Based Pricing

By Danielle Bedard, Mark McCoy and Carly Del Piano

In the spring and summer of 2017, biopharmaceutical companies signed a variety of innovative contracts with payers under the banner of value-based pricing. Typically in such deals, manufacturers promise the payer rebates or discounts if the medications don’t yield the expected medical outcome. When the arrangement works, both parties gain a clearer picture of the medicine’s value in real-world settings. However, even after a decade of experimentation in value-based pricing, payers and manufacturers today continue to grapple with operational, regulatory and legal hurdles.

Before looking at the obstacles, it's worth sketching the variety and scope of recent value-based contracts, which reflect a growing willingness by payers and drug manufacturers to experiment, cocreate and collaborate.

In May 2017, a top-tier biopharmaceutical company signed an outcomes-based contract with a major East Coast health plan. The agreement guaranteed the payer a rebate for the cost of a new heart drug if an eligible patient suffers a heart attack or stroke while on the medicine. The same month, a leading national insurer and a large manufacturer signed a multiyear research collaboration in outcomes-based risk sharing. The two will explore raising or lowering a drug’s price, depending on whether the insurer’s de-identified, integrated claims data and clinical records show that it helps patients in real-world settings.

A few months later, another top drug manufacturer announced plans to work with the U.S. Centers for Medicare and Medicaid Services (CMS) on an indication-based pricing model for an advanced cancer therapy. The idea is, the price of the treatment will rise or fall, depending on the anticipated benefit for each indication.

Value-based contracts like these increase the ability of insurers, employers, patients and other stakeholders to analyze whether the drugs they pay for deliver the benefits they promise. But the approach can’t work if the contracts are too complicated to implement and monitor. What’s more, these deals are bound to fail if the partners worry excessively about regulatory and legal pitfalls.

First, consider the operational challenges. A December 2011 Health Affairs article documented a host of logistical hurdles that continue to confound manufacturers and payers who design such contracts today. “Many of the steps involved in risk sharing—such as developing data collection protocols, negotiating arrangements, assessing product performance, policing contractual arrangements and designing procedures to adjudicate disputes—can be costly and time-consuming,” the authors wrote.

Documenting patient outcomes requires meticulous data collection. Who pays for that? Who guarantees protection of patient privacy? And who ensures that patient “failures” aren’t the result of poor care in the clinic or lax medication adherence? Health Affairs predicted that these questions would persist as value-based deals proliferated. Sure enough, in a Pharmaceutical Research and Manufacturers of America (PhRMA) member survey on barriers to value-based contracts in 2017, manufacturers named the same conundrums.

On the regulatory and legal front, PhRMA’s survey shows that many manufacturers worry about a Medicaid regulation known as “best price.” Established in 1990 as part of the Medicaid Drug Rebate Program, the rule ensures that Medicaid patients have access to medicines at the lowest price charged by the manufacturer in any patient setting. This policy makes sense when the overarching goal is to protect the poor from potential price gouging. But it can be a major hindrance in the context of value-based contracts. The rule may mean that the reduced or rebated payment a drug company receives from an insurer when one patient dies or fails
to respond to a treatment becomes the “best price” charged to all Medicaid patients.

This is especially troubling with rare diseases, some 80 percent of which are genetic in origin. Many patients are diagnosed in childhood, and for a variety of reasons, a high percentage receives care under state Medicaid programs. For manufacturers, the downside risk of a value-based contract is overwhelming, as a single unfortunate outcome on a drug—possibly the result of comorbidities or poor medication adherence—could torpedo pricing in one of the largest potential markets, namely, Medicaid.

In other words, a well-intentioned policy has thrown a wet blanket on pricing experiments that could help elucidate the health-economic value of important medicines. In the words of Dana Goldman, director of the Leonard D. Schaeffer Center for Health Policy and Economics at the University of Southern California, rules such as best-price “have transformed the U.S. into one of the world’s least innovative testing grounds for new pricing strategies, even compared with public-sector players in other developed countries.”

The best-price rule is just one of several regulatory barriers to the creation and broad adoption of value-based pricing models. Federal antifraud policies, including anti-kickback laws, raise concerns because through this lens, a doctor who prescribes a drug to a Medicare patient and is compensated based on how the medicine performs, or as part of a shared-savings program, might look like he or she is receiving a kickback. Violations of the federal Anti-Kickback Statute carry fines up $25,000 and prison sentences. Fines under the Physician Self-Referral (Stark) Law are four times as much.

Washington is aware of the healthcare industry’s concerns about best-price rules and anti-fraud laws. In 2016, CMS itself expressed concern about the rule and encouraged manufacturers to seek guidance when exploring such arrangements. And in June 2017, several news outlets reported that the White House intended to clear the pathway to value-based pricing.

Efforts to reform anti-kickback laws could also bear fruit—as long as manufacturers, payers, providers and patient organizations can bring their combined influence to bear. For example, there are annual opportunities to petition the Office of Inspector General (OIG), an arm of the Department of Health and Human Services, regarding “safe harbors” to the anti-kickback statute. In March 2017, PhRMA, the Advanced Medical Technology Association (AdvaMed), and a number of private companies used this avenue to explain how antifraud laws impede progress in value-based healthcare. Together and separately, they urged OIG to clarify its guidance.

Some operational questions about value-based pricing may be resolved naturally thanks to rapid improvements in healthcare IT and data analytics. But laws and policies are iterative, advancing in slower, human increments of time. That’s why healthcare stakeholders must pull in unison toward the goal of value-based innovation.

At the very least, innovative contracts that lead to favorable formulary placement can help patients by reducing copays and cost-sharing on medicines that can make them well. And, in the best of scenarios, these deals can point toward a more rational, collaborative and cost-effective healthcare system.

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SPOTLIGHT ON CLINICAL TRIAL RECRUITMENT

Promoting Trial Enrollment Will Lead to More Cost-Effective Drugs

By Marie Emms

The challenges of recruiting and retaining patients in clinical trials have been well documented over many years. A 2013 report from the Tufts Center for the Study of Drug Development noted that clinical trial timelines typically double in length as investigators struggle to complete enrollment. Only 39 percent of sites in a given clinical trial meet the sponsor’s enrollment targets, according to Tufts, while 11 percent fail to enroll a single patient.

These hurdles translate into delays and higher R&D costs, which are reflected in elevated prices once medications reach the market. Payers are certainly aware of these correlations. Yet, when Syneos Health asked insurers how they would deal with rising prices of rare disease treatments in the future, some proposed measures that, in the long term, would slow the development of new treatments and put upward pressure to prices.

For example, some payers said that if a sponsor excluded patients from a trial because of health conditions, such as cardiovascular complaints or impaired kidney function, the payers might deny coverage to patients with such conditions once the drug was commercialized. “If patients are excluded from a trial,” one payer told us, “maybe they shouldn’t be on the drug.”
It’s not unusual for payers to restrict coverage when biomarkers or test data show that certain patients are unlikely to benefit from a drug. Pegging insurance coverage to clinical trial inclusion, however, conjures a very different logical framework—one that could bring adverse, unintended consequences.

Today, when a child with a rare disease is excluded from a clinical trial for health reasons, the parents don’t give up hope of accessing the new treatment. In many cases, they work harder than ever to inform other parents and get other children enrolled, knowing there’s a chance the treatment will benefit their own child once it’s approved. Word of mouth is a potent communication channel in rare diseases where patient populations are small and widely dispersed. More and more, trial sponsors depend on this channel in trial recruitment.

But if parents and family members believe exclusion from a trial carries a high risk of being denied insurance coverage down the road, many won’t even try to enroll their children, and they certainly won’t encourage other parents to take the risk. Suddenly, the tough challenge of recruiting patients becomes that much harder, and the prospect for speeding new treatments through the pipeline dims in proportion.

Potentially, investigators could respond to the threat of future coverage restrictions by relaxing trial inclusion criteria, but few trial sponsors would choose that option. If investigators have the ability to identify subsets of patients that won’t respond well to a drug, enrolling people outside that cohort serves no one’s interest—least of all the patients.

Advocacy groups can help sponsors navigate these and other uncertainties—and, in rare diseases, they already do so. Using social media and other tools, they often assist in identifying patients, building registries and constructing natural histories of diseases that are of vital interest to researchers. Advocacy also plays a critical role in educating families, recruiting patients, and keeping them compliant with challenging drug regimens in a trial.

Unfortunately, many payers interviewed by Syneos Health expressed mistrust of advocacy groups working with these conditions. Because such organizations often receive funding from clinical trial sponsors, payers say they can’t count on objective input. This issue comes to the fore when patients or families working with advocates describe positive responses to medications via patient-reported outcome measures (PROs). In reality, payers must learn to peer beyond the complex industry-advocacy relationships and recognize, wherever possible, the authenticity of patients’ voices.

Without the collaboration of advocacy groups, it’s hard to envision manufacturers creating various life-altering treatments those of which turned HIV/AIDS from a death sentence to a manageable condition. What’s more, in the case of HIV, patients and advocacy groups earned the trust of payers.

The model of strong collaboration between payers and advocacy already exists, and we all need to learn from that model. It may be the best strategy for averting unintended consequences as payers and manufacturers grapple with pricing of rare disease medicines.

Marie Emms, is Head of Global Clinical Trial Engagement at Syneos Health
An Advocacy Response to Payer Concerns

By Jeanine O’Kane

When health insurers talk about rare diseases, empathy for patients isn’t a throwaway line or an afterthought. In hours of interviews, payers expressed deep concern for patients and their families—especially for parents of children whose lives are in peril. But in at least two respects, the consensus we heard from payers is at odds with views of advocacy groups.

They don’t see eye to eye on how to interpret the patient’s experience of an illness when calculating the value of an orphan drug. They also disagree on whether the rapid proliferation of expensive treatments for rare diseases poses an existential threat to the U.S. healthcare system.

The first area of discord—valuing the patient’s experience—makes it hard to figure out what role advocacy groups should play in debates about orphan drug pricing. In short, payers welcome the opinions of patient organizations when those groups take a stand against high prices. But, when rare-disease advocates defend the pricing of drugs developed by companies with which they collaborate, payers say the groups have been manipulated.

Likewise, when advocacy groups become activists in the regulatory process, pressing for the speedy approval of promising medicines, insurers worry emotions will overrule evidence. One insurer we spoke with described a case in which “an FDA director reversed his decision after meeting with advocacy groups, calling into question the credibility of [the agency’s] decisions across the board.”

Payers, even though they are sympathetic to patients, are not swayed by encounters with the families, said another executive—the managing director of a regional affiliate. “On a scale of one to ten, where ten is clinical efficacy, [the voices of] these groups are a three to five. They are out there, and they are a consideration, but we try to go beyond them to the evidence.”

To gain a fair and balanced picture, we discussed key takeaways from the payer interviews with several prominent advocacy leaders. “I understand where payers are coming from,” the director of one patient organization told us. “But remember, patients are not the payer’s customers.” That role is filled by employers and the government, she explained.

In short, she says, patient testimony should be irrelevant to coverage decisions. “Payers serve companies that run employer-funded plans,” the advocacy leader said. “At the end of the day, those companies serve employees, who are now, or may become, patients. Payers must integrate patients and treat them as customers.”

The second area of dispute concerns sustainability of the pharmaceutical business model when it comes to rare diseases. Many payers interviewed by Syneos Health believed manufacturers are abusing the incentives and intent of the Orphan Drug Act of 1983—especially when the high price assigned to an orphan indication remains unchanged when the drug is later used to treat common illnesses. And nearly all payers said the high prices of orphan drugs jeopardize the healthcare system’s stability.

Yet, the healthcare system is not in jeopardy, said the founder of a rare disease advocacy group who examined anonymized summaries of the payer interviews. “Payers need to recognize that orphan drug prices will come down drastically over time,” she said. Many factors will contribute to price adjustments. On the patient side, digital and social tools will enable people with rare diseases to accelerate patient identification and enrollment in clinical trials, helping to address one of the heaviest cost burdens in drug development. Such tools will also help patients participate in more accurate registries, which will yield the kinds of real-world performance and outcomes data payers are looking for.
Meanwhile, technical innovations in the private sector will affect the cost equation in fundamental and positive ways, the advocacy leader said. She was surprised that some payers view genetic advances fueling personalized medicine with alarm. In interviews, payers worried these advances signal a future where each personalized condition is treated like a rare disease, with pricing borrowed from the orphan drug playbook. But many advocacy organizations take a more optimistic stance.

Next-generation drugs, including gene therapies, promise to replace costly medicines the patient takes for years or decades, with a single, curative shot. Even if the treatment is expensive, the cost over a lifetime will be far less, the advocacy leader said. “Scientific breakthroughs, innovation in contract services, the ability to bring clinical trials right to the patient’s home and to monitor them in the real world—all of these innovations and forward momentum will cooperate to drive down costs.”

The last two decades of technical innovation in diverse but related fields, from biotechnology to electrical engineering to computer science, artificial intelligence, and the Internet, suggest optimists in the advocacy camp have a strong case. Current pricing structures paint a grim picture from the payers’ vantage point—but that is nothing more than a portrait of the moment. It pays to remember that rare diseases are a landscape of constant change, and advocacy groups hold the paintbrush that brings it all to life.

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About Syneos Health

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