Opening a New Era in Rare Disease Medicines

HELPING PAYERS AND ADVOCACY GROUPS SEE EYE TO EYE

In criticizing high orphan drug prices, some payers disparage ties between manufacturers and patient advocates. Jeanine O'Kane and Marie Emms, senior executives at Syneos Health, argue these relationships foster innovations that lower prices over time. In creating registries, assisting trial recruitment, and gathering real world evidence, patients and advocacy groups form the front line in our battle against rare diseases.

Health insurers whose plans include families struggling with rare disease often express empathy for the patients, and I believe they are sincere. Why? Because, in 2017, my company conducted many hours of interviews with medical and pharmacy directors at managed care organizations and integrated delivery networks representing 47.2 million covered lives. In these conversations, many payers expressed deep concern for patients on their plans—especially for children whose lives are in peril, and for parents who battle bravely to save their lives. But, in at least two respects, payers took stances on the economics of rare diseases that were at odds with what advocacy groups in rare disease believe.

First of all, payers and advocates 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 3-to-5. 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 our 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.

"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. Competition among multiple products treating the same rare conditions will have an impact. And, on the patient side, digital and social tools will enable people with rare diseases to work with researchers and accelerate patient identification and enrollment in clinical trials, which amount to one of the biggest cost burdens in drug development [See sidebar]. Such tools will also help patients participate in more accurate registries, which will yield exactly the kinds of real-world performance and outcomes data payers have told us they seek.

Technical innovations in the private sector will also 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 a pricing borrowed from the orphan drug playbook. But many advocacy organizations take a more optimistic stance.

Advocates argue that 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.

To view the full report titled, How Payers and Manufacturers Can Find Common Ground in Rare Disease visit: SyneosHealth.com/Rare.

PROMOTING TRIAL ENROLLMENT BENEFITS ALL STAKEHOLDERS

The challenges of recruiting and retaining patients in clinical trials are well known. 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.[1]

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.

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 life-altering treatments of the sort that 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. For the sake of patients and families living with rare diseases, shoring up trust is a top priority in rare diseases today. It may be the best strategy for averting unintended consequences as payers and manufacturers grapple with pricing of rare disease medicines.

Read the Syneos Health Rare Disease Payer Report here: SyneosHealth.com/Rare.

1 http://csdd.tufts.edu/files/uploads/jan-feb_2013_ir_summary.pdf