Denise Myshko

ACA Expands Pharma Market

Prescription drug coverage through the ACA's health exchanges includes 8 million patients. While this is an opportunity for the pharmaceutical industry, it also puts more focus on value, costs, and outcomes.

Pharmaceutical companies are finding a changed market for prescription drugs now that consumers are able to purchase health insurance coverage through the health exchanges that were created through the Affordable Care Act. As health exchanges continue to evolve they are becoming a significant component of the managed markets segment, with strong ties to Medicaid.

With an estimated 8 million more people with insurance and drug coverage, this is a huge opportunity for companies with an estimated $26 billion in additional retail drug spending through 2021 on the table because of expanded coverage.

With the enormity of the opportunity also come challenges with managing this new segment. There is a growing focus on value, cost, and outcomes. The health insurance marketplace will increasingly link access and coverage to those services and drugs that have proven good value, lower overall healthcare cost, high quality, and demonstrated positive outcomes.

"The healthcare insurance and delivery market will be integrated and incentivized to better coordinate around these objectives and to view drugs in the broader outcome/value scenario," says Joel Owerbach, Pharm.D., VP of health policy and strategy for Alliance Life Sciences. "Tomorrow's managed markets segment will look like today's marketplace. The marketplace will define the future of all commercial and managed market formularies and benefits. Those benefits, formularies, and pharmaceutical management approaches that are successful within the marketplace plans in the 2014 to 2015 timeframe will expand to become the norm across most of the commercial business."

Exchange Drug Coverage

Dr. Owerbach says there are about 250 new exchange formularies this year that have been created by more than 275 insurers in the marketplace.

"Overall, there is a similarity between the 2014 formularies and their commercial or employer group counterparts due to a number of factors, including the requirement that marketplace formularies must provide the greater of one drug in every USP category and class or the same number of prescription drugs in each category and class as the EHB benchmark plan for that applicable state.

"The benchmark plan formularies were generally open formulary, broad drug access plans in 2011 and 2012," he continues. "This isn't surprising considering the predominance of Blue Cross Blue Shield small business plans — about 70% — making up the various state benchmarks. Additionally, the time crunch for developing formularies in 2013, only four to six weeks from the Feb. 20, 2013, date, and formal publication of the pharmaceutical guidelines, dictated that most formularies would likely mimic the insurers' current commercial formularies, with some tweaking. This was the case with only minor observable differences."

Overall, Dr. Owerbach says the exchange formularies have higher deductibles that must be met before benefit coverage begins; have a higher out-of-pocket maximum before 100% coverage compared with high deductible health benefits; have drugs allocated to more drug tiers; have a higher prevalence of coinsurance design; have higher copays for each tier of coverage; and may have more requirements for prior authorization and step therapy.

Exchanges are either state, federal, or joint-run depending on the state. There are five categories of insurance plans: Bronze, Silver, Gold, Platinum, and Catastrophic, with the Bronze plan having the lowest premium of the categories of plans but charging the highest out-of-pocket costs for healthcare services and the Platinum plan is designed to incur the lowest out-of-pocket expenses for enrollees. (See the digital edition of PharmaVOICE for more information about the exchange plans.)

Silver plans with combined deductibles offered through the health insurance exchanges may require patients to pay more than twice as much out of pocket for prescription medicines overall as they would under a typical employer plan, according to a new study by Milliman and sponsored by Pharmaceutical Research and Manufacturers of America (PhRMA).

According to Milliman's analysis, the typical deductible for Silver plans is $2,000. Previous research from Avalere Health found that in the lower-cost Bronze plans, deductibles are even higher, averaging more than $4,000.

Healthcare Plan Impact on Pharma

- A new sales channel with 8 million beneficiaries in exchange-based plans represents a tremendous growth opportunity for pharma. Therapies treating chronic conditions that often go untreated by uninsured individuals should perform well.
- Narrow networks limit opportunities for pharma because MCOs may include only those physicians who more closely follow formulary, which threatens therapies covered as nonpreferred agents. This threat is particularly acute in indications that have a heavy generic presence.
- The shift to closed formularies strengthens MCOs' negotiating positions. Health plans can reduce the breadth of drugs prescribed by physicians, thereby allowing them to reduce costs either by excluding higher-cost therapies or by extracting greater rebates from covered agents.
- Agents that are excluded on these plans will likely face reduced prescribing unless physicians fight for a medical appeal. As a result, formulary inclusion becomes far more important on a plan with a closed formulary than under an open formulary. Therefore, formulary placement on these plans becomes vital to avoid limited uptake by physicians.
- The inclusion of deductibles averaging more than $1,000 is one of the biggest hurdles for the pharmaceutical industry as the lack of first-dollar coverage may delay patients from seeing physicians or filling prescriptions. Specialty therapies may largely avoid this issue, but drugs treating chronic indications may suffer.
- With electronic health records systems and e-prescribing, physicians understand patient formularies better than before. That knowledge, combined with the various levers used by MCOs — closed formularies, narrow networks, and increased cost-sharing — will drive prescribing of lower-cost therapies, typically generics and preferred brands. Pharma must gain preferred coverage or convince physicians that efficacy gains of a branded agent justify a higher price.

Source: Decision Resources Group

An Avalere study released in June finds that the out-of-pocket burden on patients with serious illnesses is high. In seven of 19 classes of medicines for serious illnesses, such as cancer; HIV/AIDS; autoimmune diseases such as rheumatoid arthritis and multiple sclerosis; and bipolar disorder, more than 20% of Silver plans require coinsurance of 40% or more for all drugs in those classes. Similarly, in 10 of the 19 selected classes, at least 20% of Silver plans require coinsurance of 30% or more for drugs in the classes.

Dean Rosen, CEO of Breakaway Policy Strategies and a partner at Mehlman Castagnetti Rosen Bingel & Thomas, says there will likely be an impact on potential access to pharmaceuticals based on co-pays and co-insurance and the requirement that enrollees meet a deductible before being able to access pharmaceutical coverage.

"Exchange formularies seem to be more restrictive than the commercial market," he says. "The plans have to meet an overall actuarial standard and they have to meet a requirement that the medical loss ratio is a certain percentage of premiums that is mandated under the law that goes to benefits. They have new fees and taxes and they have to take all comers. There is no exclusion for preexisting conditions. The plans have tried to offer affordable premiums and that means tighter formularies, higher cost sharing for drugs, and, in some cases, narrower provider networks."

Mr. Rosen says these challenges will likely continue, and access may even get tighter over time. The countervailing force, he says, is that providers, patient groups, and biopharma companies, may push back on those benefit designs, which included more worst-case risk scenarios than originally anticipated.

Benefit wise, payers have shifted a lot of responsibility to patients, with coinsurance models and copay models, and this is especially true with specialty drugs, says Karla Anderson, principal, pharmaceuticals and life sciences, at PwC.

"Patient responsibility is quite significant in the health exchange," she says. "In a commercial plan, there may be more of a known demographic and patient utilization is predictable. In the exchange plans, we have observed high copayment/coinsurance scenarios being put in place. The plans are trying to use disincentives to control utilization."

Jane DuBose, senior director of advisory services, Decision Resources Group, says higher copay tiers will likely continue in exchange plans and to some extent, the market will be similar to that of the employer-sponsored market.

"Some exchange formularies are mimicking employer-sponsored formularies, but others are smaller, and they have reduced the number of brands that are available in some classes," Ms. DuBose says. "Exchange formularies typically have more cost-sharing with more co-insurance than in the employer-sponsored world."

> "It's a push and pull between premium rates and out-of-pocket costs. Insurers have felt the political and competitive pressures to have premiums come in at affordable rates."
>
> **JANE DUBOSE** / Decision Resources Group

This is being done to keep premium costs affordable.

"There will be cost-sharing situations, especially in Silver and Bronze plans, where the individual at the point of service would have to pay 30% or 40% of the costs," Ms. DuBose says. "The plans traded lower premium costs for higher out-of-pocket costs."

Dr. Owerbach notes that the formulary rules will continue through the 2015 benefit/formulary season.

"There will likely be a change for 2016, but insurers are awaiting formal guidance from CMS, which is expected to be issued by the end of 2014," he says.

Based on experience in the first year, plan evaluation of drugs, desired competitive premium positioning, and market segmentation, he says to expect the following: continued consolidation in drug classes/categories where permitted; increasing access restrictions on branded drugs; focus and segmentation for specialty drugs; and adoption of Medicaid and Medicare D type formularies for selected plans and markets.

In the area of benefit design, Dr. Owerbach expects additional tiers will likely be added to the current three-tier structure, further increasing the number of plans with four to six tiers; an increase in copay/coinsurance levels for all

> "Our clients are looking for ways to get closer to the patients to become part of the cycle of care, and they are also looking at mechanisms for how to help consumers navigate their health plans."
>
> **KIM RAMKO** / EY

branded and specialty products; and the expansion of limited pharmacy networks where retail access is restricted and there is mandatory mail and mandatory specialty networks.

Pharmacy Use in Exchange Plans

According to new research by Express Scripts looking at pharmacy usage trends in public health insurance exchange plans, use of specialty medications was greater among exchange enrollees versus patients enrolled in a commercial health plan.

In total spend, six of the top 10 costliest medications used by exchange enrollees were specialty drugs. In commercial health plans, only four of the top 10 costliest medications were specialty drugs.

Additionally, more than six in every 1,000 prescriptions in the exchange plans were for a medication to treat HIV. This proportion is nearly four times higher in exchange plans than in commercial health plans. The proportion of pain medication was 35% higher in exchange plans. The proportion of anti-seizure medications was 27% higher in exchange plans. And the proportion of contraceptives was 31% lower in exchange plans.

To some degree, some of the findings were expected, says Julie Huppert, VP of healthcare reform at Express Scripts.

"Enrollees in the public exchange line of business are sicker and more expensive to treat than the traditional population as was evidenced in our first-quarter 2014 survey," she says. "We had the opportunity to see the utilization trends by those who opted in early during the open enrollment period, and we may see these trends evolve. The early enrollees were older and they are the same demographic profile for those who were receiving subsidized coverage."

Ms. Huppert says the marketplace will evolve in a similar fashion to how the Medicare marketplace changed when Part D medication coverage was added.

"There was a different set of needs for that specific population," she says. "The population in the exchange plans may be very different from the traditional employer-sponsored insurance population over the long run, which will lead to unique needs. This line of business will be managed differently from the traditional employer population, and may lead to the need for formulary utilization management, plan design, and other management tools that are aimed at the more prevalent conditions in this population."

Ms. Huppert says going forward, there will likely be additional benefit tools that come into play, and insurers will need to balance between attracting and retaining their membership and managing the population for the best health outcomes.

"Exchange plans will evolve over time as the marketplace learns about this population more explicitly," she says. "Medical claims take several months to be processed and analyzed to understand the different populations."

Kim Ramko, global life sciences advisory leader at EY, says it will be interesting to see how certain medications are compensated.

"Will the government end up paying more to make up for the gap or will the exchange plans make medications less available?" she asks.

Ms. Ramko points out that by law, the exchange formularies have to include one product in every therapeutic class for a disease or chronic condition.

"To manage costs, the drugs on formulary tend to be the lowest cost ones available," Ms. Ramko says. "Obviously, generics are going to be preferred over a lot of branded products. Today, our clients are trying to figure out how to keep their branded drugs on the formulary. They are looking for ways to get closer to the patients to become part of that cycle of care and they are looking at mechanisms to help those consumers or patients navigate their health plans."

Impact on Pharma Companies

Dr. Owerbach says there are three key points for pharma companies to consider when working with the new marketplace exchange plans: the rules of the game and the playing field are changing for all parties; the marketplace is a window to what changes are ahead for the broader book of commercial and government business; and strategic and tactical

2015 Predictions for Health Exchanges

» Successful exchanges will be hot commodities.

More states will jump onto the bandwagon driven by successful state-run exchanges. Maryland scuttled its exchange for 2015 and jumped onto Connecticut's ship, adopting the technology that fueled the successful Access Health CT. Expect other struggling state-run exchanges to take similar steps. New Mexico and Idaho will have exchanges to watch in 2015 as both states switch to fully state-run operations.

» Exchange competition could grow.

With a short window to decide if they will participate in exchanges in 2015, many carriers have not hesitated. Wellmark Blue Cross and Blue Shield will enter both the South Dakota and Iowa exchanges; it already dominates both states' commercial markets. Co-ops in Montana, Massachusetts, and Kentucky all plan to enter neighboring states for 2015. While few markets show signs of erosion in 2015, that could change. However, most will wait until 2016 before exiting exchanges.

» Benefit backlash could be brewing.

Already exchange customers have found that many low-priced plans come with provider networks much smaller than a standard PPO. Exchanges plans frequently employ utilization restrictions such as prior authorization and have relatively narrow formularies. That could induce significant churn among exchange carriers.

» Can exchanges be sustained?

A fear for all state-run exchanges is their ability to fund operations without federal and state dollars. Hawaii has spent more than $200 million yet enrolled only 7,000 people. DC Health Link is considering a 3% fee on all insurers, and not just on those selling in its exchange. States such as Colorado and Nevada have lower exchange fees than the 3.5% levied by Healthcare.gov. If operational costs lag, those fees could increase. For now, no state exchange is in danger of folding. But as the exchanges move into 2015, sustainability will remain a primary concern.

Source: Decision Resources Group

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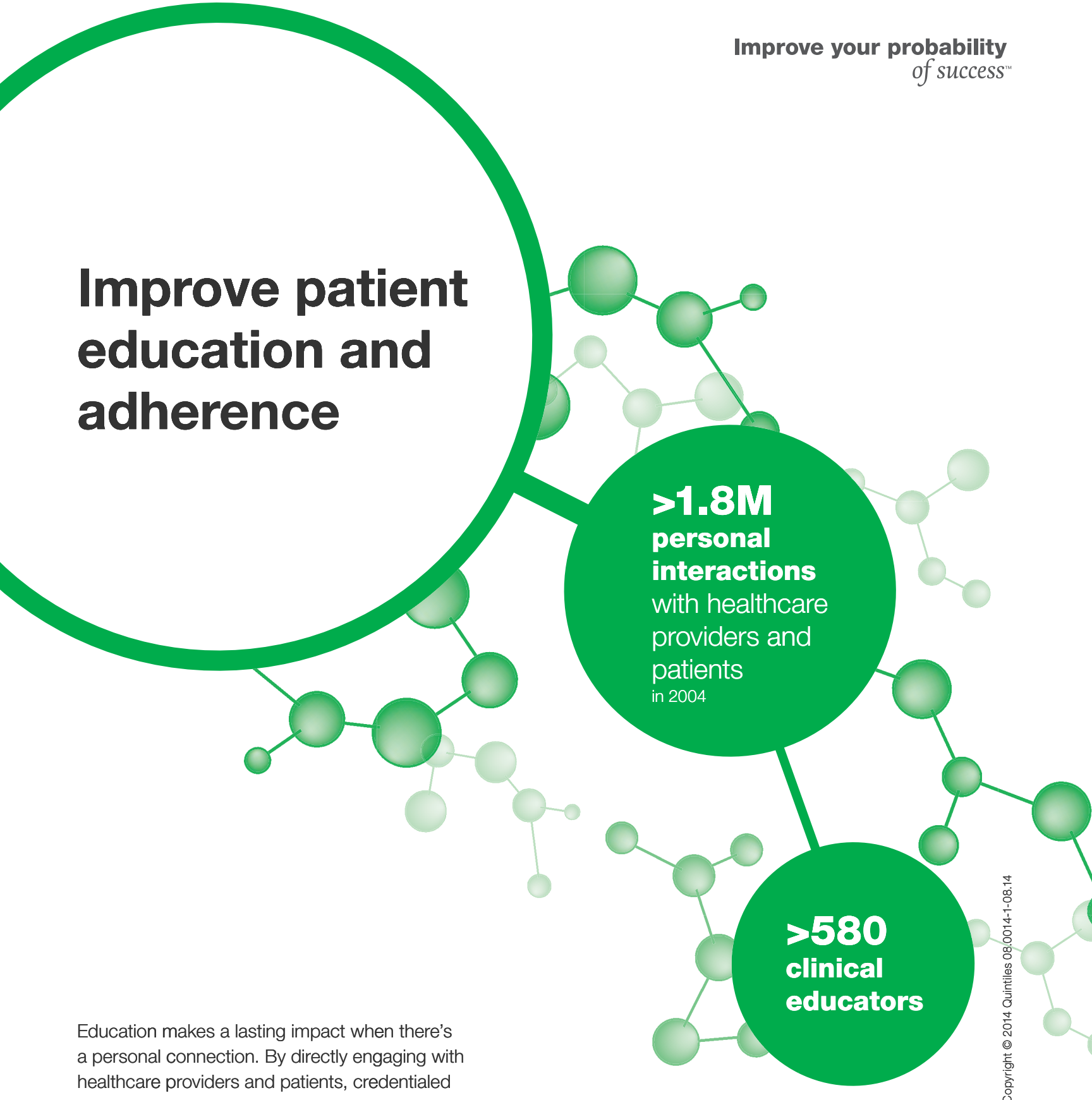

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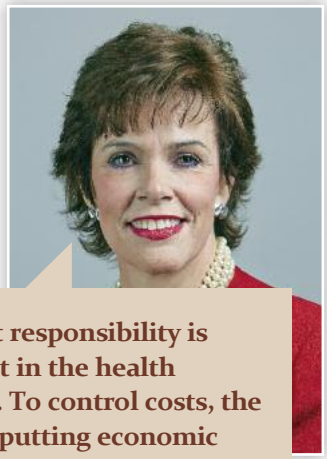
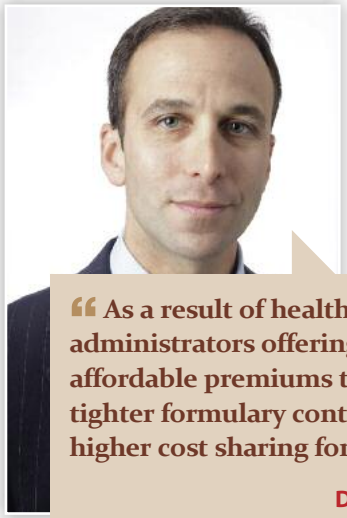


> **"Patient responsibility is significant in the health exchange. To control costs, the plans are putting economic disincentives in place."**
>
> **KARLA ANDERSON** / PwC



> **"As a result of healthcare plan administrators offering more affordable premiums this means tighter formulary controls and higher cost sharing for drugs."**
>
> **DEAN ROSEN**
> Breakaway Policy Strategies

focus and readiness will be key for success in the new marketplace and long term, across all commercial managed markets.

"There are new insurer players in the market, regional insurers entering new markets, and national insurers expanding their footprint," he says. "This will be a growing and expanding component of the managed markets segment. There are also new and potentially unpredictable enrollment challenges: an influx of uninsured, previous individual market enrollees, churn due to Medicaid eligibility changes, and employer coverage changes sending more workers to this market."

"There will be greater cost controls and pricing negotiation expectations on pharma each year in this segment, with spillover potential," Dr. Owerbach continues. "It is important for the industry to pay attention, learn, and strategize from what is seen in this segment to better plan for the impact on the broader book of business on existing and pipeline products."

Mr. Rosen says pharmaceutical companies need to have an overall understanding of healthcare in the exchange environment.

"Companies need to have a good understanding of what is happening in these benefit plans and at what level people are enrolling," he says. "More than 60% of people are enrolled in the Silver plans and another 20% are enrolled in the Bronze level plans. These are the two lower level plans by cost."

Ms. DuBose points out that there are several unanswered questions regarding pharmaceutical coverage in the exchanges. One question is the use of outcomes-based contracting.

"There have been a few outcomes-based contracts that have been implemented," she says. "The two sides are trying to figure how to measure it, would it be replicable, and what disease states it would work in."

Ms. DuBose says when contracting for next year, pharma companies need to consider that the Silver plans are the predominant benefit design, which means there is going to be coinsurance and deductibles.

"There is this newly insured population that needs medication and pharma companies are going to have to work with payers to generate access," she says. "Behind the scenes, there are alliances with advocacy groups to help patients pay for some of the cost sharing, including the use of copay coupons. So perhaps a potential contracting strategy for payers would be to allow copay coupons to be used to help the individuals access the medications."

Ms. Anderson says contracting for 2015 will still be challenging for manufacturers based on the changing landscape and the lack of historic data.

"Manufacturers, to some degree, will be taking a bet on what the upside is going to be for them; what they don't know is how the exchanges are going to respond to market uptake," she says. "For example, will the exchanges instill a tight formulary with less choice in order to steer more volume toward selected manufacturers? Or will the formulary be fairly open with high copay or coinsurance deductibles, especially on the specialty drugs? We don't know."

Dr. Owerbach says over the next one to three years, we might see greater market segmentation by key insurers.

"New formularies and benefits may drive the need for separate contracting terms," he says. "With some insurers gaining hundreds of thousands of new marketplace enrollees, this could drive selective and targeted new contracting interest and arrangements with pharma. Insurers will be driving toward value and lower costs in this transparent and competitive market and will be requesting concessions and migration to shared risk/outcome type contracts from pharma."

He says pharma will need to evaluate the traditional contracting value in light of the emerging reality in this market. This includes benefit design and redefining "access."

"The high deductibles, copays, and larger spread between preferred and non-preferred tiers weakens the access value of formulary positioning," Dr. Owerbach says. "The member, with cooperation from the prescriber, becomes the key product decision maker relative to his or her ability to afford the copay at any tier level. Simply gaining a preferred brand position on a formulary may not return the contract value, as even preferred brand positioning often is associated with a significantly higher copay or coinsurance compared with generics or compared with traditional commercial coverage of preferred brands."

Additionally, Dr. Owerbach says depending on the demographics of the marketplace and the emerging focus on quality measures, there may be a greater emphasis on certain classes of drugs versus others.

"Products with a lower perceived value to the insurer, i.e., ones that don't demonstrate cost reductions or quality of care improvements, may struggle to gain preferred status, and bundling such products in rebate agreements with other drugs that do have stronger perceived value is one way in which this risk could be mitigated," he says. "Pharma will need to strategically assess where, when, and with whom they should include a product in contracting and how to leverage potential partnership opportunities."

Another unanswered question is how the manufacturers will address their product financial assistance programs based on exchanges, Ms. Anderson says.

"The composition of the patient assistance programs is going to change over time because of enrollment in the exchanges," she says.

Ms. Anderson says the patients who were part of a patient assistance program already have a relationship with a company and now there may be significant copay or coinsurance.

"Companies have to think about those they were serving previously through a patient assistance program who may, in fact, have a negative experience by moving from a subsidized program to a plan where they have a financial responsibility," she says. "To patients, this is the healthcare system and they may not make the distinction between the patient assistance program and a health plan where the pharma company has no control over benefit decisions. There is an awareness that needs to be proactively managed." PV

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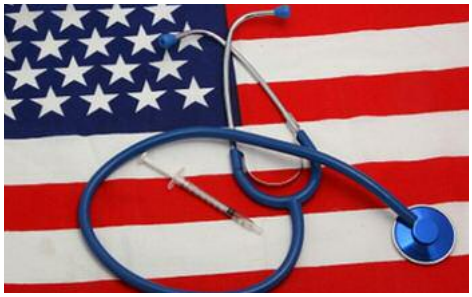
Patients *and the* Healthcare Exchange Plans

Engaging with patients and consumers in the new health plans will require a coordinated approach.



There are some significant implications for engaging consumers who have enrolled in the health marketplace plans, says Karla Anderson, principal, pharmaceuticals & life sciences, at PwC.

The Affordable Care Act's key provisions include measures to eliminate preexisting conditions, stop insurance companies from dropping patients when they sick, along with many more new benefits, rights and protections. The law also expands Medicaid to 15.9 million Americans, and creates state specific health insurance marketplaces.

Open enrollment for the health insurance marketplace for 2014 went from Oct. 1, 2013, to March 31, 2014. By the end of open enrollment, 8 million Americans had enrolled in a marketplace plan and 6 million enrolled in Medicaid or CHIP through the marketplaces. About 85% of the 8 million who enrolled in private insurance received cost assistance, and six in 10 uninsured Americans can be covered for $100 or less a month.

A post-open enrollment survey by Kaiser Family Foundation found that almost six out of 10 of the 8 million who enrolled in the marketplace were previously uninsured. Most of them hadn't had insurance in the past two years.

Decision Resources Group evaluated the healthcare exchanges to pull out key learnings from 2014 open enrollment's slow start and last-minute sprint. Unique methods of outreach like Connecticut's retail stores and examples of highly successful user-friendliness, such as the simplicity of Kynect's online functionality, provide a peek into what best practice could look like in the exchanges, while misadventures, like Oregon's forced use of paper applications due to the Cover Oregon website failure, provide cautionary tales.

> **"Health plans had to comply with new, extremely rigorous regulatory requirements. They had to come up with new benefit designs and a completely new model with federal regulators in a lot of cases. It was a challenge borne of the fact that the federal administration had a huge to-do list and didn't do it well."**
>
> **DEAN ROSEN** / Breakaway Policy Strategies

State Exchanges, which opened for enrollment Oct. 1, 2013, are run by states and overseen by the federal government. Blue Cross and Blue Shield plans will likely be among the leaders in the states where they are dominant and able to leverage that clout into narrow-network plans with a price advantage over competitors.

Jane DuBose, senior director of advisory services, Decision Resources Group, says some carriers did well in the open enrollment phase.

"The Blue plans, for example, in most states did really well," she says. "Some of the co-op plans were able to enroll at or more than their expectations and some did poorly. The national plans, United and Aetna were very cautious in the first year and they are reevaluating for the next year. United, in particular, has already announced that it is going to be in new markets."

Decision Resources Group finds that state-run exchanges did not guarantee success and no two states had similar health exchange experiences. Looking ahead, backlash to limited pharmacy benefits and provider networks in exchange policies could lead to broader policies in exchanges for 2015. Additionally, many markets will have more carriers in the exchange, improving competition.

Dean Rosen, CEO of Breakaway Policy Strategies and a partner at Mehlman Castagnetti Rosen Bingel & Thomas, says the actual implementation was lousy from the standpoint of getting people signed up and the functionality of the website.

"The plans were incredibly rushed," he says. "Health plans had to comply with new, extremely rigorous regulatory requirements. They had to come up with new benefit designs and a completely new model with federal regulators in a lot of cases. It was a challenge borne of the fact that the federal administration had a huge to-do list and didn't do it well. And in some cases, the government didn't have the people who were capable of managing that type of large-scale project."

Open enrollment for 2015 goes from Nov. 15, 2014, to February 15, 2015.

According to Decision Resources Group,

New Mexico and Idaho are exchanges to watch from 2015 as they switch to fully state-run operations.

Joel Owerbach, Pharm.D., VP of health policy and strategy for Alliance Life Sciences, says while the implementation of the exchanges was unorganized and intensively politicized, the results have been positive.

"Recent survey results show that the majority who signed up are happy with their plan," he says. "And the goal of reducing the ranks of the uninsured appears to be heading in the right direction. An additional 7 million+ are expected to sign up during this next open enrollment for 2015, with a projected enrollment of 24 million by 2016, and Medicaid enrollment continues to grow, particularly in those states that expanded the qualification limits.

Dr. Owerbach also says in 2015 many insurers are looking to expand into new marketplaces, and national insurers are planning to expand their footprints as well due to very limited 2014 participation.

"Based on experiences with Medicare D program development and launch almost a decade ago, we expected the first open enrollment of the exchanges to be messy," he says. "However, I expect that process will continue to improve. The exchanges are going to live and be a growing, significant part of the health care landscape in the years ahead."

The Exchange Plans

Exchanges are either state, federal or joint-run depending on the state.

There are five categories of insurance plans: Bronze, Silver, Gold, Platinum, and Catastrophic.

The Bronze plan is intended to have the lowest premium of the categories of plans but charge the highest out-of-pocket costs for healthcare services. For prescriptions, Bronze plans require a coinsurance of 32% for generics; 35% for preferred branded drugs; 36% for nonpreferred branded drugs; and 34% for specialty drugs.

The Silver plan has lower out-of-pocket costs than the Bronze plan but higher out- of-pocket costs than both the Gold and Platinum plans. All Silver plans share the same minimum health benefits but the way they charge out-of-pocket costs can differ significantly. For prescription drugs, the Silver plans charge a copay of $13 for generics; $47 for preferred branded drugs; $89 for nonpreferred branded drugs; and a coinsurance fee of 31% for specialty drugs.

Gold plans are required to cover 80% of the medical costs with the remaining 20% paid by the plan enrollee. These plans charge a copay of $11 for generics; $39 for preferred brand drugs; and $85 for nonpreferred brand drugs; and coinsurance of 28% for specialty drug.

A Platinum plan is designed to incur the lowest out-of-pocket expenses for enrollees. A typical Platinum plan enrollee pays about 10% of the costs of covered healthcare services with the plan paying the remainder. These plans charge a copay of $7 for generics; $31 for preferred brand drugs; $61 for non-preferred brand drugs; and $126 for specialty drugs.

Ms. DuBose says 85% of those who signed up for the exchange plans chose a Silver plan because that is where the subsidies are triggered.

"If a consumer meets the low-income standard, that is his or her point of entry," she says. "That is slightly higher than people had predicted it to be."

Silver plans with combined deductibles offered through the health insurance exchanges may require patients to pay more than twice as much out of pocket for prescription medicines overall as they would under a typical employer plan, finds a new study by Milliman and sponsored by Pharmaceutical Research and Manufacturers of America (PhRMA). This is a far larger increase in out-of-pocket costs than was found for other medical care.

With combined deductible plans, patients are responsible for 100% of their non-preventive medical and pharmacy costs before meeting the deductible. The findings reveal that the large combined deductibles for all medical spending that are common in Silver plans in exchanges may disproportionately impact out-of-pocket costs for patients relying on prescription medicines.

The Milliman report also noted that Silver plans are nearly four times more likely to have a single combined deductible for medical and pharmacy benefits (46% of the time) compared with typical employer-sponsored plans (12% of the time). This is an important distinction, particularly for patients with chronic illnesses, because it means prescription medicines are not covered until patients meet the deductible.

The exchange plans are also having an impact on physician prescribing behavior. The emphasis on drug costs is changing the way doctors in accountable care organizations prescribe, finds a recent survey by Decision Resources Group. For example, a majority of the pharmacy directors and medical directors at managed care organizations (MCOs) are more frequently prescribing generic drugs for acute coronary syndrome and atrial fibrillation or will be in the next 12 months.

Reaching Consumers

Ms. DuBose says education programs for this audience should drill into the world of insurance, helping patients understand their benefits.

"Some people in the exchanges are entering this world of coinsurance and copays and prior authorization for the first time," she says.

Effective engagement with plans and insurers requires an account management team that is trained, educated, and conversant on healthcare reform, is marketplace savvy, and data enabled, Dr. Owerbach says.

"This includes detailed data on the marketplace and the specific insurer, enrollment, benefits, formulary and key drug/competitor access positioning," he says. "Corporate staff will have to have the training, tools, data, and support to create and amend strategic direction that will ensure tactical success with the insurers and their programs."

He says there will need to be coordination among multiple departments and areas of accountability who are impacted by the marketplace — government programs, managed markets, brand teams, contracting, sales, etc.

"A coordinated approach to this new segment will be important for navigational success through the evolution and growing sophistication of the insurers, as well as to leverage and capitalize on new partnership opportunities," he says. PV