Payer Decision Making: Economic and Clinical Considerations

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TOPICS

Economics:

- Formal evaluations
- Informal evaluations
- Budgets and finance

Value frameworks:

- Perspectives
- Inclusion
- Merging clinical and economic considerations

Real World Data to Real World Evidence:

- where is this going and why

Economics

Economic evidence

- ❑ Cost
- ❑ Price elasticity
- ❑ Efficiency
- ❑ Value

Economic evaluation

- ❑ CEA
- ❑ CBA
- ❑ Budget impact
- ❑ Net monetary impact
- ❑ Combinations

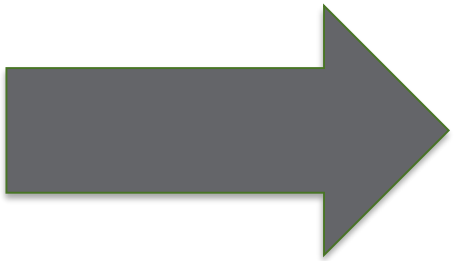
US payers

Pharmaceutical firms make decisions on what drugs to bring to market and what price to set

PAYERS ARE:

Price Takers

Technology Takers



Reactive

- **Attempt to limit expenses**
- **Skeptical of benefits**

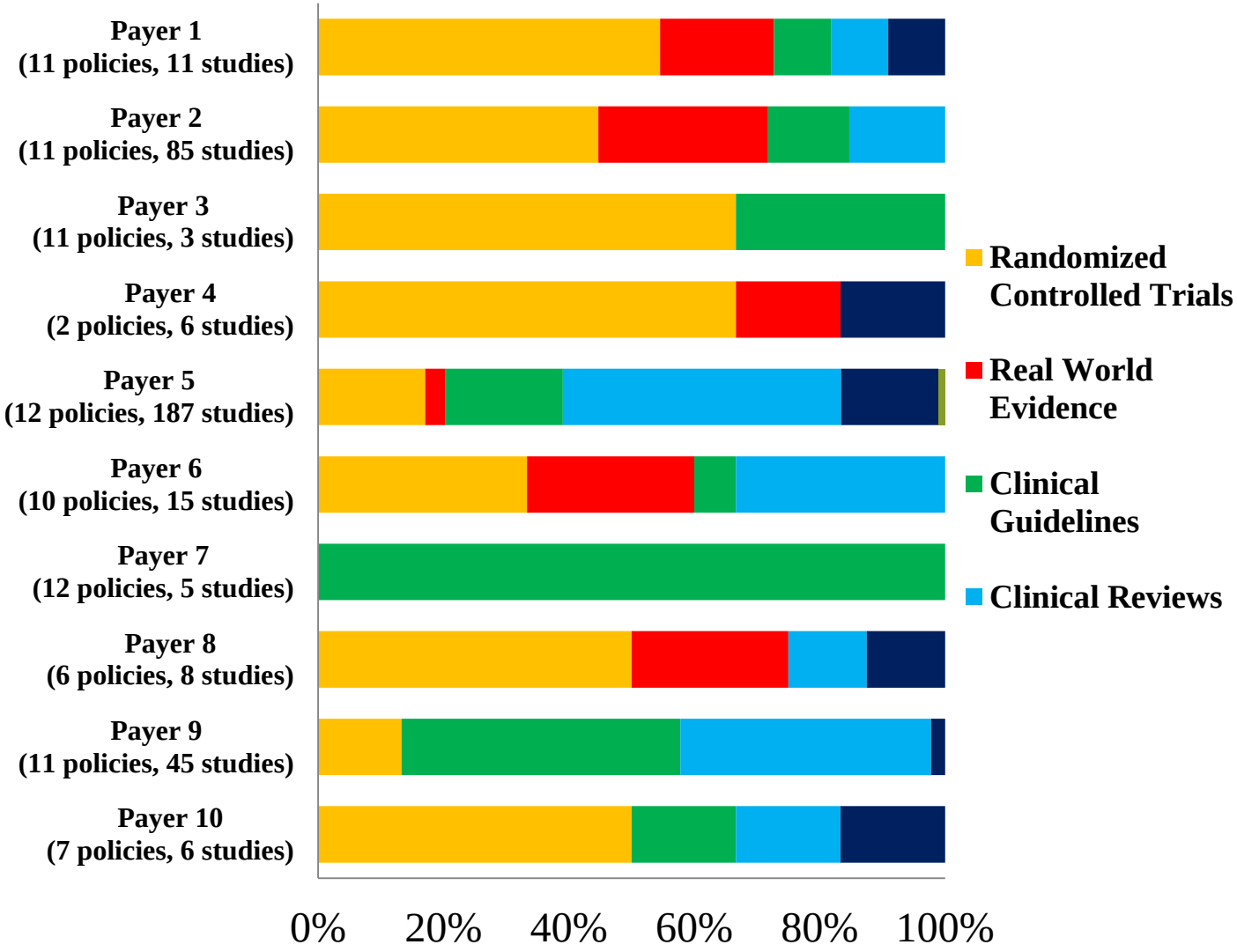
Decision

- Payers make coverage decisions not treatment decisions

❑ Yes, decisions on payment and under what conditions payment is made will impact decisions regarding treatment…

- ❑ …however payers are not actively treating individual patients and are making decisions for a population…
- ❑ …their job is to provide access/payment to treat the patient while spending the least amount of money to do this

CEA is rarely used



Data for MS drug policies. Presented at AMCP by **James Chambers, PhD, MPharm, MSc**
Assistant Professor, Tufts Medical Center

CEA is thought not to be acceptable

- Most payers do not explicitly use comparative effectiveness analysis or other sophisticated tools.
- Not generally accepted in the US for making healthcare decisions.

> "In the modern American political system, for a policy option to successfully navigate the path from a bill to a law often requires widespread public appeal, or at least little public opposition. This study should offer a warning to the research community that, despite the cost-saving potential of CEA, it is likely to engender widespread opposition when put into practice in the United States—particularly if decisions are widely known by the public."

Botta MD, Blendon RJ, Benson JM. Cost-effective decision making and US Public Opinion (letter) JAMA Int Med Jan2014(174)(1)141

And CEA will not manage the budget

- CEA allows for choosing the most cost-effective treatment
  - Biggest bang for the buck
- However the most cost-effective treatment could be the most expensive leading to a serious budget catastrophe
- At an individual level a given intervention may be more effective allowing for use of a less expensive alternative in some patients

If no CEA?

- Payers use a variety of mechanisms to achieve the desired result of successfully treating patients while restraining costs:
  - ❑ Qualitative decision making e.g. comparative effectiveness
  - ❑ Cost constraint procedures e.g. step edits
  - ❑ Benefit designs promoting lower cost alternatives
  - ❑ Build a dam: prior authorization

Evaluating value: cost and clinical outcomes

Intervention	Clinical Utility vs. standard of care	Cost per patient	Managed care decision
A			?
B			YES
C			NO
D			YES

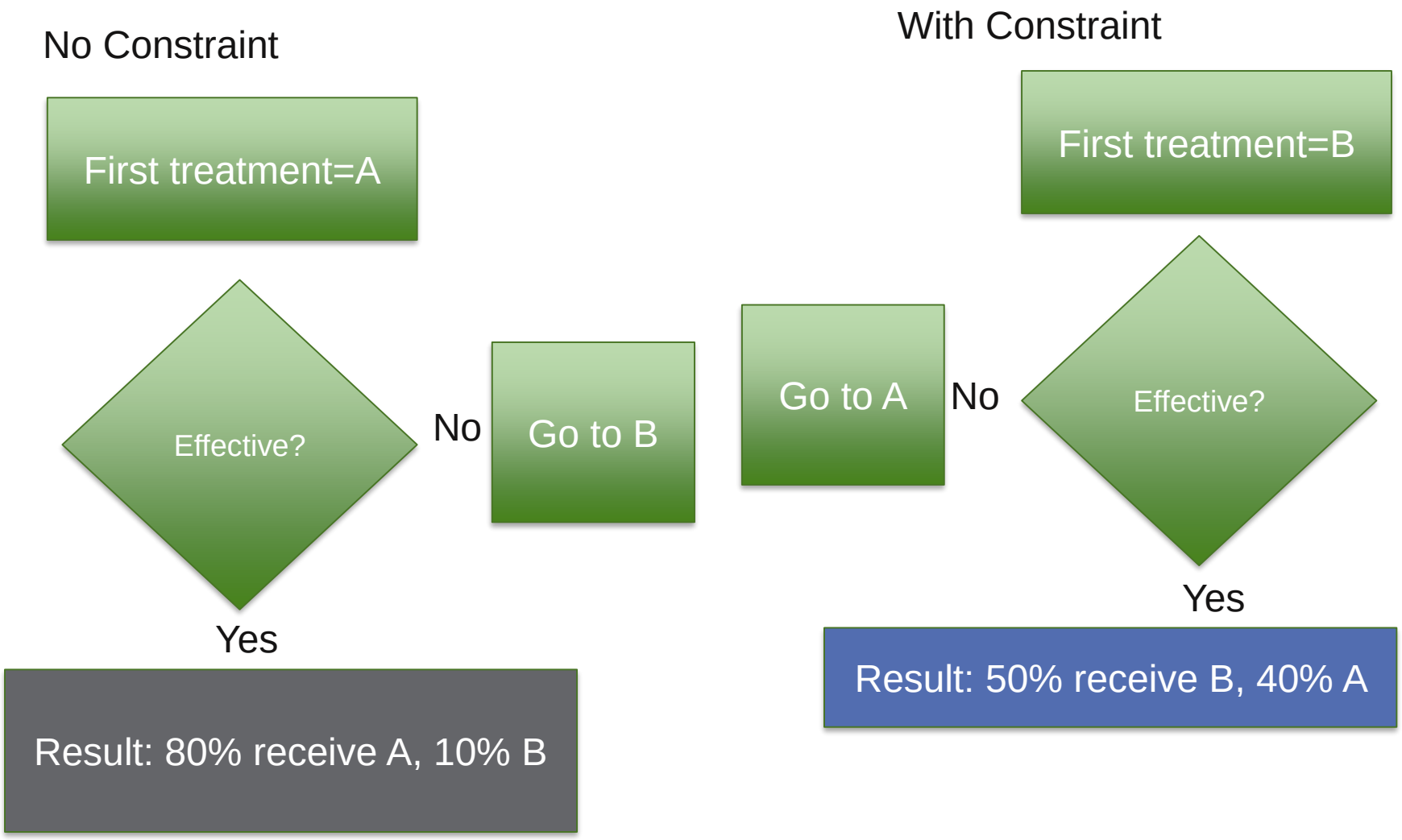
Working around CEA

Most US payers do not use Cost Effectiveness Analysis

- Politically unacceptable
- Opens up criticism that they are too focused on cost
- But creates a problem when evaluating new treatments that are have more clinical utility but are more costly than existing therapies
- Therefore, payers use work around approaches like Utilization Management

Cost constraint procedure

A= 80% effective, $$
B=50% effective, $



Dam building: prior authorization

Prior Authorization sets height of dam controlling the amount of flow

- Can be adjusted on an annual basis
- Will not stop all use
- Can be overwhelmed

Available Value-Assessment Tools

- ACC/AHA-Cost Value Methodology✓
- ASCO-Value Framework
- Drug Effectiveness Review Project (DERP, Oregon)
- DrugAbacus (Memorial Sloan Kettering)✓
- ICER Value Framework✓
- NCCN Evidence Blocks
- NCCN Resource Stratification
- Oregon State Health Evidence Review Commission Prioritization✓
- Premera-Value Based Drug Formulary✓

✓=$/QALY used

Value assessment frameworks can provide a common language and allow us to move ahead with a rational discussion of costs and benefits

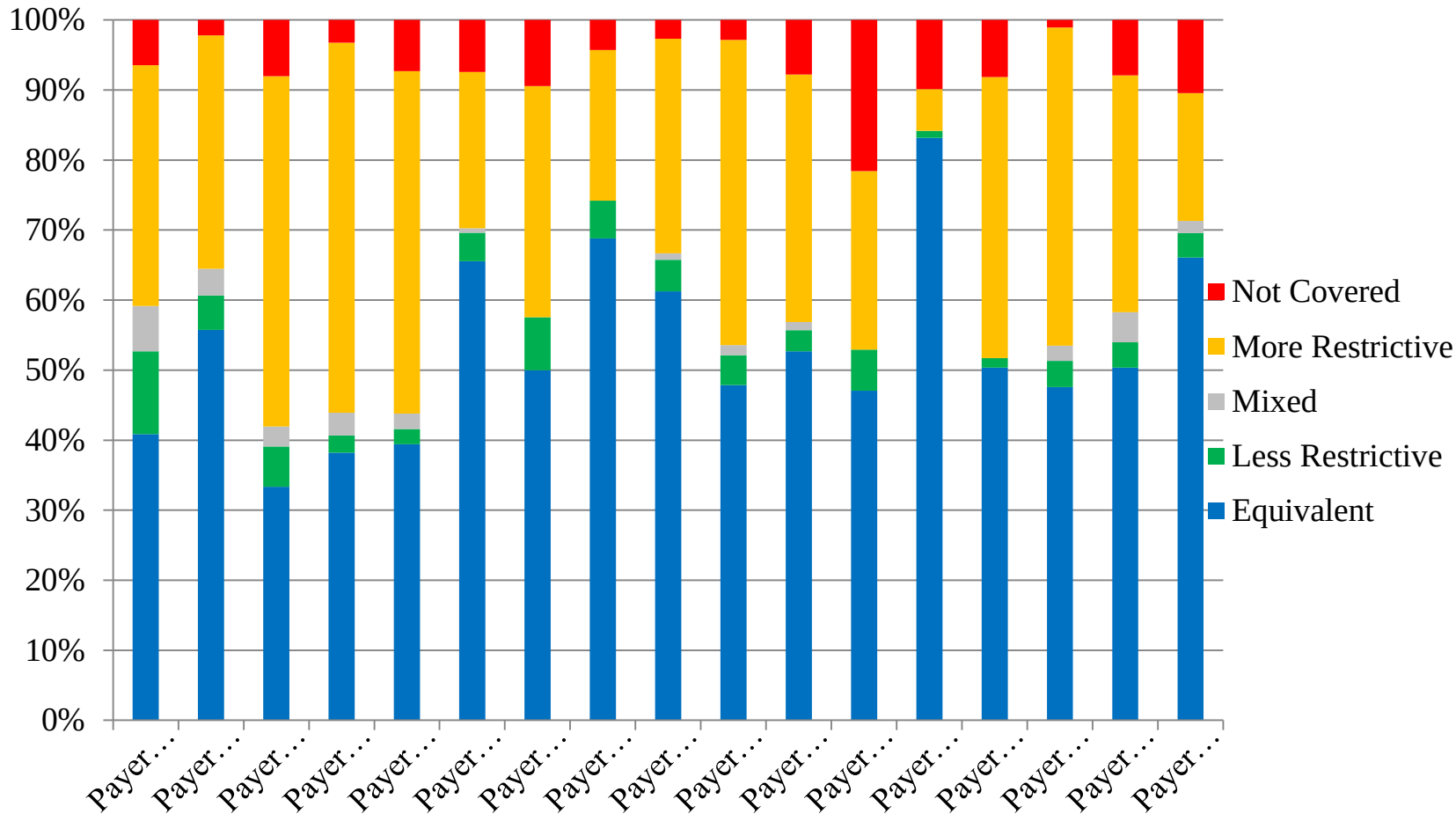
Current use of value frameworks

- Value frameworks are another way of describing HTA
- Not all of the frameworks in use incorporate a formal economic or cost-utility function
- US payers each have their own approaches which may be less formal and less sophisticated than the proposed frameworks or HTA
- No payers have endorsed ICER or other frameworks as a reference for coverage decision making (i.e. no standard)

Value of value frameworks

- Moving the discussion ahead
  - Common vocabulary
  - Introduce decision makers and the public to economic constructs and analysis in decision making
- Making data sources and tools explicit
  - Citing data sources
  - Describing processes
- Enhancing the science of decision making
  - We need to address the lack of uniformity in decision making by independent payers in the US

Payer decisions are highly variable



Tufts Medical Center, Private Payer Drug Coverage Database, March 2017

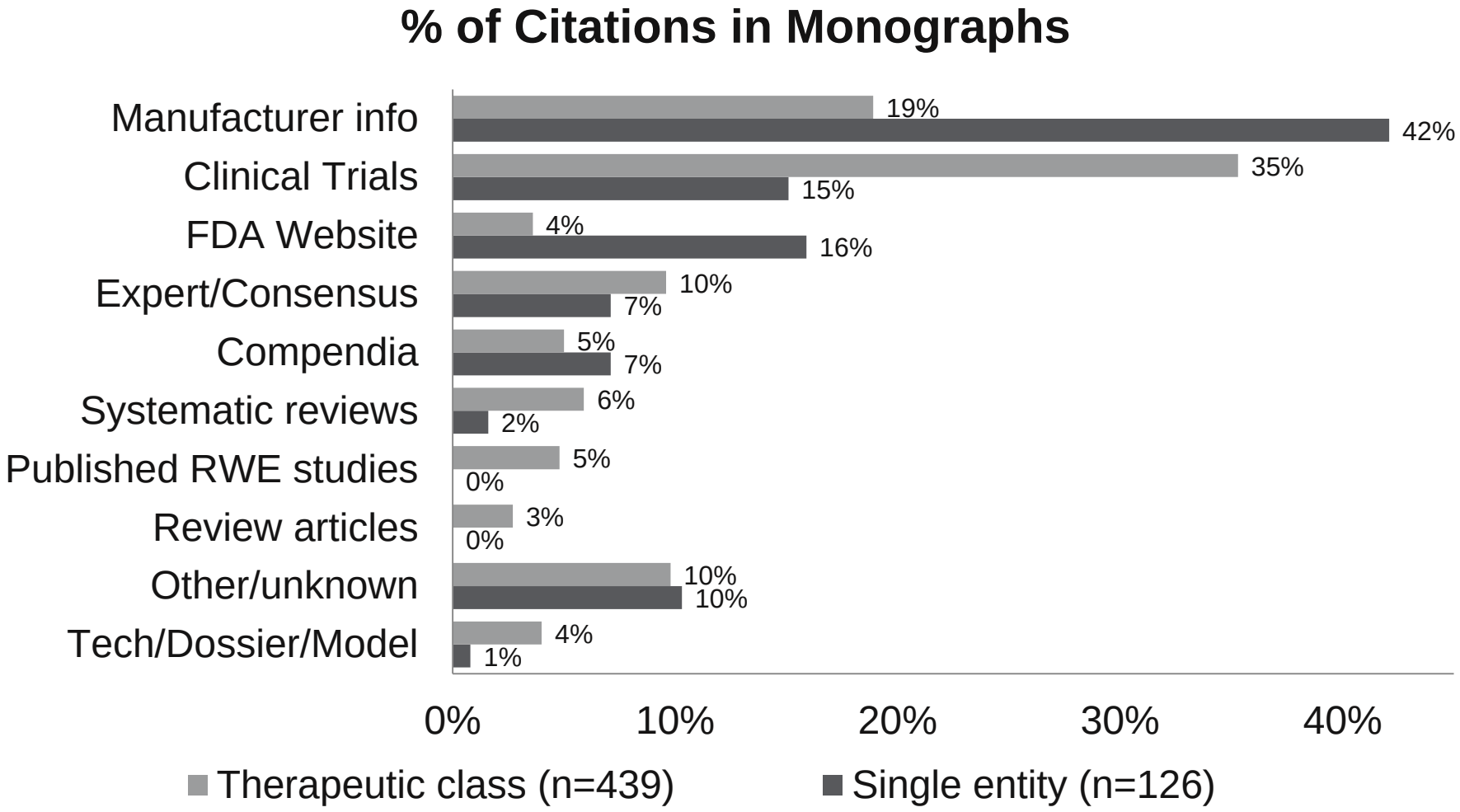
Future of value frameworks

1) Value frameworks are not going to go away
2) Methods and approaches may be internalized by payers
3) Nongovernment payers will not be transparent unless compelled to be so
4) Government payers will be transparent but will avoid CEA and related tools for some time
5) ICER and other nonpayer/nongovernment organizations will play a roll by engaging in a public discourse
6) This roll for these pseudo-HTA organizations will require them to be more inclusive of various stakeholders, and more transparent in methods and discussion

Where does data come from?

- Payer decision makers use a broad range of data
- We have already seen that they use cost but do not use formal economic tools like CEA (although that would be useful)
- Most commonly used data sources
  - Manufacturer data
  - Published studies, esp. RCT

Data sources for P&T Monographs



Hurwitz JT et al. JMCP online March 2017.

RWE in practice

- Depends on your definition of RWE
- Only 5% of plans used published RWE trials
  - Not many trials available right now
  - Likely to become more common
- Many plans do look at their own data but it has limited use for making formulary or clinical policy decisions
- There are collaborations between plans and pharma to develop better evidence and use more observational data
  - Quality metrics
  - Utilization
- Many outcomes based contracts contain RWD collection elements

Thank you