Evolving payer preferences for health economic information and communication in the US

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Introduction

The US healthcare system is experiencing a period of accelerated transformation, driven by the emergence of innovative, high-cost therapies, and a rapidly evolving policy landscape. As more advanced treatments enter the market, payers are confronted with increasing complexity in assessing their clinical and economic value, as well as in determining appropriate coverage and reimbursement strategies.

In this context, the need to balance clinical benefit with economic value has intensified the demand for robust, timely, and decision-relevant evidence. Payers are increasingly relying on a diverse array of data sources, including randomised controlled trials, real-world evidence, and health economic modelling, to inform their evaluations. Moreover, the timing of evidence delivery across the product development and launch continuum has become a critical factor in shaping payer decision-making.

Our previous research has shown that US payers exhibit a relatively low level of trust in manufacturer-provided health economic models (1).

Despite this scepticism, payers continue to recognise the value and necessity of these models in supporting formulary decision-making.

As the demand for transparent and credible economic evidence grows, understanding payer preferences and expectations regarding the structure, content, and delivery of manufacturer-provided models becomes increasingly important.

This research explores how payer expectations are evolving in response to these challenges, with a particular focus on the types of economic evidence deemed most compelling, and the preferred modalities and timing for engagement with manufacturers.

Objective

The objective of this research was to generate new insights into how US payers perceive and engage with health economic models provided by manufacturers, with a focus on identifying evolving needs and preferences that can inform more effective and commercially relevant evidence communication strategies.

Methods

In March 2025, experienced stakeholders from US payer organisations were invited to participate in a comprehensive 30-minute online survey incorporating both quantitative and qualitative research components. Eligibility criteria included current residence in the US, current or former affiliation with a US payer organisation, a minimum of 5 years' experience as a payer or actuary, and current or prior participation as a voting member on a Pharmacy and Therapeutics (P&T) committee. Individuals without direct involvement in payer decision-making processes were excluded.

The survey consisted of 53 questions designed to capture payer perspectives on a range of topics, including evolving preferences related to health economic evidence. In addition to structured response formats, participants provided qualitative commentary within the survey, enriching the contextual depth of the findings.
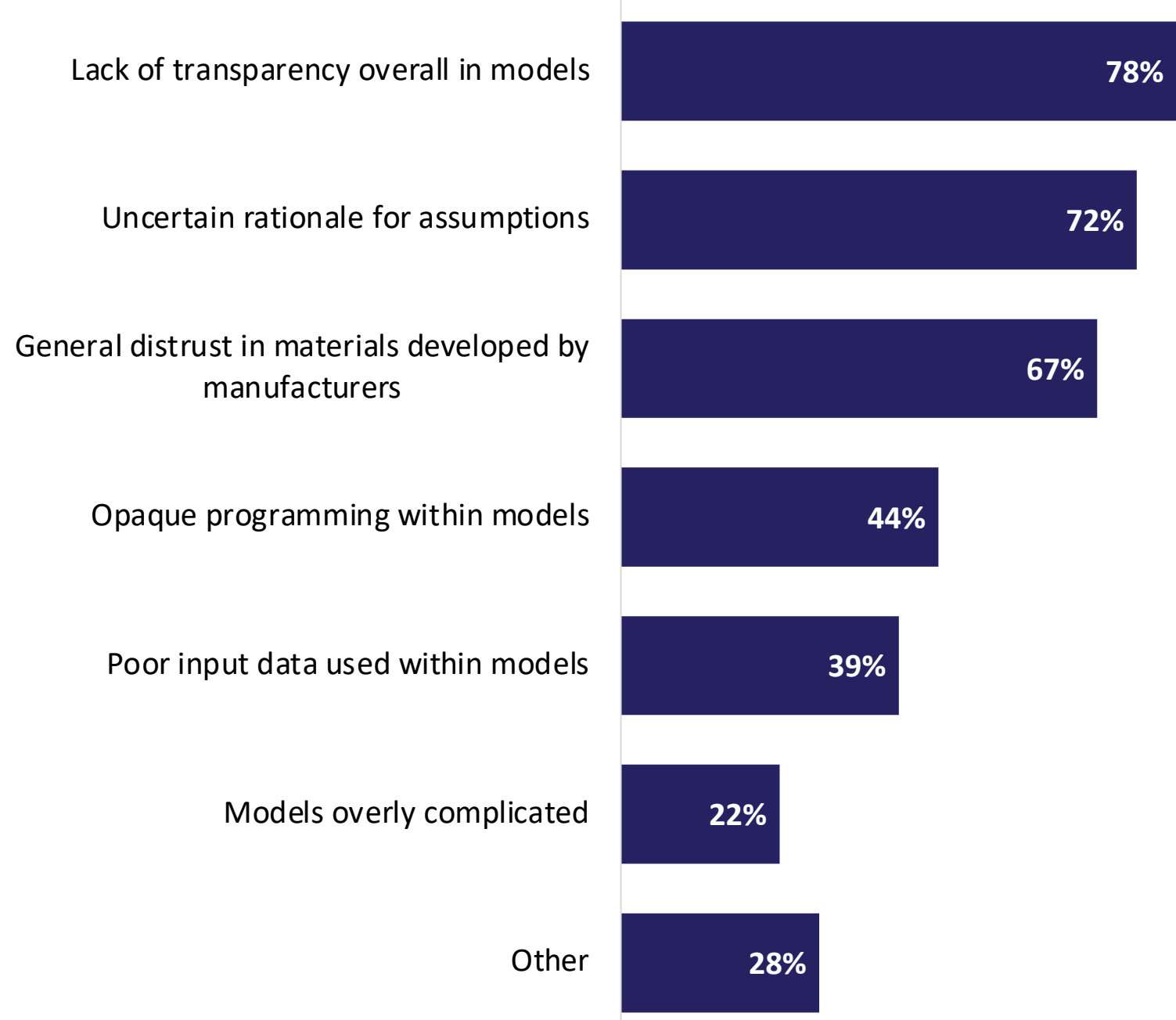
Descriptive statistical analyses and thematic synthesis of qualitative responses were conducted to identify key trends and insights relevant to payer expectations and evidence engagement.

Results

A total of 18 stakeholders (4 medical directors, 11 pharmacy directors, and 3 individuals specialising in industry or trade relations) participated in the survey. These participants represented a diverse mix of national and regional managed care organisations (MCOs), pharmacy benefit managers (PBMs), and integrated delivery networks (IDNs).

Survey findings reaffirmed an ongoing lack of trust in manufacturer-provided health economic models. Specifically, 61% reported a low level of trust, while only 6% expressed a high level of trust (data not shown). These figures have remained largely consistent with prior research (1). The most frequently cited reason for low trust was a lack of transparency, reported by 78% of participants (Figure 1).

Figure 1: Reasons for lack of trust in manufacturer-provided models

Only 6% of participants reported directly using manufacturer-provided models for health economic assessments without additional internal analysis. Nevertheless, these models still serve important secondary functions: 39% use the models to validate their own models, and 33% rely on them to support input parameters and assumptions (Figure 2).

Among various model types, payers expressed a clear preference for budget impact models. Half of the participants (50%) rated these models as moderately valuable, with fewer considering them not valuable. In contrast, cost-effectiveness analyses, simple cost calculators, and cost utility analyses were viewed as less useful, with 22–28% rating them as not at all valuable (Figure 3).

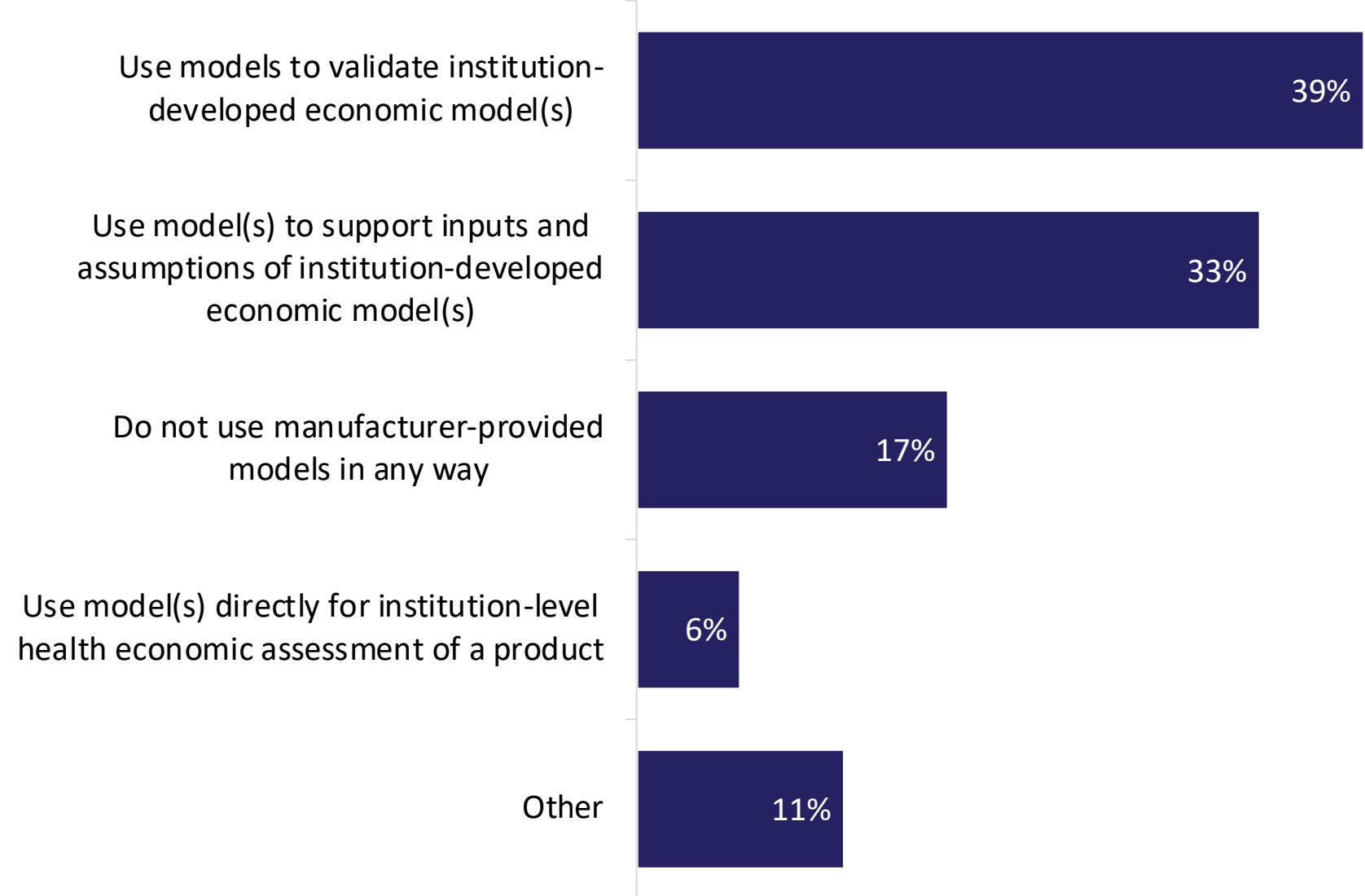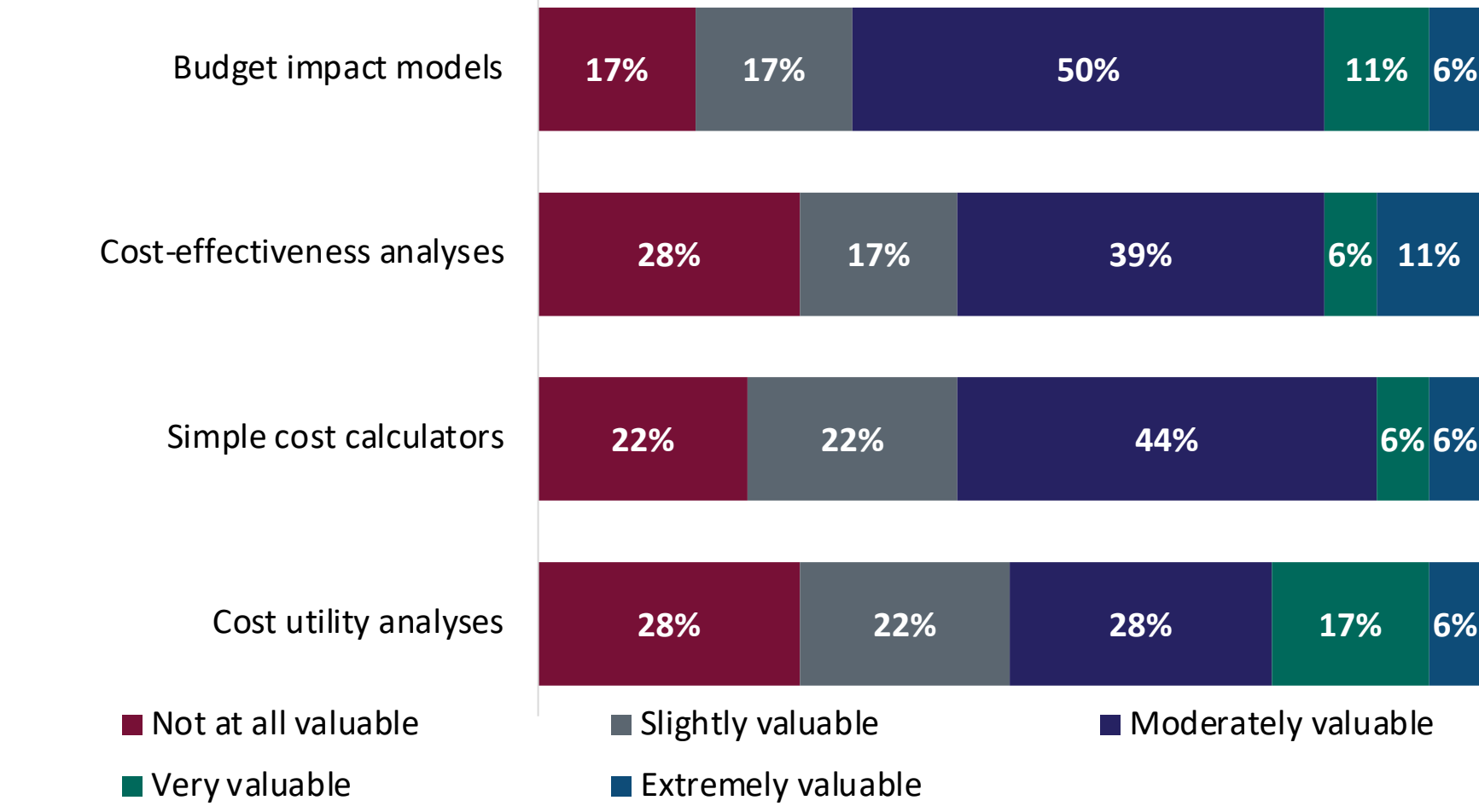Figure 2: Use case of manufacturer-provided models

Figure 3: Perceived value of different types of economic models

Regarding preferred time horizons for models, 55% favoured models that present a 2–3-year economic impact, while 39% preferred a 1-year model (data not shown).

When asked about preferences for incorporating real-world evidence (RWE) into health economic models, the dominant approach among payers was to use RWE to validate findings and assumptions from randomised controlled trials (RCTs), with 56% favouring this method.

Other approaches, such as integrating RWE as a core component, using RWE only when RCT data are unavailable, relying solely on RCTs, or selecting alternative methods, were evenly distributed, each preferred by 11% of participants (Figure 4).

Figure 4: Perception of using RWE in health economic models

Regarding preferred formats for receiving economic results and evidence from manufacturers, peer-reviewed publications or journal articles were most favoured (72%), followed by webinars or virtual presentations (50%), and face-to-face presentations with live model demonstrations (39%) (Figure 5).
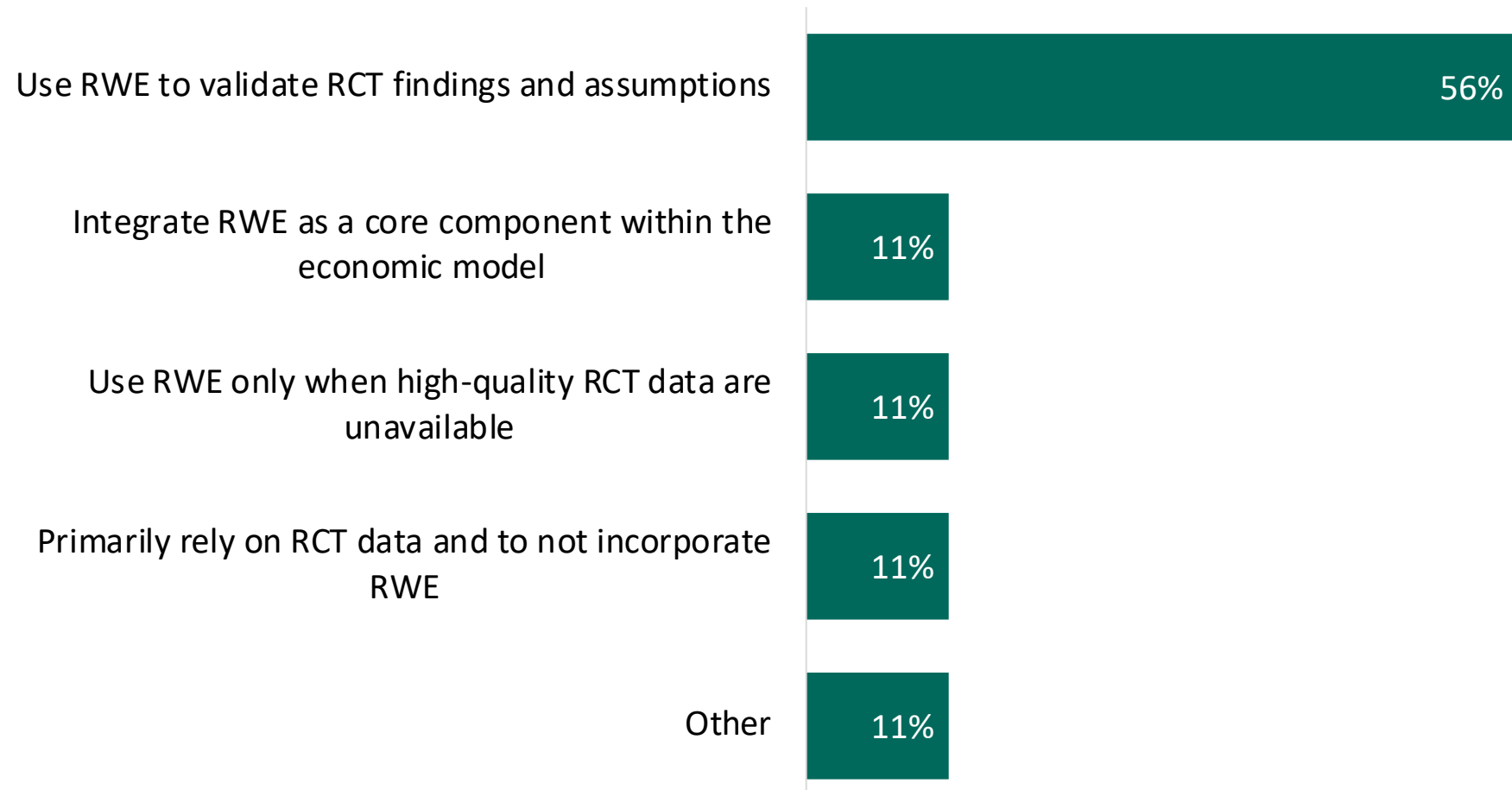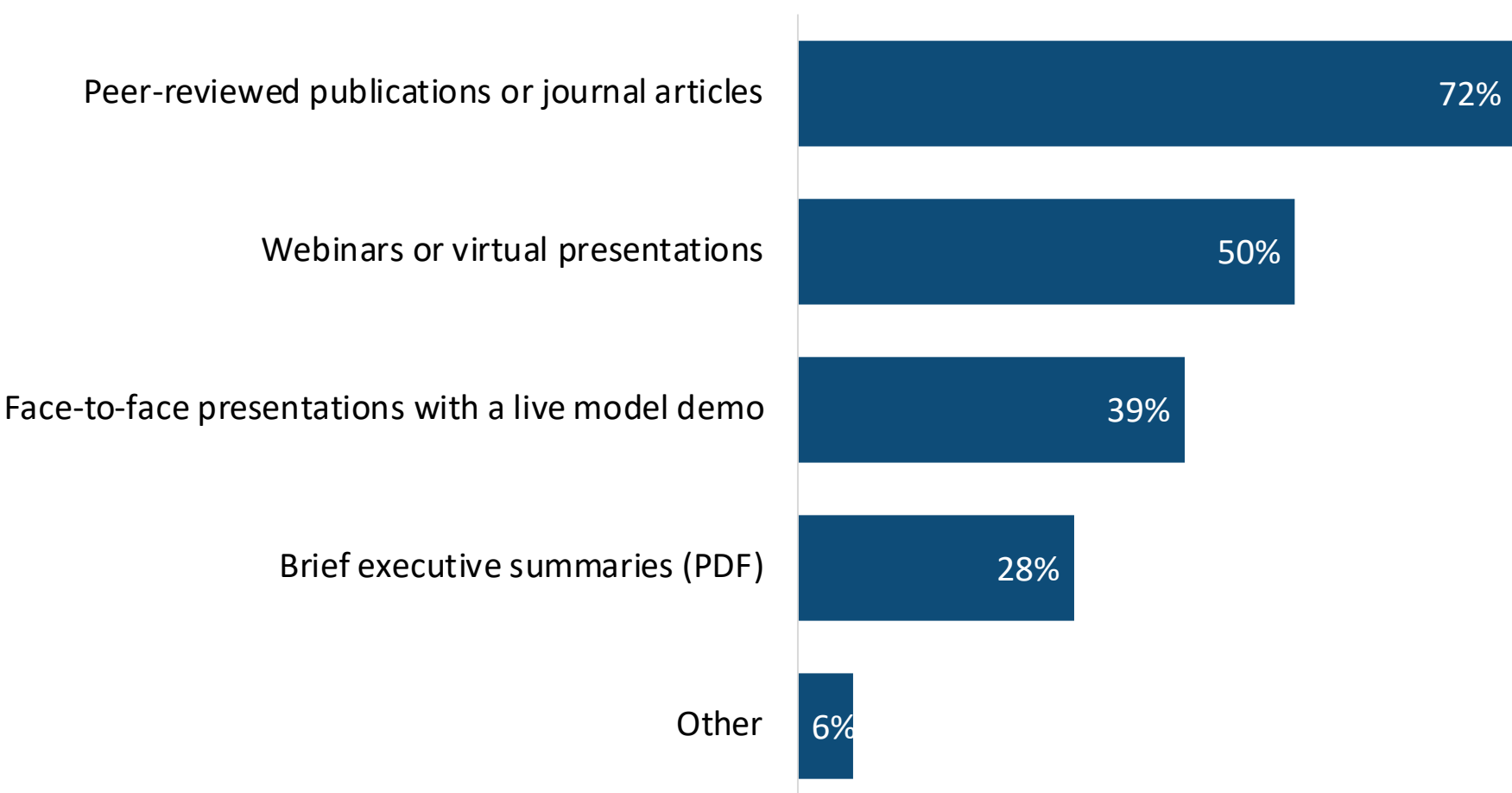
Figure 5: Preferred formats for communicating health economic results

Conclusion

As the US access and payer landscape continue to shift toward greater scrutiny of healthcare economics, manufacturers must evolve their engagement strategies. Delivering transparent, credible, and commercially relevant economic evidence that is aligned with payer expectations is essential to building trust and supporting informed coverage decisions. A tailored approach that reflects payer priorities and real-world decision-making dynamics will be critical to driving meaningful engagement and maximising product uptake.

References

1. Lodowski N, et al. Payer Preferences Around Manufacturer Provided Evidence and Engagements in the US. Value Health. 2024; 27(12): S2. Poster presented at: ISPOR Europe; November 2024; Barcelona, Spain.

Abbreviations

IDN, integrated delivery network

MCO, managed care organisation

P&T, Pharmacy and Therapeutics

PBM, pharmacy benefit manager

RCT, randomised controlled trial

RWE, real-world evidence