The Debate on Indication-Based Pricing

Adrian Towse
Director of the Office of Health Economics
Visting Professor, London School of Economics

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I. Potential benefits of IBP – aligning price with value could expand patient access

Matching payments with value
- Permits rational prices which reflect true differences in value across indications (Bach 2014; Pearson et al. 2017; Flume et al. 2016)
- Reimbursement systems that do not account for changing value across indications or over time may produce suboptimal long-term societal outcomes (Garrison & Veenstra 2009)
- Allows physicians to make value-based prescribing decisions (Bradley, 2017)
- Outcomes contracts can reduce uncertainty; net price can thereby reflect actual value in the real-world setting (Yeung and Carlson 2017)
- Could encourage research into better targeting (Sachs et al. 2017)
- Can be used as a tool to make treatment indications with poor cost-effectiveness more affordable (Bach 2016)

Expand patient access
- Would facilitate reimbursement in indications for which, based on current prices, the treatment is not cost-effective (Hui et al. 2017)
- IBP expands patient access and maximises quality-adjusted life years (QALYs) gained from a given budget, as well as encouraging the development of new indications. This provides the right signals for R&D (Mestre-Ferrandiz et al. 2015)

Balancing the needs of all stakeholders
- Could balance affordability for payers, sustainability for manufacturers and access for patients (Pearson et al. 2017)
II. Potential drawbacks of IBP – unaffordable for payers?

Some argue that IBP would benefit industry at the expense of rising costs for payers

- "Relative to uniform pricing, IBP results in higher prices for patients who benefit the most, higher utilization by patients who benefit the least, higher overall spending, and higher manufacturer profits" (Chandra & Garthwaite 2017)
- Payers clear that IBP by itself does not meet challenges to affordability (Pearson et al. 2017; Bach 2016)

We would qualify this: In the short-run expenditure is likely to rise, but in the long-run IBP would provide the right incentives for R&D and could increase price competition at the indication-level, driving down prices and delivering better value to the health system.

II. Potential drawbacks of IBP – unaffordable for payers?

Uniform pricing scenarios: IBP scenario (static)

- Prices, ↑ Spend, ↑ Patient access, ↑ Welfare
- Transfer of extra surplus to producers

OVERALL ... 
↑ Spend 
↑ Welfare (but transfer to producers)

- Prices, ↓ Patient access, ↓ Welfare
- Extra surplus to producers

Value ($): HV - High value; MV: Medium value; LV: Low value

N: Number of patients (N_u under uniform pricing, N_IBP under IBP)

P: Price (P_U under uniform pricing scenarios, P_H [high value] P_M [medium value] P_L [low value] under IBP)

No patient access

Consumer (payer) surplus
Producer surplus
No surplus
II. Potential drawbacks of IBP – unaffordable for payers?

IBP scenario (static)

IBP scenario (dynamic)

Dynamic price for the medium / low value indications ($P_{Md}/P_{Ld}$)

This leads to transfer of surplus from producer to consumer (payer)

III. IBP – The details matter

What format should IBP take?

- IBP aligns payments with value, but efficacy differs from effectiveness; this means that evidence-based IBP prices (set ex-ante) might be quite different to outcomes-based reimbursement (based on realised value) (Yeung & Carlson 2017)

Barrier (opportunity?): data collection

- Poor data availability for tracking use by indication per patient (Pearson et al. 2017; Bach 2014)
- Feasibility of data collection must be balanced with the clinical relevance of the outcome (Yeung & Carlson 2017)
- Data lacking on effectiveness in sub-populations (Sachs et al. 2017)
- IBP could facilitate the collection of richer real-world data, and provide greater transparency in the utilisation of cancer drugs (Bach 2014)
III. IBP – The details matter

Legal and contractual barriers (surmountable?)

- Market-specific contractual barriers, e.g. Medicaid's best-price rule (Pearson et al. 2017)
  - This could be overcome, e.g. through contracts using weighted average price for multiple indications, or through product differentiation (Sachs et al. 2017)
- Bulk purchases by pharmacies, and volume-based payments by doctors and hospitals (Bach 2014)
- Off-label use, anti-kickback statute (Pearson et al. 2017)
- Privacy concerns inhibit data sharing with manufacturers (Sachs et al. 2017)

Political challenges may be greater than technical challenges (Bach 2014)

In summary...

- The case for IBP continues to be debated.
- Some argue that IBP would lead to higher prices and increasing expenditure on medicines.
- This depends on how uniform prices are set and the extent IBP promotes price competition
- In principle it could be both efficient – increasing the numbers of patients using a medicine and increasing the numbers of new indications that offer value for money – and potentially promote competition.
- If IBP were to be implemented, a number of barriers need to be overcome to enable its potential benefits to be realised.
- US health plans and PBMs are currently piloting IBP approaches with the objective to better manage expenditure
Reference list


Contacts

To enquire about additional information and analyses, please contact Adrian Towse at atowse@ohe.org

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OHE Consulting Ltd
Southside, 7th Floor
105 Victoria Street
London SW1E 6QT
United Kingdom
+44 20 7747 8850
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