Pharmacoeconomic Analysis and Outcome-based agreements: What does it mean for Canadian Private Payers?

Tuesday, October 27, 2020 | 2:15 pm - 3:45 pm EST

Moderator:
Julie Blouin, SunLife

Speakers:
Daria O'Reilly, TELUS Health
Ned Pojskic, Greenshield
Sumeet Singh, Eversana
Lou Garrison, University of Washington

SUNLIFE

In this panel, we will explore 2 topics

- **Pharmacoeconomic analyses**
  - Are pharmacoeconomic (PE) analyses relevant for private payers, and why?
  - What costs, outcomes, and time horizon should be considered in a pharmacoconomic analysis for private payers?
    - Should a PE analysis for private payers be different than a PE analysis for a health technology assessment body?
    - Should costs related to the public health care sector (e.g. hospitalization costs, medical procedure costs) be included in a PE analysis for private payers?

- **Outcome-based agreements**
  - What are the challenges with implementing outcome-based agreement in the Canadian private sector?
  - What could be learn from the US private payers experience?

Value of Pharmacoeconomics and the Canadian Private Payer

CAPT Virtual Conference October 26-27, 2020
Panel session: Pharmacoeconomic Analyses and Outcome-based Agreements: What does it mean for Canadian Private Payers?

Daria O'Reilly, PhD – Lead Health Economist
Pharmacy Consulting Team, TELUS Health

#HealthBenefitsTrends

TELUS Health

Are PE analyses relevant for private payers?

FDA approves $2M medicine, most expensive ever

Zolgensma, the one-time gene therapy that will cost $2.125 million US to treat a rare condition called spinal muscular atrophy

The Associated Press · Posted: May 24, 2019 4:58 PM ET | Last Updated: May 24

Who is the ‘private payer’?

1. Insurer?
2. Employee (Plan member)?
3. Employer (Plan sponsor)?

Users of private payer PE analyses results

Ned Pojskic: …*insurers are "stewards of our plan sponsors' precious health care dollars…(we take) utmost responsibility in ensuring every dollar spent produces maximum value in terms of health outcomes*."

Which costs to include?

- Remove publicly-funded costs
- Exclude caregivers
- Productivity
- Relevant comparators

What time horizon is relevant for private payers?

- Lifetime horizons mostly inappropriate
- Uncertainty

Should a PE analysis for private payer be much different than for an HTA body?

- Balance between academic exercise and needs
- CUA not always necessary

Importance of BIA to private payers

- Demographics
- Appropriate comparators
- Market size

Summary

- Public and private payers serve different populations
- Insurers becoming more sophisticated in HTA/EE methods
- Private payer perspective is important
- Comparison of public vs. private payer ICERs
  - increased ICER by $8,188 (~ 2% on average), 14% SD suggests that the difference can be large in either direction.

Questions

EVERSANA™

Pharmacoeconomic Analysis and Outcome-based agreements: What does it mean for Canadian Private Payers?

Sumeet Singh

1. Are PE analyses relevant for private payers?
2. Should PE analyses for private payers differ from those for HTA/public payers?
3. Should a societal or health system perspective be considered at all by private payers?

Questions

Are PE analyses relevant for private payers?

- No other viable mechanism for managed formularies to assess value for money of new drugs
- Canadian pharmaceuticals ecosystem is aligning as never before on PE analysis to assess value for money
    - HTA – CADTH, INESSS
    - pCPA and public payer funding decisions
    - PMPRB

Should PE analyses for private payers differ from those for HTA/public payers?

Depends upon the product and clinical area

Some considerations based on our experience:

Perspective: Private payer perspective (i.e., excluding costs borne by the public health care system) is increasingly of interest.

Costs: Inclusion of productivity costs/disability payments may be important to consider

Population: Honing in on cost effectiveness in the private payer beneficiary population to the extent possible (e.g., conducting scenario analyses using subgroup data from younger patients if available and relevant)

Time horizon: Generally similar to analyses for HTA, although may consider implementing changes in coverage that occur over a typical beneficiary's lifespan (e.g., drug costs borne by public payer after age 65)

Should a societal or health system perspective be considered at all by private payers?

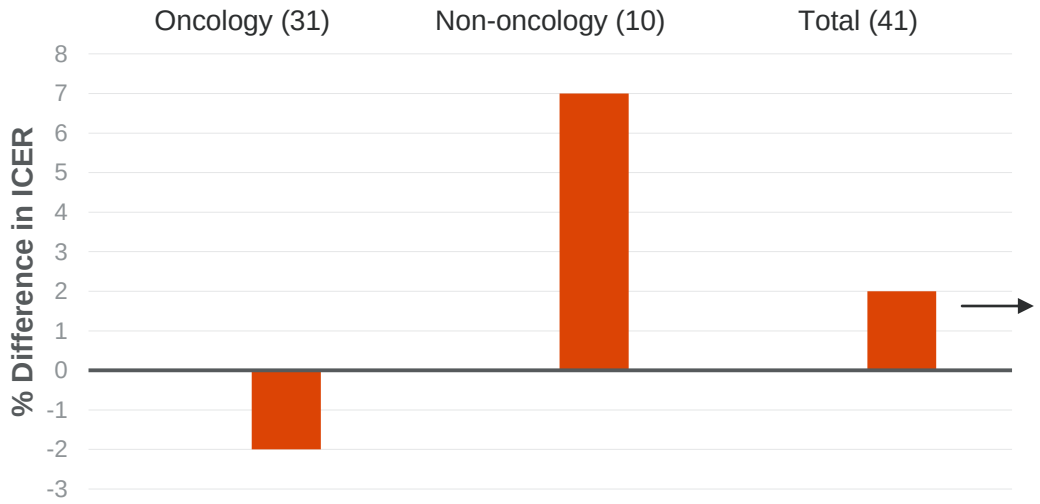
Three reasons for private payers to consider retaining the health system/societal perspective

- Rationalize and communicate why private payer decisions may differ from public payer
- Potential challenges in interpreting and operationalizing results of PE analyses from the private payer perspective
- Appropriateness of assigning zero value to public health system impacts

Should a societal or health system perspective be considered at all by private payers?

In many cases, ICERs from the private payer and health system perspective will align closely, however there can be important exceptions

Comparison of private payer and public payer ICERs



Mean Δ ICER = $8,188; 95% CI: -$97,200 to $113,600

Source: O'Reilly, DJ and Lavoie, R. Determining cost-effectiveness: Perspective matters. *CADTH Symposium 2020.*

Should a societal or health system perspective be considered at all by private payers?

1. *Rationalize and communicate why private payer decisions may differ from public payer*

Scenario in which private payer ICER may be **higher** than the public payer ICER:

- Newer treatment results in reduced monitoring or adverse event management costs (lower burden on the public health care system). Excluding these cost offsets would result in **higher ICERs** from the private payer perspective.

Scenario in which private payer ICER may be **lower** than the public payer ICER:

- New drug extends life, thereby incurring greater total monitoring/follow up costs (physician visits, diagnostics, etc.) versus comparators. Excluding these costs would result in **lower ICERs** from the private payer perspective.

Should a societal or health system perspective be considered at all by private payers?

2. *Challenges in interpreting and operationalizing private payer perspective pharmacoeconomic analyses*

- Do the same willingness-to-pay thresholds apply as for public health system/societal perspective?
  - Nominally $50,000 - $100,000/QALY in Canada
  - Do these thresholds need to be adjusted up or down, and if so, on what basis?
- What is the likely overall impact on private payer spending of basing reimbursement and pricing decisions on PE analyses with a private payer perspective?
- What are the implications for price negotiations?

When a private payer ICER is **higher** than a public payer ICER, how likely is it that private payers will be able to negotiate a lower price than public payers?

When a private payer ICER is **lower** than a public payer ICER, how amenable will private payers be to paying more than public payers? What if the optimal price is even higher than the PMPRB ceiling price?

Should a societal or health system perspective be considered at all by private payers?

3. *Are effects of new drugs on the public health system completely irrelevant to private payers?*

…Perhaps not

- Freeing up of public health care resources because a new drug requires less monitoring or has fewer AEs could improve system capacity. **Does this result in better overall management and health outcomes for private payer beneficiaries?**

- If so, it may not be appropriate for private payers to assign no value at all to such benefits (or conversely, no costs when a new technology imposes health system burdens).

Pharmacoeconomic Analyses and Outcomes-Based Agreements: What Does It Mean for Canadian Private Payers?: A U.S. Health Economist's Perspective

Louis P. Garrison, PhD
The CHOICE Institute, School of Pharmacy, University of Washington, Seattle WA, USA

Sarah NguyenSarah Nguyen

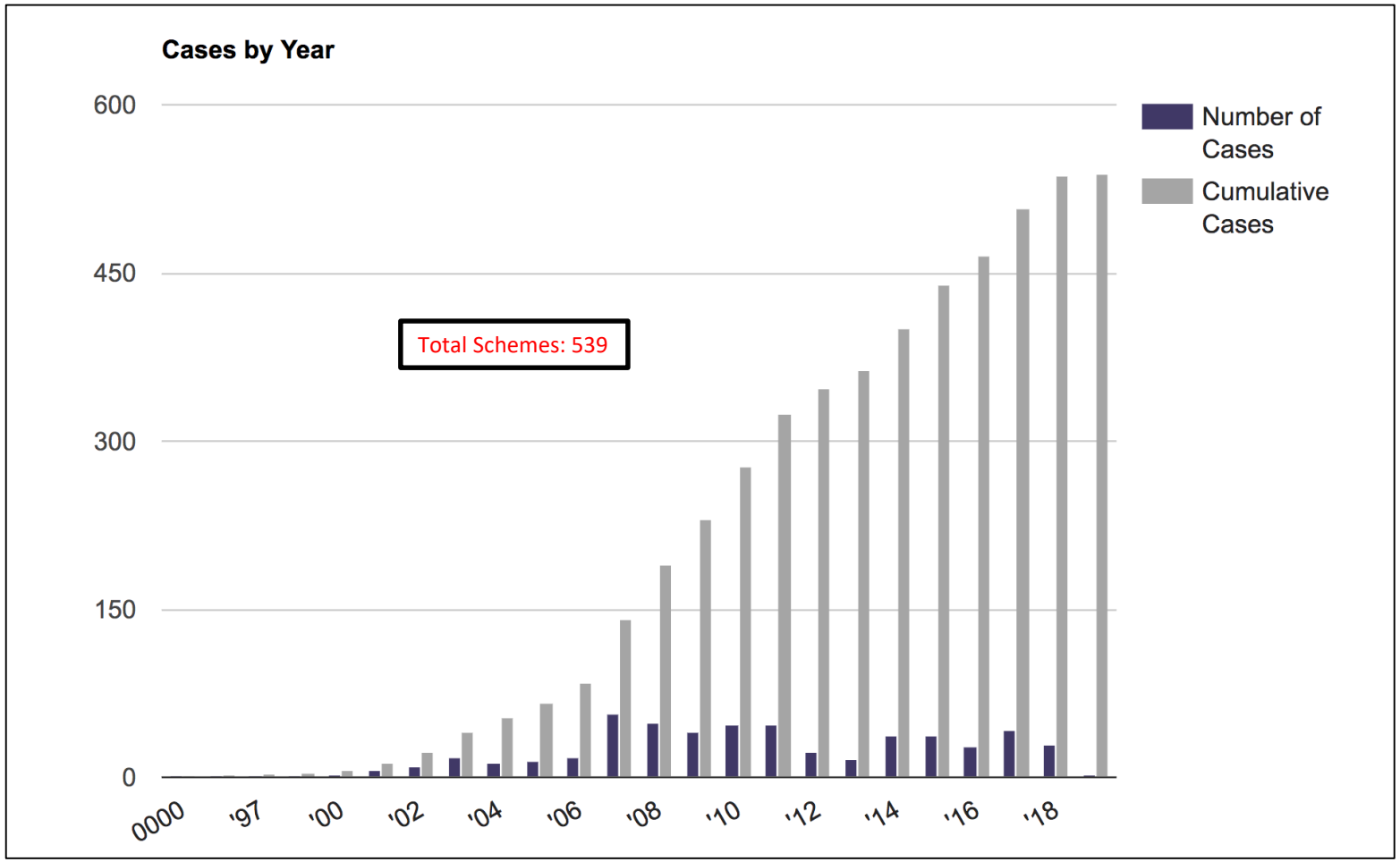
Canadian Association for Population Therapeutics Annual Conference
October 27, 2020

Innovative Product Listing Agreements:
A Variety of Names—Similar Concepts

- ISPOR Task Force (2013)—"Performance-Based Risk-Sharing Arrangements" (PBRSAs)
- managed entry agreements (MEA)
- outcomes-based schemes
- risk-sharing agreements
- coverage with evidence development (CED)
- access with evidence development
- patient access schemes (PAS)
- conditional licensing
- pay-for-performance programs (P4P)
- **value-based arrangements**
- And others?

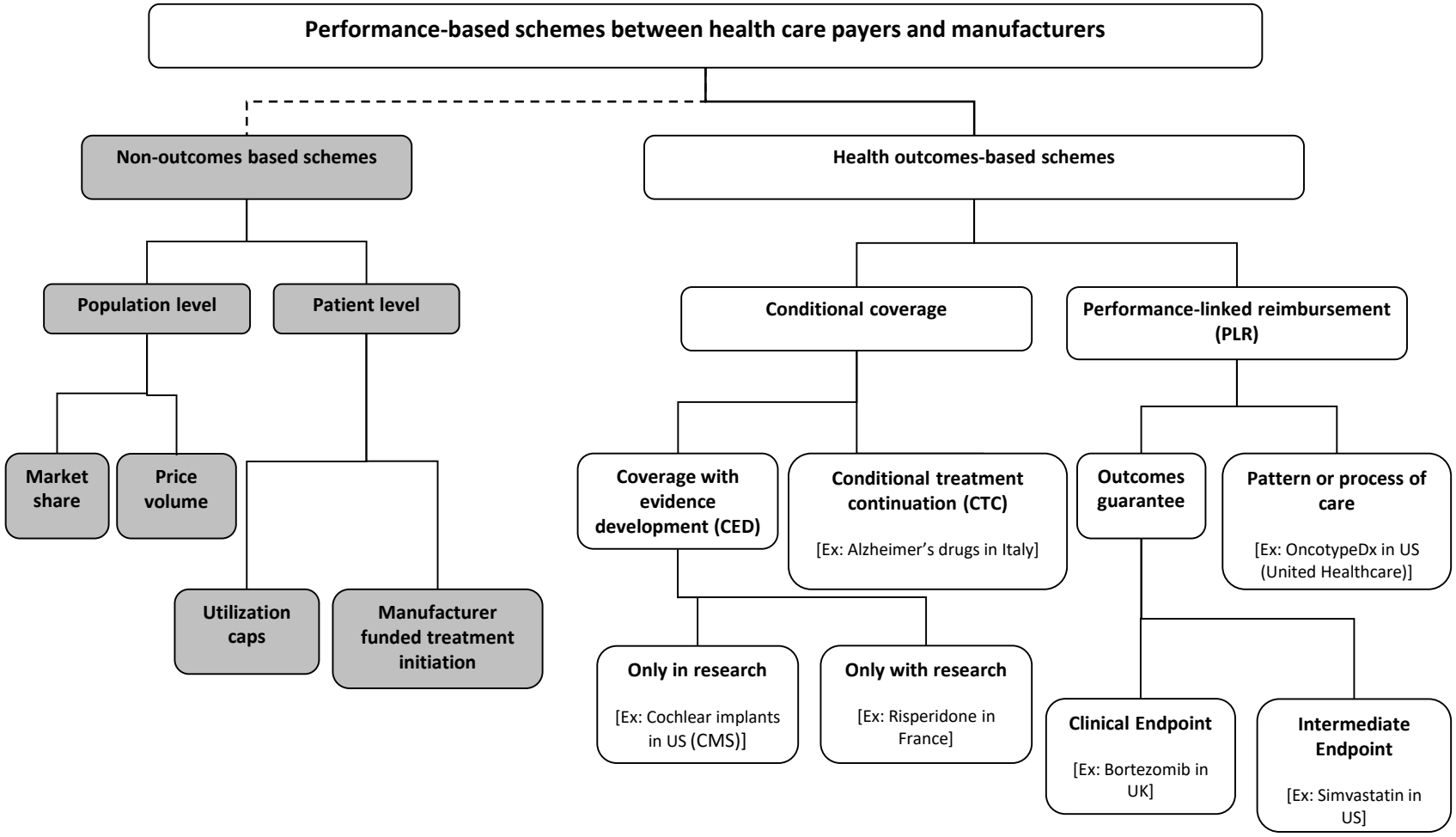
“It takes time . . .”

- Merck:
  - 1994—Proscar “Money-back guarantee” in BPH
  - 1998—Zocor “Get to Goal”
  - 2009—Januvia/Janumet with Cigna
  - 2016—Januvia/Janumet with AetnaCare
- 2007--Velcade story in NYT
- 2008—UW began study and database
- 2012-3 ISPOR PBRSA Task Force
- 2010-2019 ISPOR Short Course—20 sessions—2,751 registrants (231 in 2019)
- **2020 Virtual Courses—July 8 (International); October 21, ISPOR APAC**



Source: UW PBRSA Database

UW Taxonomy (Carlson et al.)



PBRSA—Five Key Characteristics

1. ***There is a program of data collection*** agreed between the manufacturer (or provider, in some instances) and the payer..
2. ***This data collection is typically initiated during the time period following the regulatory approval*** (which may be full, conditional, or adaptive), and linked to post-launch coverage decisions..
3. ***The price, reimbursement, and/or revenue for the product are linked to the outcome of this program of data collection*** either explicitly by a pre-agreed rule or implicitly through an option to renegotiate coverage, price, and revenue at a later date
4. ***The data collection is intended to address uncertainty*** **about …. *For example:***
   - efficacy or effectiveness in the tested population as compared to current standard of care;
   - the efficacy or effectiveness in a broader, more heterogeneous population than used in registration trials or in pre-licensing testing
5. ***These arrangements provide a different distribution of risk*** **between the payer and the manufacturer than the historical manufacturer-payer relationship.**

Source: ISPOR PBRSA Task Force Report

POLICY

Private Sector Risk-Sharing Agreements in the United States: Trends, Barriers, and Prospects

Louis P. Garrison, Jr, PhD; Josh J. Carlson, PhD; Preeti S. Bajaj, PhD; Adrian Towse, MA, MPhil; Peter J. Neumann, ScD; Sean D. Sullivan, PhD; Kimberly Westrich, MA; and Robert W. Dubois, MD, PhD

Key findings:

- Lots of interest and talk by manufacturers
- Substantial implementation barriers
  - Need better data systems
  - Costs of negotiation
- More interest in financially-based RSAs
- Shift incentives? ACOs and government subsidies?

Value-Based Arrangements May Be More Prevalent Than Assumed

Nirosha Mahendraratnam, PhD; Corinna Sorenson, PhD, MHSA, MPH; Elizabeth Richardson, MSc; Gregory W. Daniel, PhD, MPH, RPh; Lisabeth Buelt, MPH; Kimberly Westrich, MA; Jingyuan Qian, MPP; Hilary Campbell, PharmD, JD; Mark McClellan, MD, PhD; and Robert W. Dubois, MD, PhD

CONCLUSIONS: This study reveals that the majority of VBAs are not publicly disclosed, which could underestimate their true prevalence and impact. Given the effort required to implement a VBA, future arrangements would likely benefit from a framework or other evaluative tool to help assess VBA pursuit desirability and guide the negotiation and implementation process.

Am J Manag Care. 2019;25(2):70-76

ClinicoEconomics and Outcomes Research

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ORIGINAL RESEARCH

Targeting improved patient outcomes using innovative product listing agreements: a survey of Canadian and international key opinion leaders

This article was published in the following Dove Press journal:
ClinicoEconomics and Outcomes Research
26 August 2016
Number of times this article has been viewed

Melissa Thompson[1]
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Rebecca Yu[8]

[1]Cornerstone Research Group Inc.,

Objectives: To address the uncertainty associated with procuring pharmaceutical products, product listing agreements (PLAs) are increasingly being used to support responsible funding decisions in Canada and elsewhere. These agreements typically involve financial-based rebating initiatives or, less frequently, outcome-based contracts. A qualitative survey was conducted to improve the understanding of outcome-based and more innovative PLAs (IPLAs) based on input from Canadian and international key opinion leaders in the areas of drug manufacturing and reimbursement.

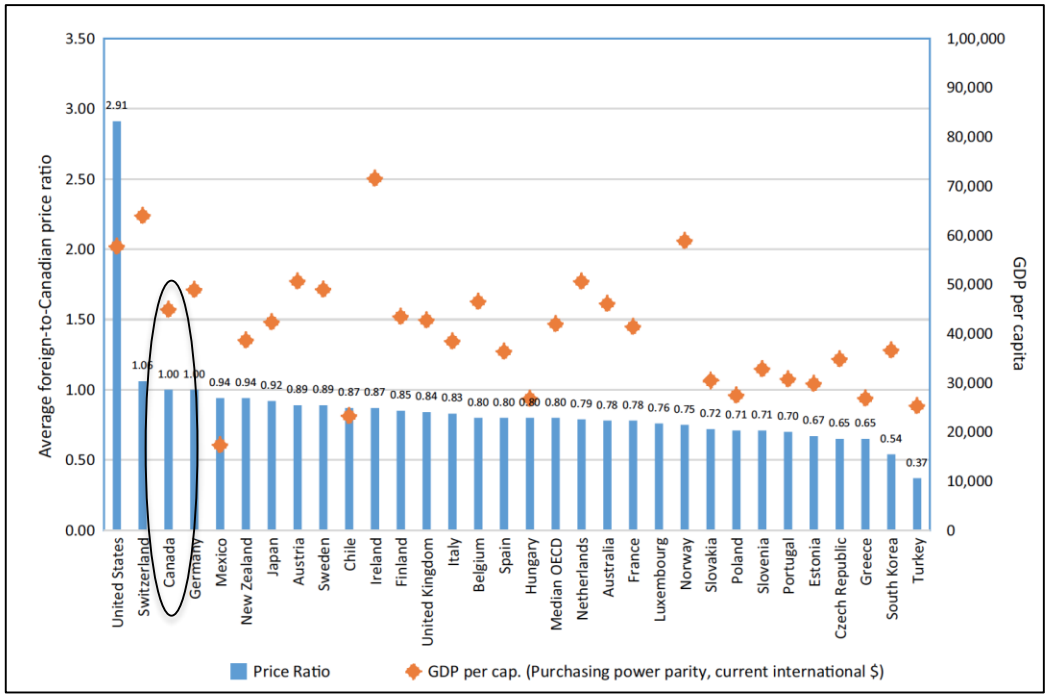
Methods: Results from a structured literature review were used to inform survey development. Potential participants were invited via email to partake in the survey, which was conducted over phone or in person. Responses were compiled anonymously for review and reporting.

Results: Twenty-one individuals participated in the survey, including health technology

"The use of more innovative financial- and outcomes-based PLAs remains of interest to payers, manufacturers, and HTA leaders across Canada."

"The participants suggested that ~80%–95% of Canadian PLAs are financial-based rather than outcomes-based."

Average Foreign-to-Canadian Price Ratios for Patented Drugs by Country, 2016



Source: Danzon, PharmacoEconomics, 2018

Short Answers to Good Questions

- Are pharmacoeconomic (PE) analyses relevant for private payers, and why? ***Yes, need to understand incentives.***
- What costs, outcomes, and time horizon should be considered in a pharmacoeconomic analysis for private payers?
  - ***Short-term for the plan and long-term for plan members/patients***
  - ***Do budget impact and cost-utility analysis***
  - ***Do two perspectives: Private plan and societal***
- Should a PE analysis for private payers be much different than a PE analysis for a health technology assessment body?
  - ***Need to do private plan perspective as well as societal.***
- Should costs related to the public health care sector (e.g. hospitalization costs, medical procedure costs) be included in a PE analysis for private payers?
  - ***Yes, from societal perspective; No, from private perspective.***

Thanks!

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