What You Need To Know About How Payers Define Value

Key Insights and Discussion Guide
Founding Partners Forum

Advisors to our work

The Medical Affairs Leadership Council is grateful to the individuals and organizations that shared their insights, analysis, and time with us. We would especially like to recognize the following organizations for being particularly generous with their time and expertise.

With sincere appreciation

Health Plans:

Aetna
Blue Cross Blue Shield of South Carolina
Community Health Choice, Inc.
Geisinger Health Plan
Group Health Cooperative of South Central Wisconsin
Health Alliance Plan
Health Care Service Corporation (Blue Cross and Blue Shield of Illinois, Montana, New Mexico, Oklahoma & Texas)
Health New England, Inc.
HealthNow (BlueCross BlueShield of Western New York)
Humana
Independent Health Association, Inc.
L.A. Care Health Plan
Moda Health
Tufts Health Plan
United Healthcare
Washington State Health Care Authority

Technology Assessment Firms:

AHRQ
ECRI Institute
ICER
IPD Analytics
LindaCare
Lumere
MCG Health
SharedClarity

Industry Advisors:

Centura Health
Froedert Health
Lewin Group
OptumInsight
OptumRx

Into the Mind of the Payer Research Overview

Research Scope:

The purpose of this research initiative is to understand how different health plans evaluate drugs and devices relative to acceptable treatment alternatives under rapidly evolving payment models and definitions of value.

Key Questions:

- What value drivers matter most when deciding formulary inclusion and medical benefit coverage?
- What sources and types of medical evidence are most useful when assessing the value of drugs and devices?
- Are health plans willing to collaborate with life science firms to expand how value is measured and defined moving forward?

Research Methodology:

Our research targets a variety of health plans offering Medicaid, Medicare Advantage, employer-sponsored and individual plans, including:

- National health plans (>9M lives)
- Blues health plans (Affiliated with the BlueCross BlueShield Association)
- Large (>75K lives) and small (30K-75K lives) regional health plans
- Large (>75K lives) and small (30K-75K lives) provider-sponsored health plans

It also includes perspectives from specialists who influence decision-making, including actuaries, Health Tech Assessment organizations, PBMs, value-based contracting leaders, market access leaders, and federal regulators.

To date, our research includes perspectives from 18+ health plan executives and 20+ experts who influence payer decision making.

Interviews with health plan **C-suite Medical Leaders** and **Functional and Clinical Directors** to learn:

- Who will participate in and influence the decision-making process in light of new, complex therapies and procedures?
- How will a shift towards precision medicine impact what is accepted as high-quality medical evidence?
- How do plans envision collaborating with life sciences firms and are there any examples of this work to date?
- What circumstances shift standard decision-making processes (e.g., therapeutic area, plan type, product life cycle, therapy type)?
- What analyses are performed internally versus outsourced externally today; how will this change 3-5 years from now?
- What is the relative value of different sources of data and real world evidence at different points in decision-making processes?

Into the mind of the payer

Headlines reflect two critical pain points of health plan medical leaders

1 DRUG PRICES

NPR

"As Drug Costs Soar, People Delay Or Skip Cancer Treatments"

The New York Times

"Drug Goes From $13.50 a Tablet to $750, Overnight"

$329B

Total prescription drug expenditures, 2016

≈21%

Percentage of industry EBITDA[1] in pharma and biotech, 2016

2 HOSPITAL PRICES

Vox

"She Didn't Get Treated At The ER. But She Got A $5,751 Bill Anyway"

STAT

"An Outrageous Hospital Charge: I Paid $710 For An Hour Of Babysitting"

$1.1T

Total hospital expenditures, 2016

≈22%

Percentage of industry EBITDA in inpatient acute care, 2016

1) Earnings before interest, taxes, depreciation, and amortization.

Source: Szabo L, "As Drug Costs Soar, People Delay or Skip Cancer Treatments," NPR, March 15, 2017; Pollack A, "Drug Goes from $13.50 a Tablet to $750, Overnight," The New York Times, September 20, 2015; Kliff S, "She Didn't Get Treated at the ER. But She Got a $5,751 Bill Anyway," Vox, May 1, 2018; Cortes A, "An Outrageous Hospital Charge: I Paid $710 For an Hour of Babysitting," STAT, April 12, 2017; CMS, National Health Expenditure Data; Singhal S, Latko B, and Martin C, "The Future of Healthcare: Finding the Opportunities That Lie Beneath the Uncertainty," McKinsey&Company, January 2018; Advisory Board Research interviews and analysis.

What keeps plans up at night?

Key strategic objectives for health plans

Objective	*Levers and considerations*	*Current playbook*
 **Grow and retain membership**	Premiums, out-of-pocket costs, network composition, benefits, quality rating, member satisfaction	Appeal to purchasers with plan designs that prioritize member convenience, usability in coverage and care
 **Contract efficient, high-quality providers**	Provider contracting, market consolidation, quality incentives, regional supply and labor costs	Align perceptions of value and financial incentives with provider networks and individual HCPs to manage population health
 **Drive appropriate utilization**	Consumer behavior, preventive care, care management, access, site of care differences	Shift financial risk and build support infrastructure to encourage members to use services effectively

Source: Advisory Board Research interviews and analysis.

Purchaser needs driving payer perceptions of value

Plan identity is shifting from care financier to patient navigator

	Individuals	Employers	Medicare Advantage	Medicaid
Customer				
*Market share**	8%	60%	8%	24%
Trend	Number of exchange plans declining due to **low profitability**	Increasingly **self-funding** in response to cost pressures	Rapidly growing, with enrollment expected to **nearly double** by 2025	Federal funding set to **phase down**
New plan role	**Utility**	**Concierge**	**Social Support**	**Gatekeeper**

* Numbers are approximate.

Source: Highlights Report, AIS's Directory of Health Plans, Managed Markets Insight & Technology LLC, May 2019; Health Insurance of the Total Population, Henry J Kaiser Family Foundation, 2017; "A Dozen Facts About Medicare Advantage," Henry J Kaiser Family Foundation, November 13, 2018; Advisory Board Research interviews and analysis.

Payment models designed to shift network behavior

Non-compliant providers risk being shut out of network

CASE EXAMPLE

CareFirst BlueCross BlueShield

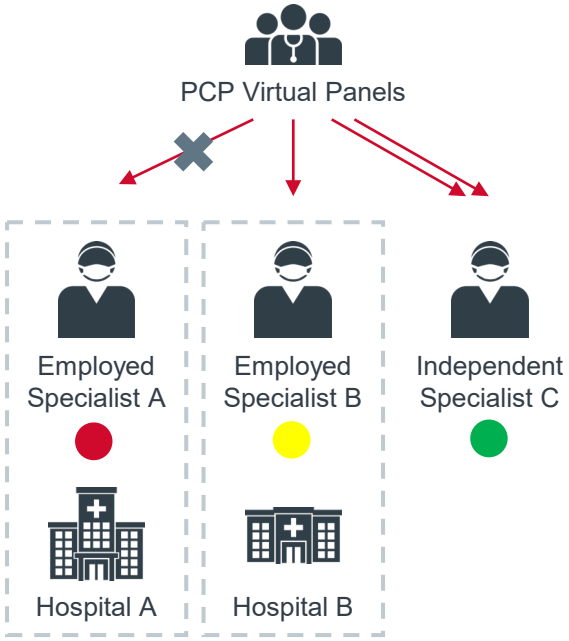
3.4 million member non-for-profit health services company • Maryland, Washington D.C., northern Virginia

- Operates a Patient-Centered Medical Home (PCMH) program providing opportunities for virtual panels of 10-15 PCPs to earn bonuses based on quality and total cost metrics
- Provides PCPs with color-coded rankings of specialists based on risk-adjusted PMPM costs
- Panel shares in savings if risk-adjusted PMPM cost is below set target

90% Of eligible PCPs now participate (4,379 providers in 430 Panels)

$1.2B Savings from PCMH program since 2011

Specialists color-coded by total cost



1) Per member per month.

Source: "CareFirst Patient-Centered Medical Home Program Nets $1.2B In Savings Since 2011," CareFirst BlueCross BlueShield, June 27, 2018; "Patient-Centered Medical Home 2017 Program Performance Report," CareFirst BlueCross BlueShield, 2017; Advisory Board Research interviews and analysis.

Higher prices raise the stakes on utilization controls

Payers, especially integrated networks, recognize rising financial risk

Kymriah ← *Example* → **Mazor X**

- CAR-T gene therapy, approved August 2017
- Cost: $475,000

- Robotic-assisted technology for spine surgery, approved 2018
- Cost: $850,000 (capital)

Potential for bad debt ← *Cost incurred* → **Absorbed into the DRG**

Many hoops and conditions for separately payable drugs being denied after administration

Robotic equipment costs amortized across bundled payments with no corresponding reimbursement increase

Triggered response: Case-by-case utilization reviews for high-stakes treatments

1. IDN puts into queue for leadership to review, approve
2. Leadership group assesses expected efficacy, applicability to given case
3. IDN considers site of care, secures prior authorization, contracts with insurer for inpatient administration
4. IDN connects patient to financial assistance

Source: Sagonowsky E, "Novartis could cut its Kymriah price to $160,000 and keep its profit margins: study," FiercePharma, February 2018; Al Idrus A, "Mazor picks up $20M from Medtronic as it launches spine surgery robot," FierceBiotech, July 2016; Advisory Board Research interviews and analysis.

How payers think about value

Insights on the current and future state of medical value

1

How do payers define value?

Three dynamic elements of the **local ecosystem shape how payers perceive value** 'priorities' and their ability to influence appropriate use

2

How do they assess value?

In light of medical innovation—and its complexity—payers are building **new capabilities and bringing in new perspectives** to drive 'smarter' decisions

3

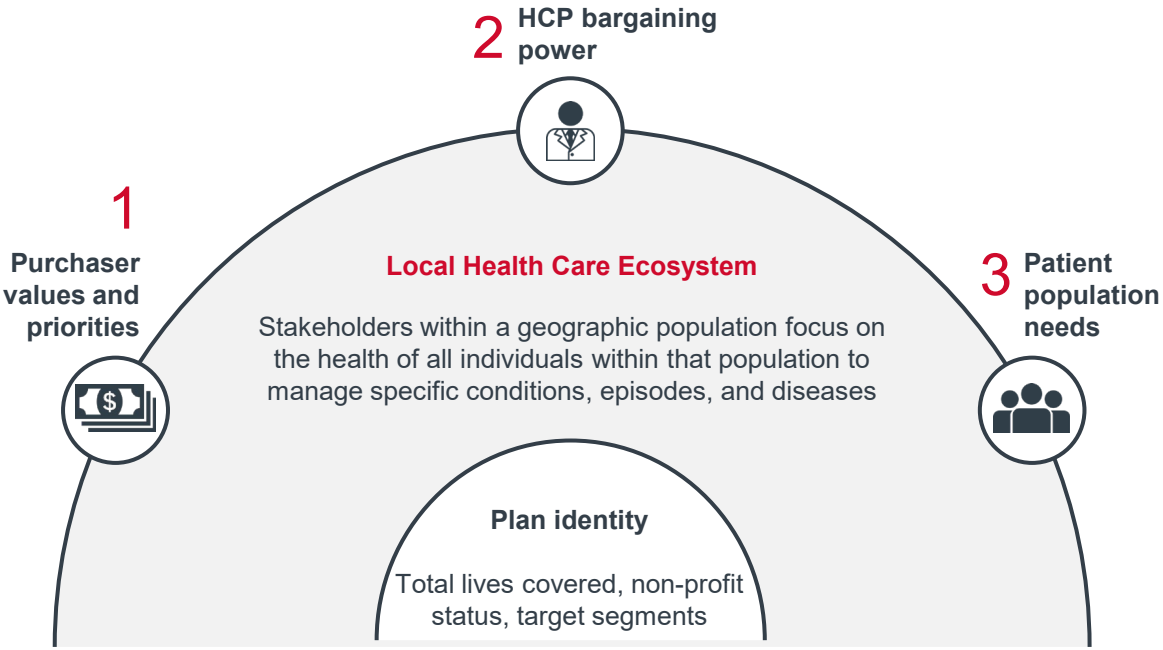
How will the value framework evolve?

Complex questions about the role of payers in value delivery amid changing payment models, market dynamics and political uncertainty **will shape value discussions 3-5 years** from now

Source: Advisory Board Research interviews and analysis.

Local ecosystems shape value ‘priorities’

Three factors beyond traditional plan identity influence decision-making



Source: Advisory Board Research interviews and analysis.

Key purchaser attributes greatly inform benefit design

Trend toward activist purchasers looking to inflect cost *and* user experience

FACTORS SHAPING EMPLOYERS' DEMANDS

War for talent

Competition for specialized, in-demand talent often pressures employers to offer more generous benefit packages – typically with wide networks, open formularies, and broad coverage

Tolerance for administrative burden

Some employers want to minimize any UM[1], coverage restrictions, or financial assistance programs (including co-pay coupons) that increase process steps for providers and patients

Industry margins

Employers in industries facing long-term cost pressures (e.g., manufacturers, retailers, health systems) prefer closed benefit designs, narrow networks and more PAs[2] to reduce spend

Regional and cultural perspectives

Local, cultural influences inform employers' desire to cover specific "optional" services such as family planning, HIV prevention, alternative medicine, or nutrition

STATE PREFERRED MEDICATION LISTS

CASE EXAMPLE

Washington State Health Care Authority

2M+ members; largest health care purchaser in Washington

- On January 1, 2018, implemented the Apple Health (Medicaid) PDL – a single preferred drug list for five Managed Medicaid plans

Goal to **standardize entire list by 2020** without disrupting care for patients on existing medications

Phased quarterly roll-out of PDL by drug class; **team implemented list for 27 drug classes in 2018,** prioritizing categories by utilization and rebate potential

Initial feedback has been **overwhelmingly positive;** standard PDL reduces administrative burden for providers and patients switching plans

1) Utilization management .
2) Prior authorizations.

Source: Advisory Board Research interviews and analysis.

Plans must consider collective HCP preferences

Three factors inform level of payer influence over HCP behavior

Level of plan influence

1 HCPs' culture of medicine

- Reliance on evidence and willingness to adhere to clinical guidelines
- Relationship with patients and caregivers
- Attitude towards new/alternative therapies
- Preferences for devices/procedures

"The west is more progressive in its physicians' willingness to manage disease and its emphasis on evidence [relative to the east coast]. Western care sites will allow midlevel practitioners to do more…New England has been slower to adopt these values."

Pharmacy Director, *Large Regional Health Plan*

2 Provider dynamics

- Number of physicians and practice groups
- Prevalence of specialists and KOLs
- Involvement of community HCPs
- Presence of AMCs and Centers of Excellence; participation in clinical trials

"Who is doing the care? [This] informs how much control the payer has… Provider groups, particularly in imaging, demand that certain things be covered or they will threaten to leave the network."

VP of HHS Consulting, *The Lewin Group*

3 Level of shared risk

- Integration with provider network
- Financial risk agreements (upside, downside)

"Because of our relationship with our provider parent… when we put guidelines in place, we want to follow the local standard of care."

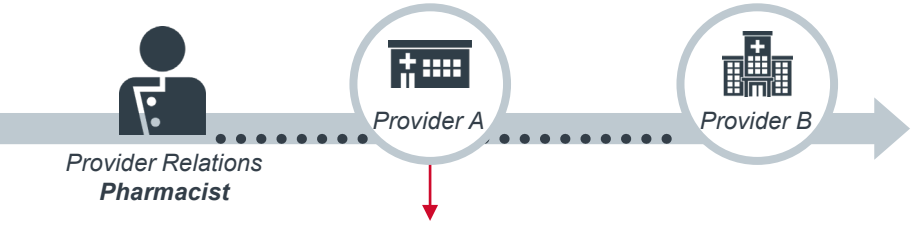
CMO, *Large Provider-Sponsored Health Plan*

Source: Advisory Board Research interviews and analysis.

Stealing a page from the MSL playbook

Some health plans deploy pharmacists to engage HCPs directly

BCBS Vermont's pharmacist delivers pharmacy data to providers



Pharmacist responsibilities

Share pharmacy scorecard that compares the clinicians' costs to **peer benchmarks**

Sample scorecard metrics:

- Formulary adherence rates
- Total pharmacy costs

Present on **provider-requested topics** at practice lunch-and-learns

Sample provider-requested topics:

- Formulary diabetes drug options
- Targeting members for MTM[1]

Pharmacist program results

1,159

Providers reached by pharmacist, 2018

69%

Success rate in switching diabetes medication, 2018

$100K+

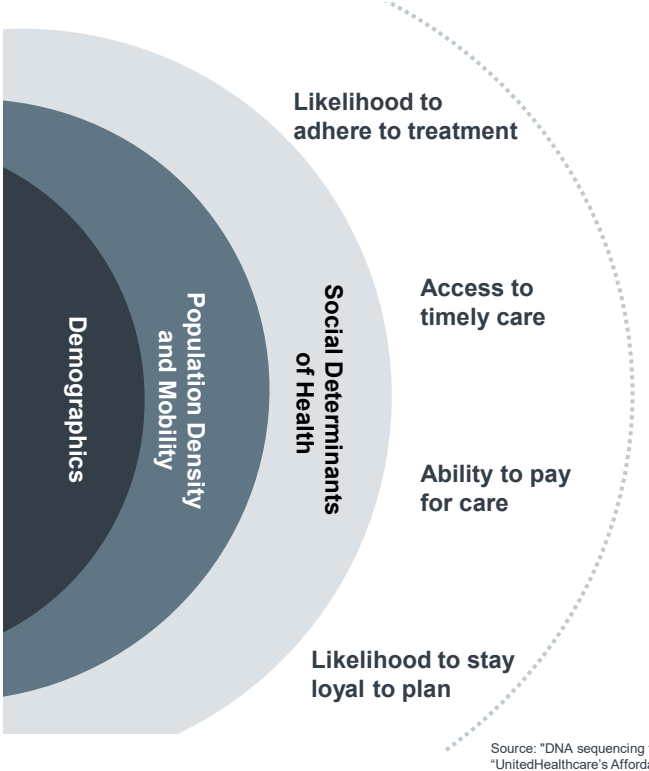
Saved by BCBSVT from members participating in MTM, 2018

1) Medication Therapy Management.

Source: Blue Cross and Blue Shield of Vermont, Montpelier, VT; Advisory Board Research interviews and analysis.

Broadening definition of unmet need forces trade-offs

Local market characteristics influence priorities for value-added benefits



Plans address multi-layered impact of population DNA on health costs

Geisinger Health Plan pilots population-wide genomic testing

- Expects 10-15% of patients to benefit from early detection of cancer and heart disease

UnitedHealthcare, Anthem, Kaiser and regional payers invest millions in affordable housing

- Expect to reduce acute care costs (average $2400 per patient) and ED utilization associated with homelessness

Source: "DNA sequencing to become part of Geisinger's routine clinical care," Geisinger, May 7, 2018; BusinessWire "UnitedHealthcare's Affordable-Housing Initiative Helps Connect Michigan Residents to Quality Housing and Support Services to Help Them Live Healthier Lives," Businesswire, January 24, 2018; Advisory Board Research interviews and analysis.

Beyond demographics and geography—the interplay of government, employers, HCPs and micro populations in a local market impacts how payers perceive value

1. What 'local ecosystem' insights do your field teams bring back to the corporate office?
2. How do those insights change the way medical and commercial communicate with clinical customers?
3. How can you facilitate greater internal knowledge-sharing about the interplay among major actors within local markets?

How payers think about value

Insights on the current and future state of medical value

1

How do payers define value?

Three dynamic elements of the **local ecosystem shape how payers perceive value** 'priorities' and their ability to influence appropriate use

2

How do they assess value?

In light of medical innovation—and its complexity—payers are building **new capabilities and bringing in new perspectives** to drive 'smarter' decisions

3

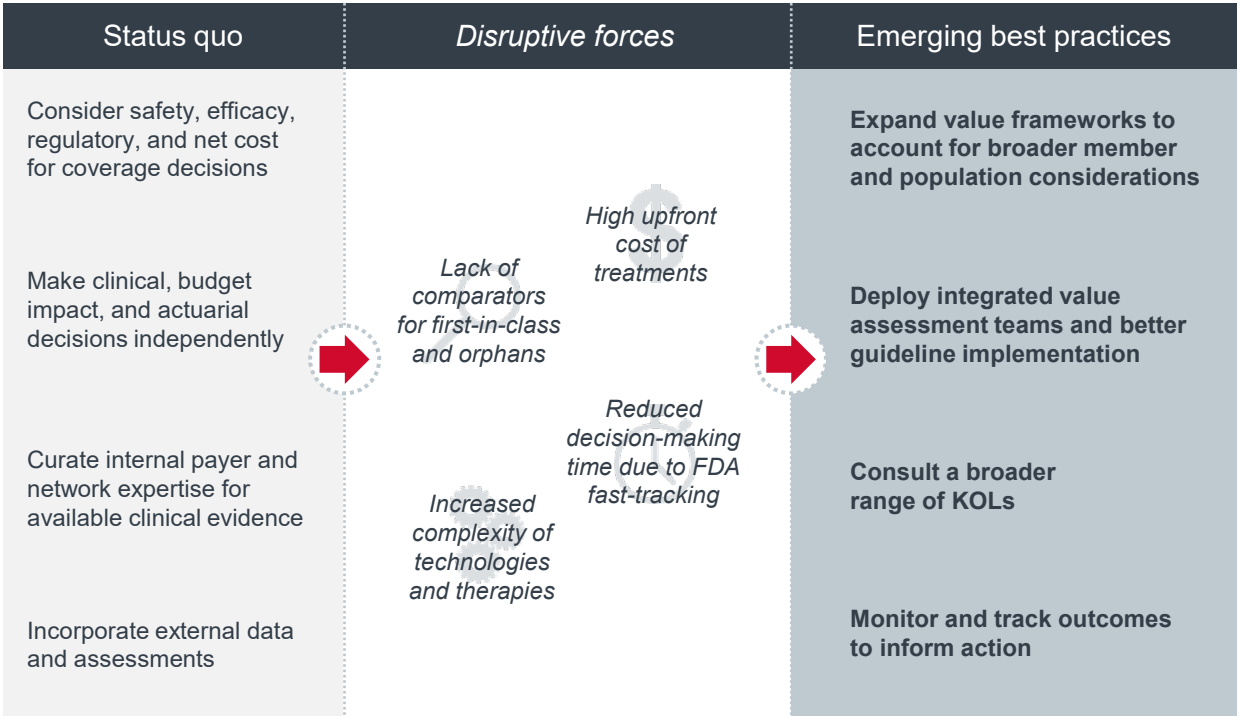
How will the value framework evolve?

Complex questions about the role of payers in value delivery amid changing payment models, market dynamics and political uncertainty **will shape value discussions 3-5 years** from now

Source: Advisory Board Research interviews and analysis.

Payers are adapting their assessment processes

More complex therapies, coupled with limited evidence, demand change



Source: Advisory Board Research interviews and analysis.

Most plans agree on value drivers – in theory…

Few have a 'rubric' for weighing factors within and across drivers

Standard Framework

1. Is it safe and effective according to peer-reviewed studies, and has it been approved?
2. Do we have to cover it?
3. What's the best way to cover the treatment that optimizes for budget impact?

Evolving framework of medical value assessments

Clinical benefit	Patient access	Total cost of care	Avoidable cost	Patient (member) experience	Social benefit
• Curative • Durability	• Site of care • Out-of-pocket cost	• Utilization management • Care management burden • Medical administration	• Hospitalizations • ED/urgent	• Adverse reactions • Pre-authorization requirements, step therapy • Ease of use (e.g., ROA[1], dosage)	• QALYs[2] • Herd immunity

1) Route of administration.
2) Quality-adjusted life years,

Source: Advisory Board Research interviews and analysis.

Third party HTAs[1] weigh in on value

Scale and scope of support has evolved well beyond passive reports

Regulatory

Traditional HTAs at the state and/or federal level, making coverage decisions for public entities

Name you know: VA CHOIR, Oregon HERC

Rising in influence: Washington State HTA Program, Louisiana Department of Health

Policy

These policy and PR engines aim to influence regulations and, more broadly, the national conversation around pricing and coverage

Name you know: ICER

Rising in influence: AHRQ

Advocacy

Patient and provider advocates create clinical guidelines to promote high quality, standardized care at the national level

Name you know: NCCN

Rising in influence: AMCP

Advisory

Emerging advisors form continuous relationships with individual orgs via consultative and analytic decision support, coupled with traditional product/category assessments

Name you know: ECRI Institute, Hayes Inc.

Rising in influence: Lumere, IPD Analytics

1) Health Technology Assessment organizations.

Source: Advisory Board Research interviews and analysis.

Next generation HTAs expand payers' visibility

Migrating from static reports to dynamic, embedded platforms

	IPD Analytics	Lumere
	"The right lessons from the past can help you plan for and predict the future."	*"We aim to democratize access to comprehensive clinical evidence."*

Payer pain point	• Lack of future market visibility
	  ➢ New entrants
	  ➢ Loss of exclusivity
	• Difficulty with optimal comparison sets
		• Incomplete product, category knowledge
		• Limited insight into recalls, reported AEs[1]
		• Physician buy-in and compliance

Solutions	• Aggregates disparate data sources on clinical trials, pipelines, regulatory filings, past launches, and relevant IP cases to help payers' assess impact of market changes and anticipate future scenarios
	• Provides real-time legal, regulatory, clinical alerts
	• Legal, pharmacy experts advise on relevant comparisons and category definitions
		• Web-based analytics platform combines broad base of clinical evidence with product details as well as pricing and cost data
		  ➢ Covers 30,000+ drugs/devices
		  ➢ Draws on 120,000 journal articles, plus relevant data on recalls and adverse events
		• Monitors physician utilization, spotlights variation
		• Integrates into product, category evaluation workflows

1) Adverse events.

Source: Advisory Board Research interviews and analysis.

Real-time reviews flag spikes in utilization

Allows payers to increase patient access by cutting prior authorizations

Indigo Health Plan's[1] PA removal process

Removed PA for codes with the **highest approval rates** and **lowest costs**

Performed **monthly** reviews of cost/utilization data

Removed 200-250 codes in year 1; set 5% target rate of reduction for year 2

Benefits of monthly data monitoring

- ✓ Quickly identifies increases in utilization or costs
- ✓ Allows plan to establish triggers to prevent spikes in utilization
- ✓ Gives physicians more real-time feedback, rather than 3-6 month lag
- ✓ Recognizes high-performers sooner

0	**Spikes** in cost or utilization	416	Total PA **codes removed** over 2 years	40%	Total **reduction** in PA codes over 2 years

1) Pseudonym.

Source: Advisory Board Research interviews and analysis.

Payers are breaking down traditional internal and external silos to build new capabilities and perspectives that drive ‘smarter’ decisions

1. When do you need to engage multiple stakeholders within payer/provider organizations in discussions about value?
2. Where do you focus your HTA strategy today?
3. How might the growing influence and expanded purview of HTAs impact your approach to engaging third-party ‘influencers’?

How payers think about value

Insights on the current and future state of medical value

1

How do payers define value?

Three dynamic elements of the **local ecosystem shape how payers perceive value** 'priorities' and their ability to influence appropriate use

2

How do they assess value?

In light of medical innovation—and its complexity—payers are building **new capabilities and bringing in new perspectives** to drive 'smarter' decisions

3

How will the value framework evolve?

Complex questions about the role of payers in value delivery amid changing payment models, market dynamics and political uncertainty **will shape value discussions 3-5 years** from now

Source: Advisory Board Research interviews and analysis.

Payers want evidence to direct appropriate use

In the absence of clarity on who and when, payers default to net cost

Payers cite many reasons for rejecting evidence

- The evidence isn't strong enough: the study is too short, too small, or not replicated yet
- The study population is so different than their own
- Information about the site of care (e.g., hospital, PCP office, trial center) is not included in the study
- The study design (e.g., algorithm, economic model) is not transparent
- The outcome is dependent on many factors, including adherence

Complex questions will shape the future value equation

1. How do you **stratify populations to match** each patient to the best therapy?
2. What **time horizon matters** when measuring value endpoints?
3. Who **gets credit** for delivering value to patients?

Source: Advisory Board Research interviews and analysis.

Some plans will pay more now to save costs later

Use claims, EHR data to revise access protocols, scope appropriate use

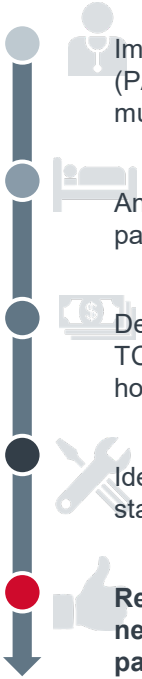
Expanding access can lower total cost of care (TCOC)

CASE EXAMPLE

Gallagher[1] Health Plan

Nationally-recognized PSHP[2] with 600,000 members

- Churn far lower than comparable plans, allowing for longer time horizon for realizing value
- Recently reviewed cost, quality impact of access restrictions on multiple sclerosis drugs



Implemented step therapy and prior authorization (PA) requirements to control spend on costly multiple sclerosis (MS) drugs

Analyzed ED and hospitalization rates for MS patients at different phases of step therapy protocol

Determined step therapy and PA delays increased TCOC; patients on cheaper drugs had more ED and hospital visits

Identified patients most likely to benefit from rapid start on newer, more expensive therapies

Revised UM protocols to expedite access to new, high-cost therapies for right subset of MS patients

1) Pseudonym.
2) Provider-sponsored health plan.

Source: Advisory Board Research interviews and analysis.

12-18 months is not the default for medical value

Align value end points to meaningful time-to-impact horizon

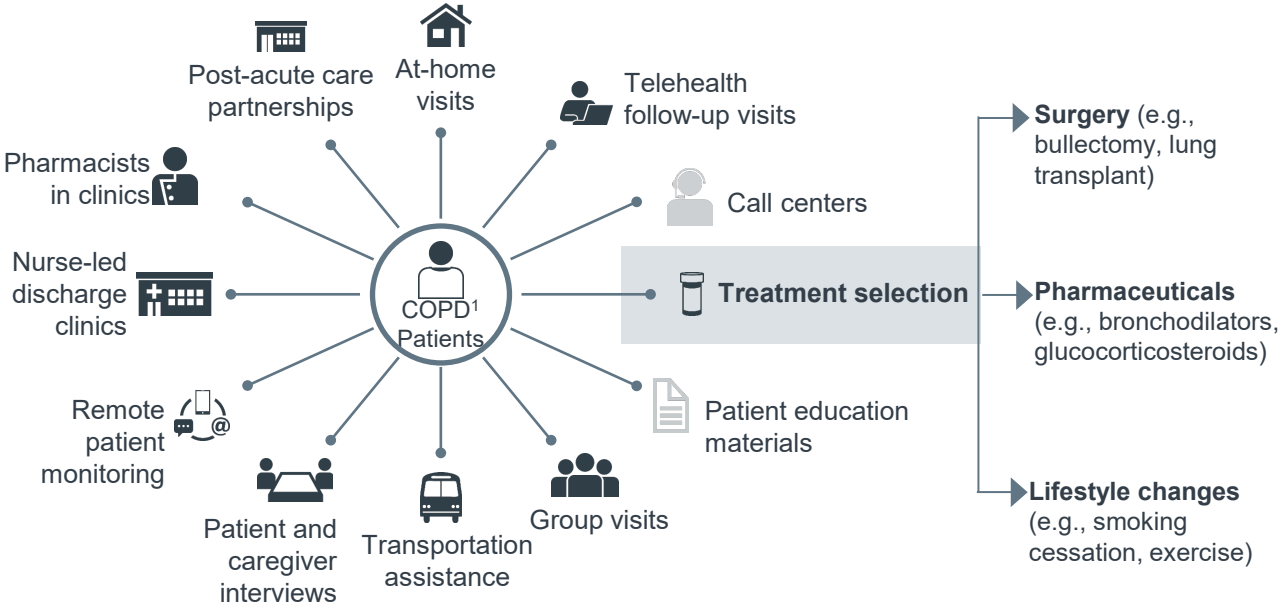
	Temporary	Average	Long-term	Lifetime
	<12 months	*12-18 months*	*2-5 years*	*5+ years*
PAYER PROFILE	State sponsored and operated	Large national, Blues	Regional not-for-profit, Blues	Health system-sponsored health plan
BUSINESS LINES	• Public exchanges • COBRA • Medicaid (states with limited coverage)	• Employer-sponsored plans • Employer-sponsored/ individual plans in growing metro regions	• Medicaid (states with limited mobility; disability) • Accountable care organizations • Clinically integrated networks	• Medicare Advantage • Rural/suburban provider-sponsored plans
VALUE ENDPOINTS	**Which value endpoints align with annual budgets and contracts?**		**Which value endpoints impact individual and population-level total cost of care?**	

Source: Advisory Board Research interviews and analysis.

Cost accounting for avoided readmissions is hard

Prepare to acknowledge plan and provider role in realizing value

Key elements in a COPD readmission reduction plan



Source: Advisory Board Research interviews and analysis.

Complex questions about the role of payers in value delivery amid changing reimbursement models, market dynamics and political uncertainty will shape value discussions 3-5 years from now

1. How do you adapt study designs to address payer concerns about comparators, timelines or appropriate populations?

2. What is medical's role in generating evidence that aligns with innovative payment models?

ABOUT OUR RESEARCH

Change has always defined health care, but today's leaders face unprecedented challenges and market shifts. Developing successful strategies and advancing make-or-break objectives has never been more challenging due to mounting complexity, intensifying competition, and a growing roster of stakeholders.

HOW WE HELP

We provide the knowledge you need to stay current, along with the strategic guidance, data, and tools you need to prioritize your next actions.

WHO WE SERVE

Hospitals • Health systems • Medical groups • Post-acute care providers • Life sciences firms • Digital health companies • Health plans • Health care professional services firms

- **Connect** with Advisory Board expert and access more resources by contacting us at **healthtech@advisory.com**
- **Visit advisory.com/resources/DigitalHealthInnovation** for the latest market trends and industry insights for digital tech business leaders.

THE ADVISORY BOARD ADVANTAGE

Our team of 200+ experts harness a time-tested research process and the collective wisdom of our 4,500+ member network to develop provocative insights, actionable strategies and practical tools to support the business imperatives of organizations across the health care ecosystem.

Advisory Board helps leaders in the health care industry work smarter and faster by providing provocative market trends, industry insights, and actionable strategies to support key business imperatives.

With more than 40 years of experience, a team of nearly 200 experts, and a network of over 4,500 member organizations, we help stakeholders across the health care ecosystem unpack the now and predict the next in the health care industry.

We know that together we can change the business of health care for the better. Join us by visiting advisory.com.

655 New York Avenue NW, Washington DC 20001
202-266-5600 | **advisory.com**