EXCLUSIVE TKG MANAGED MARKETS ADVISORY PANEL HIGHLIGHTS

In March, The Kinetix Group (TKG) hosted a discussion panel at the 2019 Managed Care & Specialty Pharmacy Annual Meeting in San Diego, CA. Healthcare leaders shared their direct experiences of value-based contracting, while reflecting on the impact of new regulatory environments and discussing the partnerships needed to successfully manage risk.

BEYOND THE COST OF A DRUG: DIFFERENTIATING PHARMA AND ITS PRODUCTS

- In risk-based arrangements, high-quality post-clinical, patient-reported data is more important than ever to assess new drugs and better manage patients
- Payors and health systems also seek new findings that show a profound impact on high-cost diseases and so could benefit the entire care-delivery process
- Health systems look to enter performance-based contracts with manufacturers willing to share accountability for patient outcomes and costs
- Pharmaceutical companies should develop national risk pools that can mitigate the impact of patients' ever-changing landscape of insurance plans
- Direct-to-consumer price messaging may alarm patients who don't know that assistance is available and can prevent them from seeking needed treatment

REBATES

- Eliminating safe harbor drug-rebate provisions through the Anti-Kickback Statute would dramatically alter current structures of drug price negotiations and payments; health plans, PBMs, retail pharmacies, prescription drug wholesalers, and other organizations relevant to these entities' operations could require entirely new business models to successfully manage their operations
- Rebates (shared between Part D plans and the federal government) directly reduce plan costs, which helps to reduce a Medicare Advantage plan's bid amount; this, in turn, reduces premiums. The increase in rebates over time was likely a key contributor to slower growth in Part D plan premiums
- Estimates suggest that, when the rule to shift drug rebates to point-of-service takes effect, most beneficiaries will see an increase in their total out-of-pocket payments and premium costs
- Drug manufacturers could launch authorized generics to allow for differing list price and rebate strategies in different markets, or could delay action until they better understand how Part D plans respond to safe harbor changes

BIOSIMILARS

- Switching to biosimilars can be challenging:
  - Physicians may not want to switch a patient already stable on a drug
  - Different stakeholders (e.g., hospitals vs. private practice physicians) may push for competing biosimilars to be on the preferred list, according to best pricing options offered
  - If administered at home by patients or by home health, a biosimilar may be covered as a pharmacy benefit
  - Patients who lose copay assistance can end up paying more for a generic, leading to bad relationships between health plans and patients
- The creation of uniform rulings to authorize biosimilars with 'skinny labels' (labels that correspond only to non-patented indications of a reference product) have proved complex
- Specialties that focus on episodic care, such as oncology, are particularly willing to try new biosimilars; to date, biosimilars primarily target rheumatology, dermatology, gastroenterology, and hematology/oncology patients

SPECIAL POPULATIONS

- Managing Medicare Advantage patient populations does not fundamentally differ from managing non-MA populations, other than in the robust data available for the former group
  - Case managers have access to these patients' clinical systems and their pharmacy and medical benefits
  - More personal contact via coordinated systems of plan affiliates working together to raise Star Ratings
- Pilots can help better coordinate transitions of care and other innovations, such as meeting coverage challenges for such specific disease states as:
  - *Congestive heart failure:* Stem cell therapy approvals in the next 2-3 years may cause price explosions; specialists willing and able to care for complex heart failure patients are few; differentiating patients to be treated versus those to be supported in palliative care is complex
  - *Behavioral health:* New approvals will reshape approaches (e.g., infusion therapies for post-partum depression, therapies derived from the marijuana plant); provider-based therapies with long-acting antipsychotics have added high administration costs to high-priced therapies
  - *Oncology and gene therapies:* Extremely high-cost therapies (e.g., $1M, 2M, 4M for a 1-time use drug) will meet resistance under current reinsurance models; plans cannot financially shoulder the cost

VALUE-BASED CONTRACTING WITH PHARMACEUTICAL COMPANIES

- Performance-based contract collaborations between health systems, health plans, and manufactures could work if risks are equitably shared
- Indication-based contracting could result in two indications priced at opposite ends of a pricing spectrum to better align reimbursement with value; in this way, indication-based prescribing strategies could curb overall costs
- Manufacturers, payors, and other stakeholders are concerned that Medicaid's best price policy may unintentionally undermine value-based efforts to lower drug costs and improve access to therapies
- Pharmaceutical companies could base couponing on financial means testing (especially in the contexts of high-deductible health plans and of patients seeking highly-competitive products, such as to treat NASH)
- With no objective definition of value, appraising small improvements of function can be problematic

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thekinetixgroup.com info@kinetixgroup.com linkedin.com/company/the-kinetix-group twitter.com/thekinetixgroup