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Financing and Reimbursement of Cures in the US

RESEARCH BRIEF

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Impact of Patient Mobility on Annuity/Performance-Based Contracting.

Spreading payments over time for durable or curative therapies can provide a better alignment between benefits and costs, but creates challenges when patients switch insurance coverage during the contract term. We describe approaches for dealing with patient mobility, including a novel approach that mitigates concerns about transferring contract terms between payers.

Payers are being challenged by a new generation of treatments with durable or even curative benefit, limited efficacy information at launch, and high prices. Financial tools customized to the nature of the therapy and the specific payer needs (precision financing (1)) can help mitigate some of these challenges.

One important financial tool is the spreading of payments over time (annuities), with downstream payments potentially being based on treatment efficacy (performance-based contracting). Spreading payments over time can moderate the challenge created by a large upfront price (particularly for a surge of patients at product approval) and improve the match between cash flows and benefits.[+] A problem with this approach is that many patients in the United States do not maintain continuous insurance coverage with the same payer for extended periods,[*] and receipt of a curative therapy may actually increase the likelihood for patients to switch from a plan chosen to provide coverage for the condition. Patient mobility, the movement of a patient from one insurance payer to another, can create major issues for these contracts both because of lack of clarity regarding who is responsible for ongoing payments (or who receives the benefit of rebates) and because of operational challenges regarding sharing of patient and contract information.

KEY TAKEAWAYS

- Annuities and performance-based contracts help align cost and benefit for potentially curative or durable therapies.
- Patients switching insurance plans complicates extended payment schedules because payers are reluctant to accept agreements negotiated by other payers and do not want others to be aware of terms they have negotiated.
- There are multiple ways to manage patient mobility, with the best solution depending upon the circumstances.
- If both the initial and new payers have similarly structured payment plans for a particular treatment, changing to the new payers' negotiated payment amounts could permit payer switching without sharing information on terms.

As part of recent FoCUS Design Labs, three approaches have been suggested for dealing

[+] Expense recognition may still occur upfront depending on payment risk, downstream obligations, and predictability.

[*] In a study of commercially insured patients in Massachusetts, 26% switched insurers during a two-year period (2).

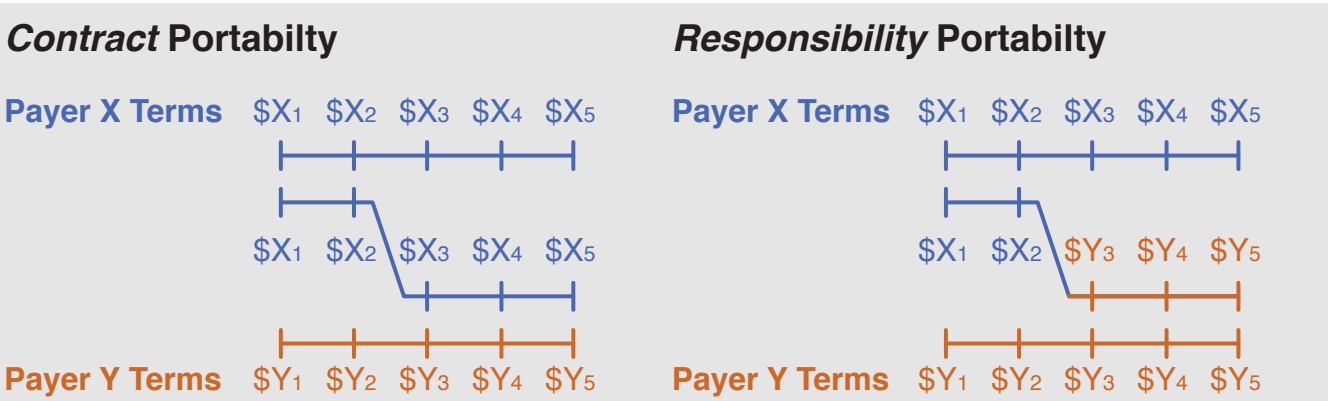

Figure 1. Comparison of Option 2 (contracted payment amount switches to new payer) and Option 4 (responsibility switches, but amount changes).

with patient mobility that interrupts payments spread over time:

1. The initial payer retains responsibility for the terms of the contract
2. The new payer assumes responsibility for the terms of the contract
3. The contract is terminated, with an appropriate payment being made to recognize the expected value of future payments

Each of these approaches has positives and negatives. The first option leaves satisfaction of the contract in the hands of the original contracting party, which may seem appropriate since they could alternatively have chosen to pay the full cost at the time of treatment. It may also be the best option if the only remaining payments are potential rebates. However, it requires payments to continue for a patient no longer covered by a payer and may be complicated by the need to continue sharing patient information with the original payer.

Requiring the new payer to assume payments helps align the party responsible for payments with the one benefiting from the treatment, which may be particularly appropriate when there are large cost-offsets. If the first payer bears the entire cost of the treatment while the second payer reaps substantial benefits from cost reductions, payers might be discouraged from covering treatments that clearly provide long-term financial benefit. However, switching who is responsible for payments exposes the new payer to terms that may be poorer than they themselves would have negotiated, and may relate to treatments that would not have been covered by the new payer. There might also be opportunities for the original payer to manipulate the system, such as by back loading payments and creating plan terms that encourage cured patients to switch to other payers, offloading the bulk of payments onto receiving plans. From an operational perspective, proprietary information on contract terms would need to be shared between the payers.

Conceptually, requiring contracts to be ended with a terminal payment when patients switch plans would be the simplest option. However, this approach would reduce the benefits from having longer-term contracts, particularly when there is uncertainty regarding efficacy or substantial cost-offsets.

The FoCUS team has recently developed a fourth alternative that may be superior when a new payer assumes responsibility for contracted payments. Consider a patient who undergoes treatment and then switches between two payers, each of whom covers the treatment and pays for it using similarly structured contracts that differ primarily in the level of discount that has been secured by each payer. Instead of continuing payments at the level negotiated by the original payer, assume that the amounts of the payments switch to those negotiated by the second payer (Figure 1). The manufacturer is still receiving an acceptable negotiated price, but Payer Y does not have to accept the potentially poorer terms negotiated by Payer X, and neither Payer X nor Payer Y needs to know confidential information negotiated by the other payer.

In the above scenario, both payers covered the product and used similar contracting terms. Such a situation could arise if the product was generally believed to have high value and deal structure was determined by the developer, agreed to by negotiations of relevant payers, or dictated by some third-party aggregator of patients (such as a specialty distributor). If this was not the case, different payers might have different payment structures or might not even cover the treatment. While terms could continue to switch, this would lead to high risk for the developer, such as if the patient switched from a payer using multi-year contracting to a payer who made a single upfront payment and the developer received no further payments from the second payer.

When considering these four options for managing patient mobility when payments are spread over time, the best

solution will vary depending on the circumstances. Amount of cost-offsets, level of uncertainty regarding treatment outcomes, and similarity of perspectives regarding coverage across payers may all be important in determining which would be preferred in a particular situation.

REFERENCES

(1) MIT NEWDIGS Research Brief 2018F203v015
(2) Barnett et al., Insurance Transitions and Changes in Physician and Emergency Department Utilization: An Observational Study, Journal of General Internal Medicine. 2017 Oct;32(10):1146-1155.

ABOUT FOCUS

The MIT NEWDIGS consortium FoCUS Project (Financing and Reimbursement of Cures in the US) seeks to collaboratively address the need for new, innovative financing and reimbursement models for durable therapies that ensure patient access and sustainability for all stakeholders. Our mission is to deliver an understanding of financial challenges created by durable therapies leading to system-wide, implementable precision financing models. This multi-stakeholder effort gathers developers, providers, regulators, patient advocacy groups, payers from all segments of the US healthcare system, and academics working in healthcare policy, financing, and reimbursement.

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