October 2020: Shining the Spotlight on our Members

LETTER FROM THE EXECUTIVE DIRECTOR

I am a firm believer in the power of the collective and in the synergy and success that comes from collaboration across stakeholder groups. It's not just a founding principle. It's been an integral part of the Alliance's mission and approach to work for the past 16 years.

Our members are terrific about acknowledging our successes and I would like to return the accolades. Please join me in congratulating these Alliance members who have been recognized by others for their accomplishments:

(Read the full letter HERE)

ALLIANCE UPDATES

- Alliance Webinar Presenters Answer Your Questions
- The Alliance Welcomes New Members 98point6 and North Central Accountable Community of Health
- Joining the Alliance

Alliance's Webinar Presenters Answer Your Questions

We enjoyed a record number of participants for our lively and provocative discussion with **Dr. Jamie Robinson**, Professor of Health Economics in the School of Public Health at the University of California, Berkeley, and **Sarah Emond**, Executive Vice President and Chief Operating Officer at the Institute for Clinical and Economic Review from our latest webinar "**Bending the Pharmaceutical Cost Curve: New Roles for Purchasers, Plans, Physicians, and**

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Join Us

Do you know someone who would like to learn more about membership in the Alliance? Learn more about the value of Alliance membership.

Choosing Wisely

Choosing Wisely is a campaign designed to provide easy-to-understand guides for getting better, safer, more effective care. It is a partnership between the Alliance, The American Board of Internal Medicine (ABIM), the Washington State Medical Association and others. Learn more.

Visit the Community Checkup website

The Community Checkup website helps consumers make informed choices by giving them access to a robust and accessible supply of data and resources. Learn more.

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Patients." Access to webinars is limited to Alliance members. For membership information, please contact Theresa Lampkin Tamura at ttamura@wahealthalliance.org.

We received many more questions than we had time to answer and our speakers Dr. Jamie Robinson and Sarah Emond kindly agreed to respond to them here. Please note, the questions have been edited slightly for context.

1. The prescribing decisions are becoming progressively more complex and nuanced for providers in the "trenches." What are your thoughts about how to provide efficient point of service guidance vs. all of the abrasion currently experienced as providers attempt to navigate all of the different PBM/formulary/tiers?

   JR – *It's a nightmare for the doctors, the maze of prior authorization and step edits. On the other hand, many drugs are severely overpriced relative to their value. As I have argued in various publications, if a drug manufacturer sets its net price aligned with value (as defined by ICER based on its detailed studies), the insurer/PBM should remove prior authorization and step edits except to forestall clinically inappropriate prescriptions (not use them to save money).*

   SE – *One of the beautiful things about a drug reimbursement program that provides broad access up to a fair price for all drugs in a class, is that the administrative burden for physicians should reduce significantly. Instead of trying to understand what drugs are covered for which patients, they can focus on the clinical characteristics of the drug for the patient in front of them, then prescribe the right drug.*

2. What purchasers are opposed to biosimilars? What is the pushback from consumers, if any?

   JR – *It's all about the confidential rebates with PBMs. Some insurers and PBMs have negotiated rebates with biologics manufacturers that make the net price of those products cheaper than the biosimilars, and hence are putting step edits and cost sharing obstacles to biosimilars market penetration. The problem is that the rebates are not transparent and in most cases are not transferred on to the patients, who must pay the full list price of the biologics out of their deductible and coinsurance provisions. Rebates should be transparent and should be passed forward to the patients.*

   SE – *One of the perverse incentives on the medical benefit right now is that providers receive a higher administrative fee if they prescribe a more expensive drug. It's possible that there is resistance to switching to biosimilars because of the potential financial impact. For purchasers, many have*

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The Washington Health Alliance brings together those who give, get and pay for health care to create a high-quality, affordable system for the people of Washington state.

become dependent on the rebates they receive from branded drugs. In some cases, the net price, after rebates, of branded biologics is lower than the biosimilar price, which makes it difficult to change the current paradigm. There has also been a fair amount of fear among patients, especially those who may be asked to switch from a branded drug that is working well for them, to a biosimilar. One way to avoid that problem is to focus on getting patients trying a biologic for the first time to use the biosimilar.

3. As purchasers, how do we free ourselves from "rebate addiction," particularly when we rely on our brokers, PBM and carriers? Are there first-step approaches we should take to better direct expectations and manage new approaches?

   JR – *Require that 100% of the rebate flow back to the employer; the PBM should be paid a fee for its services, not a hidden share of a hidden rebate. Patient cost sharing should be linked to the post rebate, net price, not the list price. This requires transparency of net prices, at least as estimated. They do this in Germany. They can do it here.*

   SE – *The first step is transparency. Ask your brokers and PBMs: What drugs am I getting a rebate on? How large is that rebate? What does comparative effectiveness tell us about the appropriateness of that drug being the preferred drug? Is the rebate based on volume? Are there opportunities to switch to an upfront discount so that my employees can benefit from the lower net price through cost-sharing? Asking these questions opens up the opportunity to rely on other pieces of information – like comparative effectiveness – to decide what to pay for what drug to ensure patient access.*

4. As PBMs and payors, our greatest challenge in driving utilization has been the patent and exclusionary contracts you discussed that delay market access. What policy-based or other approaches do you recognize that could help overcome these barriers that delay market access to these medications?

   JR – *There is a public policy dimension to biosimilars policy.*

   SE – *The patent thicket is real. Most of the solutions we need rely on federal policy. Check out the work of groups like I-Mak, and the work they are doing to try and get some sense into the prescription drug IP issue.*

Directed to Dr. Robinson:

1. I am curious about the bundles you mentioned - are you aware of any purchasers/employers piloting these in the

states? How could we start something like that in our market?

Medicare is the leader here. No need to reinvent the wheel. Just copy the Oncology Care Model for cancer bundles.

2. Please review the lessons learned from EU other than reference pricing.

   Please see articles on European drug pricing here.

Directed to Sarah Emond:

1. What do you think about having a preferred drug list on the medical benefit with tiered cost-sharing? Have you seen manufacturers provide this discount to the purchasing provider or the pharmacy?

   I think there are opportunities to move to high value care with drugs in the medical benefit, but I'm not sure tiering and cost-sharing are the way to go. The origins of tiering and cost-sharing date back to when there were lots of choices and often generics – so formularies made sense to drive people to the higher value options. Things are much more complicated on the Medical side. Sometimes there are not many therapeutic alternatives; there might not be many generics available; and the patient doesn't have the luxury of shopping around the way they might be able to do on the retail side. I think the better option is to leverage information on fair price to set the reimbursement to the provider.

2. We may be missing the larger healthcare impact by not measuring all healthcare services. How does ICER look at the value for all healthcare services?

   We look at more than just prescription drugs. This year, we've been evaluating tools to address the opioid crisis, including a review of digital apps for opioid use disorder, and the comparative effectiveness of supervised injection facilities for people who use drugs. Over the years, we've looked at community health workers, palliative care, and diabetes management programs. We're always interested in recommendations for topics (submit here). We do intend to keep a focus on prescription drugs, however. Spending on drugs is the fastest growing piece of the health care spending pie, and our methods are well-suited to add another piece of information when evaluating the price chosen by a company with a government-granted monopoly.

3. Direct-to-Consumer (DTC) marketing has made the provider's input in drug selection less than desirable. How

does ICER suggest Plans and Purchasers blunt the impact of DTC marketing?

ICER doesn't have an official position on DTC marketing, but one way to blunt the impact is to only pay up to the fair price. That way, if a patient is asking for the brand new drug they saw on TV, you as a plan or purchaser don't care because you are only reimbursing up to the amount that aligns with the clinical benefit the patient receives.

The Alliance Welcomes New Members 98point6 and North Central Accountable Community of Health

Pioneering a New Approach to Primary Care

Founded in 2015, Seattle-based 98point6 offers private, text-based diagnosis and treatment via mobile app. Recently recognized by *The Tech Tribune* as one of the 2021 Best Tech Startups in Seattle, 98point6 pairs AI and machine learning with board-certified physicians, to make primary care more accessible and affordable, leading to better health. For employers, health plans and retail partners, 98point6 can increase primary care utilization among those not actively or appropriately engaged in their health—enabling earlier medical intervention and reducing the overall cost of care.

Using Data to Make a Difference

The mission of the North Central Accountable Community of Health (NCACH) is to: improve the health of the North Central region's communities and the people who live in them; improve health care access, quality and the experience of care; and lower per capita health care costs in the region (which includes Chelan, Douglas, Grant and Okanogan counties). The NCACH supports the use of data to inform decisions and guide direction as it designs and implements health improvement projects, for example:

- checking assumptions (Is what we think is happening actually happening?)
- assessing regional health needs and assets (Where are our strengths and weaknesses?)
- highlighting disparities (Where do some groups experience better outcomes than others?)
- selecting projects and prioritizing target populations (Given limited resources, where should we focus?)
- identifying key questions or gaps (What should we be thinking about as we plan and implement our projects?)
- monitoring progress and impact (Are we on the right track? Are we having the intended impact? If not, how should we adjust?)

In the 2020 Community Checkup report, NCACH performed

better than the state average for access to primary care in all age categories for its Medicaid-insured population with the exception of those 45 to 64. For that group, the score was on par with the state average.

Learn more about 98point6 and Northwest Central Accountable Community of Health here.

Joining the Alliance

Our members can be the best ambassadors for our work. If you know someone who would like to learn more about membership in the Alliance, we have an online tool to help you talk about the value of Alliance membership at Join Us.