Getting value for money from private payor drug plans:

Considering more than just costs.

Part 2 of a 2-part series.

Introduction

The drug pipeline is filled with new, more specialized and more expensive drugs to treat various diseases. High-priced drugs make it challenging for plan sponsors to provide a sustainable and comprehensive plan to their plan members and thus, decisions about reimbursement can be difficult. While it is imperative that plan sponsors know the financial risk associated with listing a pharmaceutical product on their drug plan, it is equally important to know whether the cost of listing a drug represents good value for money. For instance, an expensive drug may increase survival, improve productivity, or reduce disability claims. Cost-effectiveness analysis (CEA) is relatively new to Canadian private payor and is one aspect of TELUS Health's Enhanced Drug Review (EDR) program to help ensure plan sponsors get value for their drug plan spend, for employees. CEA considers the cost and benefits of therapies to determine if new drugs are worth the increased cost. The goal is not to find the cheapest alternative, rather, it is to find the drugs that offer the most efficient use of the money spent. A drug may be costly—but it may be cost-effective. The analysis can identify therapies that represent good value for money and therefore, can help to inform an evidence-informed, value-based drug plan.

While published guidelines for conducting CEA from the public payor perspective exist, there are several aspects to consider when conducting an analysis from a private payor perspective, as well as some methods to avoid. This guidance document is intended to help those producing CEAs for private payor so the analyses are credible and relevant for plan sponsors, economic information is standardized, as are the methods, and reporting. The ultimate goal is to facilitate well-informed decision-making specific to private payor. CEAs submitted to private payor should follow the recommendations set out in this document, as well as the Guidelines for the Economic Evaluation of Health Technologies: Canada 4th Edition published by the Canadian Agency for Drugs and Technologies in Health (CADTH). Use of a standard approach increases transparency in the process and confidence that the results are relevant to the private payor and useful for reimbursement decision-making. These guidelines will be reviewed and revised as necessary.

This article is part 2 of a 2-part series following the publication of our Budget Impact Analysis (BIA) guidance document.

Private payor perspective

When conducting a CEA, the costs included must be relevant to the decision-maker. Public plan decision-makers are interested in healthcare system costs, such as hospitalizations and physician visits, whereas plan sponsors are more concerned about the drug cost and it's potential to improve workplace productivity, reduce absenteeism, or prevent a disability claim. As a result, the objectives differ due to the population they cover and the benefits they value in a drug.

It is not necessary to create a completely new economic model for the private payor, but some adjustments should be made to what is submitted to the public payor. Creating the option to remove all public payor costs would be a first and simple adaptation. Also, it should be noted that a societal perspective is not the same as a private payor perspective. For example, patient out of pocket costs (e.g., transportation, parking, hotel) or caregiver burden are not relevant. It is recommended that manufacturers include the costs of other benefits that might be impacted. Remember, the payor is the employer who pays for all the benefits. As a result, if possible, include productivity costs in the analysis relevant to the private payor (e.g., absenteeism, presenteeism); disability costs, allied healthcare provider costs (e.g., chiropractic, physiotherapy, massage), assistive devices, rehabilitation and out of hospital costs that are not covered by the public healthcare system.

Productivity costs

Benefits program providers need to show that their programs, like drug programs, contribute to key business drivers including increased productivity and fewer sick days (reducing absenteeism) however, these are not always included in the pharmacoeconomic analysis that are submitted for review. If they are included, they might not be from the private payor perspective. For example, it makes sense to exclude caregiver productivity losses from a private payor perspective because the caregiver and the person with the illness are unlikely to be covered by the same plan sponsor, especially if the patient is an adult. On the other hand, if it is a childhood disease associated with significant morbidity that requires full-time caregiving by a parent, it would be logical to include the caregiver's productivity loss since the child would not be the one occupying employment. It is noted that, from a societal perspective, both the patient and the caregiver's productivity would be relevant.

When a patient leaves the workforce due to their illness, productivity losses should be estimated using a friction cost approach, i.e., a temporary friction period for replacing a lost employee who becomes disabled. It would normally last a few months, the time it takes to replace the missing employee and get them fully trained and operational. For low-qualification labour, it might be only a few weeks. For highly qualified positions, it might be 6-12 months. A common value is three months. A friction cost approach is more limited than a human capital approach that implies a permanent productivity loss, which may be adequate from a societal perspective (a permanent loss to society) but not reflective of the plan sponsor's context, where a lost employee will eventually be replaced.

For estimating the productivity loss resulting from patients prematurely leaving the workforce, the friction cost approach is recommended for a private payor perspective – the human capital approach can be presented as ancillary information. The human-capital method takes the patient's perspective and counts any hour not worked as an hour lost. By contrast, the friction-cost method takes the employer's perspective, and only counts as lost those hours not worked until another employee takes over the patient's work.

Drug acquisition costs/drug dosing

As is the case for the budget impact analysis, the daily dose should be calculated directly from the data. In other cases, when there are several comparators, it is better to apply the dosing schedule as found in the product monograph and then adjust for relative dose intensity, when applicable. Adjusting for relative dose intensity observed in the randomized controlled trial is fine if this adjustment is applied to all drugs, not just the new drug (reducing its cost), as this could introduce bias.

When estimating treatment duration, the mean duration should be used instead of the median because the median may underestimate the true cost of a treatment.

It is imperative to provide explicit details about how the annual drug costs were calculated so that the costs can be validated by the reviewer. Also, the methods used to calculate drugs costs need to be consistent between the BIA and CEA.

Appropriate comparators and coverage

Similar to the TELUS Health budget impact guidance document, incorporating the appropriate comparator drugs is key to ensuring the model is relevant to plan administrators. Comparators need to reflect the current standard of care in Canada for the target population (e.g., off-label use when relevant). Drugs that are not used in actual practice should be excluded. As each payor may have different drugs covered on their formularies, it is beneficial to provide the option in the model to easily remove/include comparator drugs (e.g., drugs provided in hospitals may not be covered by the private insurer). Additionally, because a CEA intends to provide the most relevant analysis associated with reimbursing the new drug by a private payor, the base case analysis should consider that publicly funded comparators cost nothing to the private payor. This is common for intravenous drugs used in oncology. However, including the flexibility to include/exclude all drugs is preferred as some private clinics are providing IV drug administration and covered by private payor.

Extrapolation

When short-term data needs to be extrapolated over the longer term to meet the time horizon of the economic model, an estimation of the natural history of the condition and the effectiveness of the intervention is required. While it is recommended that the time horizon be long enough to capture all potential differences in costs and outcomes associated with the interventions being compared, extrapolating well beyond the trial data introduces significant uncertainty. As a result, manufacturers should consider the appropriateness and relevance of the time horizon chosen, especially if there are no meaningful differences in the long-term costs and outcomes of interventions (e.g., convergence of clinical pathways for the remainder of patients' lifetimes). Justifying the plausibility of the extrapolation may involve reference to external data sources, biology or clinical expert judgment. It is not acceptable to assume that the relative effectiveness will be maintained for the duration of the intervention without adequate justification.

Furthermore, private plan age demographics have an implication on the length of the time horizon. Private payor cover mostly a working population aged under 65 years and their dependents. In general, individuals aged 65 years and over will account for 10% or less in private drug plans. A time horizon that goes significantly beyond aged 65 becomes progressively less relevant for private payor because these costs and outcomes are not reflective of their plan members population. In other words, a lifetime horizon is not always appropriate and having the flexibility to adjust the time horizon is preferred.

Health-related quality of life (HRQoL)

As set out in the CADTH Guidelines, preference-based measures that reflect the Canadian general population should be used to populate the cost-utility analysis. When assigning utilities, the same health state should be associated with the same utility value. Having different utilities for the same health state across different treatments is considered invalid and can introduce bias if the utility value is materially different between two treatments. Any disutility associated with the treatments should be captured in the impact of adverse events on HRQoL.

It is not appropriate to include a utility by time to death especially if survival with the new treatment extends beyond the time horizon of the model because ultimately everyone dies. Disutility before death creates bias in favour of the new drug and is discouraged. Also, time-to-death utility is inconsistent with most oncology CUAs that use utility based on progression status. It could introduce further distortion in decision-making.

Conclusion

Cost-effectiveness analyses can provide evidence of value for money that will help in the decision-making process when trying to determine reimbursement of new pharmaceuticals. While the public sector has been using incremental cost-effectiveness ratios (ICER) to help inform reimbursement decisions for decades, it is not appropriate to use the ICER calculated from the public payor perspective and apply it to the private payor decision-making process. Calculating ICERs with relevant parameters means that plan sponsors are able to make more evidence-informed decisions. Public and private payor have different objectives because the populations they cover are different and therefore, place value on different benefits from drugs.

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