Current and future payment of cell and gene therapies

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Abstract

Background: A significant increase in the number of modeled cell and gene therapies (CGTs) is expected over the next several years. Quantifying their payer impact is complex as the high costs of these therapies and potential for long-term outcomes in a system designed to focus on shorter-term outcomes and lower costs present an enormous challenge to payers. This study focuses on current payment mechanisms used by payers and how they project to be used over the near future to balance affordable access and cost-containment strategies for these innovations.

Methods: Xcenda fielded an online survey in October 2020 to a panel of managed care network professionals. Respondents involved in the review of CGTs were asked about current payer strategies for these and how they plan to address the challenges associated with these highly complex therapy treatments.

Results: A total of 47 advisors responded to the survey: 30% were trade representatives, 4% were directors, and 60% were directors of business. A double-blind, 15-minute, online, quantitative survey consisting of both closed-ended and open-ended questions. The study focuses on understanding current methodologies payers use to manage and appropriate reimbursement for them. Results: For CGTs that have launched in the past 2 years, 57% used case rate negotiations, were in use 28% of the time, and annualized or installment plans, were used 15% of the time. Looking ahead over the next 12 months, most respondents (66%) are very/extremely likely to leverage reinsurance. Use of value-/outcomes-based contracting and spreading payments over time will evolve into indication-based case rates. This is compared to outcomes-based payment models and case management, which is only used 11% of the time. (P<0.05). Value-based or outcomes-based contracts are in use 28% of the time, and annualized or installment plans, were used 15% of the time, and annualized or installment plans, were used 15% of the time. (P<0.05). In addition, most respondents (66%) are very/extremely likely to leverage reinsurance. Use of value-/outcomes-based contracting and spreading payments over time will evolve into indication-based case rates. This is compared to outcomes-based payment models and case management, which is only used 11% of the time. (P<0.05). Value-based or outcomes-based contracts are in use 28% of the time, and annualized or installment plans, were used 15% of the time. (P<0.05). In addition, most respondents (66%) are very/extremely likely to leverage reinsurance. Use of value-/outcomes-based contracting and spreading payments over time will evolve into indication-based case rates. This is compared to outcomes-based payment models and case management, which is only used 11% of the time. (P<0.05). Value-based or outcomes-based contracts are in use 28% of the time, and annualized or installment plans, were used 15% of the time. (P<0.05). In addition, most respondents (66%) are very/extremely likely to leverage reinsurance. Use of value-/outcomes-based contracting and spreading payments over time will evolve into indication-based case rates. This is compared to outcomes-based payment models and case management, which is only used 11% of the time. (P<0.05). Value-based or outcomes-based contracts are in use 28% of the time, and annualized or installment plans, were used 15% of the time. (P<0.05). In addition, most respondents (66%) are very/extremely likely to leverage reinsurance. Use of value-/outcomes-based contracting and spreading payments over time will evolve into indication-based case rates. This is compared to outcomes-based payment models and case management, which is only used 11% of the time. (P<0.05). Value-based or outcomes-based contracts are in use 28% of the time, and annualized or installment plans, were used 15% of the time. (P<0.05). In addition, most respondents (66%) are very/extremely likely to leverage reinsurance. Use of value-/outcomes-based contracting and spreading payments over time will evolve into indication-based case rates. This is compared to outcomes-based payment models and case management, which is only used 11% of the time. (P<0.05). Value-based or outcomes-based contracts are in use 28% of the time, and annualized or installment plans, were used 15% of the time. (P<0.05). In addition, most respondents (66%) are very/extremely likely to leverage reinsurance. Use of value-/outcomes-based contracting and spreading payments over time will evolve into indication-based case rates. This is compared to outcomes-based payment models and case management, which is only used 11% of the time. (P<0.05). Value-based or outcomes-based contracts are in use 28% of the time, and annualized or installment plans, were used 15% of the time. (P<0.05). In addition, most respondents (66%) are very/extremely likely to leverage reinsurance. Use of value-/outcomes-based contracting and spreading payments over time will evolve into indication-based case rates. This is compared to outcomes-based payment models and case management, which is only used 11% of the time. (P<0.05). Value-based or outcomes-based contracts are in use 28% of the time, and annualized or installment plans, were used 15% of the time. (P<0.05).

Conclusion: Results from this study can help payers understand current methodologies payers use to manage and appropriate reimbursement for CGTs,2 payers still struggle to absorb these high-cost, high-value treatments and provide the hope of curative treatments to patients and their families. The key for CGT reimbursement is navigating the challenge of aligning the high humanistic value of these high-cost treatments with potentially long-term outcomes in a system designed to focus on shorter-term outcomes and lower costs. Payers will need to address the array of complex issues surrounding CGT and provide the hope of curative treatments to patients and their families. The landscape1 will need to be addressed before case-rate payments by indication and value-based options reach their full potential.

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