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How Employers Can Leverage Value, Health Equity Incentives to Address Health Plan Affordability Concerns

Matthew Gavidia

As health care coverage affordability continues to draw concerns from employers, panelists of a webinar held by the National Alliance of Healthcare Purchaser Coalitions (National Alliance) discussed the key roles that value-based design and health equity strategies can have in ameliorating cost and improving employee benefits.

Speaking on findings of the National Alliance's Fall 2021 Pulse of the Purchaser Survey, Gaye Fortner, MSN, president and CEO, HC21 Business Coalition, moderator of the webinar, "Building Better Benefits: Rethinking Value-Based Benefit Design," noted several of the significant threats to health care affordability cited by employer survey respondents, including drug prices (80%), hospital prices (73%), and a lack of price transparency (57%).

In addressing these issues, panelists Bruce Sherman, MD, medical advisor, National Alliance; Cindy Dempsey, MHA, director of total rewards, Genesco; and Kimberly Westrich, MA, vice president of health services research, National Pharmaceutical Council (NPC), provided insight on several solutions ranging from equitable health benefits to value-based benefit design for high-deductible health plans (HDHPs).

Sherman began the discussion by highlighting the direct association between health status and socioeconomic status, in which a number

SPOTLIGHT ON

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MA Primary Care Payment Models Influenced Telemedicine Usage During the Pandemic, Research Shows

Allison Inerro

A study published Friday in *JAMA Health Forum* found a significant association between the type of primary care payment model and telemedicine use during the COVID-19 pandemic for beneficiaries enrolled in Medicare Advantage (MA).

Patients used telemedicine services at the highest rates when they were in primary care groups "reimbursed under advanced value-based payment models," according to the authors, most of whom are executives at Humana, the second-largest MA insurer in the country.

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When the primary care groups were reimbursed under fee-for-service (FFS), patient telemedicine use was lower; the authors noted that those organizations had the strongest incentive to increase telemedicine use, as they were not supported with contracted value-based payments.

Early in the pandemic, virtually all in-person outpatient visits were canceled, and the revenue of practices that rely on FFS were the most impacted. In this Research Letter, the investigators looked at the effect on payment model and practice size on telemedicine use.

The study was conducted using data from Humana's health maintenance organization plans, identifying beneficiaries continuously enrolled in these plans from January 1, 2019, to September 30, 2020. Contract data for the patients' primary care provider (PCP) was segmented by FFS; shared savings with upside-only financial risk; shared savings with downside financial risk; or capitation.

Advanced value-based payment models were represented by the downside financial risk and capitation contracts.

Paid claims data were analyzed for audio-visual and audio-only telemedicine from January 1, 2020, to September 30, 2020, for changes in weekly rates of telemedicine utilization, stratified by primary care payment model. The link between telemedicine use and payment model were evaluated using a patient-level negative binomial regression model that adjusted for patient age, sex, race/ethnicity, Medicare eligibility criteria, comorbidity, and practice size, and included hospital referral region fixed effects.

A population of 1.1 million individuals in MA plans was included.

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of chronic diseases, such as diabetes and hypertension, are inversely associated with income.

“What is particularly concerning for low-wage workers is that in addition to having the highest prevalence of unhealthy lifestyle behaviors, they also have a significant financial burden in that they are the group with the highest proportion of health care costs as a percentage of their wages,” said Sherman. “Not only are they paying out more because they have a greater prevalence of disease, but they're also earning less.”

Adding in health literacy concerns that may contribute to the increased use of high intensity resources, namely hospitalizations or emergency department visits, as well as a lower adherence to preventive care services, the gap in quality of care between low- and high-income workers has also spotlighted race as a major factor.

Sherman noted that when assessing specialty drug use by employees with an autoimmune disorder, findings indicated that as income drops, an increasing gap was shown between the proportion of White individuals taking specialty medications vs those identified as Black and Hispanic.

“We have issues of implicit bias, we have issues of culturally sensitive and appropriate care, we have issues in medical mistrust. These can't necessarily be addressed by benefit design, per se, but employers certainly can take steps to help to address these—there are things that employers can do from a plan design standpoint,” he said.

Citing benefits equity as a notable strategy, Sherman said that currently 93% of employers have plan designs with employee cost irrespective of their income for different plan options.

In promoting greater equity from the standpoint of employer subsidies for benefit design, he added that employers should consider the growing research on associations of race and income as influencing factors of health benefit utilization and cost.

“Understanding that data can provide a roadmap for directed and strategic interventions to better support the health and well-being of their benefits enrollees,” Sherman said.

Panelist Cindy Dempsey next provided an example of how her organization, Genesco, a fashion retailer with over 13,000 employees in the United States and Canada, worked to incentivize value in its benefit design to ensure equity and engagement.

With a majority of its workforce being part time and of a younger demographic (average age, 31 years), she noted that the health plan that was in place when she started 5 years ago was geared toward moderate utilizers with moderate income, and had a myriad of diffi-

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cult-to-understand penalties and surcharges. Less than half (47%) of eligible employees enrolled in benefits, and of those enrolled, 69% had employee-only coverage.

“When we looked at what our members actually paid in claims to participate in the health plan, a huge spike was observed in the people who paid less than \$500 into the plan in co-pays and coinsurance and deductibles,” said Dempsey.

“So, even the people who utilized the plan for the most part never reached the deductible—what that means is that there were all these employees paying just about \$2000 a year for medical coverage, which was basically around 7% of their income, and most of them got zero value out of the plan.”

As this helped explain why a majority of employees were not enrolled in health benefits, Dempsey implemented several redesign objectives based on employee feedback:

- Choice: offer a choice of plans that better meets the needs of diverse employee population
- Difference: offer plans with meaningfully different actuarial values
- Company cost: company remains agnostic to plan choice
- Employee cost: reduce the cost of access, expand covered preventive services, and reduce/eliminate penalties
- Value: improve the value of the benefit

In offering plans personalized by lower income/lower utilization, higher income/high value, and a mid-value option, continuous migration in enrollment was noted since the first year the plans were offered, with employees choosing the plan that best fit their needs.

“We have continued to expand our preventive drug list...We are continually asking our carrier and our partner vendor partners to find ways to put necessary medications in front of the deductibles and reduce the cost share, and then we’ve reduced or eliminated altogether, the cost of telemedicine,” added Dempsey.

Kimberly Westrich lastly provided a sneak peek of the content to be discussed in the second part of the webinar series to be held on February 15, 2022, in which she will be serving as moderator.

With one-third of all covered workers enrolled in HDHPs as of 2021, health savings account (HSA)-eligible plans have emerged as the predominant model of these health plans.

The upcoming webinar will address 3 different publications that all have action steps for employers who seek to design their HDHPs to incentivize greater value, including action briefs released by NPC with

Compared with FFS, the marginal effects of payment model on telemedicine visits per 1000 patients were -12.9 (95% CI, -17.4 to -8.4) for shared savings with upside-only financial risk, 71.5 (95% CI, 66.9-76.1) for shared savings with downside financial risk, and 105.6 (95% CI, 96.1-115.1) for capitation (all $P < .001$).

The effect was largest for practices with 8 or more clinicians, which represented 11.2% of the patients in the study.

The findings suggest “that accountability for cost, quality, and disease management under value-based payment models—and the infrastructure, technology, and management systems of organizations engaging in these models—may have been a stronger catalyst for telemedicine adoption than recouping revenue from deferred in-person visits,” the authors wrote.

One limitation to the research is that it could not include other practice characteristics that may be linked with telemedicine adoption beyond payment model and size. The authors said additional research is needed to understand how to create optimal telemedicine practices as the country moves out of the pandemic and what drives adoption of telemedicine within practices.

Earlier this week, CMS announced that it would extend some Medicare telehealth coverage policies, first temporarily granted last year, until the end of 2023 while it gathers more data. ■

Reference

Powers BW, Drzayich Anto D, Zhao Y, et al. Association between primary care payment model and telemedicine use for Medicare Advantage enrollees during the COVID-19 pandemic. *JAMA Health Forum*. 2021;2(7):e211597. doi:10.1001/jamahealthforum.2021.1597

the National Alliance, Paul Fronstin, MD, from the Employee Benefit Research Institute, and A. Mark Fendrick, MD, from the Center for Value-Based Insurance Design, and one to be released on February 14, 2022, on best practices. ■

Payers, Value-based Care Policies Impact Biosimilar Adoption, Cardinal Health Report Finds

Mary Caffrey

Payers and value-based care policies have had more impact on the adoption of biosimilars than their inclusion in clinical care guidelines, according to a new report from Cardinal Health examining the biosimilars landscape and forecasting their use in 2022.

Bruce Feinberg, DO, vice president and chief medical officer for Cardinal Health Specialty Solutions, writes that Cardinal's 2018 prediction that payers could make or break the biosimilars market turned out to be "prescient." Some steps by payers helped the cause of lower-cost versions of biologics, while others seemed to defy logic.

Overall, the new report, "2022 Biosimilars Report: The U.S. Journey and Path Ahead," offers an optimistic view of the landscape. The overview outlines how biosimilars will move beyond their comfort zones in oncology and rheumatology and more boldly into therapeutic areas such as ophthalmology and diabetes care.

But much of the year will be spent preparing for the disruption to come in early 2023, when Humira, the top-selling drug in the world, will face competition from up to 7 biosimilars, with more in the pipeline.

The year 2022 "is set to be a turning point," in the United States, the report states, with biosimilars poised to deliver \$133 billion in aggregate savings by 2025.

"Total savings to patient out-of-pocket costs based on

just the current biologics with biosimilars approved are estimated to reach up to \$238 million," predicted Heidi Hunter, president, Cardinal Health Specialty Solutions, in the report's final section, which offers predictions.

Cardinal Health's overview offered a primer on the landscape since the first supportive care biosimilars came on the scene in 2015, noting that specialists in oncology and, to a lesser degree, rheumatology have gained experience with these products, and provider survey data contained in the report reflects this familiarity.

As Feinberg explained, biosimilars have already shaped the market, especially where payment models have supported their use. He offered the example of the Oncology Care Model in Medicare, which has rewarded participating practices for taking advantage of savings from biosimilar use.

"Significant progress has been made in the adoption of biosimilars in the U.S., particularly in oncology, where all 3 classes of therapeutic oncology biosimilars (i.e., rituximab, bevacizumab, and trastuzumab) have exceeded 60% market share," the report found. "Savings from biosimilars increased to approximately \$8 billion in 2020 alone, more than tripling savings derived from previous years. In addition, for the first time in 7 years, oncology expenditure growth fell below 10% due to the impact of biosimilars and new product launches."

By contrast, Feinberg wrote, "Commercial payers and pharmacy benefit managers (PBMs) initially impeded biosimilar adoption in oncology in the early years of biosimilar availability, but as coverage has improved in recent years, market uptake of oncology biosimilars has similarly increased."

The report predicts 5 trends for 2022, starting with a call to watch for market response to the approval of Viatris' Semglee (insulin glargine-yfgn). While 2021 did not have many biosimilar approvals, this approval of the first interchangeable insulin, a biosimilar for the reference product Lantus, was a major newsmaker.

Cardinal Health's report states that how payers, PBMs, and retail pharmacists react to Semglee will tell the market a lot about the value of the FDA designation for interchangeability,

which allows pharmacist substitution without prescriber approval. “As a result, pharmacists are now positioned to not only play an essential role in educating patients and ensuring clinical confidence in biosimilars, but also to serve as key change agents who may steer millions of diabetes patients to high-quality, lower-cost treatment options,” the report states.

Other predictions for 2022 are:

- Manufacturers will protect their positions as Humira (adalimumab) faces competition from up to 7 biosimilars next year, and other rheumatology and immunology drugs prepare for biosimilar competition.
- Although biosimilars for retinal care will continue to get attention, overall uptake in this area will be slow even as the number of patients with wet age-related macular degeneration rises and costs per treatment are \$2000 on average. Byooviz (ranibizumab-nuna), the first biosimilar in ophthalmology, is expected to launch in June 2022.
- The Biden administration’s executive order for biosimilar approval transparency along with market transparency will help the cause. Rulemaking from FDA and actions by the Federal Trade Commission will support competition, and so will a new approach to payment models that promote biosimilar use in Medicare.
- An increased emphasis on real-world evidence will provide particular insight into the effects of switching therapies.

While Cardinal’s report states that the best is yet to come for biosimilars, it shows products have already climbed on providers’ radar. Cardinal Health’s provider survey finds that those providers who have used biosimilars the most have increased their comfort level with the products—even when switching patients to biosimilars during curative treatment. Among the survey findings:

- In the 4 specialist categories surveyed—oncologists (N = 323), rheumatologists (N = 102), ophthalmologists (N = 102), and diabetes care specialists (N = 54)—only the ophthalmologists reported less than half (40%) being “very familiar” with biosimilars. Outside of ophthalmology, more than 90% of the specialists were “very familiar” or “somewhat familiar” with biosimilar therapies.

- 67% of oncologists said they would prescribe biosimilars to a patient having success on a reference product regardless of payer considerations, while rheumatologists (35%) and diabetes care specialists (72%) were more likely to prescribe to existing patients if this was required by a payer or PBM.
- More than 7 of 10 oncologists said they were “very” or “moderately” comfortable with automatic substitution of biosimilars, and only 5% said they would not subscribe biosimilars for indications without clinical trial data.
- More than 90% of oncologists said they are comfortable with switching between biosimilars at least in some cases.

Cost savings to both patients and a practice are considerations for providers, although its degree of importance may vary. However, two-thirds of rheumatologists say that the economics of prescribing remain a barrier to biosimilar adoption.

The report describes “momentum” around bringing biosimilars to market as strong, and that the trend to move beyond oncology and rheumatology will define the next 5 years.

“The year ahead is sure to include many significant biosimilar milestones,” the report states. ■

Experts Discuss How Employers Can Take on HSA HDHP Challenges While Encouraging Value-Based Care

Gianna Melillo

In part 2 of a webinar series hosted by the National Alliance of Healthcare Purchaser Coalitions, experts discussed employer opportunities for improving value and crafting smarter deductibles in health savings account (HSA)

high-deductible health plans (HDHPs).

According to the Internal Revenue Service (IRS), as of 2022, an HDHP has a deductible of at least \$1400 for an individual and \$2800 for a family, while the plan's yearly out-of-pocket expenses cannot exceed \$7050 for an individual or \$14,000 for a family; the limits do not apply to out-of-network services.

Although HDHPs are becoming increasingly common, are often paired with HSAs, and are popular among employers as they shift costs to workers, previous research has shown individuals in HDHPs are more likely to delay necessary medical care, experience cost barriers, and have claims rejected by insurance. In addition, concerns have been raised regarding employees' understanding of HDHPs and whether these plans actually deter individuals from seeking preventive care.

On the other hand, HDHPs could help incentivize employees to think through what the highest value care for their particular needs is and what may be low-value care and not necessarily worth their health care dollars, explained Kimberly Westrich, MA, vice president of health services research at the National Pharmaceutical Council, who served as the webinar's moderator.

For all these reasons, employers' careful crafting of HDHPs is crucial; incentivizing uptake of high-value care and yielding cost savings from rejecting low-value care was a key theme of the discussion.

When it comes to identifying good practices in HSA HDHPs, Laura Rudder Huff, vice president of Gallagher Research & Insights, laid out some consensus statements made by a variety of stakeholders surveyed. In her presentation, Huff defined a good practice as "a design that consistently helps enrollees maximize the value of their benefits and navigate treatment options."

Of the 50 employers—each with at least 5000 employees—surveyed, 68% reported they see a strong or moderate outcome where out-of-pocket costs create a financial burden for certain segments of employees, particularly those who earn low or middle wages.

Huff's research also revealed "52% [of employers] are seeing strong or moderate outcomes in that the out-of-

pocket costs prompt employees to delay medical care, 46% have received some pushback from their employees with dissatisfaction about the HDHP design, and 36% have said that they've noticed some out-of-pocket costs can prompt employees to decrease medication adherence or abandon medications."

Researchers were also able to identify 11 good practices, of which 9 had consensus (66% or more agreed or somewhat agreed with the practice). Some of the top good practices included:

- Offering ongoing education of the plan
- Emphasizing the HSA retirement and tax-free advantages
- Offering real-time tools providing medical prices at various locations

However, for all 9 agreed-upon practices, a gap existed between agreement and actual implementation. "So, just because employers agree or have consensus that something is a good practice, it can still be difficult for them to implement," Huff said.

One method of addressing discordance between employee use of high- and low-value care is encouraging employer uptake of predeductible coverage for preventive services.

"In an HSA plan, the deductible is quite strict. It has to cover just about everything that the health plan covers, with the exception of some preventive services. And that's been a criticism of these plans since they were introduced back in 2004," explained Paul Fronstin, PhD, director of the Health Research & Education Program at the Employee Benefit Research Institute.

In the summer of 2019, the IRS did relax some restrictions on what can be excluded from the deductible and covered on a predeductible basis, Fronstin said, noting the guidance was very specific and only included 14 particular services. This notice was a Trump administration initiative, highlighting the rare bipartisan support value-based insurance design holds.

An additional survey conducted by Fronstin and Mark Fendrick, MD, professor of internal medicine, health management, and health policy at the University of Michigan, and co-editor-in-chief of *The American Journal of*

Managed Care[®], revealed 76% of those asked in 2020 added predeductible coverage based on the update, but coverage was not evenly distributed across the 14 services.

“Employers were very discriminatory,” Fronstin said. “They picked and chose what they thought they should add coverage for,” and coverage was not free across the board as some employers introduced co-insurance or co-payments.

Importantly, the survey also showed the expansion of services covered did not lead to an increase in premiums. Encouraging more flexibility in predeductible services and drugs covered remains a central goal in advancing value-based insurance design.

“I strongly support Americans paying lots of money out-of-pocket for the care they should not be buying in the first place and the care that you all [employers] should not be covering in the first place,” Fendrick said.

Using insurer coverage of ivermectin for COVID-19 as an antithetical example, Fendrick noted insurers are not “really taking that aggressive position on trying to reduce the utilization of the services that there’s clearly no clinical beneficial evidence that you should be covering it, at least generously.”

Research published in *JAMA* last month found that during one week in August 2021, insurers heavily subsidized costs of ivermectin prescriptions for COVID-19, despite no evidence showing the treatment has any benefit for the condition.

“Wasteful insurer spending on these prescriptions, estimated at \$2.5 million in the week of August 13, 2021, would extrapolate to \$129.7 million annually,” while “the true amount of waste is even higher because estimates did not include Medicaid spending,” the researchers wrote.

Dissuading uptake of low-value care via high out-of-pocket costs will result in cost savings that encourage generous benefits for high-value care.

An additional concern of HDHPs is that the onus of deductible payment falls on those who are sick and utilizing care, while premiums will be spread across the entire population.

“Many of my patients facing high deductibles and chronic

disease needs view January as a very worrisome time, and we’ve seen a flattening, if not dropping off, of percent of enrollees in an HSA-eligible plan,” Fendrick said. As a result, in January, the number of individuals applying for charity care and the Medicare population both rise.

Individuals harmed by high deductibles are often financially insecure, Black and Brown populations, and have chronic diseases, while evidence supporting the expansion of the services covered show the move would lead to improvements in health equity, Fendrick explained.

Legislation addressing the need for expansion, the Chronic Disease Management Act, has been drafted. It aims to directly amend IRS code and allow HAS-qualified health plans the flexibility to expand the list of 14 services.

“It is my hope that we all can continue to work to put cost sharing in a way to make it easy, not hard, for patients to get the care we know will improve their individual health,” Fendrick concluded. “But at the same time, continue to put those barriers in front of those services...that will allow you to save a whole bunch of money on things that you’re currently covering, that you shouldn’t be covering as generously to allow that headroom, and prevent those patients in need from getting the care they really do deserve without having to have a bake sale or do an online Kickstarter campaign.” ■

CMS Official Cites OCM as Example of Biosimilar Success

Mary Caffrey

CMS’ decision to allow the Oncology Care Model (OCM) to end this summer without a replacement is drawing howls from participating practices, but the OCM drew notice from an official with the Center for Medicare and Medicaid Innovation (CMMI), who discussed how it propelled the uptake of biosimilars in Medicare Part B.

Purva Rawal, PhD, CMMI senior advisor and chief strategy officer, mentioned the successful use of biosimilars in the OCM during her talk before the Association for Accessible Medicines' Access! annual meeting, held in Orlando, Florida, February 15-16.

"Given our interest in making drugs more affordable for beneficiaries and the Medicare and Medicaid program, we at the Innovation Center are exploring the potentially important role biosimilar adoption may have for the success of our value-based payment models," Rawal told the group, which represents leaders in the generic drug and biosimilars industries.

"Many of you are likely familiar with our Oncology Care Model. It's in its sixth and final year. We're hearing about success in terms of participants prescribing lower-cost biosimilars, achieving savings in total cost of care and maintaining quality outcomes, which is critical. So, we're hoping that these anecdotal reports of success show through in our future evaluation results."

Rawal said CMS is committed to policies that will expand the use of biosimilars, given the need to make drugs more affordable and "the potentially important role biosimilar adoption may have for the success of our value-based payment models."

Most of Rawal's talk focused on the "strategy refresh," a process that CMMI has undertaken to revamp how it implements alternative payment models; this is CMMI's core mission under the Affordable Care Act. In an essay in *Health Affairs* and in a white paper published last fall, CMS spelled out plans to add health equity to all models, and—of concern to the AAM audience—to renew its focus on limiting spending in Medicare and Medicaid.

"Importantly, we also want to increase the momentum and the movement toward value-based care and reignite that sense of inevitability that many of us felt 10 years ago," Rawal said.

Those practices taking part in the Oncology Care Model have asked CMS and CMMI to allow an extension while the strategy refresh takes place. The Community Oncology Alliance released a survey of practices that warned patient-friendly services such as navigators or weekend appointments could be curtailed in some practices if funds available under the OCM are withdrawn.

Rawal told the AAM how the policy that aimed to give specialty practices, including oncologists, incentives to prescribe biosimilars isn't working as hoped. Under Medicare Part B, a practice would normally be paid less to prescribe a lower-priced alternative under the average sales price + 6% formula, but the law was written to prevent this revenue drop.

"The statutory payment policy theoretically incentivizes biosimilar use by making the drug add-on amount comparable across the reference biological and each biosimilar product. But this payment approach doesn't ensure that the prescribers' margin on a biosimilar is comparable to the margin they may be able to obtain on the reference biological," Rawal said. "So, we're starting to see some market competition, overall lowering of drug prices for biologicals, where biosimilars have been introduced. But the uptake of biosimilars has been slower than we anticipated, as many of you are aware, even with the add-on being based on the reference biologic."

Barriers to biosimilar uptake are "concerning," to CMS, and CMMI seeks to remove them, Rawal said. She said some challenges may be related to provider education.

A recent survey by Cardinal Health found that oncologists have higher acceptance of biosimilars than rheumatologists. Oncologists have pointed to examples of pharmacy benefit managers interfering with their effort to use biosimilars; they say some PBMs demand use of higher-cost reference products, which could be connected to financial arrangements between the PBM and the manufacturer.

Rawal credited the AAM for collaborating on ideas to promote biosimilar and generic use. Value-based care, she said, proved its worth during the pandemic and will do so going forward.

"We've seen early evidence that providers in population-based payments and alternative payment models were more resilient," Rawal said. "That resilience allowed them to continue to provide access to patients, such as through telehealth.

"So, we have new evidence on the value of value-based payment, and value-based care from the pandemic, and we want to use this experience to accelerate our work to drive accountable care." ■