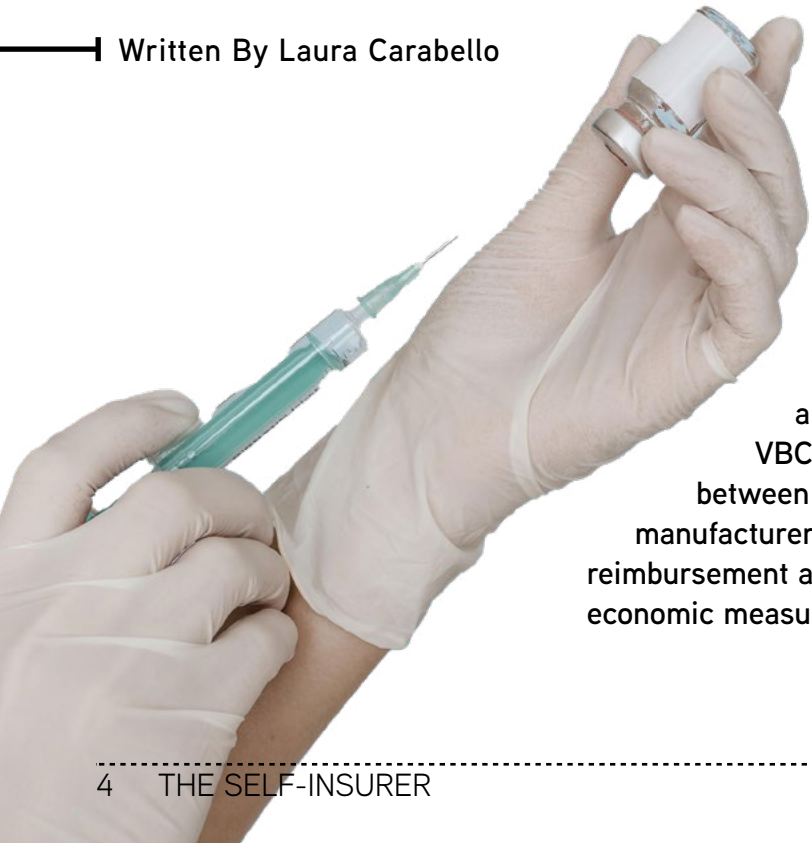
Growth of **Value-Based Purchasing** and **Contracting** for **Cell & Gene Therapies**

Editor's Note: This is the second of a two-part article. Part one appeared in the March edition of the Self-Insurer. Also, for information on this subject, please consider attending SIIA's Cell & Gene Therapy Stakeholder Forum, scheduled for May 27-28 in Minneapolis. Details can be accessed at www.siia.org.

Written By Laura Carabello



IMPROVING ACCESS AND AFFORDABILITY WITHOUT BANKRUPTING THE HEALTH PLAN

As research and development of these cutting-edge therapies rapidly progress, employers have an opportunity to explore and implement cost-effective approaches for making these therapies available to employees and covered dependents who need them. Strategies include paying over time, negotiating rebates based on the therapy's effectiveness and buying stop-loss insurance.

Value-based contracts (VBCs), also referred to as risk-sharing or outcome-based agreements, are newer, evolving payment models used by pharmaceutical manufacturers and payers to connect reimbursement, coverage, or payment to a therapy's actual outcome in a real-world setting. VBCs are performance-based reimbursement agreements between payers/plan sponsors and pharmaceutical manufacturers in which the price, quantity and nature of reimbursement are tied to agreed-upon clinical, intermediate, or economic measurable objective endpoints.

"VBCs can help provide earlier access to therapies for patients while allowing employers, health plans and payers to reduce their uncertainty regarding clinical value and help manage the risk with the therapy and overall financial impact if the therapy was not successful," explains Bob Gilkin, Senior VP, Trade and Specialty Strategy, AscellaHealth. "Additionally, pharmaceutical manufacturers can utilize VBCs to demonstrate the effectiveness of their product while sharing risk for the therapy outcome. VBCs provide a potential solution to address escalating costs and uncertain real-world effectiveness of medications."

The chart below demonstrates a sample of Value-Based Arrangements.

Value-Based Arrangements		
Drug Name	**US Price**	**VBA**
Lenmeldy	**$4.25m**	The world's most expensive drug, a one-time gene treatment for metachromatic leukodystrophy (MLD), that adds a missing gene to the bone marrow cells of children, reversing the condition's root cause in the brain. *Manufacturer offers innovative outcomes-and value-based agreements* to both private and government insurers to ensure broad, expedient and sustainable reimbursed access.
Casgevy:	**$2.2m**	First cell-based gene therapy employing CRIS-PR-based gene-editing technology for treating sick-le cell disease (SCD) in patients ages 12 and older who have recurrent vaso-occlusive crises (VOCs). Approved first in the UK, followed by the US.
Lyfgenia:	**$3.1m**	Another cell-based gene therapy for SCD patients aged 12 and older with a history of vaso-occlusive events. *CMS oversees the Medicaid program and intro-duced a pilot "access model" for expensive CGTs designating sickle cell as its initial focus. CMS will negotiate an "outcomes-based agreement" that links payment for a drug to the health benefit it delivers. In sickle cell, for example, the targeted outcomes could be continued elimination of pain crises over time.*
Hemgenix:	**$3.5m**	First gene therapy, one-time treatment for adults with moderate to severe bleeding disorder hemo-philia B. Manufacturer anticipates *discounts, including value-based agreements with commercial payers. Manufacturer and UK's National Institute for Health and Care Excellence (NICE) have agreed the English government will pay for the treatment under an out-comes-based model.*
Zolgensma	**$2.32m**	A one-time gene therapy treatment for spinal mus-cular atrophy (SMA) in children under the age of two. *Manufacturer will allow payments over five years, at $425,000 per year, and will give partial rebates if the treatment doesn't work.*

Source: 2024 AscellaHealth


Bob Gilkin

Gilkin advises that VBCs may potentially increase drug costs because the drug therapy costs are typically separated from overall healthcare costs and do not take into consideration the impact of the potentially greater benefits of more expensive therapies on overall patient outcomes and healthcare costs.

"Since payers are responsible for their patients' total cost of care, they need to consider the impact that CGTs may potentially reduce downstream medical utilization costs, longer-term complications and additional healthcare costs that can impact premiums for employers and patients," he adds. "VBCs may provide an avenue where payer and pharmaceutical manufacturers are aligned and can demonstrate the positive impact of these therapies from health and economic perspectives."

With the low volume of patients currently impacted by VBCs, Gilkin says it is unlikely that these agreements will directly impact premiums in the near future, noting, "But they hold the potential that if they prove to demonstrate positive health outcomes and show overall healthcare savings, they could positively reduce premiums in the future."


Jakki Lynch

Jakki Lynch, CCM, CMAS, CCFA, director of Cost Containment, Carbon Stop-Loss Solutions, further explains that in an effort to address the upfront high cost of care and uncertainty of the clinical outcomes, the market has seen an emergence of a broad range of innovative proposed payment models in the form of therapy product carve-outs, pay-over-time methodologies, clinical warranty templates based on retrospective payment adjustments and cost rebates tied to patient outcomes with new market intermediary solution providers that facilitate these services on behalf of all payer types.

"Outcomes-based contracts are the preference but come with ambiguity secondary to challenges on establishing transparent and verifiable outcomes criteria," she continues. "They require substantial resources for tracking outcomes and do not address the total cost of care with provider markup, administration charges and additional costs for potential complications. Certain manufacturers are accepting innovative payments for their therapies, including Luxturna, Zolgensma, Zynteglo, Hemgenix and Roctavian."

Based on the significant cost and the complexities of the therapies, Lynch says plans need a comprehensive approach that spans the full spectrum of management strategies with specialized financial and clinical resources to manage and mitigate this emerging complex and novel risk.

"Strategic focus and risk assessment should include treatment plan validation supporting optimal member outcomes and covered plan benefits as well as optimal all-inclusive contract rates with favorable terms inclusive of value risk-based rebates," she advises. "Claim payment integrity microanalysis with comprehensive medical record reviews ensure correct health plan or third-party administrator payments and contract terms compliance."

Lynch offers the following Branch Contract Optimization + Claim Payment Integrity Review (CPIR) that demonstrates the effectiveness of bespoke specialty financial and clinical solutions to address this complex risk.

Axicabtagene Ciloleucel Immunotherapy Inpatient Treatment			
Payable Charges Without CPIR			$1,562,351
CPIR Payable Charges			$786,962
CPIR Savings			$775,389
CPIR Issues: Unit billing and payment determination errors for immunotherapy product, room and board acuity, post infusion hospital acquired infection resulting in delayed discharge.			

Jesse Roderick

Jesse Roderick, senior vice president of Accident & Health Claims, QBE North America. thinks that depending on the plan sponsors' risk appetite and financial strategy, they may decide to pursue VBCs that align payment with the outcomes achieved by the therapy, making this an effective strategy to manage the high costs associated with treatments while ensuring patients receive effective care.

"These contracts can mitigate some financial risks by tying payments to the therapy's success, making it more feasible for health plans to cover therapies and thereby increasing patient access to potentially lifesaving treatments," he imparts. "There are several value-based purchasing models in the current market that meet payer requirements. These include outcomes-based agreements, where reimbursement is linked to clinical outcomes, performance-based contracts that require meeting predefined metrics, and installment payment plans which spread the cost over time."

OTHER NOVEL SOLUTIONS

New programs are being developed to help finance the risk of gene therapy treatments. Many pharmacy benefit managers (PBMs) and carriers offer coverage of gene therapies for a fixed per member per month (PMPM) fee. Some insurance companies are selling Netflix-like subscriptions where companies pay a monthly fee — often less than $2 a month per employee — for access to gene therapy. One large PBM covers 10 gene therapies through a subscription-type model, requiring employers to pay $1.25 PMPM, and the PBM assumes any additional financial risk.

In some instances, a subscription model can also be structured to exclude patients with pre-existing conditions. While state and federal laws prevent insurance companies from denying coverage for pre-existing conditions, like the inherited diseases that gene therapies target, organizations that self-insure aren't required to cover all treatments and may reject some as a way to save money.

There are also outcomes-based agreements that offer pricing flexibility through rebates tied to the therapy's results or a series of payments that can be made over time. These arrangements are typically negotiated with payers or PBMs that offer employers supplemental coverage. Outcomes-based contracting with pharmaceutical manufacturers typically offers milestone-based and performance-based arrangements.


Jeff Auten

Jeff Auten, director of Clinical Consulting (PharmD) at Leaf Health, concurs that multi-year performance-based contracts will be the mainstay of reimbursement models for gene therapies. "…allowing self-funded plan sponsors to spread therapy cost over several years and annual payments based on defined clinical metrics."

Lockton, the world's largest insurance broker, says these solutions will be challenging for employers, especially those with high employee turnover, since the member may leave the plan before the multi-year contract ends. For these payers, milestone-based or warranty-based arrangements may be appropriate, although these solutions may be challenging to operationalize since they require ongoing patient monitoring and a system that connects the provider, payer, and manufacturer to track outcomes and reconcile with the payment contract.


Terri Martin

At Custom Design Benefits, Terri Martin and Alberta Manga, Medical & Risk Management, also observe this trend: "Our clients have demonstrated their commitment to value-based contracts during this plan year's renewals. Employers and health plans are increasingly adopting value-based contracts to enhance member access to treatment, anticipating that these arrangements will help manage the overall cost and access to quality facilities for their members."

They do not point to any specific payment model and say there have not been any guarantees associated with the contracts.

"To establish guarantees, members who receive treatment must be monitored by Case Management for at least a year," they caution. "This ensures that their progress and outcomes can be accurately tracked and evaluated. If a member changes employers, they can no longer be followed. Even monitoring for a year is not enough time to evaluate if the treatment is a cure."


Alberta Manga

ROLE OF STOP-LOSS INSURANCE

Lockton maintains that the main payment option to pay for these therapies for a self-funded plan sponsor is their stop-loss policy, which should be evaluated on a year-to-year basis to reflect a material change in experience or price adjustments. They say that none of the carriers are denying coverage outright for CGTs or requiring the plan to transfer the liability to

another entity, such as a carve-out program. They also say it is critical to align the terms of the underlying health plan and the stop-loss coverage to ensure stop-loss reimbursement of claims related to these expensive treatments.

Jamie L. Holowka

Stop-loss policies can protect the underlying health plan, at least temporarily, by transferring the risk of high-cost claimants. In some cases, stop-loss insurers can "laser" a specific enrollee or drug to set higher coverage thresholds, effectively removing financial protection for the employer. Consulting actuaries at Milliman observe a slowdown in demand for CGTs and believe the surge will emanate only from patients who tend to have the most severe cases or conditions with no other treatment options. For the foreseeable future, they recommend coverage under traditional means like stop-loss.

Jamie L. Holowka, B.S., Pharm.D., director of Clinical Strategy, Complete Captive Management Services, says that through her experience in medical stop-loss and re-insurance, she has participated in the payment and contracting process of more than two dozen gene therapies and hundreds of cellular therapies.

"I have observed the facts fall out through the medical data showing that some recipients had no response, but serious consequences, other recipients had a temporary response, also with serious consequences, and some had a response for a limited durability (limited amount of time) and supportive therapy, and treatment is still ultimately necessary," she explains. "Because of these lesser discussed outcomes to promote science, manufacturers contract with providers and carriers to authorize the therapies."

Between these entities, she says there could be 340b contracts or traditional rebates and outcomes-based contracting. Since carriers may front the payment (at best) but stop-loss (and re-insurance) is the actual payer, she maintains that it is unacceptable that current contract participation does not extend to the stop-loss and re-insurance carriers.

"For all the CGTs, the manufacturer is not able to bill IF they are unable to produce enough product to meet FDA approved specifications (doses)," she continues. "For CGTs, IF a recipient passes away after a pre-determined amount of time, a 100% refund is returned to the carrier. If a recipient dies or the disease progresses, depending on onset and time, the carrier will receive a 75%-100% refund for the therapy."

Although gene therapies are still limited to a one-in-a-lifetime dose, regardless of effectiveness, she believes that many providers still maintain or start their competitor therapies before or after the gene or cellular therapy, including bone marrow transplantation and other specialty therapies.

She contends that although we are living in an amazing medical science space, the risk is completely on the employer covering the products while the network retains all the incentives, adding, "For most of these diseases, the only potential cure remains known to be stem cell transplants, like a bone marrow transplant. Potentially eligible recipients would be so much better served with a donor match campaign."

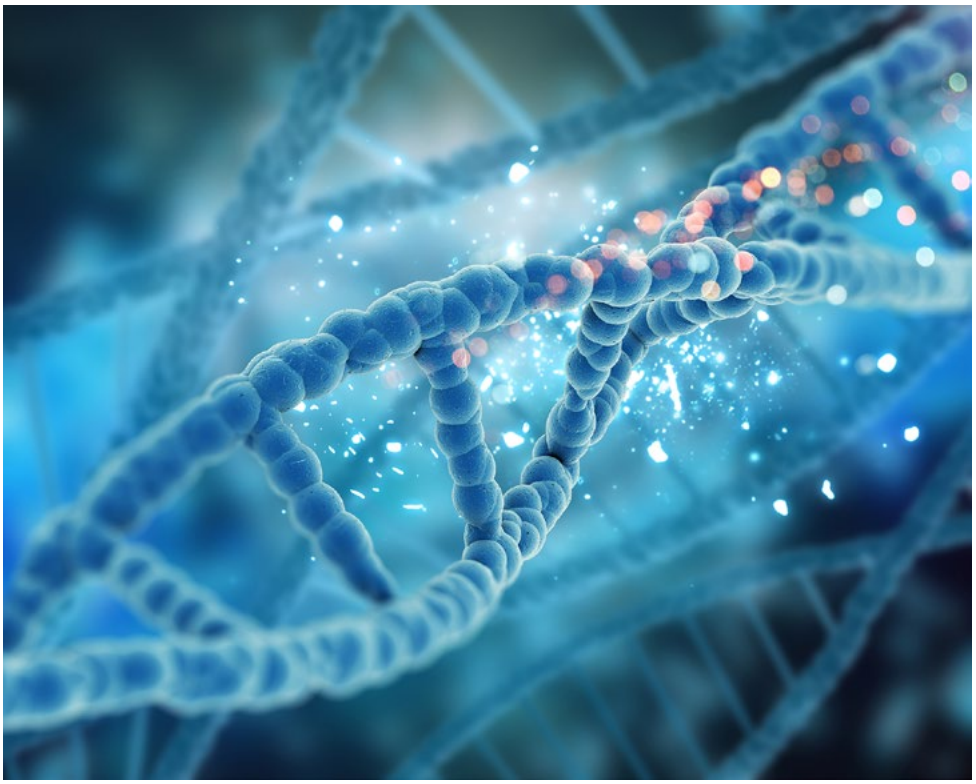
Roderick concurs, "The availability of stop-loss coverage can encourage plan sponsors to provide benefits for CGTs. Knowing there is a mechanism to manage the financial risk associated with these treatments makes it more feasible for plan sponsors to include them in their coverage options."

When plan sponsors partner with the right medical stop-loss insurance providers, he feels it supports the implementation of VBCs by covering the financial risk of high-cost claims.

"This enables plan sponsors to confidently enter into value-based agreements, aligning financial protection with value-based care models to help ensure that members receive the best possible outcomes while managing costs effectively," he comments.

MANAGEMENT SOLUTIONS

A debate continues on whether to cover gene therapy under the medical or pharmacy component of the plan. Some argue that the pharmacy component enables plan sponsors to better manage the cost, although this option requires a full understanding of the programs that the administrator has in place. For instance, if



outcomes-based contracting is under consideration to cover gene therapy, the medical component of the plan may be preferred since the member's outcomes will likely be tracked through the medical claims experience.

Lockton cites other management solutions, including providing access to specific, high-value network providers, limiting out-of-network facility coverage, and adding a travel benefit to enable ease of access to high-value providers. Coverage for cancer gene therapy should be accompanied by robust programs for cancer care navigation, expert medical opinion, cancer decision-support services and identification of gene therapy clinical trials for members.

Lockton advisors say it may also be possible for some self-funded employers to cap the amount their plan will pay for specific gene therapy treatments. They explain that the Affordable Care Act's ban on dollar limits applies only to "essential health benefits" (EHBs), as defined by the plan's relevant "benchmark state," and self-funded plan sponsors may choose which state's benchmark plan they'll use to determine their plans' EHBs. Some state benchmark plans, for example, require that merely some, but not all, drugs in a specific therapeutic class be treated as EHBs.

Holowka characterizes CGTs as "interesting progressions and treatment options in the medical arsenal" but cautions, "We are still "scraping the mold off the petri dish; we have not formulated penicillin yet. They are great motivation for the development of other treatments for these rare diseases.

She advises that carrier formularies should be applied as standard to CGTs as they are with any other treatment policy and protocol in healthcare: "Clients should understand that other therapies are not inferior to CGTs and clients should not feel obligated to cover for ALL options of treatments available, when they are all considered equivalent. We need to consider that a handful of recipients does not provide solid evidence of safety or efficacy and that CGT options are being directed at our most vulnerable and most desperate populations."

COVERAGE: A WEIGHTY LIFE OR DEATH DECISION

Denying CGT coverage triggers many consequences, primarily compliance and public relations risks. Some disabilities-based discrimination claims are surfacing, even if the exclusion is targeted at a member's dependent. By amending a plan mid-year to exclude coverage because of an existing claim or impending claim, there is a risk of a HIPAA violation. Furthermore, if a self-funded employer chooses to exclude gene therapy but then determines an exception and offers coverage as a result of extenuating circumstances -- negative publicity, the child of an executive needing the treatment, etc.-- the claim will not be eligible for stop-loss reimbursement because the service is not listed as covered in the underlying health plan.

Public relations nightmares are becoming all too common since these treatments are now viewed as essential, and many are for children. Imagine the headlines for not covering an FDA-approved gene therapy for a baby with a life-threatening condition with limited, if any, treatment options. When workers think they have coverage and are then denied access to a CGT, there are life or death implications.

OTHER OBSTACLES

Self-insured plans encounter multiple obstacles to providing access to these potentially lifesaving therapies. However, the extended treatment journey for most CGTs is one barrier to utilization since

medical appointments for the individual or their loved ones could interfere with work schedules and requirements.

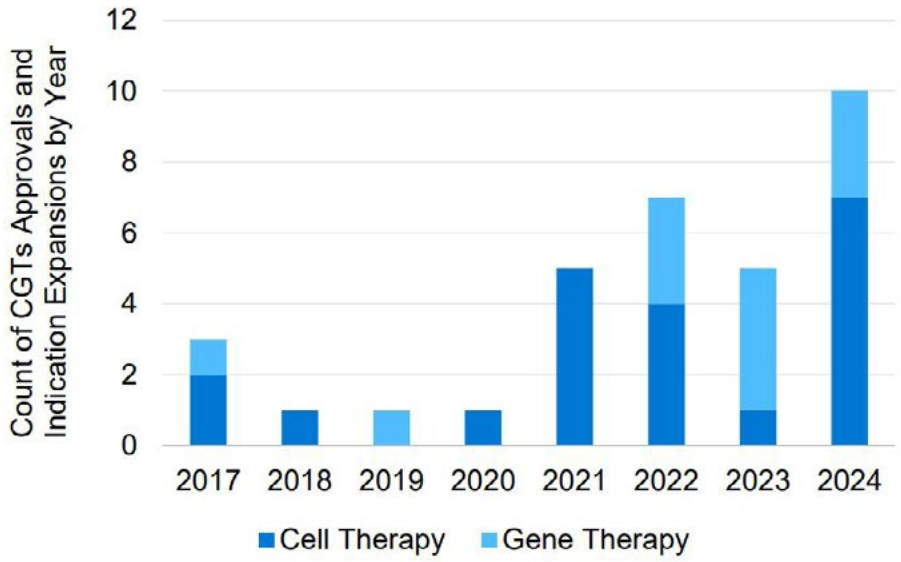
For example, the infrastructure required to deliver sickle cell therapy is extremely specialized and currently only available at very few centers, typically bone marrow treatment facilities with sickle cell expertise. Younger patients have also been reluctant to embark on the demanding treatment process that lasts more than one year and requires periodic hospitalization – disrupting school schedules and apprehension about adding additional medical burdens to their routines. Furthermore, many sickle cell patients are so advanced in their disease that gene therapy is not clinically warranted.

The advent of single-administration (CGTs) has the potential to change the landscape of treatment. A Milliman study reported that the FDA has approved 23 single-administration cell and gene therapies since 2017, totaling 35 approvals with additional expansions. Most approvals have come in the past two years, and roughly 60 more could hit the market in the next three years.

Milliman points out that these gene therapies are typically infused in one session, holding the promise of a cure that would avoid a lifetime of treatment. However, some employers, particularly retailers, hospitality, or trucking companies, where there is a large employee turnover, may hesitate to shoulder the hefty cost of a one-time treatment. Drug manufacturers argue the prices are justified because they offset a lifetime of medical costs patients would otherwise face.

Of the 17 one-time therapies approved by the FDA at the end of 2023, only eight had been used by more than 10 patients, according to Milliman's analysis of 60 million commercially insured enrollees. Kite Pharma Inc.'s $425,000 lymphoma CAR T-cell therapy Yescarta had the most claims, at just 413 since its 2017 approval.

FIGURE 1: FDA-APPROVED SINGLE-ADMINISTRATION CGTS THROUGH SEPTEMBER 2024



Source: Milliman DNA Gene and Cell Therapy Forecasting; v3.3.0, September 2024 release.


Keri Schoenbrun

THE PRICE TAG FOR A CURE

CGTs potentially offer a cure for many diseases for which traditional approaches, medicines and surgery have simply halted disease progression or modulated the course of the disease. For diseases caused by mutations in single genes that a person is born with, it is estimated that there are more than 6,000 such diseases affecting over 350 million people worldwide.

Braving the gene therapy headwinds, attendees at the recent JP Morgan investor conference heard from the Alliance for Regenerative Medicine president Tim Hunt who offered a rosy outlook for CGTs, predicting 10 such treatments will become blockbusters by 2030. Peter Marks, director of the FDA's Center for Biological Evaluation and Research, commented that 2024 was also a "good year" for gene therapy approvals, emphasizing that the agency is focused on boosting accelerated approvals with the launch of two pilots to aid gene therapies and treatments for rare diseases.

"The industry needs to think differently about CGTs," says Keri Schoenbrun, Chief Engagement Officer, Actum Pharma, a company founded by a consortium of biopharma leaders that is committed to enabling the development and market introduction of novel therapies that effectively address patient suffering from debilitating and life-threatening conditions. "Because CGTS are in a completely pioneering space, virtually all of these therapies will be unfamiliar, on some level, to the entire ecosystem. CGT companies need to

think differently about many aspects of commercialization, but particularly stakeholder education, which will need to be conducted early and often."

She says that even companies with deep experience launching products, like small molecule therapies, will need to think very differently about some fundamental work streams, especially payer education.

"Education will be about much more than articulating outcomes," explains Schoenbrun. "Drug manufacturers need to be prepared to explain diseases that may be treatable for the first time, unique methods of administration and a broader view of benefits to both patients and payers."

She advises the conversations between CGT's and payers should begin with a single premise: all options are on the table and none of the parties can be constrained by previous models.

"Start by effectively painting a picture of the overall cost of care," she continues. "Robust health economics and outcomes research studies may be needed to quantify the full burden of current treatment options relative to the emerging CGT. It starts with data but will likely require working with patient advocacy groups to understand the details and nuance of living with a given condition."

She cites recent work focused on a rare skin condition where, for example, the cost of bandages alone could reach $25,000 per patient.

Schoenbrun also points to the role of genetic testing, adding, "Expect the role of genetic testing to also evolve. Historically, payers were reluctant to reimburse for genetic testing. But as CGTs evolve, smart payers will increasingly embrace genetic testing as a way to identify patients who are likely to benefit from a given therapy. This becomes an important way for payers to manage the risk associated with high-cost interventions. Drug manufacturers will need to do their part by ensuring related genetic tests are reliable and meet increasingly stringent standards set out by the industry."

A prediction for the future from Schoenbrun: "It is important to remember we are standing at the frontier of a whole new way to treat patients. While some of the costs might seem outrageous now, these are growing pains for the industry. We will soon see improvements in process, automation and testing begin to lower costs for patients and payers."

Expounding on this topic, Dan Winkelman, Director, Offering Design Suite, IQVIA, says the decision to cover these therapies must be made on a plan-by-plan level and by disease state due to different levels of cost, efficacy, and alternative therapies.

"In some cases, the unprecedented efficacy results in positive economic models due to the likelihood of a reduction of hospital stays and/or reduced need for ongoing chronic care therapy," he advises. "For example, the economics are seemingly clear for CAR T-Cell therapy for DLBCL because it can replace Stem Cell therapy which involves longer hospitalization (3 months vs. 1 month) and has curative potential, which we call "one and done"." Another example is Luxturna for RPE65-mediated inherited retinal dystrophies. If patients have the biomarker, then this treatment can cure their blindness, resulting in a significant impact on their lives and their support system."

Dan Winkelman

In contrast, in other disease areas and therapies, he says the same efficacy could be achieved with lower cost therapies, noting, "One unique factor about these therapies is that they tend to target smaller patient populations which can buffer the budget impact despite the individual high cost of the treatment. Innovative models are required to understand the true value of treatment and must be updated regularly."■

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