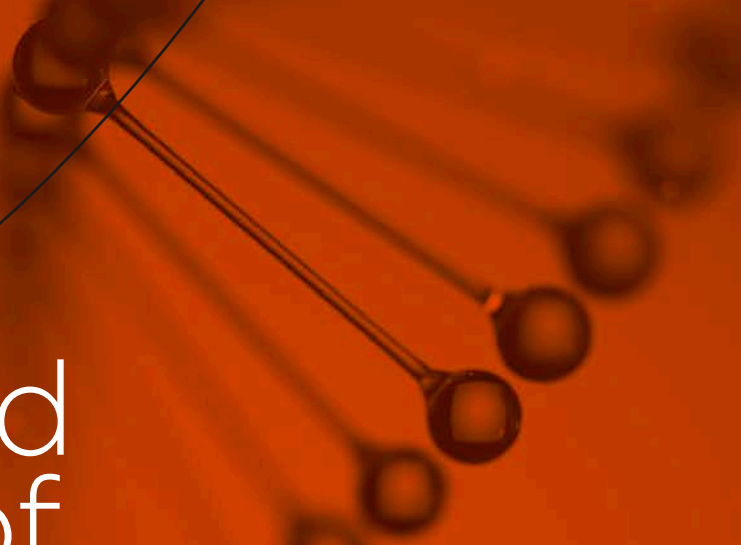
March 2023

Market Access and Reimbursement of Novel Therapeutics

Perspective from payers on managing new and expensive treatments



Center for **Connected** Medicine

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Introduction

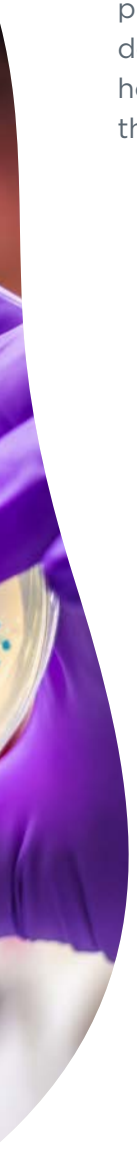
Novel therapeutics are among the most innovative and costly pharmaceutical and biotech products available, and they advance clinical care by providing first-of-their-kind treatments not previously approved or marketed in the US for rare diseases and conditions. Driven by genomics, transcriptomics, and other diagnostic technologies, novel therapeutics can improve patients' conditions — some of which are rare and difficult to treat — while also increasing knowledge of these conditions.

Payer organizations and integrated health systems face many challenges around determining whether to cover the expense of novel therapeutics; these challenges include a lack of data supporting treatments, limited incremental efficacy, and overall budget impact. Additionally, novel therapeutics illuminate issues regarding health equity and the reliability of U.S. Food and Drug Administration (FDA) approval. While organizations are struggling to rationalize the cost of these new treatments, they also want to ensure members receive appropriate treatment and excellent care quality.

This report provides an early look at this crucial topic for payer organizations, the challenges they face, and their approach to deciding whether to cover novel therapeutics for members; it will also examine when and how payer organizations share risk when they do choose to cover these treatments. Though a limited number of respondents were interviewed for this report sample, they came from a wide variety of regions as well as health plan sizes and types, and they often reported similar challenges and decision-making processes. Data from these respondents suggests that in the future, utilizing unique payment models may improve the ability of health plans (especially smaller ones) to cover novel therapeutics for members.

Report Methodology

Data for this report was collected via approximately 30-minute phone interviews with eight executives and other senior-level contacts from payer organizations and provider-sponsored health plans from July 2022 through January 2023. The in-depth interviews included a series of qualitative and quantitative questions about how their organizations are approaching challenges related to covering novel therapeutics. The demographics of survey respondents are summarized below.



10 million+ 100,000–999,999
1–9.99 million <100,000

Respondent Demographics Ordered by member size

Respondent	Member Size	Job Level			Organization Type	
		Executive	Senior director	Senior analyst	Payer	Provider-sponsored health plan
1		●			●	
2			●			●
3		●				●
4				●		●
5		●				●
6			●		●	
7		●			●	
8			●		●	

Concerns with Novel Therapeutics

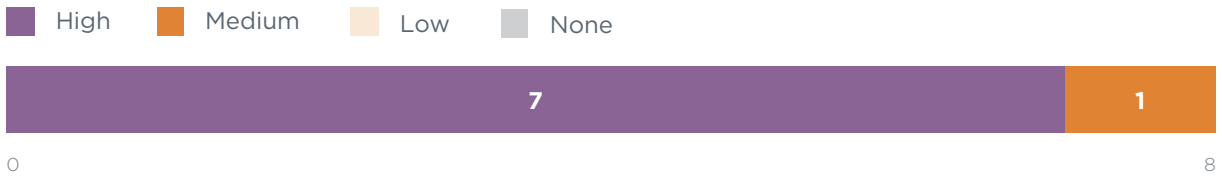
All Health Plans Concerned with Rising Cost of Novel Therapeutics

Of the payer organization representatives interviewed for this report, all but one said they considered the rising cost of novel therapeutics to be a high concern, as these treatments account for a larger portion of health plans' expenses but benefit only a small portion of the overall covered population. In addition to concerns about cost, health plans are also worried about the efficacy of novel therapeutics. While some novel therapeutics have significantly improved patients' lives, there are other cases in which only limited incremental efficacy was seen compared with the effects of less-costly and more-established treatment options. Health plans of all sizes struggle to not only build a sustainable financial model for novel therapeutics but also ensure they can provide all members with benefits that are affordable and equitable. Some respondents mentioned that novel therapeutics make it difficult to find ways to bring costs down for all members.

Smaller health plans may be especially affected by the rising costs of novel therapeutics, as a senior director from one such organization described: **"Novel therapeutics are for orphan or rare diseases, and the complexity in the development of these drugs makes the cost extreme. And by extreme, I am talking over $100,000 a year in costs. If a small plan has fewer than 50,000 lives, it only takes a couple of members who need novel therapeutics to start impacting the plan's budget significantly."**

Another dilemma that all health plans face is that they don't want to limit access to only patients who are in better financial situations. One executive shared, **"We need to be good stewards of the health care dollar. There is a limited amount of money in the system to actually pay for care. We want to be in a position to make care, whether it is therapeutics or procedures, affordable and equitable for all. We don't want to be in a situation where we are limiting access to care to people who have more money. We don't want to have that disparity in health care."**

Level of Concern with the Rising Cost of Novel Therapeutics (n=8)



Several health plans are looking to tackle the rising costs of novel therapeutics by dedicating teams to researching biosimilar products that could be adopted to provide savings while still benefiting members. One executive also stated that their pharmacy benefit management business is exploring multiple options (such as rebates) to lower costs: **"We are constantly on the cutting edge of wanting to move to solutions that will provide high value to our customers and health in general. We also want to be able to do so at scale and have processes and contract arrangements that will provide the best financial methodology. . . . Everybody in the mix of new therapeutics could do a better job of helping to keep the costs down, especially pharmaceutical companies. I don't know whether they will, but we have some leverage with them, so we have the responsibility to get involved. Another thing we do is look for opportunities to embrace alternatives, such as offering biosimilars to cover drugs."**

"We are seeing current and proposed million-dollar therapies come up more and more routinely because they are touted as being more curative. As the cost of these therapies grows, just one patient case could significantly impact a self-funded client or our ability to make health care affordable. Typically, when the cost of care escalates, the rising cost ends up being passed to members and patients through increased premiums, making health care unaffordable as a whole. So the cost of novel therapeutics is one of our top priorities, and we look at it as an organizational risk."

—Executive

Budget Impact and Limited Incremental Efficacy Are Top Challenges

When asked to identify the top three challenges associated with high-cost novel therapeutics, most respondents cited the possibility of new therapies having limited incremental efficacy over established standards of care as their highest concern. One executive described, **"Limited incremental efficacy is definitely in our top three. We have to prove value over the standard of care. That goes along with the health economic benefit. If novel therapeutics are way more expensive than the standard of care and aren't clinically better, then we are just wasting resources."**

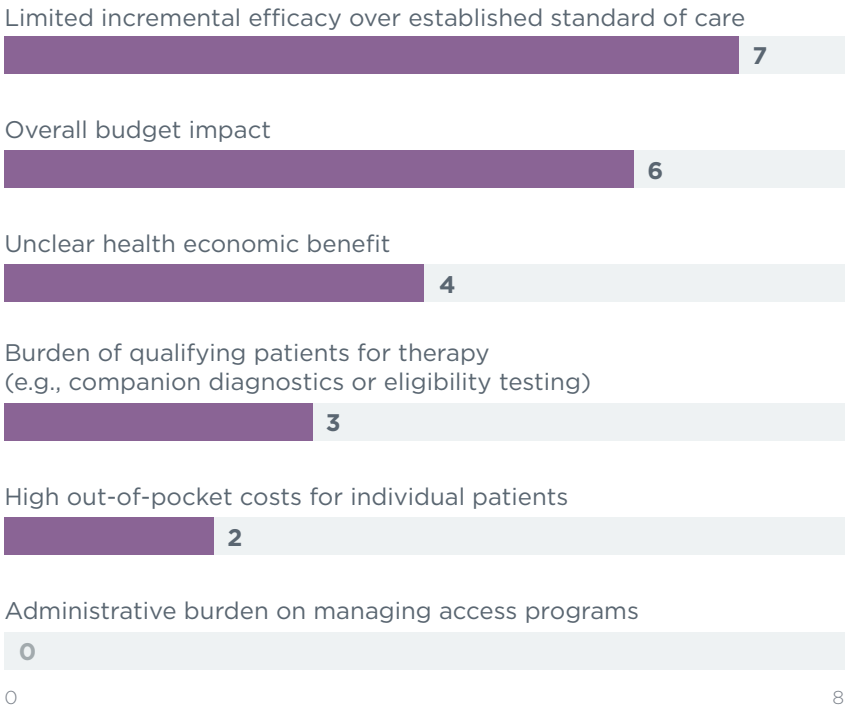
Due to concern about the high cost of novel therapeutics as well as the need for healthcare insurance companies to be profitable, budget impact is another common challenge across health plans of all sizes. Respondents expressed worry about their ability to provide care to other members if a disproportionate share of the budget goes to a few patients in need of expensive treatments.

"One of the most challenging things and biggest risks we have is the cost of innovative therapies. For some cases, the cost for one member to receive these therapies might be the same as the cost of insulin for all diabetic members. Some of the costs on the highest end are going to be very complicated. That said, there are great breakthroughs. We are seeing therapies for patients who without these therapies would certainly pass away within the first year of life. They now have the possibility of living a long life that wouldn't have been possible without the therapeutic advancement."

—Executive

Key Challenges Associated with Novel Therapeutics

Respondents chose their top three challenges.



Respondents who felt costs were a concern also often cited business sustainability as a related issue. Health plans are companies that need to make a profit to stay in business, so being strategic about which novel therapeutics they cover is essential. An executive said, **"Our playbook is clinical rigor, ensuring value, and ensuring that we have the appropriate patients and that the drugs are used appropriately. . . . Having large populations on very expensive therapies breaks the bank. That is where the clinical rigor comes in. It will help us evaluate how innovative these agents are compared to the standard of care. At the end of the day, we want to make sure the science doesn't outpace the cost structure."**

One challenge that is less top of mind is high out-of-pocket costs for patients. A few respondents noted that patients typically have several options to help offset the cost of novel therapeutics, such as coupon cards, foundational assistance, and co-pay relief.

Decision-Making with Novel Therapeutics

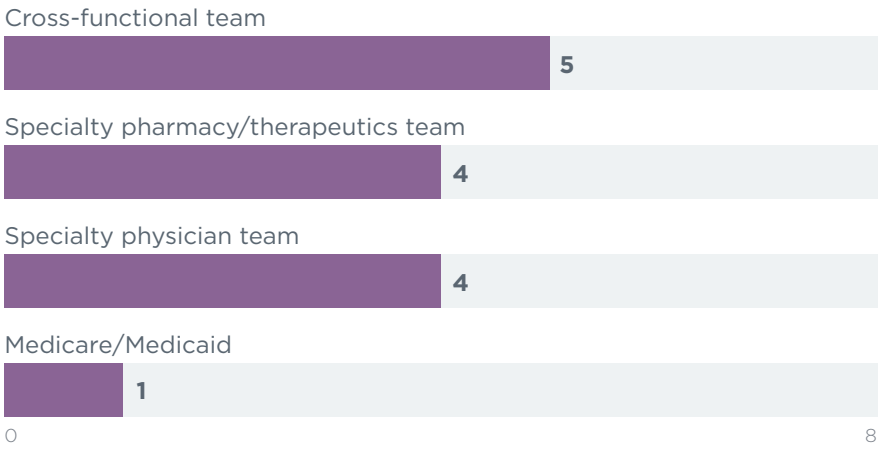
Cross-Functional Teams Most Often Determine Coverage

When deciding novel therapeutics coverage, health plans often use several different criteria and bring in multiple parties that provide clinical expertise. All respondents reported utilizing clinical specialists, such as physicians and/or pharmacists, to help determine coverage of novel therapeutics, with about two-thirds citing the use of a cross-functional team for this purpose. One executive shared, **"We have our therapeutics committee, which consists of our providers and pharmacists and chief medical officer. We discuss whether novel therapeutics are beneficial and whether we can afford them. The committee makes the call."**

The rest of respondents said their organizations have either a specialty pharmacy team or a specialty physician team making decisions about novel therapeutics coverage. An executive said, **"Our specialty pharmacy team makes most of the decisions. There isn't just one person checking the FDA (US Food and Drug Administration) website every day. Coverage decisions fundamentally come from the pharmacy and sometimes a clinical geneticist."**

Who Decides Whether to Cover Novel Therapeutics?

Respondents could select multiple options.



Two respondents mentioned that their decision-making process relies on determinations from outside parties, such as Medicare, Medicaid, or an external committee. One respondent explained, **"We would have an internal committee for making coverage decisions, but we only have Medicare and Medicaid business lines. They dictate what we can and can't cover. If we were in the commercial world, things would be different. We pay what we are allowed to pay."**

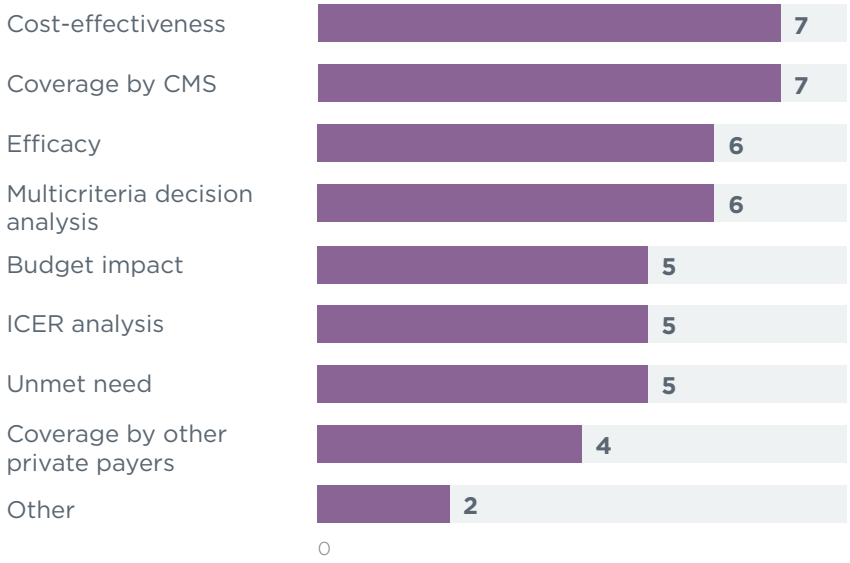
In cases where these respondent organizations have the option to cover a certain treatment, they can use an internal process to determine whether coverage will be provided for the member, as explained by this senior director: **"Organizations like ours typically have a pharmacy and therapeutics (P&T) committee that could be either binding or nonbinding, depending on the requirements. Ours is binding, so the decision is made by P&T members, who are not employed by the organization. They are an outside group that we contract with, and then they make decisions about coverage."**

"Allowing members to receive novel therapeutics almost always includes peer-to-peer discussion because these members are medically complex people. We need to figure out whether it is ethical for us to cover a certain therapeutic and how long to cover it. There is a lot that goes into these decisions. An ethics review board is involved, and there is the ongoing return of updates and information to us. There has to be a willingness to collaborate so we can understand how things are going. If a pharmaceutical company is not willing to share information, that could affect my decision to cover the treatment. I don't have to know everything, but I want to have enough data so that I know whether I should continue to cover novel therapeutics."
—Executive

Most Payers Use Several Criteria to Determine Coverage

Deciding whether to cover novel therapeutics is a complex process for health plans. Respondents said their organizations focus on treatment efficacy so that members can receive proven care and live high-quality lives, but health plans also have to consider the cost and effectiveness of these expensive treatments. On average, respondents note their health plans use four or more criteria to determine whether to cover novel therapeutics.

Criteria for Determining Novel Therapeutics Coverage



Note: "Other" includes alternative treatments for diseases and feedback brought up by key opinion leaders.

All but one respondent cited cost-effectiveness and coverage by the Centers for Medicare & Medicaid Services (CMS) as decision-making criteria for determining coverage. Since most respondents have government business lines, many noted the importance of CMS coverage, which provides strong direction on whether health plans should cover therapies. A few respondents mentioned that they need to at least cover what CMS recommends in their plans. Larger health plans are more likely to also consider other private payers' coverage decisions, as these payers constantly evaluate their position in the market against that of competitors.

"It seems obvious to me that there would be multiple criteria in the decision process in terms of safety, efficacy, costs, comparative effectiveness, and other potential options. We may even require the step therapy; for example, we typically require members with high cholesterol to take small-molecule oral medications before trying the more expensive injectable medications that have monoclonal antibodies. Since most of our business is Medicare, CMS does have some stipulations. They have six protected drug classes, and we practically have to cover all of them with very minimal requirements. We must cover pretty much all cancer drugs."

—Senior director

Although some health plans use several criteria in the decision-making process, not all criteria are given equal weight. Some respondents said that cost-effectiveness and efficacy are the highest priorities when considering whether to cover novel therapeutics. According to one executive, **"Some criteria are more informal and help us have a general market understanding. We may lean more on other criteria, like clinical efficacy and cost-benefit analysis. Also, if CMS says that they are covering something, we are covering it too."**

A few respondents said their organizations use care coordination programs to manage members and help them follow the best treatment plans, which can improve the likelihood of treatments being effective. An executive explained: **"We are doing a lot to ensure that patients with rising risk are being paired with our care coordination team. Usually, patients with higher-cost care needs have conditions that may send them to the ER or require them to see a primary care physician or specialist. Sometimes they have to travel distances to get care. By wrapping our services through our care coordination team or our population health team, we are able to mitigate some costs and ensure patients have touchpoints with a provider on the health plan side who can help them navigate their health care needs."**

Multiple respondents mentioned the nonprofit Institute for Clinical and Economic Review (ICER) as a trusted source of information when determining the most comprehensive, cost-effective clinical treatments. A senior director said, **"Honestly, if there is one institution that does the best job of all, it is ICER."**

The challenge of deciding whether to cover innovative treatments for infants and children was mentioned by a couple of respondents. Emotions can come into play when making these coverage decisions, as described by one executive: **"The situation is complicated. I don't want to be on the front page of the newspaper as the person that said no, but I also am trying to protect my clients because the situation could devastate business. Everything goes back to risk pools and risk sharing. The industry is trying to figure things out and identify the concerns, but it isn't easy."**

Occasionally, organizations (i.e., provider organizations and pharmaceutical companies) will take a drug that works for one disease and say it will work for another disease with similar indicators, even though the drug hasn't been tested for the other disease. This poses another challenge for health plans in the decision-making process, particularly in areas like oncology. One senior director explained, **"Let's say someone makes an IDH gene modulating medication for brain cancer, and then someone else finds an IDH gene mutation for stomach cancer, so they want to use the medication as well. There is no proof that it works on stomach cancer, but of course, there is a stage-four cancer patient who will die without it. So we approve the medication, but that isn't good science and probably not great patient care."**

FDA Approval Does Not Guarantee Coverage; CMS Reimbursement More Widely Accepted as Standard

Almost all respondents noted that FDA approval of novel therapeutics does not automatically lead to coverage for members. Some novel therapeutics are being fast-tracked for approval, which causes concern among payers about the data supporting treatment efficacy. Several respondents shared stories of these fast-tracked drugs, including highly expensive drugs being approved for age groups and demographics not included in the clinical trials. Multiple health plans' concerns were also aggravated by the recent FDA approval of the Alzheimer's disease treatment Aduhelm. The agency approved Aduhelm through its fast-track process despite an FDA advisory committee voting to not approve the drug due to efficacy concerns. CMS initially declined to cover Aduhelm; they later approved partial coverage for patients in clinical trials — a decision that other payers followed.

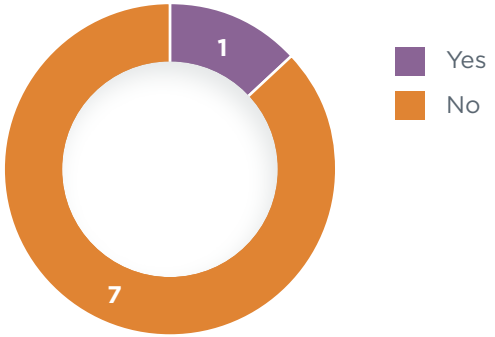
As one executive said, **"Everybody would agree that Alzheimer's is a devastating disease, and we have no treatment options, so the argument is that anything that is safe and somewhat effective should be approved. The problem with this drug is that it could have singlehandedly broken Medicare's bank due to the prevalence of Medicare members with Alzheimer's. The price tag was about $60,000 a year, so the revolt from the community is a lesson. . . . FDA approval does not guarantee coverage."**

Price was also frequently mentioned as a barrier to coverage for all members. Most health plans have a process for determining cost-benefit analyses on drugs with less testing. Additionally, payers want more analyses (especially for drugs that are fast-tracked for FDA approval) to determine whether they should partially cover costs or not cover the full course of treatment.

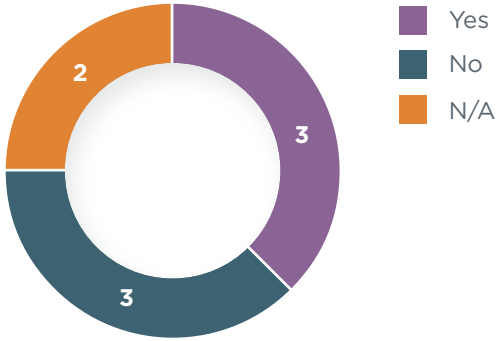
"We may still exclude something that has FDA approval if there hasn't been a demonstration of robust clinical outcomes. There have been more medications that have been approved recently on endpoint outliers, but that have not demonstrated an impact to morbidity or mortality. And those are the ones that we struggle with the most. A drug having FDA approval doesn't mean that we cover it."

—Executive

Does FDA Approval of Novel Therapeutics Automatically Mean Your Organization Will Cover Treatment for Members? (n=8)



Does Your Organization Cover Novel Therapeutics without CMS Reimbursement? (n=8)



Many respondents said they believe CMS reimbursement decisions and ICER's data offer better guidance to health plans. Organizations with government health plans — especially smaller health plans — are required to cover what is included with Medicare and Medicaid and often do not cover treatments outside of that. One executive said, **"CMS is heavily regulated. For example, there are drugs that are excluded from Medicare, so we want to exclude those drugs because CMS wouldn't reimburse us if we covered them."** When appropriate, larger health plans may do a one-off analysis to determine whether to cover something that Medicare or Medicaid doesn't cover. Commercial plans are more likely to consider covering treatments not included in CMS reimbursement.

"We do use the CMS coverage criteria in most cases. If something isn't covered by CMS, that is often a strong indicator that it may have low evidence of support. Part of what we do on a routine basis is ensure that we are not covering low-value care. If CMS says that a treatment provides low-value care or doesn't have an appropriate level of evidence that supports Medicare coverage, we usually come to the same findings when we go through our evaluations."
—Executive

Cost, Comparative Research, and Health Equity Concerns Complicate Cost-Benefit Analyses for Certain Diseases & Modalities

Cost-benefit analyses are used to help determine treatment coverage. However, many respondents said their health plans have challenges using these analyses to determine coverage of novel therapeutics. The most commonly reported challenges include the possibility of costs for novel therapeutics growing too high, insufficient data on how the treatment's success compares to that of drugs currently on the market, and equity/diversity in research on how treatments will affect different populations. A medical director expressed, **"There are two big challenges. First of all, the rare disease world is different. The costs are absurd because the number of people who can provide the treatment is so low. That is hard. There are also issues with comparative-effectiveness research. We don't know about the comparative effectiveness of the biologics, which is an issue."**

Common Challenges for Cost-Benefit Analyses

1. **Out-of-control costs/expenses**
2. **Lack of data/comparative research** (especially for small populations)
3. **Health equity/diversity**

Lacking data on the long-term outcomes for patients on newer treatments can make cost-benefit analyses difficult. For instance, one respondent mentioned Zolgensma — a $2 million drug for spinal muscular atrophy that was tested on a small group of children. The drug was priced based on a lifelong set of factors and outcomes; however, due to its newness, payer organizations haven't been able to see whether the long-term effects will come to fruition.

Most cost-benefit analyses are impacted by health equity issues regardless of disease or modality (see page 18 for more information about how diseases/modalities can affect cost-benefit analyses). Clinical trials typically include participants from one demographic (e.g., Caucasian males) instead of including participants from different demographics, but efficacy data is impacted by patients' access to basic health care and their social determinants of health, gender, race, ethnicity, and other factors. Limited data from small patient populations further hinders health plans' ability to understand how various backgrounds can impact outcomes. Multiple respondents noted that certain races/ethnicities and gender identities are underrepresented in treatment studies, creating barriers to running accurate cost-benefit analyses.

"It is a challenge to evaluate a cost-benefit analysis if people have not had access to basic care throughout their lifetime. Social determinants of health and people's choices make cost-benefit analyses even more challenging. I can analyze a bunch of people who are white-collar workers in major cities with access to care, good food, and transportation, but the cost-benefit analysis for that group will be potentially different from the analysis of a population that has food deserts, less access to transportation, and receives little to no health care until they get older and start showing up to the ER with a myriad of conditions. The cost-benefit analysis depends on the population. Most drug research has historically been done on white men. We have very limited research on the effect of drugs on women or people of non-majority ethnicities or alternative communities. We are discovering all sorts of things. For example, women's chest pain can look radically different in many cases."

—Executive

Treatments for rare/orphan diseases — including some cancers, genetic diseases, and autoimmune diseases — often have high costs, and the limited data on the benefits of these treatments leads to difficulties when evaluating cost-benefit analyses. Additionally, the efficacy and benefit of the treatments are hard to prove as universally applicable to all patients with the same rare condition because of the small data sets associated with the drug's approval. A director explained, **"With rare genetic disorders, usually the medications come with extremely high costs given the orphan-drug or orphan-therapy designation. The challenge with those medications is that often the number of members in the studies is extremely small. We may be talking about a $1 million therapy that had only 10 patients in the trials. It is hard to feel that there is robust clinical data, even if something has been approved for a rare orphan disease. It is hard to feel that the results can be applied with the same outcomes and replicated at a higher population level."**

Some respondents mentioned that it can be difficult to determine novel therapeutics coverage for more commonly treated diseases, such as diabetes and hypertension, as these diseases already have many effective, more affordable treatment options. Payer organizations also stated that modality services previously not covered by health plans — such as infertility and transgender/gender-affirming services — can complicate the process of evaluating cost-benefit analyses as some still consider these to be elective services that health plans shouldn't pay for.

A quarter of respondents said that cost-benefit analyses for all conditions make it difficult to determine novel therapeutics coverage. One executive shared, **"Everything is so disease and drug dependent, and it is also dependent on the standard of care and everyone's consensus on what benefits there are. Some treatments don't really have outcomes, so it is hard to do a cost-benefit analysis on them."**

Diseases & Modalities that Present Challenges to Evaluating Cost-Benefit Analyses

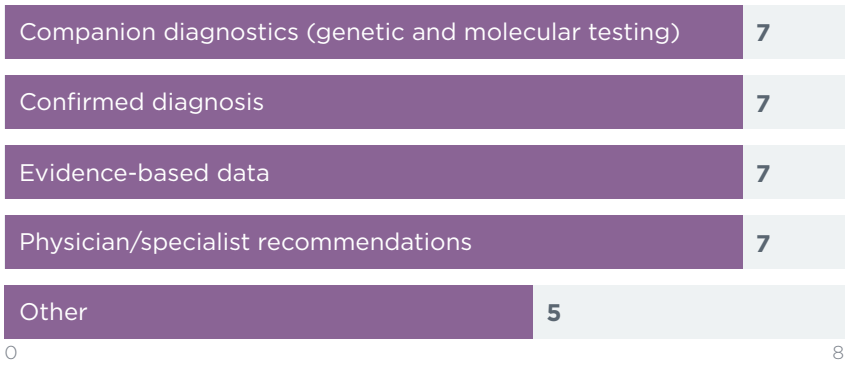
Diseases	Modalities
■ Autoimmune diseases	■ Infertility services
■ Cancers	■ Transgender/gender-affirming services
■ Diabetes/hypertension	
■ Genetic diseases	
■ Rare diseases	
■ All conditions	

Novel Therapeutics Utilization Management Policies Often Include Diagnostics & Recommendations

A utilization management policy contains clinical criteria for prior authorization, appropriateness of care, and coverage that are specific to the clinical characteristics of the population that will benefit from a specific treatment. These policies help determine whether a member is able to receive novel therapeutics treatment, and most respondents said their organizations use multiple criteria in their policies. Almost all respondents incorporate physician/specialist recommendations, companion diagnostics such as genetic and molecular testing, confirmed diagnosis, and evidence-based data into their utilization management policies. Other respondents reported including feedback from key opinion leaders, alternative existing therapies, appropriate use dosages, ethics analyses, and shared data from other health plans for a deeper understanding of novel therapeutics' efficacy and impact.

Utilization Management Criteria for Novel Therapeutics

(n=8)



Note: "Other" includes feedback from key opinion leaders, existing therapies, cost thresholds, appropriate use dosages, ethics analyses, and data sharing.

Physician/specialist recommendations: "We have various committees that review therapies as they come out for novel therapeutics or drugs. We have an internal pharmacy and therapeutics committee that is made up of physicians, pharmacists, medical directors, and practicing clinicians. They evaluate the medication and then help us create the initial coverage determination and any potential policy requirements for rare-disease therapies that are extremely expensive. We also may involve our CMO in some decisions for awareness. All of our committee structures flow through a medical director committee and then a population health oversight committee with various clinical leaders across our organization. They report to our quality committee at a board level. That is our structure and process, but it starts with the initial evaluations and recommendation proposals that are done by our pharmacy and therapeutics team."

—Executive

Companion diagnostics/confirmed diagnosis: "Confirmed diagnosis is super important because these days everything is based on a gene test. Even the oncology medications are based on gene tests. So that is a huge criterion."

—Senior director

Evidence-based data: "Having worked in this business for a long time, I am very skeptical of the data that is presented, especially if it is presented by the pharmaceutical company. If data is from ICER, which is an independent source, then that is a different story."

—Senior director

Coverage for Novel Therapeutics

Incentives Are Helpful when Considering Coverage for Novel Therapeutics

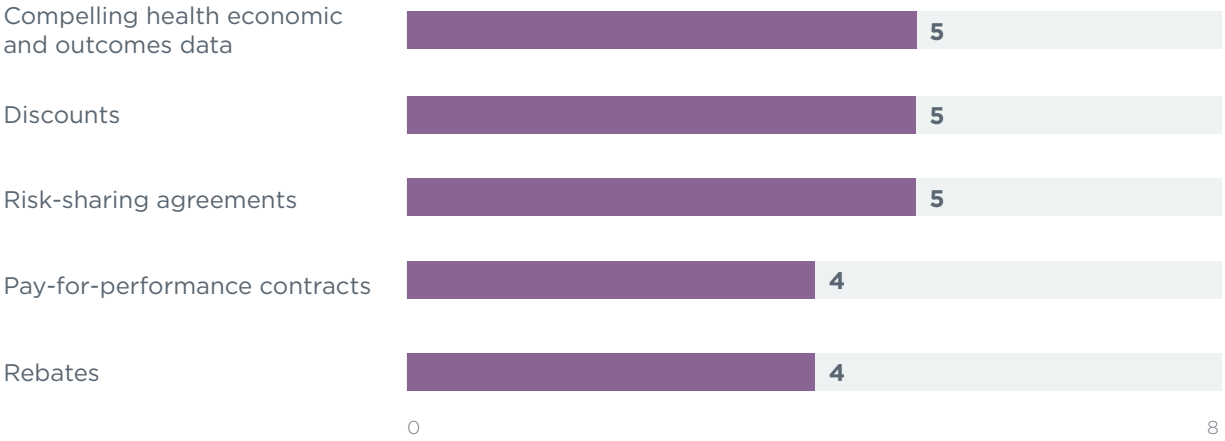
One way biotech and pharmaceutical companies are looking to reduce the cost burden and improve adoption of novel therapeutics is by offering different incentives for health plans and patients/members. There isn't currently a widely accepted incentive plan, but respondents reported that many different economic incentives and concessions are helpful when determining coverage for novel therapeutics. Respondents from larger payer organizations cited risk-sharing agreements as helpful, but these agreements are less helpful to smaller payers. Respondents noted that pay-for-performance contract models are helpful but less common.

"Pay-for-performance and risk-sharing agreements are becoming more and more common. Unfortunately, they are not always available. There is not a lot of competition, but with cholesterol drugs, we are seeing some contracts where the member must show that there is improvement in their cholesterol. That is very measurable and easy to figure out. If the members don't meet those goals, either the pharmaceutical company pays us back some money, or they get to keep what we have paid them."

—Senior director

Some respondents mentioned that discounts and rebates lower costs for patients and make it easier for them to pay. Rebates are one of the primary sources of income for pharmacy benefit managers (PBMs), so rebates can not only provide discounts on novel therapeutics for payers and patients but also enable PBMs to have a sustainable financial structure that supports future high-cost treatments.

Which Economic Incentives Are Most Helpful when Considering Coverage of Innovative Therapies? (n=8)



Only Some Health Plans Use Pay-for-Performance Reimbursements

Four out of the eight health plans represented in this report have performance-based reimbursement models for novel therapeutics established with a pharmaceutical or biotech company. These models allow health plans to be reimbursed by the manufacturer if certain outcomes or other milestones aren't met. A senior director explained how these risk-sharing models work: **"I believe our contract for a newer drug is going to be a risk-sharing agreement. Members will need to reach the clinical outcomes. I know that gene therapies are one area where risk sharing will be perfect as we don't know how long the therapies are going to last. We can sign at least a five- or six-year contract to alleviate some of the unknown that comes with these therapies."** Validated performance-based novel therapeutics include gene therapy, transfusions, and treatments for infants, patients with high cholesterol, and diabetic patients, and infants.

Not all health plans are eager to enter into performance-based arrangements. One executive expressed concern regarding barriers to pursuing these types of agreements: **"We haven't pursued any risk-sharing agreements. They are quite complicated, but as the cost of these medications continues to grow, they are something to look into. Pay-for-performance is going to be of more interest moving forward, especially since some of these million-dollar therapies are touted as being curative therapies. We will want to have some assurance that members are actually going to achieve the outcomes for which the therapies have been priced so high."**

Does Your Organization Cover Performance-Based Novel Therapeutics? (n=8)

"Yes" includes gene therapy, transfusions, and treatments for diabetic patients, infants, and patients with high cholesterol.

Milestone Payments Seen as Potential Solution to Problem of Members Switching Plans

Members switching health plans during novel therapeutic treatments presents challenges for payer organizations. When covering treatments for these members, health plans pay a large sum of money up front and typically see the benefit over time as the members pay the premiums. However, if a member receives treatment and then switches health plans, the original health plan won't see the long-term cost benefit. Many payers are unsure how to solve this financial problem. Respondents who are hopeful for a solution mentioned milestone payments as an option. Milestone payments allow a health plan to pay for a high-cost treatment over a longer period of time; that way, if the member switches plans during or after treatment, one health plan isn't stuck with the full cost. Some respondents said members switching is more of an issue in the commercial world, as CMS keeps track of and pays for everything covered by Medicare and Medicaid plans.

Other potential solutions include moving from employer-sponsored health plan coverage to true regional-based coverage, which would provide continuous coverage within a geographic area regardless of employer and allow patients to choose their preferred provider organizations. One executive expressed anticipation for this approach: **"When someone is already approved for certain treatments and then they go to a new payer, there is a grace period in which the new payer has to continue to offer the treatment. There are limits on that period, but it is usually 90 days. . . . We could start going to a market-based or regional-based approach of health plans that we can buy into as individuals. My employer gives me a stipend, and I get to invest it wherever I want. I am going to go to my local plan because they have excellent coverage of the providers I care about, whereas other plans that are not as local don't. Everybody in this business is trying to do good things for the population and for their shareholders. This business is not a mercenary business, but everybody needs to make money to stay in business."**

About the Center for Connected Medicine and KLAS

Center for Connected Medicine

The Center for Connected Medicine (CCM) at UPMC is defining the future of the modern health system through programming that informs, connects, and inspires leaders and innovators in health care. Collaborating with a network of experts from across the health care ecosystem, the CCM focuses its research and events on consumer-centered solutions, digital transformation, and scientific and medical innovation. Learn more at connectedmed.com.

KLAS Research

Driven by a mission to improve the world's health care, KLAS is a health care–focused research firm whose data helps provider, payer, and employer organizations make informed software and services decisions. Powered by insights and experiences discovered in the 25,000+ interviews with health care organization leaders and end users that KLAS conducts each year, KLAS' work creates transparency in the health care market and acts as a catalyst for software vendors and services firms to improve their offerings.

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