Genomic Medicine XV

Session 6
Why are payers reluctant to cover genetic screening tests?

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Disclaimer

The content of this presentation are my observations and opinions which do not represent official views of my current or former employers.

Why?

Top 10 Reasons Payers are Reluctant to Cover New Screening Programs:

1. Cost Effectiveness
2. Uncertain Health Benefits
3. Short-term Financial Focus
4. Budget Constraints
5. Lack of Strong Evidence
6. Logistical Challenges
7. Adverse Selection
8. Competing Priorities
9. Changing Guidelines
10. Public Health Impact

Cost Effectiveness

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Yes, payers care about cost effectiveness but it is from a different perspective.

OBSERVATIONS:

- Payers care more about outcomes than cost savings.
- Payers consider cost effectiveness in terms of PMPM benefits instead of QALYs
- Payers care about products. If a screening program can be a product that is added to a benefit program, then it may attract investment

Uncertain Health Benefits

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Health outcomes are most important to payers. They consider the risk of delivering outcomes against the financial investment required.

OBSERVATIONS:

- Payers weigh the risk of health outcomes against the cost of the program.
- Variables in the risk equation are:
  - Risk of test performance (FP/FN)
  - Risk of excess medical spend related to test performance
  - Risk of realizing outcomes from screening program
  - Risk in numbers needed to test (NNT)

When considering a screening program, payers are asked to take on the up-front financial risk with little control over the down-side risk in test performance.

Screening makes sense when testing with a low-cost, low-complexity test applied to a population identifies a smaller, high-risk population that will benefit from higher cost / higher complexity diagnostic testing.

Short-term Financial Focus

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True. This is a very practical consideration

OBSERVATIONS:

- Given the importance of health outcomes, payers need to realize the benefits of these outcomes while members are enrolled.
- The majority of members churn from a plan with 1.7-2.5 years
- Payers need to show a return on PMPY within this time frame to justify investment in a screening program.

Budget Constraints

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If a program has low-risk of producing high-impact health outcomes, payers will invest.

OBSERVATIONS:

- Payers have more good programs to fund than resources available.
- Screening programs are high-risk, resource intensive projects
- They compete against many lower-risk, high-reward programs.

Screening of low-risk populations creates a high up-front risk testing vs the risk of identifying a small population of high-risk patients that benefit from diagnostic testing or intervention

Lack of Strong Evidence

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Likely the most important factor for genetic test screening.

OBSERVATIONS:

- Evidence of program performance and clinical utility are the most important factors to reduce the risk of a screening program.
- Given the nature of screening tests, payers need strong evidence the test will identify the highest risk population and reduce the utilization of more expensive procedures on low-risk patients.
- Many screening programs cannot provide this evidence.

Logistical Challenges

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A surprisingly important factor.

OBSERVATIONS:

- Logistics of administering a screening program are surprisingly heavy and complex due to:
  - Outreach to patients and providers is necessary
  - Patient activation is very difficult and resource intensive
  - Provider awareness of guidelines and screening options is low
  - Patients have a low rate of program adoption

e.g. a pilot to offer WGS to hospitals was scraped due to low acceptance rate by hospital admins.

Adverse Selection

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Not a major concern.

OBSERVATIONS:

- Have seen these mentioned as a concern but not blocker to program consideration

Competing Priorities

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Yes, as we have already discussed.

OBSERVATIONS:

- Expensive, complex screening programs with dubious evidence of identifying high risk patients for cost-saving outcomes struggle to attract resources from the many other programs.
- If the same outcome can be achieved with a simpler (non-genetic) test, payers will favor the simpler program.
- Payers will tend to choose several smaller low-risk, low-impact programs over a large, complex screening program.

Changing Guidelines

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Guidelines are necessary, not sufficient.

OBSERVATIONS:

- Clear guidelines reduce the risk of implementation.
- Payers want firm guidelines built on consensus of experts to de-risk the choice. For screening programs, payers respect the USPSTF. If it is not on the path to A or B grade evidence for a well characterized test, it does not have a chance.
- Payers want firm guidelines – with clear guideline support. They are not concerned with changing guidelines except the appearance of unstable evidence for the health outcomes from the program.

Public Health Impact

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OBSERVATIONS:

- Payers believe that public health responsibility lies with public health agencies.
- If those agencies want to engage the payer to administer the program, they will engage to implement the program.

How could it work?

Where to spend energy on getting a screening program covered by payers:
+ strong evidence of health outcomes >> cost savings
+ strong evidence of screening test performance to identify high risk patients
+ simple, low-cost screening modality
+ recommended by USPSTF
+ high patient adoption
+ low up-front risk (e.g. cost sharing / risk sharing arrangements)

Ideal program: A high performing screening test with high impact on identifying high risk patients with clinical decision making that leads to measurable positive outcomes with cost sharing screening program with no downside risk

Reality: screening for compliance with a quality measure that leads to reimbursement bonuses will get resources (HEDIS/STARS)

Prevention programs that take years to show benefits do not get a lot of resources. Likewise, Population Health programs do not get a lot of resources

Thank you.

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