

A Better Framework to Assess the Value of Alzheimer's Treatments

Speakers



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Disclosures

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Assessing the Value of Therapies in Alzheimer's Disease

Considerations to create a practical approach to value

Presentation for Alliance for Aging Research
May 18, 2021

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THE TRADITIONAL APPROACH TO ASSESSING THERAPEUTIC VALUE DOES NOT WORK WELL FOR ALZHEIMER'S DISEASE

1. The traditional approach uses “Quality Adjusted Life Years” (QALYs)
 - The QALY is an index measure based on “utilities”, where 0=death and 1=perfect health
 - Healthy people are surveyed about “fair trade” of health status.
 - ex. If 1 year spent bed-ridden is determined to be a “fair trade” for ½ year in perfect health, then 1 year bed-ridden is equivalent to 0.5 QALY
 - Cost effectiveness is determined by comparing the net payer spending per QALY gained from a therapy to a threshold—such as, \$150,000.
2. The traditional approach does not work well for Alzheimer's and other conditions
 - The majority of costs are not captured by payer medical spending
 - QALYs don't capture the impact on family / caregivers
 - QALYs preserve the eco-system and disparities around Alzheimer's patients
 - QALYs miss many important quality-of-life facts for patients and caregivers

PRINCIPLES

1. Assessments of value should be separated from decisions about who pays and who gets paid
2. An equitable value assessment framework for AD should account for the ecosystem that surrounds people with AD
 - a. Utilize metrics that, when appropriate, apply the same standards regardless of age or socioeconomics.
 - b. Capture the health-related value of AD treatments for patients and their family caregivers
 - c. Appropriately account for changes in non-health outcomes and issues of community value related to AD patients and their caregivers

A BETTER APPROACH

- a) Same outcomes standards regardless of age or socioeconomics
 - QALYs are inherently less for older people who, on average, have shorter future lifetime.
 - Alternative: Payment can be adjusted for socio-economics differences, but quality measures themselves should not account for socioeconomic differences, so as to not mask poor quality
- b) Health-related value of AD treatments, but not just for patients
 - Caregivers face declines in their own mental and physical health
 - Clinical function metrics (eg, mild to moderate to severe AD) do not capture issues that are critically important to patients and caregivers, such as assistance with activities of daily living
- c) Account for changes in non-health outcomes and issues of community value related to AD patients and their caregivers
 - Most caregiving for AD is informal/family. This additional responsibility often results in lost productivity and wages as well as reduces support for family and community
 - AD is a disease of poverty and disparities, with higher prevalence in Black and Latino communities.
 - AD is part of an ecosystem of low-wage workers who come from communities with disproportionate burden of AD

NEXT STEPS

- Can add-ons to a QALY-based system solve the problems?
 - The add-ons for caregivers, community, informal support are much bigger than the core medical spending
- Consider other approaches
 - Examples of broad funding for societal values
 - Relative social willingness to pay
 - Germany's approach to capture broader public health system interests
 - PCORI
- Work needs to be done defining the burden of the ecology and disparities surrounding AD



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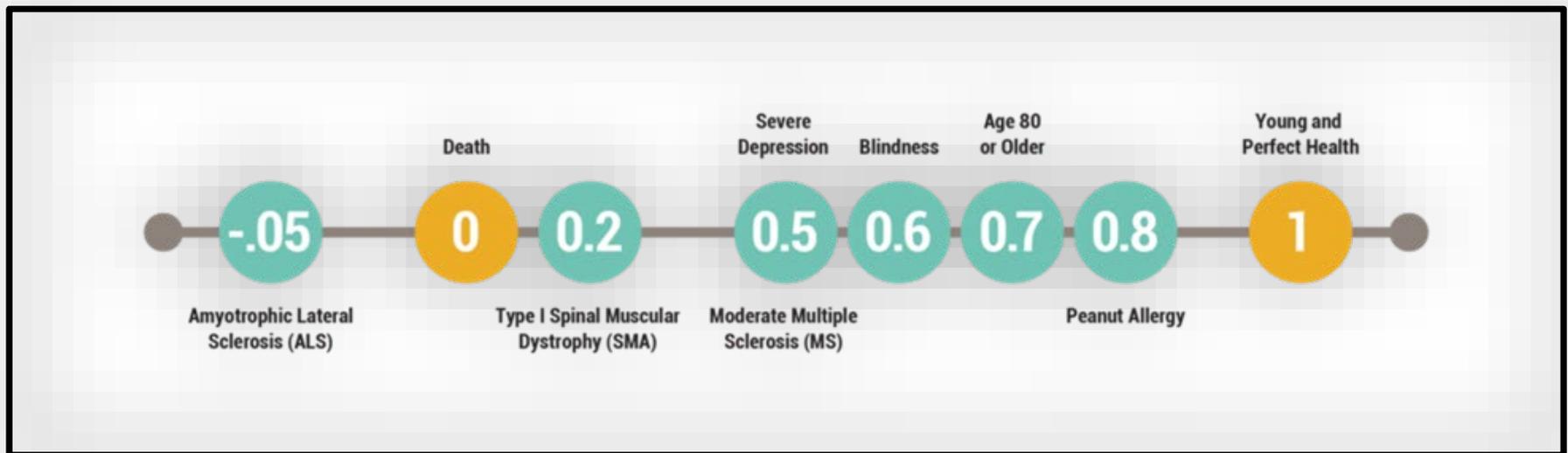
**Catalyzing Innovation
for Healthy Aging**

Why it Matters for People to Understand and Weigh In on Value Assessments for New Treatments

Susan Peschin, MHS
President and CEO
May 18, 2021

What does the Quality-Adjusted Life Year (QALY) measure?

- The Quality-Adjusted Life Year (QALY) is a health economics measure, which (theoretically) represents the degree to which a treatment extends life and improves quality of life.
- It is calculated by multiplying the “health state preference value” with the time the patient is likely to spend in that state.

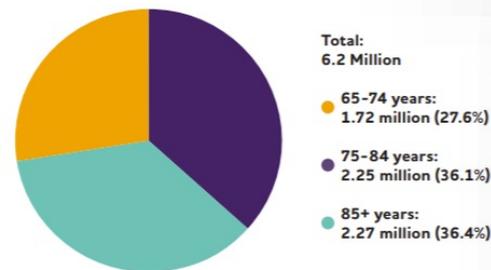


Using QALYs to value Alzheimer's disease patients and treatments presents ultimate moral quandary

- Oldest old
- Co-morbidities
- Disease modifiers versus symptomatic treatment
- Individual, family caregiver and community burden

FIGURE 2

Number and Ages of People 65 or Older with Alzheimer's Dementia, 2021*



Created from data from Rajan et al.¹²¹⁶

*Percentages do not total 100 due to rounding.

2021 ALZHEIMER'S DISEASE FACTS AND FIGURES

alzheimer's
association®

TABLE 15

Percentage of Medicare Beneficiaries Age 65 and Older with Alzheimer's or Other Dementias Who Have Specified Coexisting Conditions

Coexisting Condition	Percentage
Coronary artery disease	38
Diabetes	37
Chronic kidney disease	29
Congestive heart failure	28
Chronic obstructive pulmonary disease	25
Stroke	22
Cancer	13

Created from unpublished data from the National 5% Sample Medicare Fee-for-Service Beneficiaries for 2014.¹⁴⁰

History as a teacher: It's not NICE to discriminate

- In 2005, Britain's National Institute for Health and Clinical Excellence (NICE) determined that cholinesterase inhibitor drugs for the treatment of dementia be banned to National Health Service (NHS) patients.
- The reason? Their cost was too high and “outside the range of cost effectiveness that might be considered appropriate for the NHS.”
- This was despite NICE's admission that these drugs are **effective** in the treatment of Alzheimer's disease and despite NICE having approved even more expensive treatments.
- It was not the drugs that were judged to not be cost effective when compared to rival treatments, *it was the patients who were being condemned as not cost effective to society.*



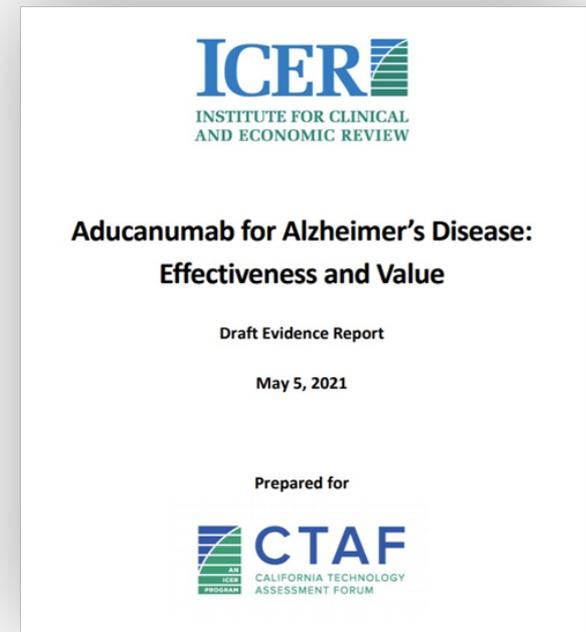
What is ICER and Why Should You Care?

- The Institute for Clinical and Economic Review (ICER) issues cost-effectiveness reports on new treatments.
- Health insurance companies use ICER reports to decide whether a treatment is worth the cost of covering it.
- ICER made up a new measure they call the Equal Value of Life Years Gained (evLYG), but it's essentially the QALY with upper and lower-case letters.
- Things to know about ICER:
 - Not transparent.
 - They take a “tough noogies” approach.
 - They use patient advocacy groups.

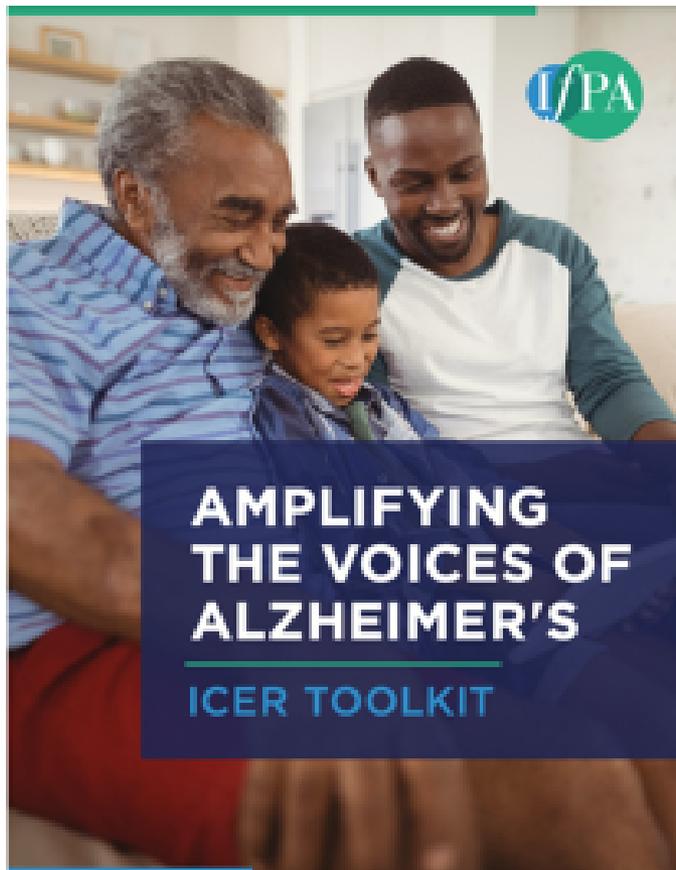


Use Your Voice!

- ICER released a draft evidence report in early May on a new AD treatment.
- Go to icer.org, click on “explore our research” and then click on “assessments.” When you scroll down, it is the first assessment listed. Click on it, and then scroll down and click on “full timeline.” The press release has all the info:
 - **Submit a written public comment until 5 PM ET on June 2nd by email to publiccomments@icer.org.**
 - **Register for ICER’s virtual public meeting about this report on July 15th.**
 - **During the virtual public meeting, there will be a limited amount of time available for interested stakeholders to make an oral comment on the report-requests to publiccomments@icer.org.**



AfPA Toolkit



ICER ASSESSMENT TIMELINE WHAT YOU CAN DO



DRAFT EVIDENCE REPORT

May 5 - June 2, 2021

WHAT YOU CAN DO:

- Submit comment
- Engage in social media to raise awareness about key issues
- Share information via newsletter, blogs, and email
- Encourage members and colleagues to participate



PUBLIC MEETING

July 16, 2021

WHAT YOU CAN DO:

- Testify at virtual ICER meeting
- Continue engaging in social media
- Spread the word via newsletters, blogs or email



FOLLOW UP

Final Evidence Report & Meeting Summary

August 6, 2021

WHAT YOU CAN DO:

- Reiterate key messages using social media, email, and newsletters

instituteforpatientaccess.org/icer-alzheimers-report/

Want to get involved? Email John Bates at Jbates@allianceforpatientaccess.org



Thank you!

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READ THE REPORT:

www.agingresearch.org/ADTreatmentValue

QUESTIONS?

Please email the Alliance for Aging Research at

info@agingresearch.org