Analyzing Healthcare Payer Management Priorities: A Focus on Unmet Needs and Cost Drivers in Non-Oncology and Oncology Spaces

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Abstract: *This survey paper examines healthcare payer management priorities, unmet needs, and cost drivers in both non-oncology and oncology areas. Analyzing responses from 123 payers, it highlights key trends in disease management, particularly in breast cancer, prostate cancer, melanoma, and multiple myeloma, due to their impact on healthcare costs. The study also discusses the growing importance of biosimilars, especially with upcoming patent expirations of major drugs. It underscores the strategic decisions of payers in cost management and anticipates future trends in payer strategies, including value-based contracting and biosimilar utilization.*

Keywords: Healthcare Payer Management, Unmet Needs, Cost Drivers, Biosimilars

1. Introduction

Over the past decade, the United States healthcare system has witnessed significant growth in new therapeutic areas, marked by the Food and Drug Administration (FDA) approval of numerous therapies and drugs to address diverse diseases [1]. While attention often gravitates toward physician-patient relationships, a pivotal aspect shaping the healthcare landscape is the role of payers—organizations that reimburse care and as a result, guide coverage decisions in the U.S. healthcare system. The evolution of payer management over the past decade has emphasized cost-effectiveness through value assessment frameworks [1]. As a result, payers institute restrictions to optimize and maintain costs within the healthcare industry, implementing measures such as prior authorization requirements, step therapies, formulary exclusions, and novel market policies.

Prior authorization is a tool enforced by healthcare insurance companies that requires patients to fulfill certain eligibility criteria in terms of diagnostic tests and clinical conditions before a physician prescribes a medication [2]. Similarly, step therapy necessitates patients to attempt and fail treatment with a less costly alternative before receiving coverage for a high-cost treatment. The practice of formulary exclusions is tied to competitive contracting, influencing whether a product is preferred, placed on a higher formulary tier, or excluded from coverage entirely[2]. Despite these efforts, U.S. payers face challenges in establishing systemic and effective means to optimize value in pharmaceutical decision-making, revealing limitations in their capabilities [2].

The future of the healthcare market space is characterized by technological advancements and biotechnology, which necessitates an understanding of payer priorities. The dynamics of the healthcare industry have been significantly influenced by new therapeutic areas, leading to the advent of high-cost therapies such as Spark Therapeutics' Luxturna.

This FDA-approved treatment targets an inherited form of vision loss and entered the U.S. market at a cost of $850,000, or $425,000 per eye [3], [4]. With a plethora of FDA-approved drugs and the introduction of high-cost therapies like Luxturna, comprehending payer management priorities is crucial. From this example, pricing itself is also a major factor. Across the US and other countries, the need to control drug costs can be in conflict with creating new innovative drugs or incite themes of indication-based pricing[5], [6].

In addition to payer management priorities, the complexities of healthcare extend to the relationships between physicians and patients. Addressing the inconsistency between how physicians seek to treat patients and how payers will cover treatments leads to a discussion of patients' unmet needs. Payers' assessments are influential on the course of patient treatment: A payer's assessment of a high unmet need influences the coverage outcome for a therapy a physician requests on behalf of their patient [7].

Drivers of cost bring matters of utilization and price to the conversation [8].This gives rise to analyzing efficiency, whether it be of the drug or of medical facilities enabling use of the drug, beside how the public is affected [9], [10]. The cost of care is the thematic foundation for understanding payer management priorities and unmet needs. Understanding payers' cost management strategies provides insight into complex coverage decisions and dynamics. This research will explore congruent themes across both oncology and non-oncology sectors.

2. Objective

The purpose of this article is to survey and analyze the current priorities, unmet needs, and key cost drivers in healthcare payer management, focusing on both non-oncology and oncology sectors.

The significance of this study lies in its comprehensive analysis of payer management strategies, providing insights into how healthcare costs are being managed in critical therapeutic areas. This is particularly relevant given the evolving healthcare landscape and the impending impact of biosimilars in the market.

3. Methodology

Titles	Payer Management Priorities/Unmet Needs (N = 35)	Identified Drivers of Cost (N = 35)
Medical Director / Chief Medical Officer	17%	17%
Pharmacy Director / Clinical Pharmacist	77%	83%
Other	6%	0%
Organization Type		
Large National Plan	23%	26%
Regional Affiliate of a Large National Plan	9%	0%
Blues Affiliate	26%	29%
Independent Plan	17%	23%
Pharmacy Benefit Management Firm (PBM)	26%	23%
Region		
Pacific & Northwest (AK, CA, HI, ID, OR, WA)	11%	11%
Mountain (AZ, CO, MT, ND, NM, NV, SD, UT, WY)	3%	0%
Midwest (IA, IL, IN, KS, KY, MI, MN, MO, NE, WI)	3%	9%
Northeast (CT, DE, MA, ME, NH, NJ, NY, OH, PA, RI, VT)	11%	14%
South (AL, AR, DC, FL, GA, LA, MD, MS, NC, OK, SC, TN, TX, VA, WV)	11%	11%
Multi-regional	17%	9%
Large national	43%	46%
Covered Lives	116.7 M	117.7 M

Figure 1: Non-oncology commercial payer sample descriptors –displays breakdown of titles, organization types, region, and covered lives

Titles	Payer Management Priorities/Unmet Needs (N = 25)	Identified Drivers of Cost (N = 28)
Medical Director / Chief Medical Officer	24%	21%
Pharmacy Director / Clinical Pharmacist	72%	79%
Other	4%	0%
Organization Type		
Large National Plan	24%	25%
Regional Affiliate of a Large National Plan	4%	0%
Blues Affiliate	24%	21%
Independent Plan	20%	29%
Pharmacy Benefit Management Firm (PBM)	28%	25%
Region		
Pacific & Northwest (AK, CA, HI, ID, OR, WA)	12%	14%
Mountain (AZ, CO, MT, ND, NM, NV, SD, UT, WY)	0%	0%
Midwest (IA, IL, IN, KS, KY, MI, MN, MO, NE, WI)	4%	11%
Northeast (CT, DE, MA, ME, NH, NJ, NY, OH, PA, RI, VT)	12%	18%
South (AL, AR, DC, FL, GA, LA, MD, MS, NC, OK, SC, TN, TX, VA, WV)	12%	7%
Multi-regional	16%	4%
Large national	44%	46%
Covered Lives	42.3 M	43.6 M

Figure 2: Non-oncology medicare payer sample descriptors - displays breakdown of titles, organization types, region, and covered lives

Titles	Payer Management Priorities/Unmet Needs (N = 35)	Identified Drivers of Cost (N = 35)
Medical Director / Chief Medical Officer	17%	17%
Pharmacy Director / Clinical Pharmacist	77%	83%
Other	6%	0%
Organization Type		
Large National Plan	23%	26%
Regional Affiliate of a Large National Plan	9%	0%
Blues Affiliate	26%	29%
Independent Plan	17%	23%
Pharmacy Benefit Management Firm (PBM)	26%	23%
Region		
Pacific & Northwest (AK, CA, HI, ID, OR, WA)	11%	11%
Mountain (AZ, CO, MT, ND, NM, NV, SD, UT, WY)	3%	0%
Midwest (IA, IL, IN, KS, KY, MI, MN, MO, NE, WI)	3%	9%
Northeast (CT, DE, MA, ME, NH, NJ, NY, OH, PA, RI, VT)	11%	14%
South (AL, AR, DC, FL, GA, LA, MD, MS, NC, OK, SC, TN, TX, VA, WV)	11%	11%
Multi-regional	17%	9%
Large national	43%	46%
Covered Lives	116.7 M	117.7 M

Figure 3: Oncology commercial payer sample descriptors - displays breakdown of titles, organization types, region, and covered lives

Figure 4: Oncology medicare payer sample descriptors - displays breakdown of titles, organization types, region, and covered lives

For the payer management and unmet needs research component of this study, a sample of 60 payers participated. Survey research was conducted for non-oncology and oncology brands separately using the QuestionPro platform.

Non-oncology therapeutic areas include diabetes, rheumatoid arthritis, asthma (not severe), atopic dermatitis, and nonalcoholic steatohepatitis (NASH)/nonalcoholic fatty liver disease (NAFLD). Thirty-five payers represent 116.7 million commercial lives, and 25 payers represent 42.3 million Medicare lives. The sample is segmented across four quadrants: non-oncology commercial payers (Figure 1); non-oncology Medicare payers (Figure 2); oncology commercial payers (Figure 3); and oncology Medicare payers (Figure 4). Descriptions of respondents' titles, organization type, and region are provided for each of the sample segments.

Typically, when selecting payers, the ideal sample would be a healthy mix of large national insurance organizations, regional blues payers, and smaller independent insurance organizations as they all exhibit different characteristics and behaviors. When recruiting for the sample, national payers were prioritized over blues affiliates and independent plans based on the number of patient lives represented by these payers. Final analyses of the collected sample responses were analyzed using Microsoft Excel.

The three core title categories for payer respondents are medical directors or chief medical officers, pharmacy directors or clinical pharmacists, and "Other" when respondents' titles were not common among the overall sample.

The categories for organization type are large national plans; regional affiliates of a large national plan; regional plans of a large non-profit health plan association (i.e., a Blues affiliate); independent plans; and pharmacy benefit management firms (PBMs).These are consistent for all segments.

For represented U.S. regions, participants specified if their payer organization was national, multi-regional, or found in a specific region of the U.S. Those specific regions were:

Pacific and Northwest states (Arizona, California, Hawaii, Idaho, Oregon, Washington); the Northeast region (Connecticut, Delaware, Massachusetts, Maine, New Hampshire, New Jersey, New York, Ohio, Pennsylvania, Rhode Island, Vermont); the South (Alabama, Arkansas, Washington DC, Florida, Georgia, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, West Virginia);the Midwest (Iowa, Illinois, Indiana, Kansas, Kentucky, Michigan, Minnesota, Missouri, Nebraska, Wisconsin); and the Mountain region (Arizona, Colorado, Montana, North Dakota, New Mexico, Nevada, South Dakota, Utah, Wyoming).

Within the Medicare line of business, 24% of payers represented large national plans, 4% regional affiliates of a large national plan, 24% represented regional plans, 20% independent plans, and 28% pharmacy benefit management firms (PBMs).In terms of U.S. regions, 44% of Medicare participants range nationally and 16% identify as multi-regional. Twelve percent work throughout the Pacific and Northwest states (Arizona, California, Hawaii, Idaho, Oregon, Washington); 12% work within the Northeast region (Connecticut, Delaware, Massachusetts, Maine, New Hampshire, New Jersey, New York, Ohio, Pennsylvania, Rhode Island, Vermont); 12% in the South (Alabama, Arkansas, Washington DC, Florida, Georgia, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, West Virginia); 4% within the Midwest (Iowa, Illinois, Indiana, Kansas, Kentucky, Michigan, Minnesota, Missouri, Nebraska, Wisconsin).

For identified drivers of cost, a sample size of 63 payers were participants for both non-oncology and oncology spaces. Thirty-five of these payers represent 117.7 million Commercial lives, while28 of these payers represent 43.6 million Medicare lives. Eighty-three percent of Commercial payer participants were pharmacy directors or clinical pharmacists while the remaining 17% were medical directors or chief medical officers. Under the Medicare sample of payers, Pharmacy directors or clinical pharmacists represented 79% of participants and 21% were medical directors or chief medical officers.

With regard to organization types, 29% of Commercial payers represented Blues affiliate plans, 26% represented large national plans, 23% represented independent plans, and another 23% represented PBMs. Twenty-nine percent of Medicare payers represented large national plans, 29% of Medicare payers represented independent plans, 25% represented large national plans, another 25% represented PBMs, and 21% represented Blues affiliates.

Regarding represented U.S. regions, 46% of Commercial participants range nationally, and 9% identify as multi-regional. Fourteen percent work within the Northeast region (Connecticut, Delaware, Massachusetts, Maine, New Hampshire, New Jersey, New York, Ohio, Pennsylvania, Rhode Island, Vermont); 11% work throughout the Pacific and Northwest states (Arizona, California, Hawaii, Idaho, Oregon, Washington); 11% in the South (Alabama, Arkansas, Washington DC, Florida, Georgia, Louisiana,

Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, West Virginia); 9% within the Midwest (Iowa, Illinois, Indiana, Kansas, Kentucky, Michigan, Minnesota, Missouri, Nebraska, Wisconsin). On the Medicare side of payer participants for payer management and unmet needs, organization type samples are as follows: 29% of payers represented independent plans, 25% represented large national plans, another 25% pharmacy benefit management firms (PBMs), and 21% represented Blues affiliate plans.

Regarding represented U.S. regions, 46% of Medicare participants range nationally, and 4% identify as multi-regional. Eighteen percent work within the Northeast region (Connecticut, Delaware, Massachusetts, Maine, New Hampshire, New Jersey, New York, Ohio, Pennsylvania, Rhode Island, Vermont); 14% percent work throughout the Pacific and Northwest states (Arizona, California, Hawaii, Idaho, Oregon, Washington); 11% within the Midwest (Iowa, Illinois, Indiana, Kansas, Kentucky, Michigan, Minnesota, Missouri, Nebraska, Wisconsin); 7% in the South (Alabama, Arkansas, Washington DC, Florida, Georgia, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, West Virginia).

4. Results and Discussion

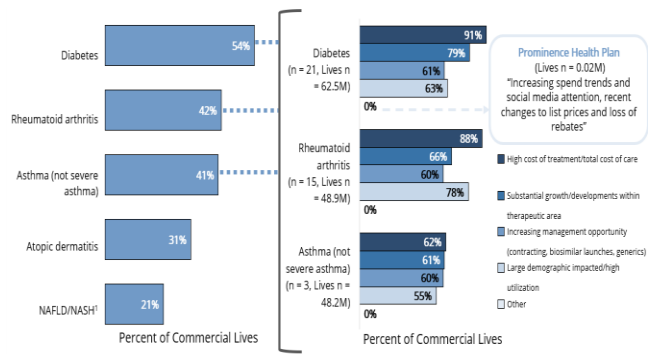**Payer Management Priorities**

Figure 5: Top payer management prioritiesfor commercial payers among non-oncology indications.

In the non-oncology indication landscape, a significant proportion of participating payers identify diabetes (91% of commercial covered lives)and rheumatoid arthritis (88% of commercial covered lives) as areas of high priority for their current utilization management strategy. Among commercial payers who selected diabetes as a therapeutic area of high utilization management importance (n=21, Lives n=62.5), the high cost of treatment is the most common management target, based on the numbers of lives associated with those payers, followed by substantial growth within the therapeutic area, and more opportunities for biosimilars. Several indications, including asthma, hypertension, and obesity, are labeled moderate priorities, while osteoporosis and chronic cough are considered very low-priority treatment areas by 36% and 38% of Commercial payers, respectively. Additionally, 59% of Medicare payers prioritize rheumatoid arthritis and 57% prioritize Crohn's disease.

As previously noted, diabetes is considered a top therapeutic area due not only to the high cost of treatment, but also to the diverse classes of drugs available on the market. The multitude of drug classes, including glucagon-like peptide-1(GLP-1) receptor agonists, dipeptidyl peptidase IV (DPP-IV) inhibitors, sodium-glucose transport protein (SGLT-2) inhibitors, insulin, and numerous combination drugs, presents a complex landscape. The prevalence of biosimilar agents further contributes to the dynamic nature of this therapeutic area. The high mortality rates associated with diabetes in the U.S. force competitive pricing and active management by payers in 2024.
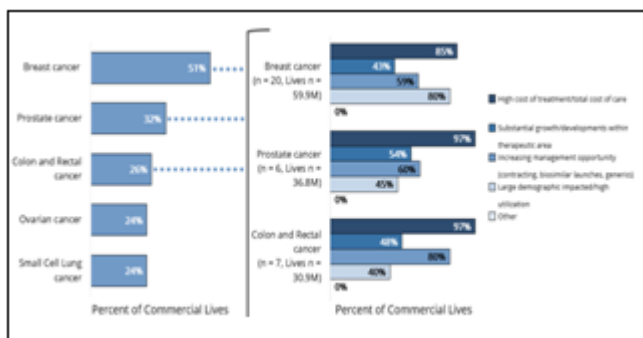

Figure 6: Top commercial payer management priorities among oncology indications.

In oncology, approximately 80% of commercial lives covered by payers prioritize prostate, colon, and rectal cancer as high-priority management areas. Moderate priorities extend to myelofibrosis, pancreatic cancer, and chronic myeloid leukemia. Breast cancer isa key oncology therapeutic area for 51% of commercial payers due to its high treatment costs [11].

Breast cancer management is particularly challenging, given the presence of step therapies aimed at cost control. An example is the payer restriction requirement to "step through" CDK4-6 inhibitors before moving to an oncologist's target therapy [11].The breast cancer space has multiple indications and drugs developed to target specific cancer-causing mutations (HER2+, HER2-, HR+, HR-, Triple-), contributing to the need for active management. The introduction of biosimilars, exemplified by Herceptin, further demonstrates the continuous effort to reduce costs within this therapeutic area.

The main drivers of these management priorities, in addition to the high cost of treatment and overall cost of care, include considerable growth within the indication, an increase of utilization management opportunities (contracting, biosimilar launches, and generics), and large demographic effects or high utilization in the space.
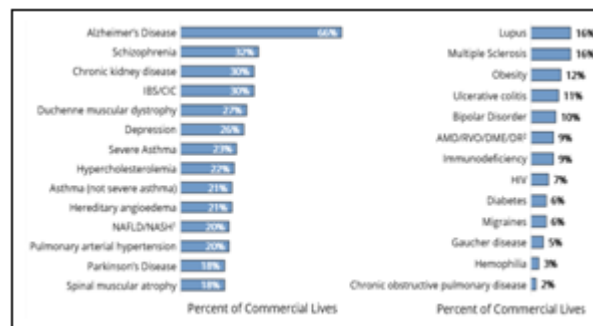
Unmet Needs

Figure 7: Top unmet needs among non-oncology indications– commercial.

While identifying high-priority therapeutic areas, the topic of unmet needs cannot be overlooked. Approximately two-thirds of payers reported that Alzheimer's disease is a therapeutic area with unmet need. The perception of high unmet need in this indication may also be influenced by the launch of Aduhelm in 2021 [12]. The performance of Aduhelm fell short of expectations, raising concerns about its clinical benefits despite statistical significance [13],[14].In addition to new entrant expectations, perceived high unmet needs in this space may also be linked to the recent Covid-19 pandemic [15].
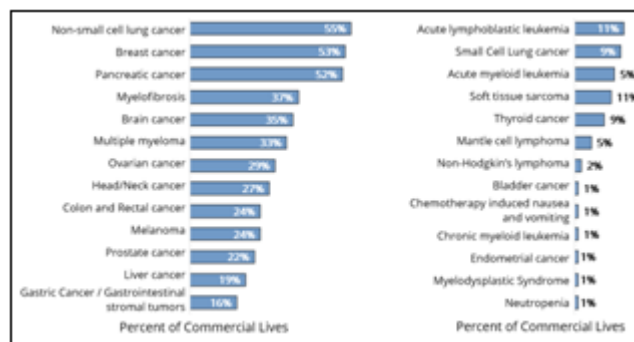

Figure 8: For commercial payers, these are the top unmet needs among oncology indications

In oncology, the pursuit of improved patient outcomes, survival rates, and quality of life is evident, particularly in non-small cell lung cancer and breast cancer. Payers actively seek information from manufacturers—including pipeline information, real-world evidence, clinical data, cost offset data, and patient support offerings—to assess their top management priorities.
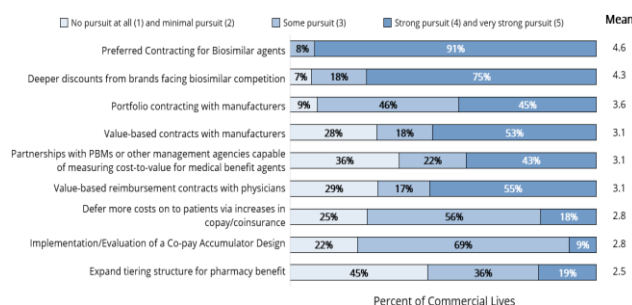
Drivers of Cost

Figure 9: Top commercial drivers of cost among non-oncology indications

In 2024, payers anticipate a stronger pursuit of biosimilar preferred contracting and value-based reimbursement contracts with physicians in the non-oncology space. Payers within this commercial space foresee Crohn's disease as having the highest cost burden, followed by hemophilia: factor VIII & IX. Migraines and atopic dermatitis present a split opinion on cost burdens, while hepatitis B and osteoporosis are anticipated to have the lowest cost burdens.
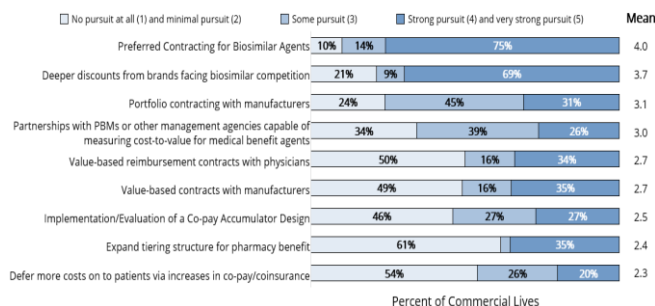

Figure 10: Top commercial drivers of cost among oncology indications

In oncology, 84% of lives covered by commercial payers identify breast cancer as the therapeutic area with the greatest cost burden, while thyroid cancer, chemotherapy-induced nausea and vomiting, and brain cancer are considered to create minimal cost burdens by approximately 30% of commercial payers.

Conclusion and Future Scope

Through a comprehensive analysis of a sample of 123 payers across the non-oncology and oncology spaces, the research has shown three core themes: payer management priorities, unmet needs, and drivers of cost.

Historically, therapeutic areas such as breast cancer, prostate cancer, melanoma, and multiple myeloma have consistently ranked as top priorities for payer management. This focus can be attributed to the high prevalence of these diseases within the general population, directly influencing the cost of care trend in the United States.

Diabetes is considered a top non-oncology therapeutic area for management in the future among 54% of payers due to its high cost of treatment. Our research indicates that payers foresee biosimilars playing a pivotal role in their cost-saving strategies for 2024 and beyond. Notably, with the expiration of patents for influential drugs like Humira and the anticipated loss of patent for Keytruda in 2026[7], biosimilars are increasingly becoming integral components of cost-effective healthcare management.

Cost drivers such as large populations, total cost of care, influx of new patients, and required life-long treatments are crucial. This research underscores the targeted efforts by payers to manage costs strategically, utilizing available resources to gain insights into top management priorities and unmet needs. Within both the non-oncology and oncology spaces, diabetes and breast cancer persist as consistent focal points in these endeavors.

A unique strategy explored by both non-oncology and oncology payers to achieve cost savings includes portfolio or value-based contracting with manufacturers. Additionally, value-based reimbursement contracts with physicians, and larger discounts driven by biosimilar competition, are becoming more common avenues for cost control. Currently, some commercial payers are actively engaging in biosimilar contracting, though not all are leveraging the tiering structure for active contracting benefits.

Global level emergencies such as COVID-19 can stress the healthcare system in terms of sudden unmet needs among patients, which is important to be considered as payer management, unmet needs, and drivers of cost are further discussed in the coming years.

In summary, this research provides a comprehensive overview of healthcare payer management priorities, highlighting significant areas such as diabetes and breast cancer. It underscores the evolving role of biosimilars and anticipates future cost-saving strategies. This study contributes to a better understanding of healthcare cost management, which is crucial for adapting to future challenges in the healthcare sector

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