## **EPISODE 19:**Chet Burrell How Technology Will Help Payers Manage the Growth of Precision Oncology to Improve Member Care and Lower CostsMr. Chet Burrell | July 2019

Karan Cushman: Welcome to [*The Precision Medicine Podcast*](https://www.interventioninsights.com/precisionmedicinepodcast)*,* sponsored by Trapelo. This is the podcast where experts come to discuss the problems oncologists, reference labs, and payers face, as precision medicine grows, and consider solutions for advancing the quality of patient-centered cancer care.

Jerome Madison: Welcome to the Precision Medicine Podcast sponsored by Trapelo. This is the podcast where experts come to discuss the problems oncologists, reference labs, and payers face as precision medicine grows and consider solutions for advancing the quality of patient-centered cancer care. Be sure to subscribe precisionmedicinepodcast.com to get the latest episodes delivered straight to your inbox.

Jerome Madison: Welcome to another episode of the Precision Medicine Podcast, and today, we have Mr. Chet Burrell, former president and CEO of Care First Blue Cross Blue Shield. Chet, welcome to the podcast.

Chet Burrell: Thank you very much.

Jerome Madison: Our subject matter on the podcast is addressing the challenges associated with the scale and access to precision medicine. But you know, we have predominantly approached this topic from the perspective of the clinician. So, we're very much privileged to have you on. So, I guess, actually to start with the first question is, what are the biggest challenges and concerns payers are facing as precision medicine is more widely accepted and grows? But also, why is it important for them to look for potential solutions now?

Chet Burrell: Well, I think the first thing I would say is that the explosion of knowledge in the precision medicine field is very, very difficult for anyone to keep up with. But that's certainly true of payers. And so the first challenge, I think, is what are valid new developments in the field? And how does one know that? What markers might be genetic markers, might be applicable to a particular type of cancer that is constantly changing? So, just from a testing point of view, that's very challenging.

Chet Burrell: The second thing is that the testing itself, there are thousands of hybrids of tests. So, it is very difficult for a payer to know in any particular case what is appropriate. These tests, because they are specialized, create the second challenge, which is that tests are very expensive and getting more so.

Chet Burrell: And then the third challenge is, what treatments, usually drugs, apply to what you find once you do the tests? And that is changing dramatically as well.

Chet Burrell: So, I think payers look at it from the standpoint of saying, "Precision medicine seems to offer great hope for tailored treatments that are more effective." But how do you know that the tests that are being conducted are appropriate and that the treatments that are connected to the outcome of those tests are effective? And I think from a payer's point of view, this went from over five years, say, the last five years, from a relatively small part of coverage and liability to a rapidly growing part of coverage and liability. And their concern is how do we keep up with all of that?

Jerome Madison: Yeah. I want to dive into that really quickly because you said “effective,” and we know that when you're talking to a clinician versus a payer versus a patient, even, effective might be a relative term in how it's defined.

Jerome Madison: Last week when we spoke, you really articulated something that really blew my mind, and I'm going to try my best to really paint this picture for the listeners out there. But from a payer perspective, you talked about how we afford, you know health care and the picture that you drew for us was of a pyramid and basically the top 10% of that pyramid representing acutely ill patients, or patients on the top 10% being sicker patients, represented half of all healthcare spending.

Jerome Madison: You went on to say that the top 2% to 3% that you call acutely ill accounted for 30% to 40% of healthcare spending. When you really look at those numbers, it's mind blowing. So, there is a study that is ongoing right now, and it's called the Beacon Study. It's a phase-three study, which is looking at a chemo-free therapy option for certain patients with metastatic colorectal cancer.

Jerome Madison: Some results were recently presented at the World Conference on gastrointestinal cancer for patients who progressed on one or two previous treatments, and they were looking specifically at BRAF V600e patients. Now just want to, for the listeners, I just want to put some context on this:

Jerome Madison: This is a triplet-targeted therapy, and the results are fantastic. These patients would typically have a 2% response rate on what would be a standard therapy for that particular patient population on chemotherapy, standard chemo, but the results of the triplet saw a 48% improvement in overall survival versus standard chemo, and it also improved progression-free survival by 62%. And when we look at that in terms of actual real time, it was 4.3 months versus 1.5 months of the group on chemotherapy. So three months.

Jerome Madison: So, when we say effective, it's noted that the cost could be enormous for this treatment, but this is being hailed as a new standard. How do payers view this dilemma of costs over benefit in this type of scenario?

Chet Burrell: Well, I think you hit the nail on the head. The effect of many of the new treatments, tailored to the individual molecular or genetic profile of an individual, can prolong life and do prolong life. Often at the cost of hundreds of thousands of dollars for that patient. Now, if that's… you, then obviously you want the treatment. But that treatment cost is socialized…is spread across all other beneficiaries of an insurer.

Chet Burrell: And so, do you think that…the average premium is $500 a month approximately in most markets for standard coverage, and you're spreading hundreds of thousands of dollars-worth of cost across everyone else. What happens is that the sheer burden of that cost has, by itself, even though it's only a small number of patients, dramatic effects on premium, because premium is designed to offset costs—a tiny portion for administrative costs and a large portion for actual claims costs.

Chet Burrell: And one of the reasons why the 2% to 3% of patients that are so critically ill— many of whom have cancer, another portion of which have heart disease, another illness, but a very substantial portion of the 2% to 3%—are various forms of cancer. It's become incredibly expensive. And what we're finding is that the drug costs alone, put aside physician costs and all other treatment costs, drug costs alone have risen to become a third of all costs and rapidly rising.

Chet Burrell: And so the bottom line here is the treatment can be effective in the sense that it improves the quality of life and it extends life, but it does so at great societal cost. And at what point does that become unsupportable? If you're a payer, you're very either reluctant or legally precluded from excluding a promising treatment. That was the last thing that one would want to do, and yet you have to cover these costs and the only way to do it is to cover it in premium.

Jerome Madison: Yeah.

Chet Burrell: And so it's a challenge. I'll just add one other thing to that. Therefore, what can you do? The thing that you can do is to assure that the tests that were run are actionable, are the right tests, would produce valid results in terms of what cancer markers are involved, molecular markers are involved. And then the right treatments were connected to the results of those tests. That's what a payer can do. As opposed to exclude coverage or block coverage, which you know, in the vast majority of cases insurers do not or carriers do not want to do.

Jerome Madison: Yeah, I think it's important to put a stamp on this. They're looking at BRAF V600e positive patients, but there was also a MIC inhibitor and an EGFR inhibitor, and in the study protocol, the patients did not have to be tested for MIC or EGFR. So it'll be interesting to see how those groups divide out and what the data continues to show about those particular patients who were tested for all three markers.

Jerome Madison: One of the other problems that we hear at Trapelo and seek to eliminate in the marketplace is the burden of prior authorization, and we hear this a lot from the clinician. But as I understand it, it's also an issue for payers.

Jerome Madison: Many physicians and administrators at various conferences have mentioned the need for automation to make precision medicine a routine clinical practice. Not just for the decision support on what markers should be tested when for which patients, but specifically the burden of prior authorization.

Jerome Madison: And I found this data, Chet, from Health Payer Intelligence, and it was a survey from the American Medical Association that said, "78% of providers reported that long prior-authorization processes are linked to patients abandoning their treatments, and providers also surveyed reported that it takes an average of 14 and a half hours to complete these requests, which is the equivalent of two business days."

Jerome Madison: So, automation, they say, is something that's needed to buy back that time, but it would seem that automation is also needed for payers. What are some of your ideas on how payers can automate the approval of testing and access to these therapies when used appropriately?

Chet Burrell: Well, clearly the prior auth process is cumbersome and time consuming and expensive for both the provider and the payer. There's often a struggle by the payer to understand, with the provider involved, why did you order, or what tests did you order for this particular patient? Why did you order them? What would you do with the result when you got it back? How is it going to affect your treatment? Is it appropriate given the circumstances?

Chet Burrell: And there is a back and forth that goes on almost case by case, which is very, very laborious. Meanwhile, the patient is waiting to see whether they can get the treatment. Some of these treatments are so new, they are considered experimental, do not have proven efficacy. And yet the physician may believe that this is critical for the health of the patient and tells the patient that, and then the patient demands that they get the treatment.

Chet Burrell: So that's very, very difficult for a payer to deal with, especially when the costs involved are enormous relative to other options. And so, what is particularly attractive about Trapelo is that it has at the fingertips of the physician, given the cancer, the stage of cancer, and other factors about the patient, "Here based on current literature and scientific evidence are the tests that you should use."

Chet Burrell: If you use those tests, and you do so through qualified labs who can actually render the result of those tests, and then you link to the result the evidence-based treatment, from the standpoint of the payer, the payer knew that that was being consistently done, I believe that most payers would find that to be exactly what they are looking for. And so you can automate that. "Here are the tests that I intend to conduct, here's why they are valid, and here's the results of those tests, how I will treat the patient based on the evidence."

Chet Burrell: And if there's a record established of that by the oncologist that the payer can see—and that's all evidenced in Trapelo—then I don't have to, as a payer, approve every single test and every single treatment. It is only the exceptions that I would have to look at, and that greatly accelerates the process for all parties involved. The provider, the payer, and the patient. And that I believe is the essential hope and value that Trapelo offers that I am not aware of any other solution of its type in the market.

Jerome Madison: Fantastic. Thank you for that feedback. And Chet, I know I can talk to you for a while about this, but we'll get you out of here on this. And we were talking about automation. It points to technology. As we look over the landscape of oncology, how can we use. Let me say that again...

Jerome Madison: As we look over the landscape of technology, how can the use of technology help payers manage the growth of precision oncology and provide better member care and potentially lower cost?

Chet Burrell: Well, I think the essential way that that can be done is very much what Trapelo is already doing. Let me describe it this way. There are something in the order of tens of thousands of diagnostic tests, molecular genetic tests, that could be run. How does one keep track of all of that? How does one know that? Even if you're an oncologist, that's very difficult to keep up with.

Chet Burrell: There are also combinations of genetic markers, not just a single marker, but we're learning that there are combinations of markers that are critical to understand in certain cases. Then you need to understand which markers are actionable. It's one thing to know a marker, but that doesn't mean that there is a treatment applicable to it or some combination of markers.

Jerome Madison: That's right.

Chet Burrell: And so what Trapelo does, which is the essence of where the technology assist is so valuable, is first it gathers all evidence based on the basis of what supports a particular test or set of tests in a particular patient case.

Chet Burrell: It then links, based on the latest evidence, the treatments that are available ranked in order of effectiveness. It puts those key pieces of information at the fingertips of the oncologist with a single sign-on onto the system that is the underlying electronic medical records system that they use.

Chet Burrell: So, you put in, as I said, a few pieces of information about the patient and out comes this incredibly valuable, very current profile of what's available to you in terms of marker testing and in terms of treatments. And it keeps up to date. It is constantly updated. So you have confidence that you're testing correctly and that you're ordering treatments correctly based on latest scientific evidence.

Chet Burrell: Without the technology that is on the desktop, it is almost unthinkable to do this. It's impossible to do it anywhere near as well. And because that's true from a payers point of view, it gives a basis, it gives a credibility, if you will, to saying, if an oncologist were to use this, then I the payer have confidence that you have done everything you can to keep up with the evidence basis of both testing and treatment. And that's exactly what the payer is looking for.

Chet Burrell: So, the technology enables it. It holds a huge amount of data available for use on demand 24/7, available within seconds of the decision-making process. Without that technology, that's unthinkable.

Jerome Madison: Wow.

Chet Burrell: That's the essence of the value.

Jerome Madison: Well, I appreciate this fresh perspective, because in many conversations that we have, and I guess that's just kind of the nature of the beast, the payer is seen in many cases as the villain, but in essence suffers from the same challenges.

Chet Burrell: And I think from the payer's point of view, there's one thing that I think people tend to forget, perhaps especially when you need the service. When you need the service, you want the service, whatever the treatment might be, and that is completely understandable and appropriate. The payer faces another challenge beyond making sure that you get what you need, which is how do they hold premiums at affordable levels?

Chet Burrell: And one of the things that, if you sat where a payer sits, in between, if you will, the buyer and the provider, what you hear from the buyer, whether that's an employer or an individual, is, "I can no longer afford premiums or the equivalent of premium. It has reached the point of unaffordability. It's not just what I pay in premium, it is what I pay out of pocket through deductibles and co-payments and co-insurance."

Chet Burrell: It's reached levels that are flat out unaffordable for many people and including employers. Other than salary and compensation, health benefits are the single greatest operating expense of most employers. So, they're screaming about the affordability of it.

Chet Burrell: And so, payers are in the middle of that, hearing on the one side that it's unaffordable and hearing on the other, "I absolutely need this treatment and don't I have coverage for it?" And so what payers try to do, in a very uncomfortable way, is reconcile those competing demands.

Chet Burrell: Let me put it this way: The analogy I would give is to climate. Too much carbon dioxide in the atmosphere warms to the point where it ultimately makes climate unaffordable. Too much costs in health care makes healthcare inaccessible. And nothing so threatens quality or accessibility to healthcare as the cost of healthcare. And that is why payers are so concerned about whether you ordered the right test or whether you provided the right treatment and made the right treatment decision, meaning what drug to apply.

Chet Burrell: And as the oncology field explodes based on increased molecular understanding and genetic understanding of what causes what and what treatments might be effective, and their solutions are in often in the hundreds of thousands of dollars, treatment cost often is, five years ago, $80,000 for a course of treatment. Now it's 150,000 and rapidly increasing.

Chet Burrell: You would think there would be concern over is this the right test and is this the right treatment?

Jerome Madison: Yeah.

Chet Burrell: That's why I think the Trapelo solution is so attractive to both the provider and to the payer, and, hopefully, the result is it causes the patient to get what they need more accurately and more promptly.

Jerome Madison: Well, we certainly appreciate your insights, Mr. Chet Burrell, former president and CEO of Care First Blue Cross Blue Shield. Well, Chet, I say former but with these innovative solutions, you're not far out of the game. You're sure you're going to be able to stay retired?

Chet Burrell: No.

Jerome Madison: Well it is our privilege. You have a lot of value and a lot of tremendously innovative ideas for the space. So, we value you and thank you for being a guest on the Precision Medicine Podcast.

Chet Burrell: Thank you very much.

Jerome Madison: You've been listening to the Precision Medicine Podcast sponsored by Trapelo. Trapelo is the first clinical decision-support tool to align the interest of oncologist labs and payers to give patients the best chance at beating cancer. To learn more, visit getTrapelo.com.

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**About Our Guest: Mr. Chet Burrell**

Chet Burrell is the founder and managing member of Silavon Healthcare Holdings, where he oversees highly selective investments in U.S healthcare companies that are believed to offer both high social-impact value and high investment value.

Over the last 40 years, Mr. Burrell has held numerous CEO-level positions and Chairmanship roles in both the public and private sectors of the U.S. healthcare system. He has been the acting President/CEO of three different Blue Cross/Blue Shield plans, including the largest private payer and health benefits management company in the mid-Atlantic area, CareFirst Blue Cross Blue Shield.

Through much of his career, Mr. Burrell has led pioneering efforts to reform financing approaches to healthcare, such as financial incentives for providers and value-based payment models to reward more cost-effective, higher-quality care. Mr. Burrell has also supported joint efforts between U.S. government policymakers and regulators to find solutions to unaffordable healthcare costs. As a board member at Intervention Insights, he aims to make an equally powerful impact on the cost-effective use of precision oncology.