Capturing the Value of Pharmaceuticals in Exchanges: Potential Role for Value-Based Insurance Design

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“One-size-fits-all” Cost-sharing Fails to Acknowledge Differences in Clinical Value Among Drugs

Cost-Sharing in Select Standardized Silver Plans

<table>
<thead>
<tr>
<th>State</th>
<th>Plan Type</th>
<th>Benefit Cost-Sharing Parameters*</th>
<th>Drug Formulary</th>
<th>OOP Max for Drugs</th>
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<tr>
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<td>Overall Deductible</td>
<td>Drug Deductible</td>
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<tr>
<td>CA</td>
<td>Silver Copay</td>
<td>Medical: $2,000</td>
<td>$500†</td>
<td>$25</td>
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<td></td>
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*Benefit cost-sharing parameters are specific to individuals. Deductibles and OOP cap may be higher for family coverage.
†For brand drugs only
‡Integrated medical and drug benefits OOP cap
• Ideally, patient copayments would be used to discourage the use of low-value care

• Increased patient cost-sharing leads to decreases in non-essential and essential care which, in some cases, lead to greater overall costs
“I can’t believe you had to spend a million dollars to show that if you make people pay more for something they will buy less of it.”

Barbara Fendrick (my mother)
High Copays Reduce Adherence to Appropriate Medication Use

- Change in Days Supplied for Selected Drug Classes When Copays Were Doubled
  - Diabetes: -25%
  - High Cholesterol: -34%
  - Hypertension: -26%

- When copays were doubled, patients took less medication in important classes. These reductions in medication levels were profound.
- Reductions in medications supplied were also noted for:
  - NSAIDs 45%
  - Antihistamines 44%
  - Antiulcerants 33%
  - Antiasthmatics 32%
  - Antidepressants 26%
- For patients taking medications for asthma, diabetes, and gastric disorders, there was a 17% increase in annual ER visits and a 10% increase in hospital stays.

ER = emergency room.

Using “Clinical Nuance” to Reallocate Spending
Principles of Value-Based Insurance Design

- Medical services differ in the benefit provided
- Clinical benefit derived from a specific service depends on the patient using it, who provides it, and where it is delivered
- V-BID premise: the more clinically beneficial the service, the lower the patient's cost share
- An opportunity exists for a cost-saving reallocation within any health budget, through increasing use of high-value interventions and reducing the use of interventions that offer little or no benefit
To date, most V-BID programs reduce cost-sharing for evidence-based services for specific diseases
- Medications, eye exams for diabetes
- Behavioral therapy, meds for depression
- Long-acting inhalers, spirometers for asthma

V-BID programs that discourage use of low-value services are being implemented
- Choosing Wisely

V-BID programs have broad multi-stakeholder and bipartisan political support
Capturing the Value of Pharmaceuticals in Exchanges
Policy Options to Include V-BID

- Recognize V-BID in plan quality ratings
- Permit carriers to market V-BID plans to consumers with specific clinical conditions
- Allow flexibility for Exchanges to include V-BID plans
  - Effective risk adjustment will be important to mitigate adverse selection concerns
- Require plans to include V-BID for high value drugs
  - ACA requirement of coverage of certain preventive services without cost-sharing can be extended to evidence-based pharmaceuticals
The use of “clinically nuanced” incentives [and disincentives] to encourage [and discourage] patient and provider behavior to redistribute medical expenditures will produce more health at any level of health expenditure.

Multiple approaches exist for Exchanges to adjust patient cost-sharing based on clinical evidence.

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