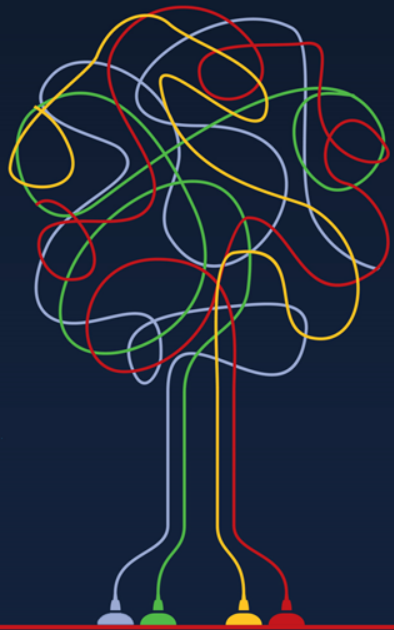


Potential Role for Value-Based Insurance Design in Specialty Pharmaceuticals

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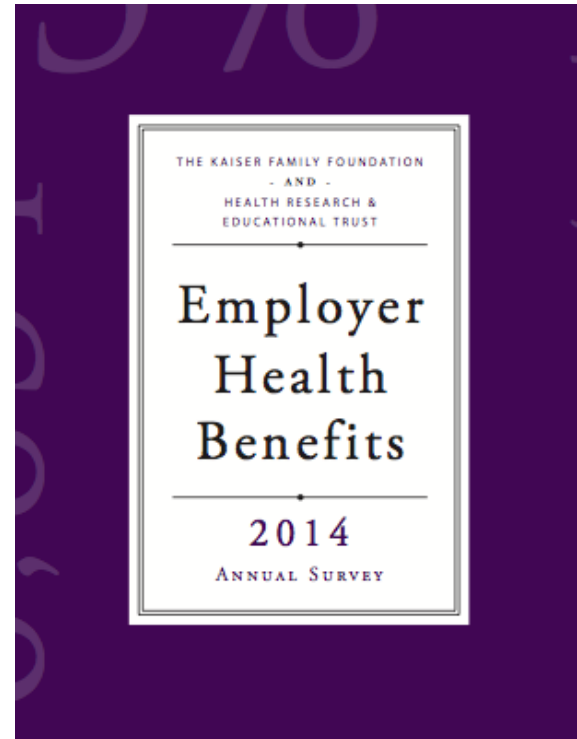
Improving Care and Bending the Cost Curve

Shifting the discussion from “How much” to “How well”

- **Innovations to prevent and treat disease have led to impressive reductions in morbidity and mortality**
- **Regardless of these advances, cost growth is the principle focus of health care reform discussions**
- **Despite unequivocal evidence of clinical benefit, substantial underutilization of high-value services persists across the entire spectrum of clinical care**
- **Attention should turn from *how much* to *how well* we spend our health care dollars**

Role of Consumer Cost-Sharing in Medical Decisions

- For today's discussion, our focus is on costs paid **by the consumer**, not the employer or third party administrator
- Ideally consumer cost-sharing levels would be set to encourage the clinically appropriate use of health care services
- Instead, archaic “one-size-fits-all” cost-sharing fails to acknowledge the differences in clinical value among medical interventions
- Consumer cost-sharing is rising



Inspiration

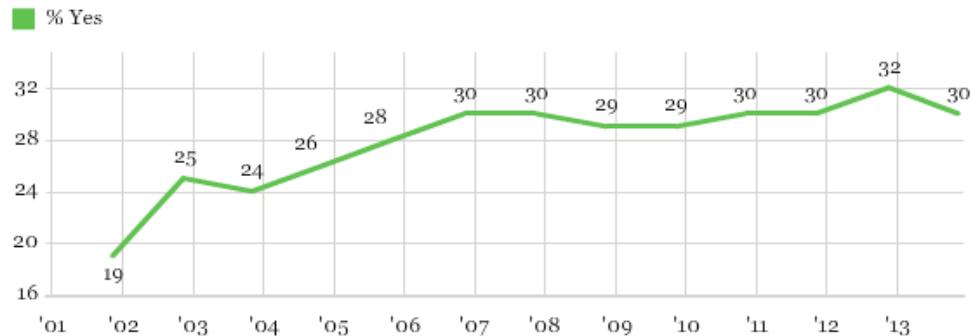
“I can’t believe you had to spend a million dollars to show that if you make people pay more for something, they will buy less of it.”

Barbara Fendrick (my mother)

Impact of Increases in Consumer Cost-Sharing on Health Care Utilization

Percentage of Americans Putting Off Medical Treatment Because of Cost

Within the last 12 months, have you or a member of your family put off any sort of medical treatment because of the cost you would have to pay?



GALLUP®

A growing body of evidence concludes that increases in consumer cost-sharing leads to a reduction in the use of essential care, which worsens health disparities, and in some cases leads to greater overall costs

Goldman D. *JAMA*. 2007;298(1):61–9. Trivedi A. *NEJM*. 2008;358:375-383. Trivedi A. *NEJM*. 2010;362(4):320-8.. Chernew M. *J Gen Intern Med* 23(8):1131–6.

The New York Times

Business Day

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ECONOMIC VIEW

When a Co-Pay Gets in the Way of Health

By SENDHIL MULLAINATHAN

Published: August 10, 2013

ECONOMISTS specialize in pointing out unpleasant trade-offs — a skill that is on full display in the health care debate.

Enlarge This Image



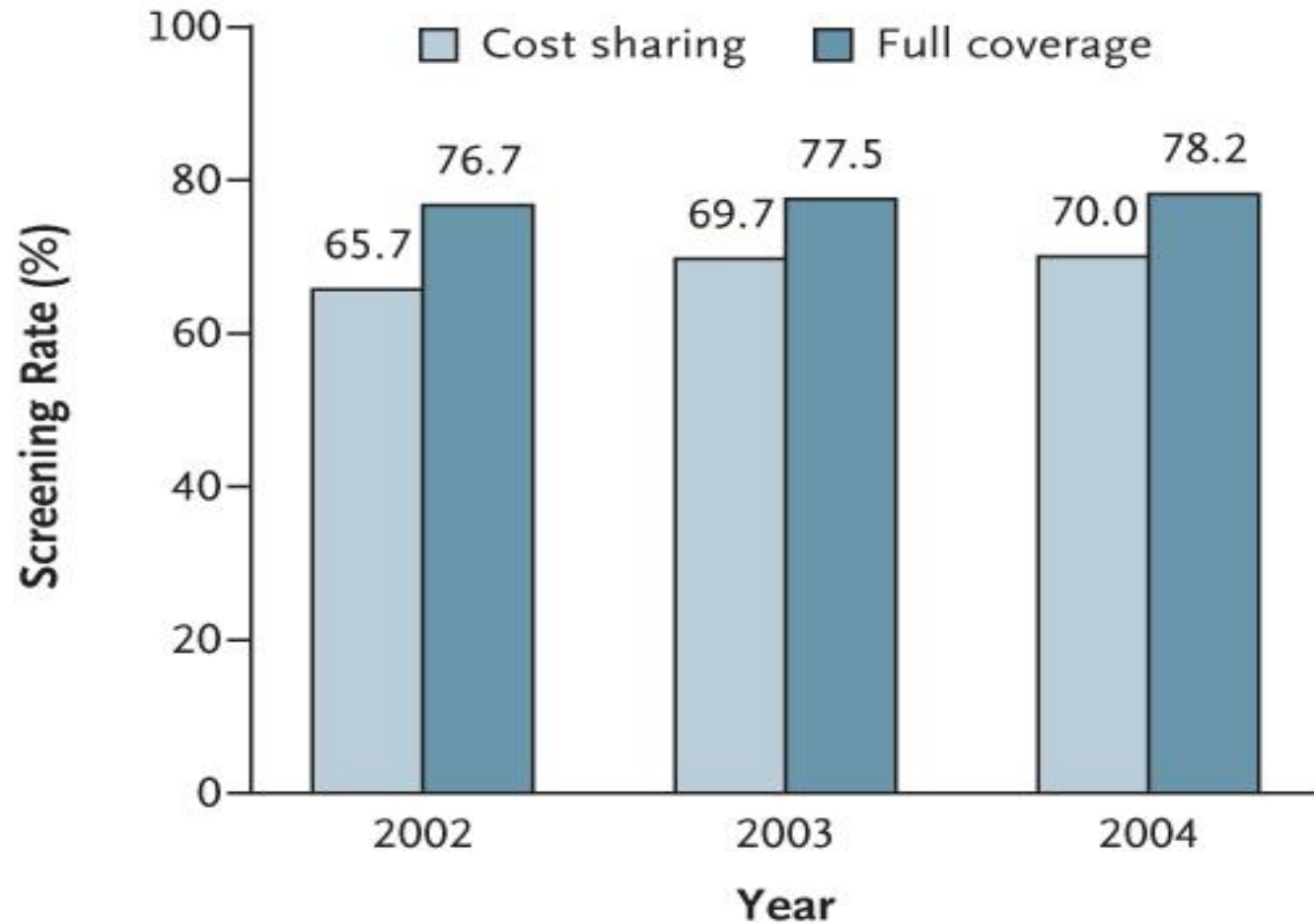
Minh Uong/The New York Times

We want patients to receive the best care available. We also want consumers to pay less. And we don't want to bankrupt the government or private insurers. Something must give.

The debate centers on how to make these trade-offs, and who gets to make them. The stakes are high, and the choices are at times unseemly. No matter how necessary, putting human suffering into dollars and cents is not

M | **V-BID**

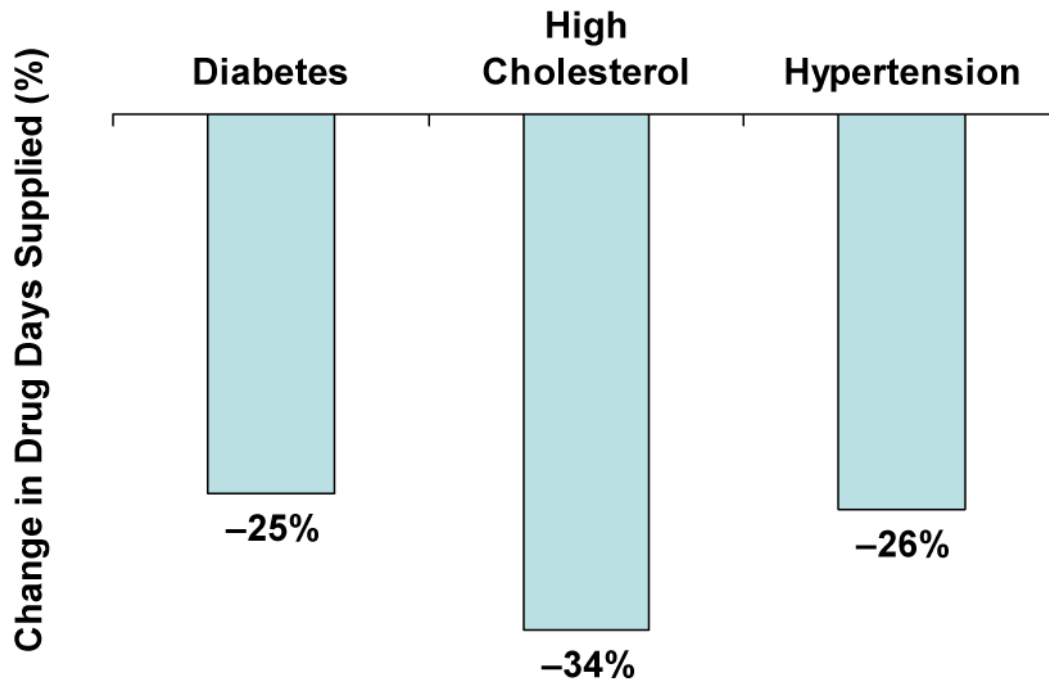
Cost-sharing Affects Mammography Use by Medicare Beneficiaries





High Copays Reduce Adherence to Appropriate Medication Use

Change in Days Supplied for Selected Drug Classes When Copays Were Doubled



- 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.

Goldman DP et al. *JAMA*. 2004;291:2344-2350.

Medication Affordability Attributable to Medicare Part D Implementation

- A recent *Health Affairs* article investigated whether the gains in affordability for prescription drugs attributable to Part D persisted during the six years that followed its implementation in 2006
- Among elderly beneficiaries with four or more chronic conditions, the prevalence of cost-related non-adherence **increased** from 14% in 2009 to 17% in 2011, reversing previous downward trends
- The prevalence among the sickest elderly of forgoing basic needs to purchase medicines **decreased** from 9% in 2007 to 7% in 2009 but **rose** to 10% in 2011

Effects of Increased Copayments for Ambulatory Visits for Medicare Advantage Beneficiaries

Copays increased:

- from \$7.38 to \$14.38 for primary care
- from \$12.66 to \$22.05 for specialty care
- remained unchanged at \$8.33 and \$11.38 in controls

In the year after copayment increases:

- 19.8 **fewer** annual outpatient visits per 100 enrollees
- 2.2 **additional** hospital admissions per 100 enrollees
- Effects worse in low-income individuals and beneficiaries with chronic illness

IBM to Drop Co-Pay for Primary-Care Visits

Article

Comments (4)



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Text



By WILLIAM M. BULKELEY

In an unusual bid to cut health-care costs, International Business Machines Corp. plans to stop requiring \$20 co-payments by employees when they visit primary-care physicians.

The company said it believed the move would save costs by encouraging people to go to primary-care doctors faster, in order to get earlier diagnoses that could save on expensive visits to specialists and emergency rooms.

IBM said that the action applies to the 80% of its workers who are enrolled in plans in which the company self-insures—that is, programs in which it pays the health-care benefits, not insurers. The new policy doesn't cover IBM employees in health-maintenance organizations.

One of the nation's largest employers with 115,000 U.S. workers, IBM spends about \$1.3 billion a year on U.S. health care. Its benefit practices are closely watched in the human-resources community, and its actions are sometimes trend-setters.

Impact of Cost-Sharing on Health Care Disparities

Effects of Increased Patient Cost Sharing on Socioeconomic Disparities in Health Care

*Michael Chernew, PhD¹ Teresa B. Gibson, PhD² Kristina Yu-Isenberg, PhD, RPh³
Michael C. Sokol, MD, MS⁴ Allison B. Rosen, MD, ScD⁵, and A. Mark Fendrick, MD⁵*

¹Department of Health Care Policy, Harvard Medical School, Boston, MA, USA; ²Thomson Healthcare, Ann Arbor, MI, USA; ³Managed Markets Division, GlaxoSmithKline, Research Triangle Park, NC, USA; ⁴Managed Markets Division, GlaxoSmithKline, Montvale, NJ, USA; ⁵Departments of Internal Medicine and Health Management and Policy, Schools of Medicine and Public Health, University of Michigan, Ann Arbor, MI, USA.

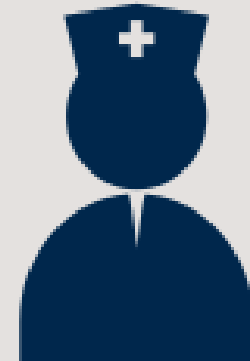
- **Rising copayments may worsen disparities and adversely affect health, particularly among patients living in low-income areas.**

Solutions Needed to Curb Cost-related Non-adherence

- **These findings highlight the need for targeted efforts to alleviate the persistent issue of cost-related non-adherence**

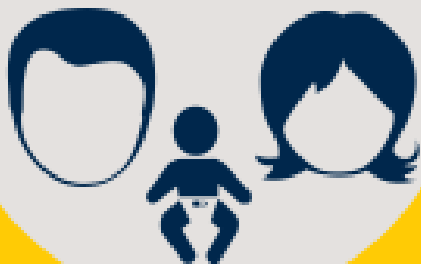
A New Approach: Clinical Nuance

1. Services differ in clinical benefit produced

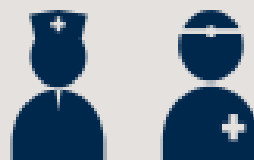


2. Clinical benefits from a specific service depend on:

Who
receives it



Who
provides it



Where
it's provided



Implementing Clinical Nuance Value-Based Insurance Design

- **Sets consumer cost-sharing level on clinical benefit – not acquisition price – of the service**
 - Reduce or eliminate financial barriers to high-value clinical services and providers
- **Successfully implemented by hundreds of public and private payers**



Evidence Supporting Value-Based Insurance Design: Improving Adherence Without Increasing Costs

- **Most V-BID programs focus on removing financial barriers to high-value prescription drugs to treat chronic conditions (e.g., diabetes, asthma, heart disease)**
- **Evidence review**
 - **Improved adherence**
 - **Lower consumer out-of-pocket costs**
 - **No significant increase in total spending**
 - **Reduction in health disparities**

DISPARITIES

By Niteesh K. Choudhry, Katsiaryna Bykov, William H. Shrank, Michele Toscano, Wayne S. Rawlins, Lonny Reisman, Troyen A. Brennan, and Jessica M. Franklin

Eliminating Medication Copayments Reduces Disparities In Cardiovascular Care

ABSTRACT Substantial racial and ethnic disparities in cardiovascular care persist in the United States. For example, African Americans and Hispanics with cardiovascular disease are 10–40 percent less likely than whites to receive secondary prevention therapies, such as aspirin and beta-blockers. Lowering copayments for these therapies improves outcomes among all patients who have had a myocardial infarction, but the impact of lower copayments on health disparities is unknown. Using self-reported race and ethnicity for participants in the Post-Myocardial Infarction Free Rx Event and Economic Evaluation (MI FREEE) trial, we found that rates of medication adherence were significantly lower and rates of adverse clinical outcomes were significantly higher for nonwhite patients than for white patients. Providing full drug coverage increased medication adherence in both groups. Among nonwhite patients, it also reduced the rates of major vascular events or revascularization by 35 percent and reduced total health care spending by 70 percent. Providing full coverage had no effect on clinical outcomes and costs for white patients. We conclude that lowering copayments for medications after myocardial infarctions may reduce racial and ethnic disparities for cardiovascular disease.

Emerging Best Practices in V-BID Implementation

A 2014 *Health Affairs* evaluation of 76 V-BID plans reported that programs that:

- were more generous
- targeted high-risk individuals
- offered wellness programs
- avoided disease management
- used mail-order prescriptions

had greater impact on adherence than plans without these features

Choudhry. N. *Health Affairs*. 2014;33(3).

WEB FIRST

By Niteesh K. Choudhry, Michael A. Fischer, Benjamin F. Smith, Gregory Brill, Charmaine Girdi, Olga S. Matlin, Troyen A. Brennan, Jerry Avorn, and William H. Shrank

Five Features Of Value-Based Insurance Design Plans Were Associated With Higher Rates Of Medication Adherence

ABSTRACT Value-based insurance design (VBID) plans selectively lower cost sharing to increase medication adherence. Existing plans have been structured in a variety of ways, and these variations could influence the effectiveness of VBID plans. We evaluated seventy-six plans introduced by a large pharmacy benefit manager during 2007–10. We found that after we adjusted for the other features and baseline trends, VBID plans that were more generous, targeted high-risk patients, offered wellness programs, did not offer disease management programs, and made the benefit available only for medication ordered by mail had a significantly greater impact on adherence than plans without these features. The effects were as large as 4–5 percentage points. These findings can provide guidance for the structure of future VBID plans.

Copayments, coinsurance, deductibles, and other benefit structures are widely used to contain health care spending by encouraging patients to consider the costs of health services before deciding to purchase them. Cost sharing helps address the overconsumption that may result from generous insurance coverage (a type of “moral hazard,” in economic terms).¹ However, it may also lead patients to reduce their use of high-value services.² Value-based insurance design (VBID) plans seek to avoid this problem by setting cost-sharing amounts in inverse relationship to the clinical benefit that an intervention offers.³

The peer-reviewed literature supports the ability of copay reductions to increase the use of essential medication and improve clinical outcomes.^{4–6} As a result, VBID plans have been adopted by many employers and health plans throughout the United States.¹⁰ In addition, the Affordable Care Act calls for the creation of guidelines to facilitate the broader use of VBID plans.

Plans used to treat chronic disease. However, the plans differ in a number of important ways. Some plans target members who meet specific clinical criteria; others reduce copays for all members. Some plans eliminate cost sharing; others only reduce it. Some plans concurrently offer disease management and wellness programs; others do not.

We sought to understand the influence of these and other plan characteristics on how VBID plans affect medication adherence. Based on our results, we identify best practices for the future implementation of VBID plans.

Study Data And Methods

SETTING AND PLAN CHARACTERISTICS We identified VBID plans introduced by a large pharmacy benefit manager, CVS Caremark, on behalf of fifty-nine employer-based plan sponsors between 2007 and 2010. We classified plans according to whether or not they had certain characteristics.

MI-FREEE: Better Quality Without Higher Costs

- Assessed impact of free access to preventive medications for Aetna members with history of MI
- Random assignment by plan sponsor
- “Enhanced prescription coverage improved medication adherence and rates of first major vascular events and decreased patient spending without increasing overall health costs.”

Choudhry NK, Avorn J, Glynn RJ, Antman EM, Schneeweiss S, Toscano M, et al. Full coverage for preventive medications after myocardial infarction. *N Engl J Med*. 2011 Dec 1;365(22):2088–97.



Evidence for Value-Based Insurance Design: Reducing Health Care Disparities

Full drug coverage:

- Reduced rates of a post-MI vascular event or revascularization among patients who self-identified as being non-white
- Reduced total health care spending by 70 percent among patients who self-identified as being non-white

DISPARITIES

By Niteesh K. Choudhry, Katsiaryna Bykov, William H. Shrank, Michele Toscano, Wayne S. R. R. Reisman, Troyen A. Brennan, and Jessica M. Franklin

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Multi-Stakeholder Support for V-BID

- **HHS - National Quality Strategy**
- **CBO**
- **SEIU**
- **MedPAC**
- **Brookings Institution**
- **The Commonwealth Fund**
- **NBCH**
- **PCPCC**
- **Partnership for Sustainable Health Care**
- **National Governor's Assoc.**
- **Academy of Actuaries**
- **Bipartisan Policy Center**
- **Kaiser Family Foundation**
- **NBGH**
- **National Coalition on Health Care**
- **Urban Institute**
- **RWJF**
- **IOM – Essential Health Benefits**

Sec 2713: Selected Preventive Services be Provided without Cost-Sharing

- **Receiving an A or B rating from the United States Preventive Services Taskforce (USPSTF)**
- **Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP)**
- **Preventive care and screenings supported by the Health Resources and Services Administration (HRSA)**



Over 100 million Americans have received expanded coverage of preventive services

V-BID in Medicare: Bipartisan Political Support

The Value-Based Insurance Design for Better Care Act of 2014

113TH CONGRESS
2D SESSION

H. R. _____

(Original Signature of Member)

To establish a demonstration program requiring the utilization of Value-Based Insurance Design to demonstrate that reducing the copayments or coinsurance charged to Medicare beneficiaries for selected high-value prescription medications and clinical services can increase their utilization and ultimately improve clinical outcomes and lower health care expenditures.

IN THE HOUSE OF REPRESENTATIVES

Mrs. BLACK (for herself and Mr. BLUMENAUER) introduced the following bill;
which was referred to the Committee on _____

The Better Care, Lower Cost Act of 2014



Sponsored by:

U.S. Sen. Ron Wyden, D-Ore.

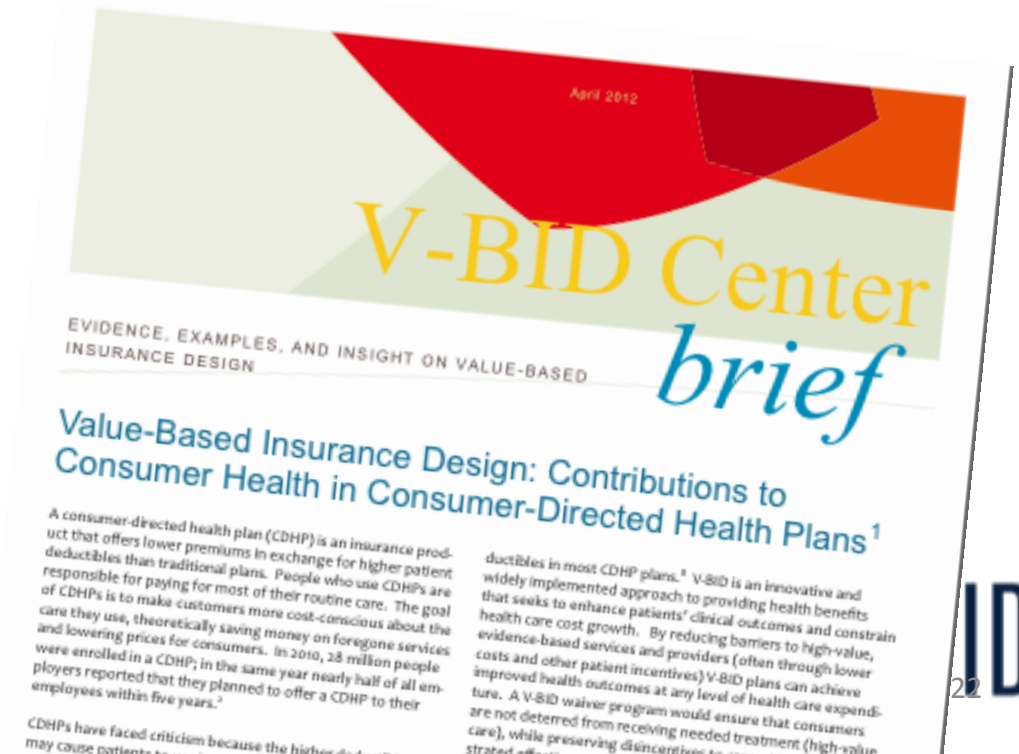
U.S. Sen. Johnny Isakson, R-Ga.

U.S. Rep. Erik Paulsen, R-Minn.

U.S. Rep. Peter Welch, D-Vt.

Barriers to V-BID in HSA-qualified HDHPs

- IRS guidance documents specifically exclude from the definition of preventive care those services or benefits meant to treat “an existing illness, injury or condition”
- Confusion persists regarding what services can and cannot be covered outside of the deductible



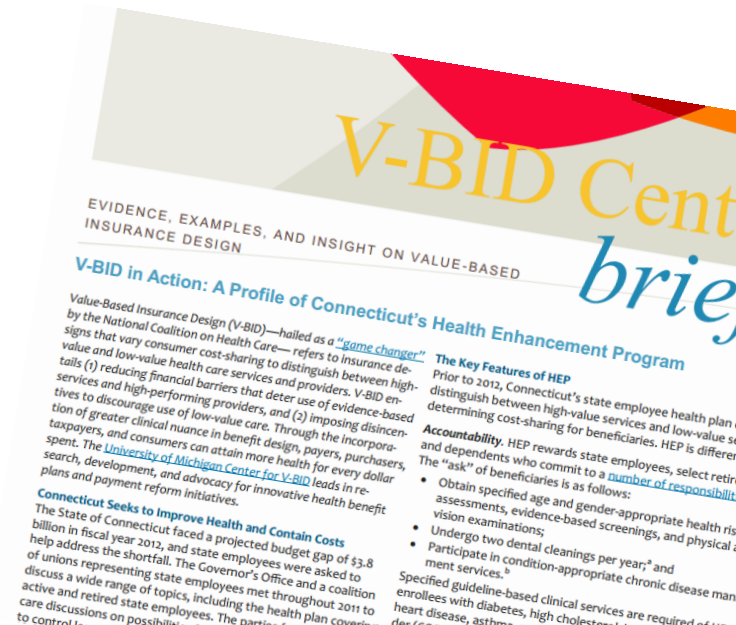
Value-Based Insurance Design Growing Role in State Health Reform

- **State Employees Benefit Plans**
 - Connecticut
 - Oregon
 - Virginia
 - Minnesota
 - Maine
 - **State Exchanges**
 - Maryland
 - California
 - **CO-OPs**
 - **Medicaid**
- 
- EVIDENCE, EXAMPLE
INSURANCE DESIGN
- V-BID in Action: A**
- Value-Based Insurance Design
by the National Coalition on
signs that vary consumer co-
value and low-value health
tails (1) reducing financial b
services and high-perform
tives to discourage use of
tion of greater clinical nu
taxpayers, and consumer
spent. The *University of*
search, development, an
plans and payment refor
- Connecticut Seeks to l**
- The State of Connectic
billion in fiscal year 201
help address the short
of unions representin
discuss a wide range
active and retired sta
care discussions on p
to control long-term



Implementing V-BID for State Employees: Connecticut State Employees Health Benefit Plan

- **Participating employees receive a reprieve from higher premiums if they commit to:**
 - Yearly physicals, age-appropriate screenings/preventive care, two free dental cleanings
 - If employees have one of five chronic conditions, they must participate in disease management programs (which include free office visits and lower drug co-pays)
- **Early results:**
 - 99% of employees enrolled and 99% compliant
 - Decrease in ER and specialty care
 - Increase in primary care visits
 - Increase in chronic disease medication adherence



CMS Rules (CMS-2334-F) Enable V-BID in Medicaid



- Plans may vary cost-sharing for drugs, outpatient, inpatient, and emergency department visits
- Plans may target cost-sharing to specific groups of individuals based on clinical information (e.g., diagnosis, risk factors)
- Plans may vary cost-sharing for an outpatient service according to where and by whom the service is provided

Value-Based Insurance Design

More than High-Value Drugs for Chronic Conditions

- **Prevention/Screening**
- **Diagnostic tests/Monitoring**
- **Treatments**
- **Clinician visits**
- **Physician networks**
- **Hospitals**
- **Role in specialty pharmaceuticals**

Applying V-BID to Specialty Pharmaceuticals Approaches

- **Impose no more than modest cost-sharing on high-value services**
- **Reduce cost-sharing in accordance with patient- or disease-specific characteristics**
- **Relieve patients from high cost-sharing if clinical goals not achieved on a different medication “reward the good soldier”**
- **Use cost-sharing to encourage patients to select high-performing providers and settings**

**Supporting Consumer Access to
Specialty Medications Through
Value-Based Insurance Design**

A. Mark Fendrick, MD
Jason Buxbaum, MHSA
Kimberly Westrich, MA



Using Clinical Nuance to Align Payer and Consumer Incentives

Many “supply side” initiatives are restructuring provider incentives:

- **Payment reform**
 - Global budgets
 - Pay-for-performance
 - Bundled payments
 - Accountable care
- **Tiered networks**
- **Health information technology**



Using Clinical Nuance to Align Payer and Consumer Incentives

Unfortunately, “supply-side” initiatives have historically paid little attention to consumer decision-making or the “demand-side” of care-seeking behavior:

- **Benefit design**
- **Shared decision-making**
- **Literacy**



Role of V-BID in Multi-Payer Reform: Using Clinical Nuance to Align Payer and Consumer Incentives

- **Adding clinical nuance into payment reform and consumer engagement initiatives can help improve quality of care, enhance patient experience, and contain cost growth**
- **The alignment of supply- and demand-side incentives can improve quality and achieve savings more efficiently than either one alone**



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