SCHOOL OF PUBLIC HEALTH
CENTER FOR VALUE-BASED INSURANCE DESIGN
UNIVERSITY OF MICHIGAN

Potential Role for Value-Based Insurance Design in Cancer Care

National Cancer Policy Forum

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V-BID

Improving Care and Bending the Cost Curve
Shifting the discussion from "How much" to "How well"

- **Innovations to prevent and treat cancer have let 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 cancer services persists across the spectrum of clinical care**
- **Attention should turn from *how much* to *how well* we spend our health care dollars**

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Role of Beneficiary Cost-Sharing in Medical Spending

- **For today's discussion, it is important to distinguish between the costs paid by the health plan or third party administrator and out-of-pocket costs paid by the beneficiary**

Impact of Cost-Sharing on Health Care Utilization

- **Ideally, consumer cost-sharing levels would be set to encourage the clinically appropriate use of services**
- **Instead, archaic "one-size-fits-all" cost-sharing fails to acknowledge the differences in clinical value among medical interventions**
- **Accumulating evidence concludes that cost-sharing increases in leads to reductions in both non-essential and essential care, which in some cases, leads to greater costs**

Goldman D. *JAMA*. 2007;298(1):61–9. Chernew M. J Gen Intern Med 23(8):1131–6.

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 Cost-Sharing on Health Care Disparities

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

Michael Chernew, PhD[1] Teresa B. Gibson, PhD[2] Kristina Yu-Isenberg, PhD, RPh[3]
Michael C. Sokol, MD, MS[4] Allison B. Rosen, MD, ScD[5], and A. Mark Fendrick, MD[5]

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

Chernew M. J Gen Intern Med 23(8):1131–6.

A New Approach: Clinical Nuance

1. Services differ in clinical benefit produced

2. Clinical benefits from a specific service depend on:

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**


WSJ.com THE WALL STREET JOUR ONLINE

June 16, 2004

FOLLOW THE MONEY

From 'One Size Fits All' To Tailored Co-Payments

June 16, 2004

University of Michigan researchers say a patient
drug should depend on how much he or she will
a move that would likely lower c

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

- **Improved adherence**
- **Lower consumer costs**
- **No significant increase in total spending**

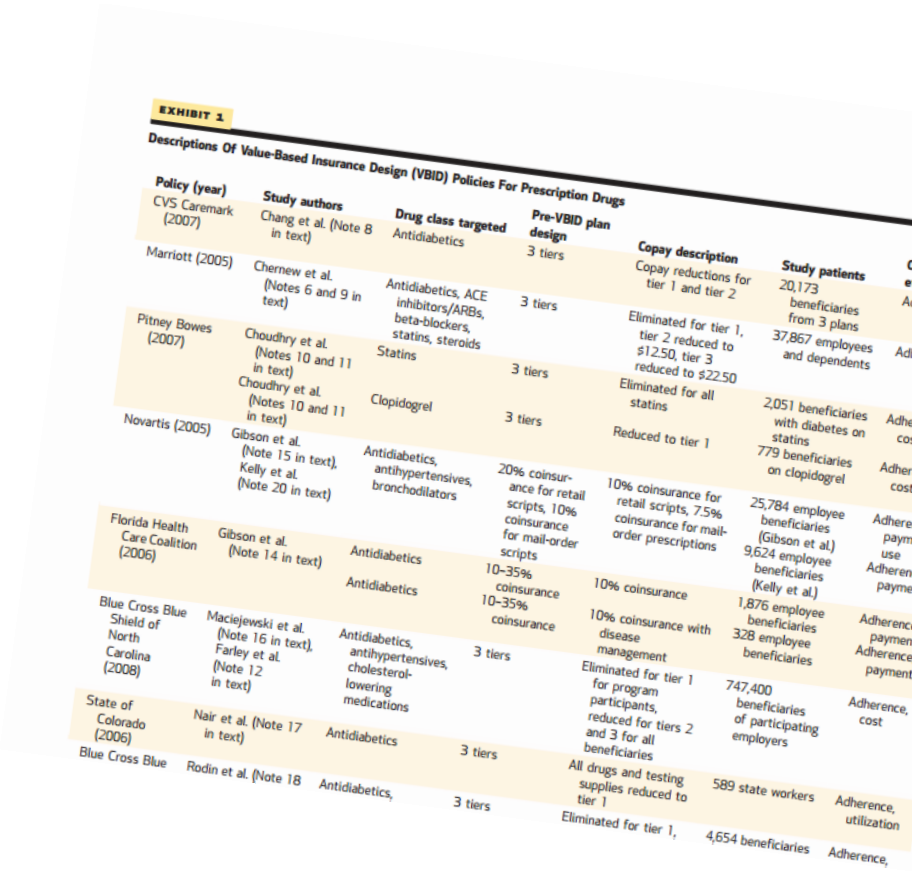


EXHIBIT 1

Descriptions Of Value-Based Insurance Design (VBID) Policies For Prescription Drugs

Policy (year)	Study authors	Drug class targeted	Pre-VBID plan design	Copay description	Study patients	
CVS Caremark (2007)	Chang et al. (Note 8 in text)	Antidiabetics	3 tiers	Copay reductions for tier 1 and tier 2	20,173 beneficiaries from 3 plans	
Marriott (2005)	Chernew et al. (Notes 6 and 9 in text)	Antidiabetics, ACE inhibitors/ARBs, beta-blockers, statins, steroids	3 tiers	Eliminated for tier 1, tier 2 reduced to $12.50, tier 3 reduced to $22.50	37,867 employees and dependents	
Pitney Bowes (2007)	Choudhry et al. (Notes 10 and 11 in text)	Statins	3 tiers	Eliminated for all statins	2,051 beneficiaries with diabetes on statins	
	Choudhry et al. (Notes 10 and 11 in text)	Clopidogrel	3 tiers	Reduced to tier 1	779 beneficiaries on clopidogrel	
Novartis (2005)	Gibson et al. (Note 15 in text), Kelly et al. (Note 20 in text)	Antidiabetics, antihypertensives, bronchodilators	20% coinsurance for retail scripts, 10% coinsurance for mail-order scripts	10% coinsurance for retail scripts, 7.5% coinsurance for mail-order prescriptions	25,784 employee beneficiaries (Gibson et al.) 9,624 employee beneficiaries (Kelly et al.)	
Florida Health Care Coalition (2006)	Gibson et al. (Note 14 in text)	Antidiabetics	10–35% coinsurance	10% coinsurance	1,876 employee beneficiaries	
		Antidiabetics	10–35% coinsurance	10% coinsurance with disease management	328 employee beneficiaries	
Blue Cross Blue Shield of North Carolina (2008)	Maciejewski et al. (Note 16 in text), Farley et al. (Note 12 in text)	Antidiabetics, antihypertensives, cholesterol-lowering medications	3 tiers	Eliminated for tier 1 for program participants, reduced for tiers 2 and 3 for all beneficiaries	747,400 beneficiaries of participating employers	
State of Colorado (2006)	Nair et al. (Note 17 in text)	Antidiabetics	3 tiers	All drugs and testing supplies reduced to tier 1	589 state workers	
Blue Cross Blue	Rodin et al. (Note 18	Antidiabetics,	3 tiers	Eliminated for tier 1,	4,654 beneficiaries	

Lee J. *Health Affairs.*. 2013;32(7):1251-1257

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. Ra
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 ca
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.

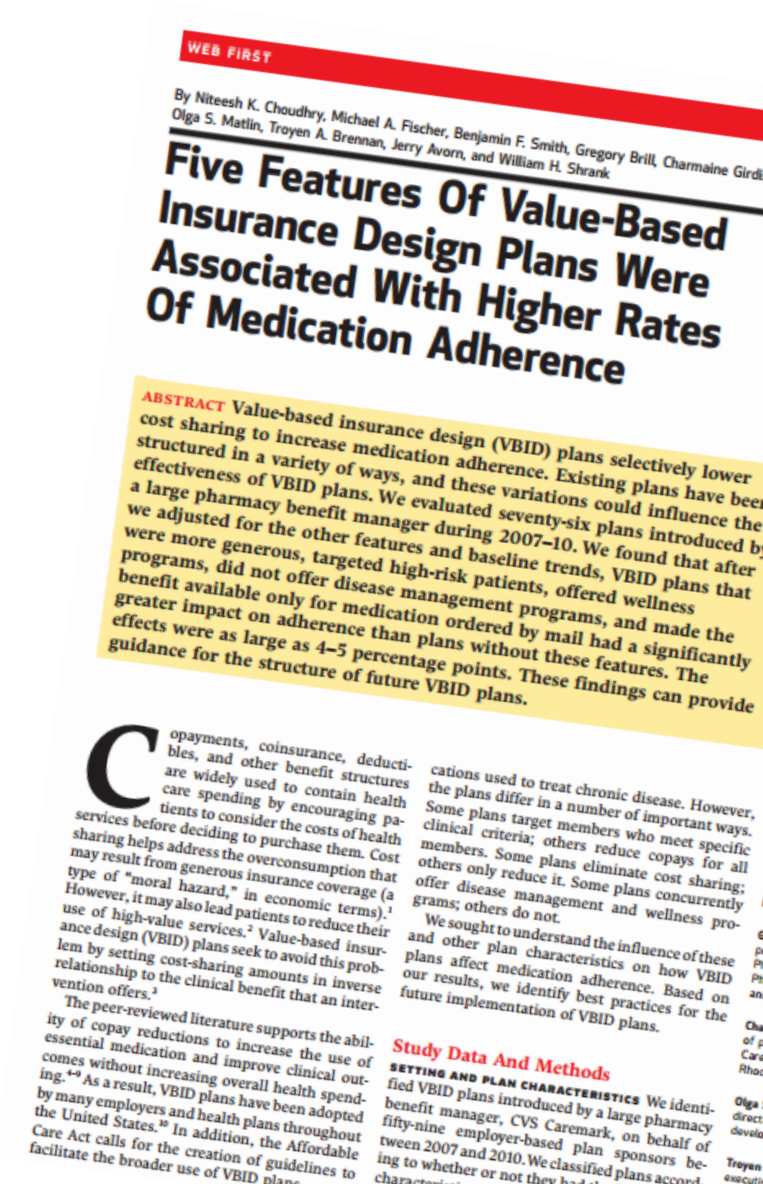
Health Aff (Millwood). 2014 May;33(5):863-70

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



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 without increasing overall health spending.[4–9] 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

cations 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

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

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

Lewin. *JAMA.* 2013;310(16):1669-1670

Policy Context: V-BID Provisions in the Patient Protection & Affordable Care Act

- **Primary Prevention**
  - **Sec. 2713 prohibits cost sharing for >60 evidence-based preventive services**
    - **Approximately 105 million Americans have received expanded coverage**
  - **Implementation of "nuanced" cancer related recommendations challenging**
    - **Screening (colonoscopy, CT for lung CA)**
    - **Treatment (chemoprevention for high risk breast cancer)**

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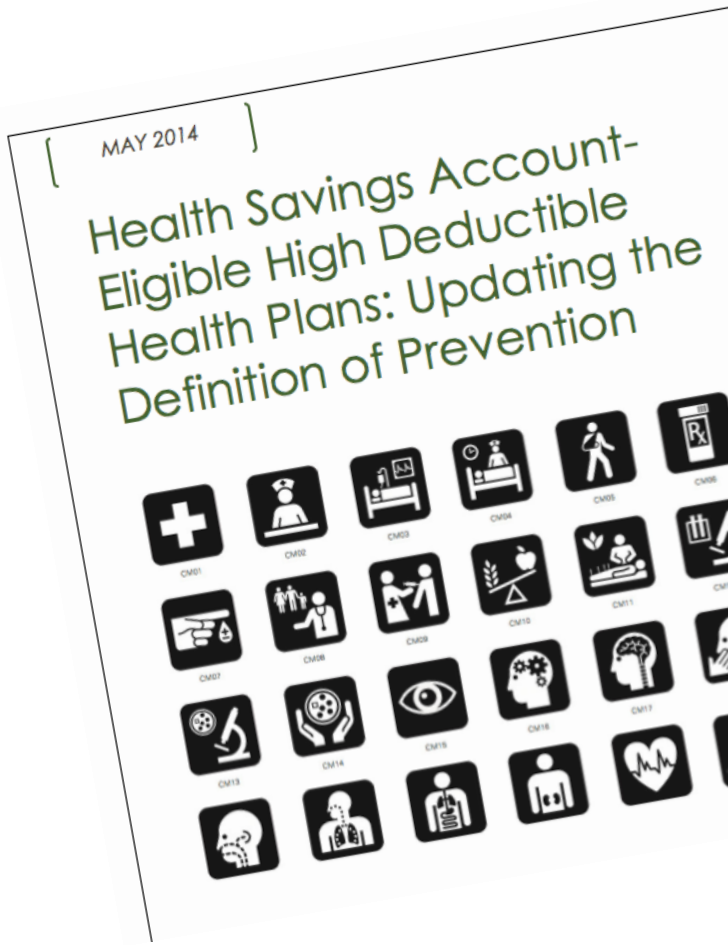
Policy Context: Barriers Exist to Extend V-BID High Value Secondary Preventive Services

- **Coverage of highly valuable secondary prevention services frequently less generous than primary prevention**
- **Follow-up of fully covered preventive care not included**
- **IRS regulations do not allow coverage of secondary preventive services before deductible in HAS-HDHPs**
- **Medicare does not allow condition-specific benefit design**



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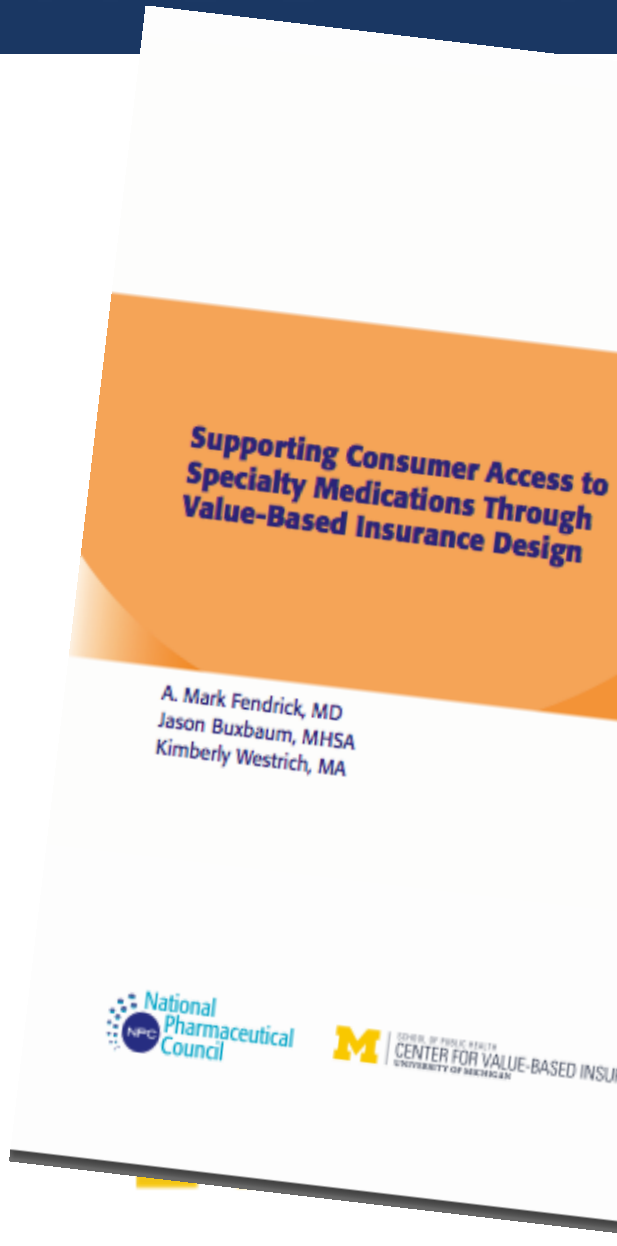
Applying V-BID to High-Cost, High Value Cancer Care

- **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 after failure on a different medication**
- **Use cost-sharing to encourage patients to select high-performing providers and settings**



V-BID: Keys to Implementation

- **Prepare for administrative complexity**
- **Communicate effectively**
- **Integrate with provider initiatives**

Fendrick et al. Center for Value Based Insurance Design. http://bit.ly/1kMP2cq

Moving Forward

- **The ultimate test of health reform will be whether it improves health and addresses rising costs**
- **Cost containment efforts should not result in preventable reductions in quality of care**
- **V-BID should be part of the solution to enhance the efficiency of spending on cancer care**

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 attractive work. It's no surprise, then, that the conversation is so heated.

What is a surprise is that amid these complex issues, one policy sidesteps these trad

Mullainathan S. When a Co-Pay Gets in the Way of Health. The New York Times. 2013 Aug 10.