

Potential Role for Value-Based Insurance Design in Specialty Pharmaceuticals

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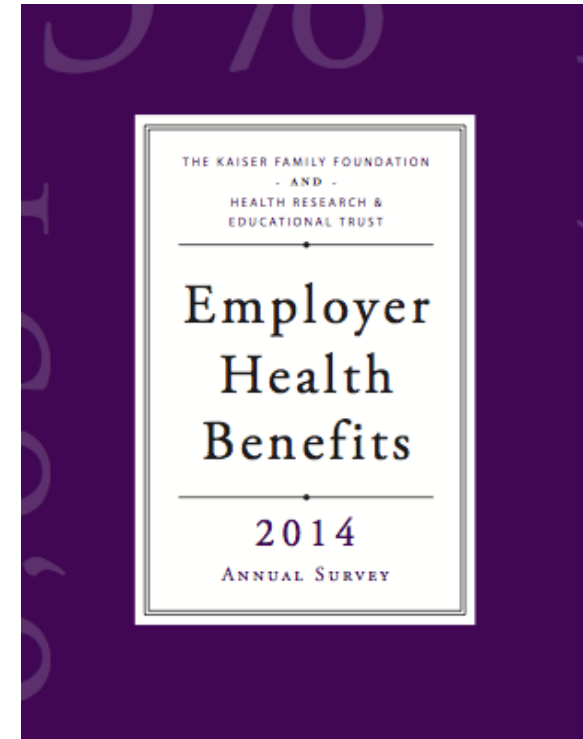
Improving Care and Bending the Cost Curve

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

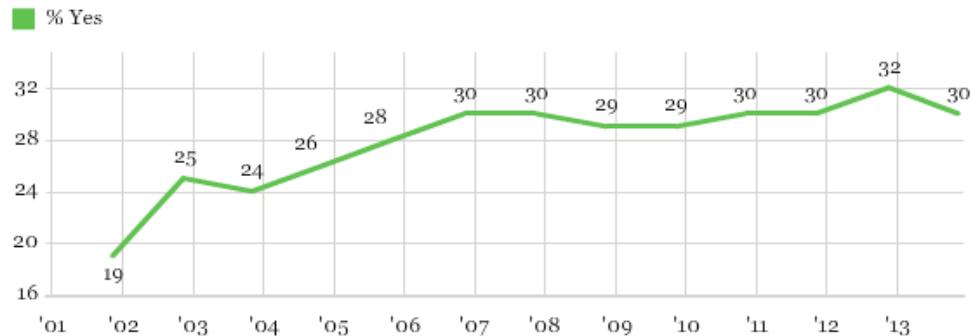
“I can’t believe you had to spend a million dollars to show that if you make people pay more for something, they will buy less of it.”

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

WORLD U.S. N.Y. / REGION BUSINESS TECHNOLOGY SCIENCE HEALTH S

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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



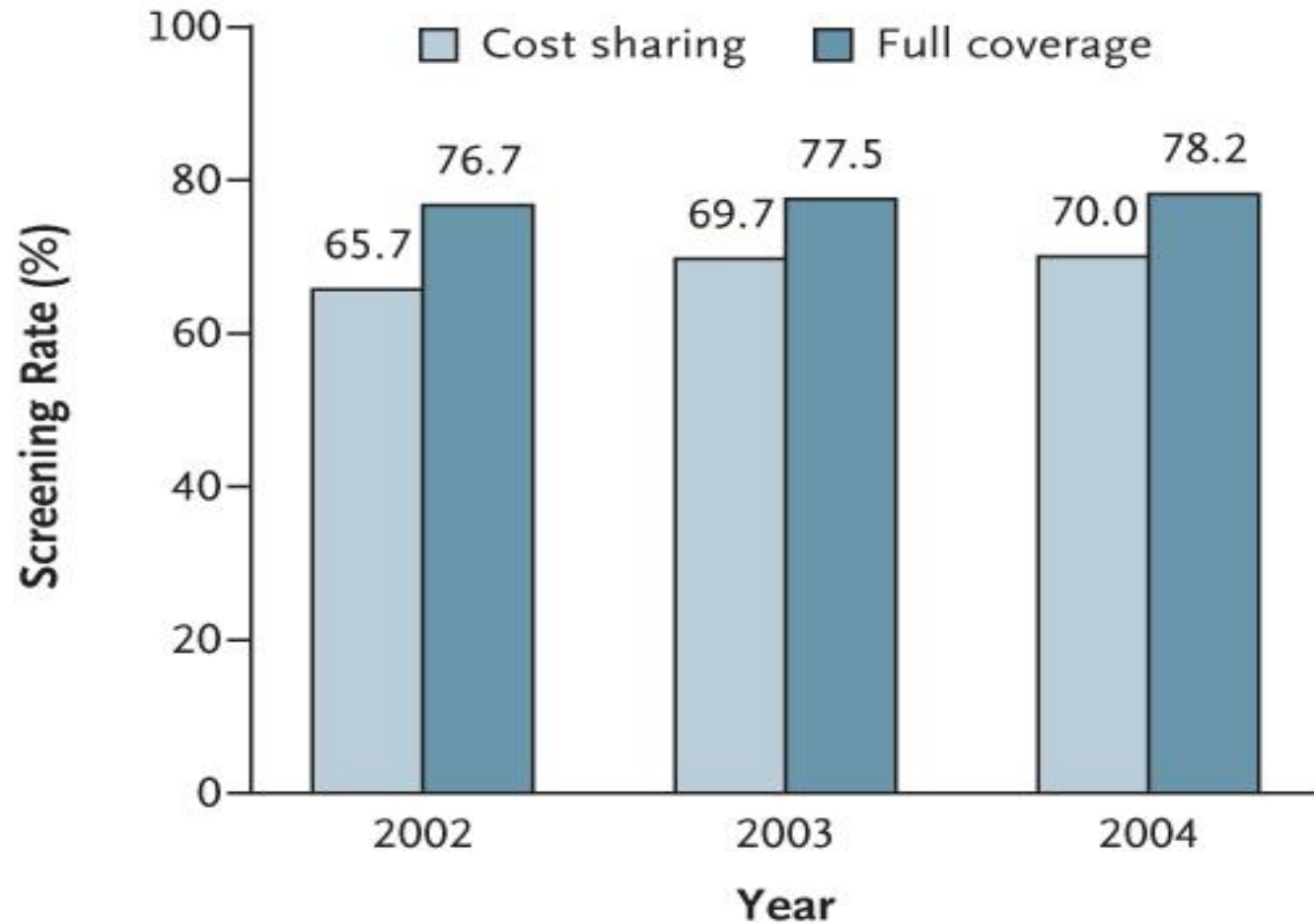
Minh Uong/The New York Times

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**

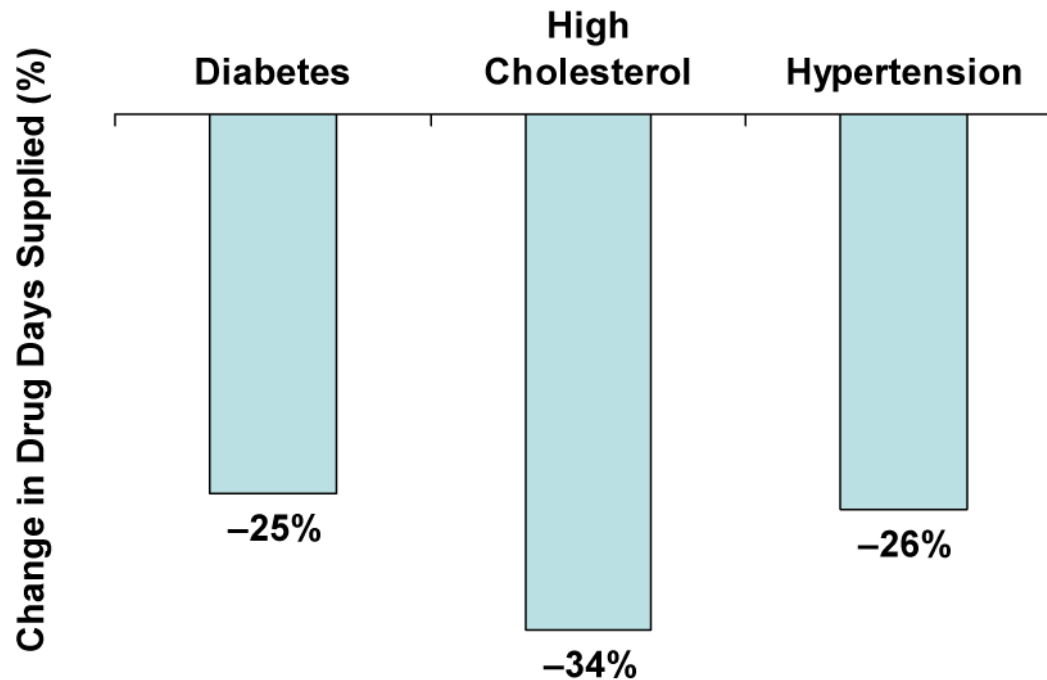
Cost-sharing Affects Mammography Use by Medicare Beneficiaries





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

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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.

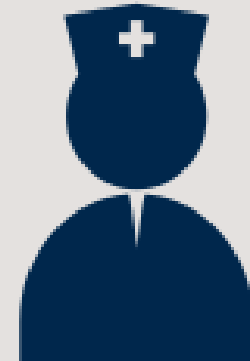
- **Rising copayments may worsen disparities and adversely affect health, particularly among patients living in low-income areas.**

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**

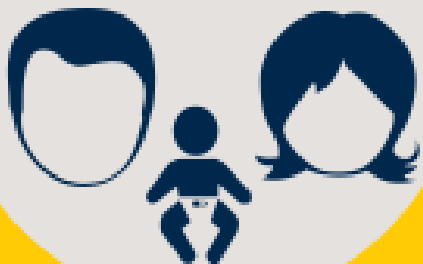
A New Approach: Clinical Nuance

1. Services differ in clinical benefit produced

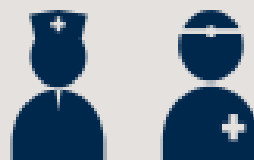


2. Clinical benefits from a specific service depend on:

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.^{4–9} 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.

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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.

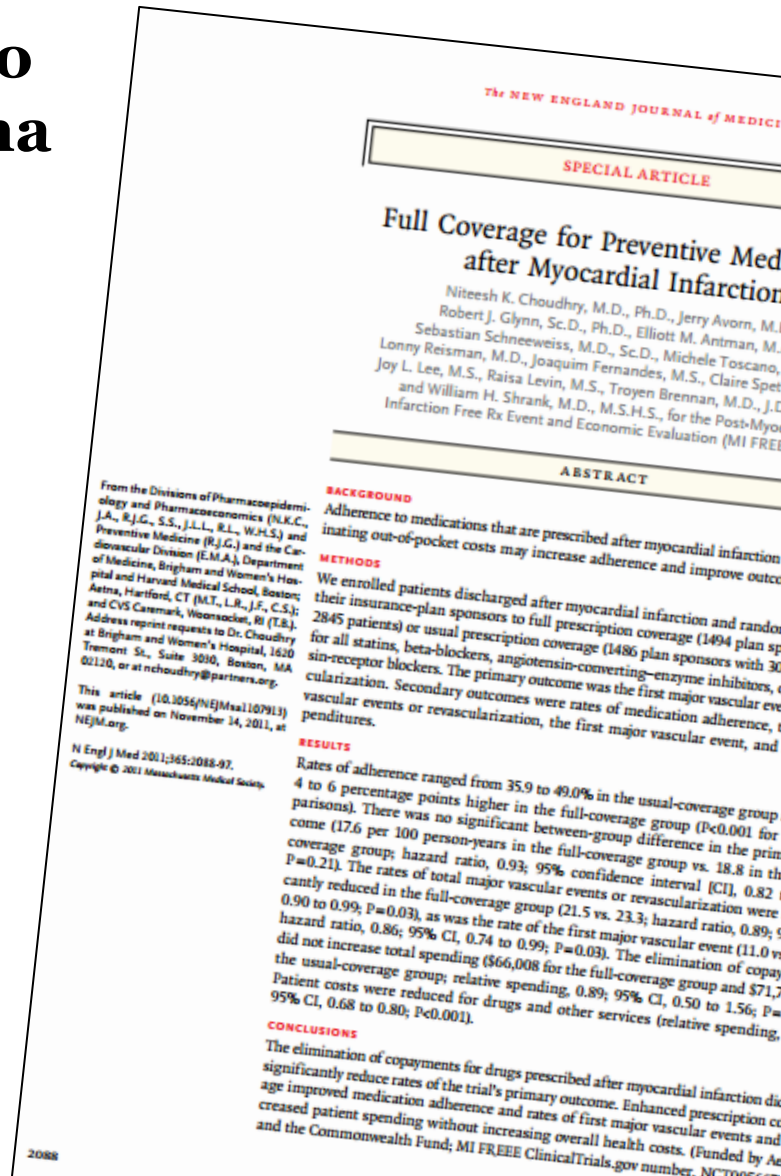
Study Data And Methods

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 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.

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

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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.

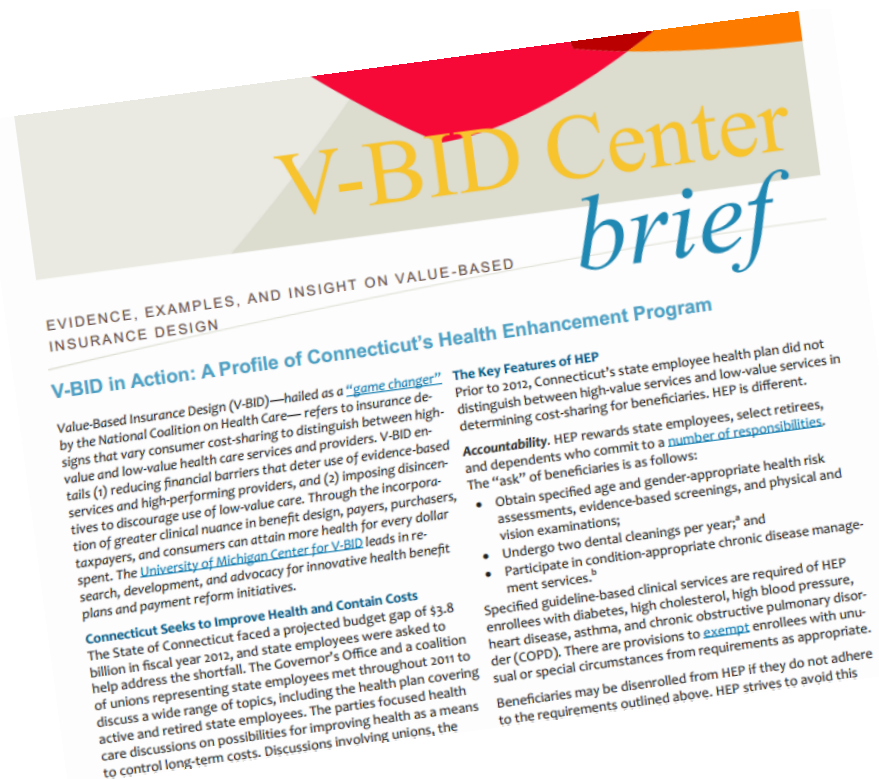
U.S. Sen. Johnny Isakson, R-Ga.

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

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

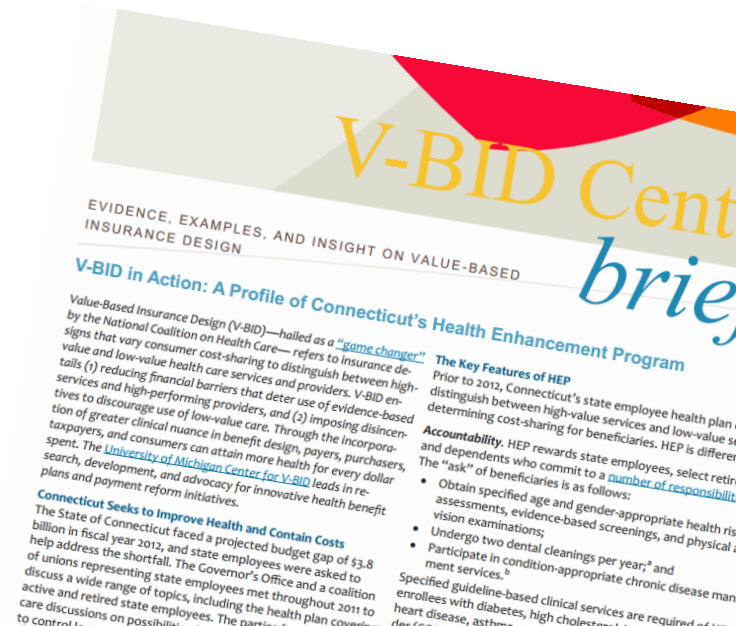
Value-Based Insurance Design Growing Role in State Health Reform

- **State Employees Benefit Plans**
 - Connecticut
 - Oregon
 - Virginia
 - Minnesota
 - Maine
 - **State Exchanges**
 - Maryland
 - California
 - **CO-OPs**
 - **Medicaid**
- 
- EVIDENCE, EXAMPLES, AND INSURANCE DESIGN
- V-BID in Action: A Case Study of the State of Connecticut**
- Value-Based Insurance Design (V-BID) is a strategy developed by the National Coalition on Value-Based Insurance (NCVI) that aims to reduce costs and improve health care quality by designing incentives that encourage providers to deliver high-value care. V-BID can be implemented in a variety of ways, including through contracts with providers, through the use of performance-based contracts, and through the use of shared savings arrangements. The State of Connecticut has implemented V-BID through a variety of mechanisms, including through the use of performance-based contracts with providers, through the use of shared savings arrangements, and through the use of a variety of other mechanisms. The State of Connecticut has implemented V-BID through a variety of mechanisms, including through the use of performance-based contracts with providers, through the use of shared savings arrangements, and through the use of a variety of other mechanisms.
- Connecticut Seeks to Implement Value-Based Insurance Design**
- The State of Connecticut is seeking to implement Value-Based Insurance Design (V-BID) as a way to reduce costs and improve health care quality. The state is currently in the process of developing a V-BID program that will be implemented in fiscal year 2018. The program will be designed to encourage providers to deliver high-value care by offering them incentives for doing so. The state is currently in the process of developing a V-BID program that will be implemented in fiscal year 2018. The program will be designed to encourage providers to deliver high-value care by offering them incentives for doing so.

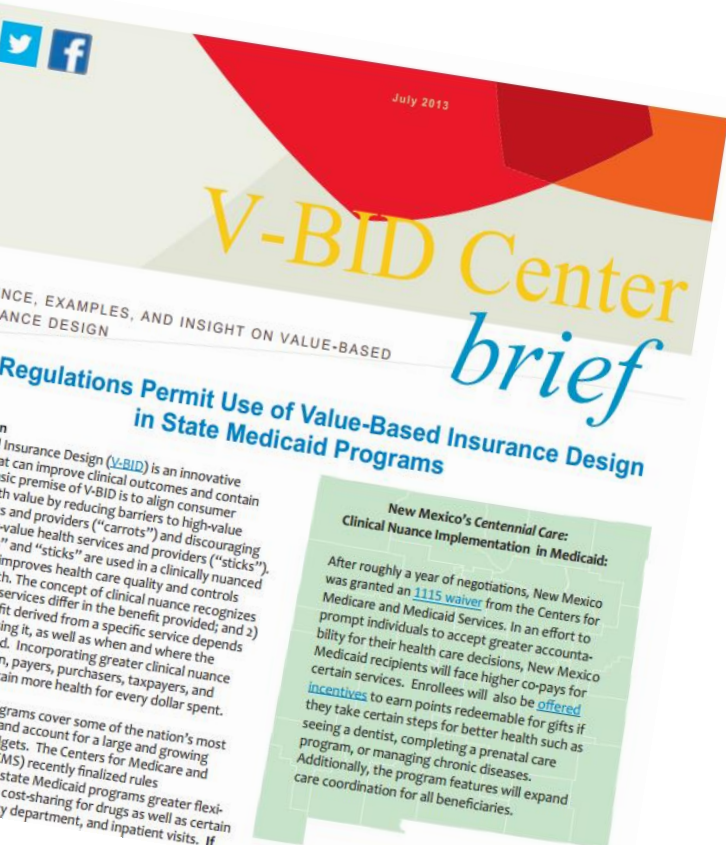


Implementing V-BID for State Employees: Connecticut State Employees Health Benefit Plan

- **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



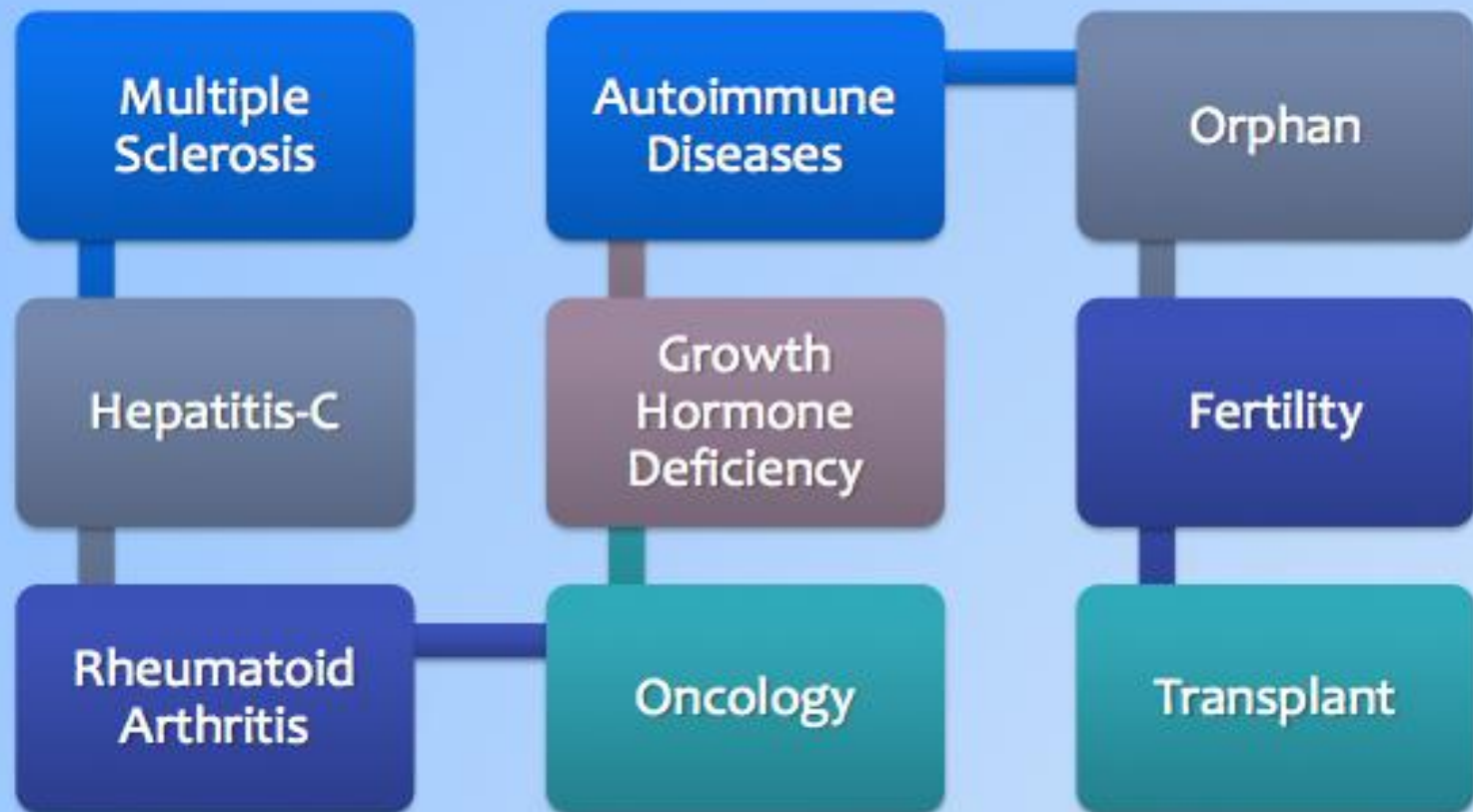
- Plans may vary cost-sharing for drugs, outpatient, inpatient, and emergency department visits
- Plans may target cost-sharing to specific groups of individuals based on clinical information (e.g., diagnosis, risk factors)
- Plans may vary cost-sharing for an outpatient service according to where and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

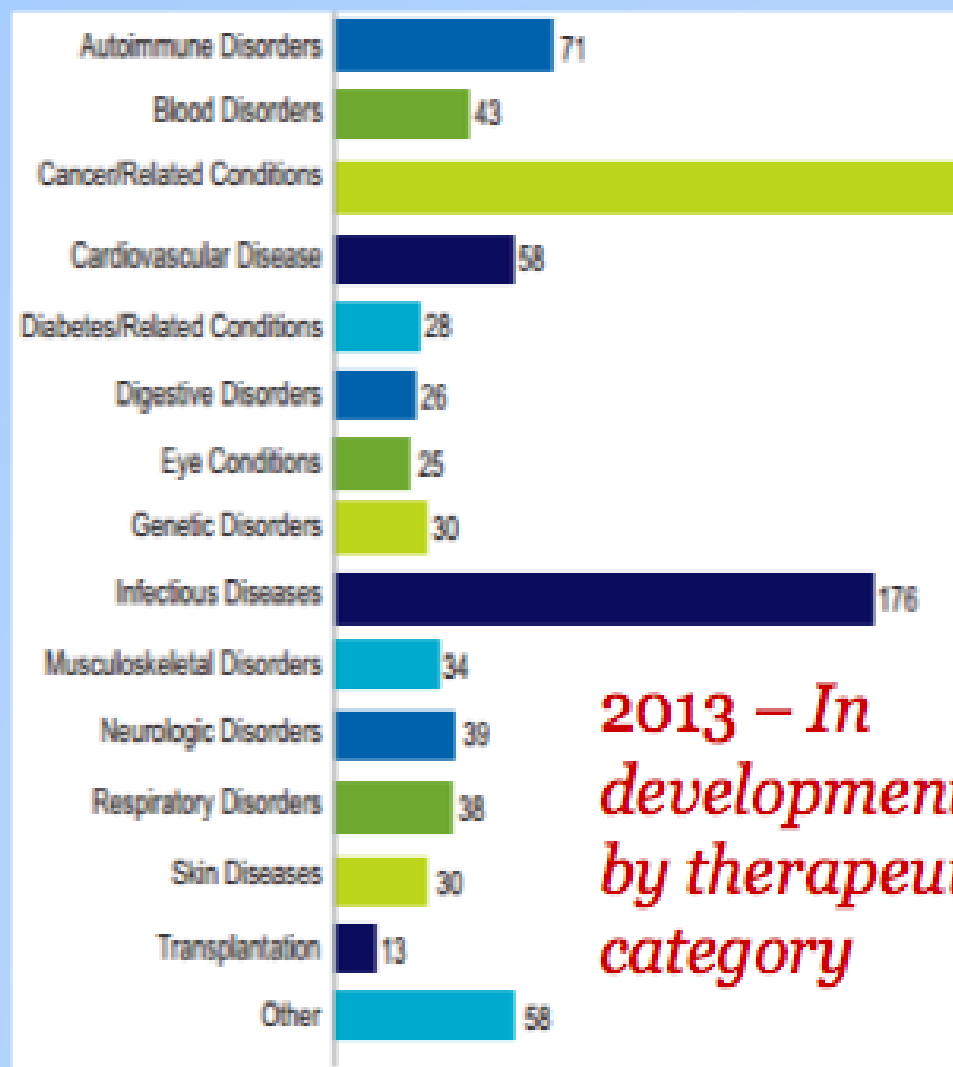
Specialty Drugs: Therapy Classes



Specialty medicines are prescription drugs that require special handling/administration and/or a higher level of patient care management ... and high cost!

Advances in Biotechnology

- The following 3 categories account for more than half of all spend:
 - Cancer
 - Rheumatoid Arthritis
 - Multiple Sclerosis
- Approximately 50%-60% of specialty drugs are represented by the oncology category



*2013 – In
development
by therapeutic
category*

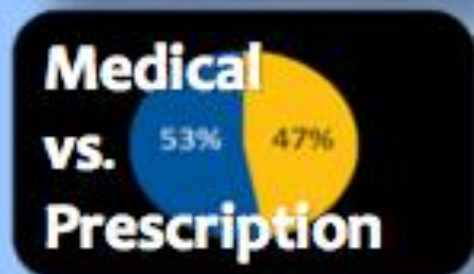
Trends & Opportunities



- 600+ drugs in the pipeline over the next 5–8 years
- Oncology represents about 45% of the pipeline
- 35% of oncology and 64% of non-oncology may be self-administered



- 46 biotech products with patent expirations through 2020*
- \$31.5 billion biosimilar opportunity
- Interchangeable alternatives will greatly affect management options and cost



- Significant amount of specialty drug spend is on the medical benefit
- Frequently administered in high cost places of treatment
- Limited ability to apply critical health and safety checks

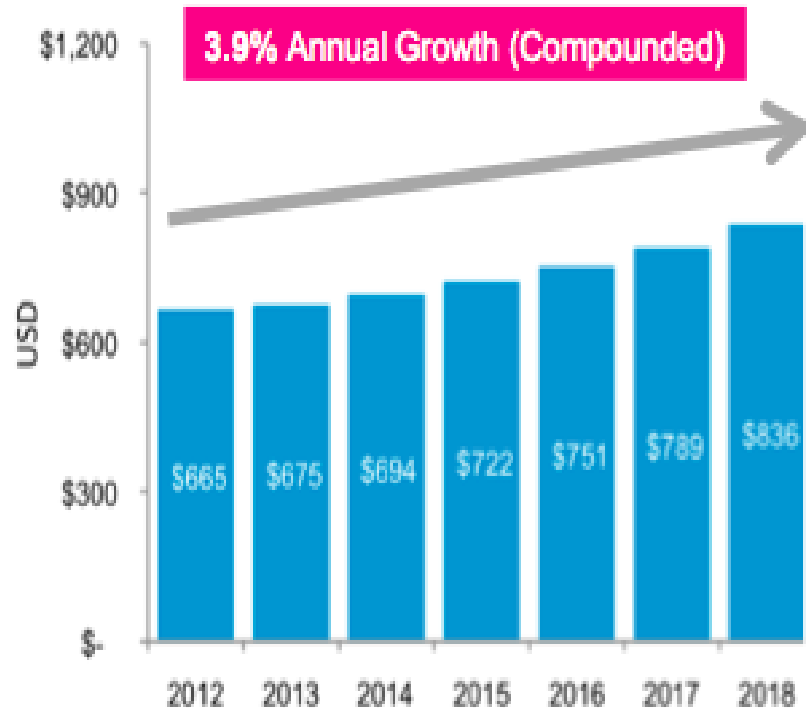


- Specialty pipeline will continue to produce high- cost drugs
- Growing impact on the viability of Benefit Plans
- Question of coverage for a small number of high cost patients vs. the whole patient population

SPECIALTY DRUG SPEND TO SURPASS TRADITIONAL SPEND BY 2018

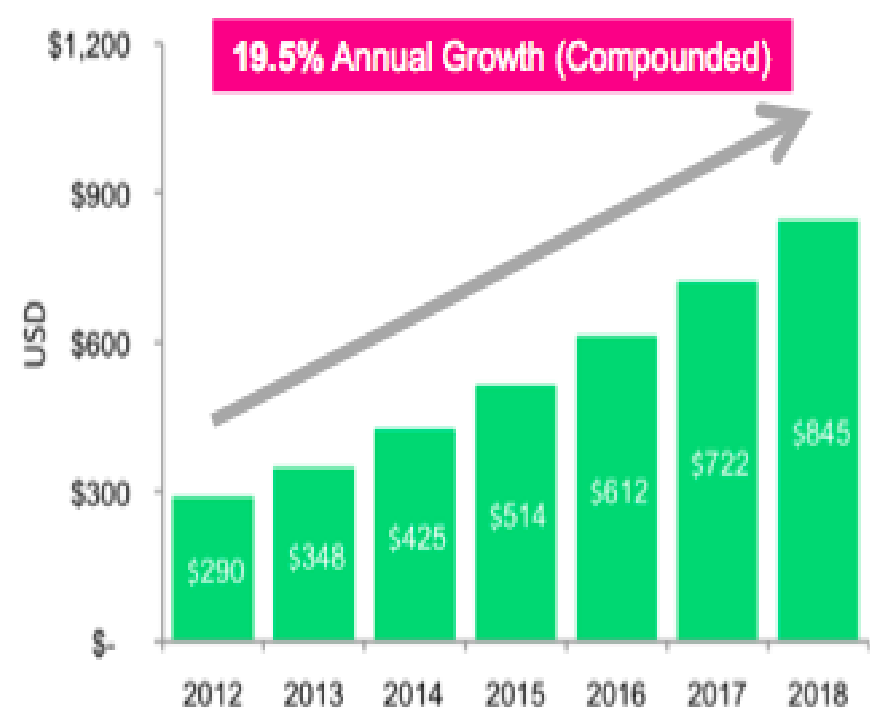
Traditional Drug Spend (Pharmacy + Medical)

PMPY Net Spend for Commercial Plan Sponsors¹



Specialty Drug Spend (Pharmacy + Medical)

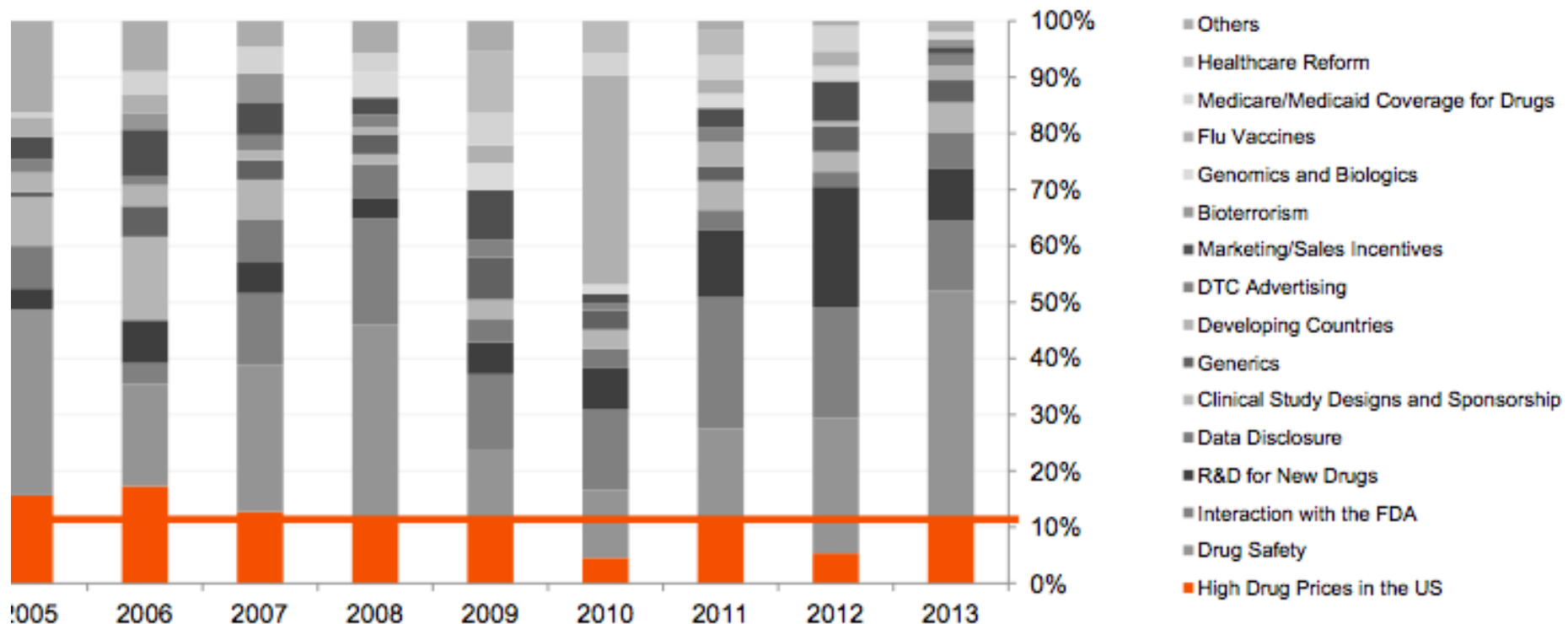
PMPY Net Spend for Commercial Plan Sponsors¹



The ability to manage total Specialty pharmacy care and spend will become increasingly important for clients

Old News?

Top ranking pharma issues that dominated the news, 2005 - 2013



CUT PRICES ON DRUGS.

Chicago Daily Tribune (1872-1922); Jan 15, 1893;
pg. 16

CUT PRICES ON DRUGS.

ARRANGING TO CARRY THE CON- FLIOT INTO THE COURTS.

**Economical Company Will Endeavor to
Prove That the Retailers and the
Wholesalers in the City Have Entered
Into a Conspiracy to Drive It Out of
Business—The Regular Dealers Accused
of Extortion—What Suburban Apothec-
aries Have to Say of the War.**

The determination of the Economical Drug
company to carry the drug war to the courts
and determine whether or not it has a right to
conduct a store at a reasonable rate of profit,
even though it conflicts with the usual prac-

1893



2014

DRUG PRICES SOAR

Morphine Going Up \$1 Per Ounce a Day and Quinine Follows

In the last two weeks there has been a big jump in the price of drugs, and, as regards opiates, which are practically a necessity in medical practice, a shortage exists which seems critical.

Morphine and codeine, which are derived from opium, can be purchased only in small quantities, and the prices asked are almost fabulous. Quotations on these drugs in the last two weeks have increased at the rate almost of \$1 per ounce a day, wholesale, and to the consumer, of course, the price is much higher. The quotations, good only for the day, are \$50. Two weeks ago the drugs were selling at \$14.

The reasons given for the phenomenal rise are the failure of the opium crop in India, and the great demand for these drugs because of the war. No new opium is coming into the country, and there will soon be a shortage that will make the drug as precious as any jewel.

Quicksilver, which in normal times is quoted from \$35 to \$40, is now \$150 per 75 pound flask. Permanganate of potassium, a disinfectant, is now \$1.50 a pound; before the war it was 12 cents a pound. As this comes principally from Germany, the high price is easily explained.

Quinine is 50 percent higher, and continues to go up. Camphor is 50 percent higher than two years ago.

1917

DRUG PRICES HERE HELD INEQUITABLE

Citizens Group Urges New Congressional Hearing

By EDWARD C. BURNS

A citizens group charged yesterday that congressional drug pricing laws, in an earlier act, were inequitable and that the public, after paying a high price for drugs, is forced to pay a still higher price for the same drugs in the hospital, where the patient is unable to pay the full price.

American, World Feel They Pay Too

By J. H. H. H. H.

WASHINGTON, April 8.—Senator Estes Kefauver opened a new campaign today for lower drug prices.

The Tennessee Democrat, introducing his bill, told the Senate it would require compulsory bidding "only for those drugs whose prices are clearly excessive, and as a rough measure of what constitutes a clearly excessive price I have taken the figure of 500 per cent."

10,000% Drug Mark-up Cited

Kefauver Seeking Answer To Reduce Drug Prices

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Dilemma in Health Care: Rising Cost and Demand

By ROBERT M. LAMONT

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2014

Americans, World's No. 1 Pill Takers, Feel They Pay Too Much for Drugs

By Roger D. Greene
Associated Press

Americans are the world's greatest pill takers. They pay nearly \$50 million a year to swallow about 53 million aspirin a day. They gulp nearly \$230 million worth of vitamin capsules annually.

They order almost 400 million prescriptions a year at a cost of nearly a billion dollars.

That's a big bill. So big, in fact, that a great many Americans are complaining about its size.

Surveys show that from 64 to 71 per cent of all drug customers think they're paying too

example, they point to the fact that six companies gambled millions of dollars to mass produce a polio vaccine before they knew the result of mass tests.

Because of such expensive activities, the industry contends, today's prescription dollar is worth more than ever.

\$10 a Year-Per Capita

Theodore G. Lumpp, president of the National Pharmaceutical Council, says the average per capita cost of drugs is about \$10 a year, compared with \$55 for alcoholic beverages, \$32 for tobacco and \$11 for auto repairs.

Is the druggist getting rich?

A survey by Eli Lilly & Co., one of the leading United States drug manufacturing firms, noted that the average retail druggist has an income of \$12,825 a year. But he usually works long hours, including Sundays and holidays.

By comparison, the United States Department of Commerce says the average physician has an income of \$12,518; the average lawyer \$9,375 and the dentist \$7,743.

With the drug industry growing swiftly, the agency is hard pressed to police it efficiently, Larrick says, adding: "We have

LONG PLANS INQUIRY ON PRICING OF DRUGS

WASHINGTON, July 23 (AP) — Senator Russell B. Long said today he was planning an investigation of drug prices and Federal health programs.

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



Improving Care and Bending the Cost Curve

- The ultimate test of health reform will be whether it improves health and addresses rising costs
- V-BID should be part of the solution to improve quality and enhance the efficiency of health care Medicare spending

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



Discussion

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