Supporting Value-Based Cancer Care:

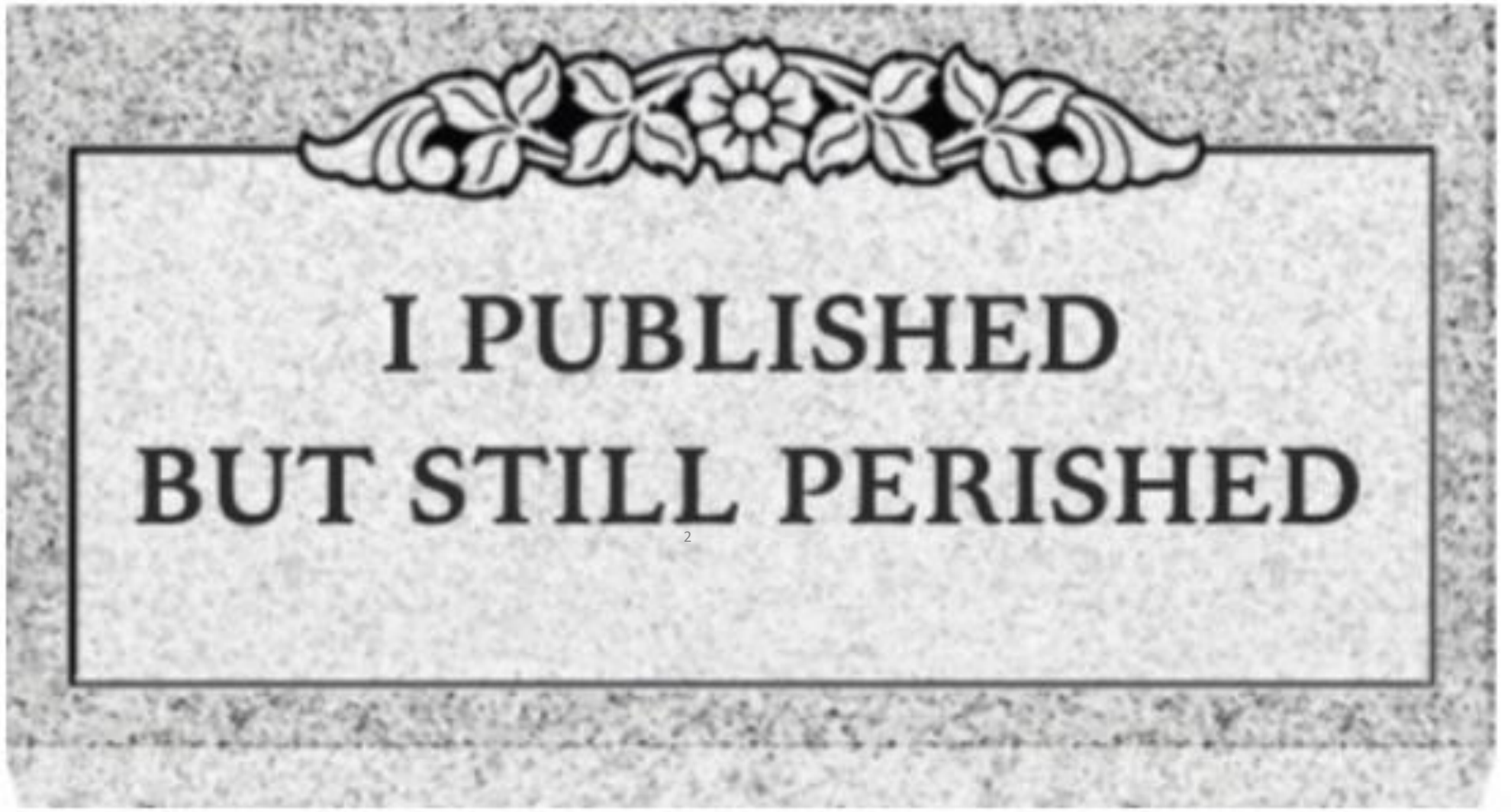
Put Patients First

A. Mark Fendrick, MD

University of Michigan Center for
Value-Based Insurance Design

www.vbidcenter.org
(slide deck and resouces available here)

@um_vbid


I PUBLISHED
BUT STILL PERISHED

Presentation of the Okon Cup, 1974

Health Care Costs Are a Top Policy Issue:
Solutions must protect consumers, reward providers and preserve innovation

- Innovations to prevent and treat malignancy have led to impressive reductions in morbidity and mortality
- Irrespective of these remarkable clinical advances, cutting health care spending is the main focus of reform discussions (how much)
- The well-meaning intentions of many ‘value-based’ health care policies, such as utilization management, health plan benefit design and Drug Price Negotiation, that aim to lower spending often clash with far more meaningful metrics such as patient-centered outcomes and health equity (how well)

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Change the health care cost discussion from “How much” to “How well”

- Everyone (almost) agrees there is enough money in the US health care system; we just spend it on the wrong services, in the wrong places, at the wrong time
- Most current clinician payment programs and consumer benefit designs pay little attention to improving patient outcomes, enhancing equity and increasing value
- Moving from a volume-driven to value-based system requires a change in both how we pay for care and how we engage consumers to seek care

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Change the health care cost discussion from “How much” to “How well”

- Everyone (almo… …oney in the US health care sys… …wrong services, in the wrong pl…
- Most current c… …nd consumer benefit design… …ving patient outcomes, enh… …value
- Moving from a… …d system requires a char… …re and how we engage consun…

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Change the health care cost discussion from “How much” to “How well”
Are we spending too much or too little on oncology care?

- Answering this question starts with an honest assessment of which services are high-value, and which are low-value
- Underutilization of high-value services and providers persists across the entire spectrum of oncology care leading to poor health outcomes and worsening health care disparities
- Spending on low-value services -- such as unnecessary tests or ineffective treatments that provide little or no benefit to patients, and can even cause harm --is rampant
- Our ability to deliver high-quality health care lags behind the rapid pace of scientific innovation

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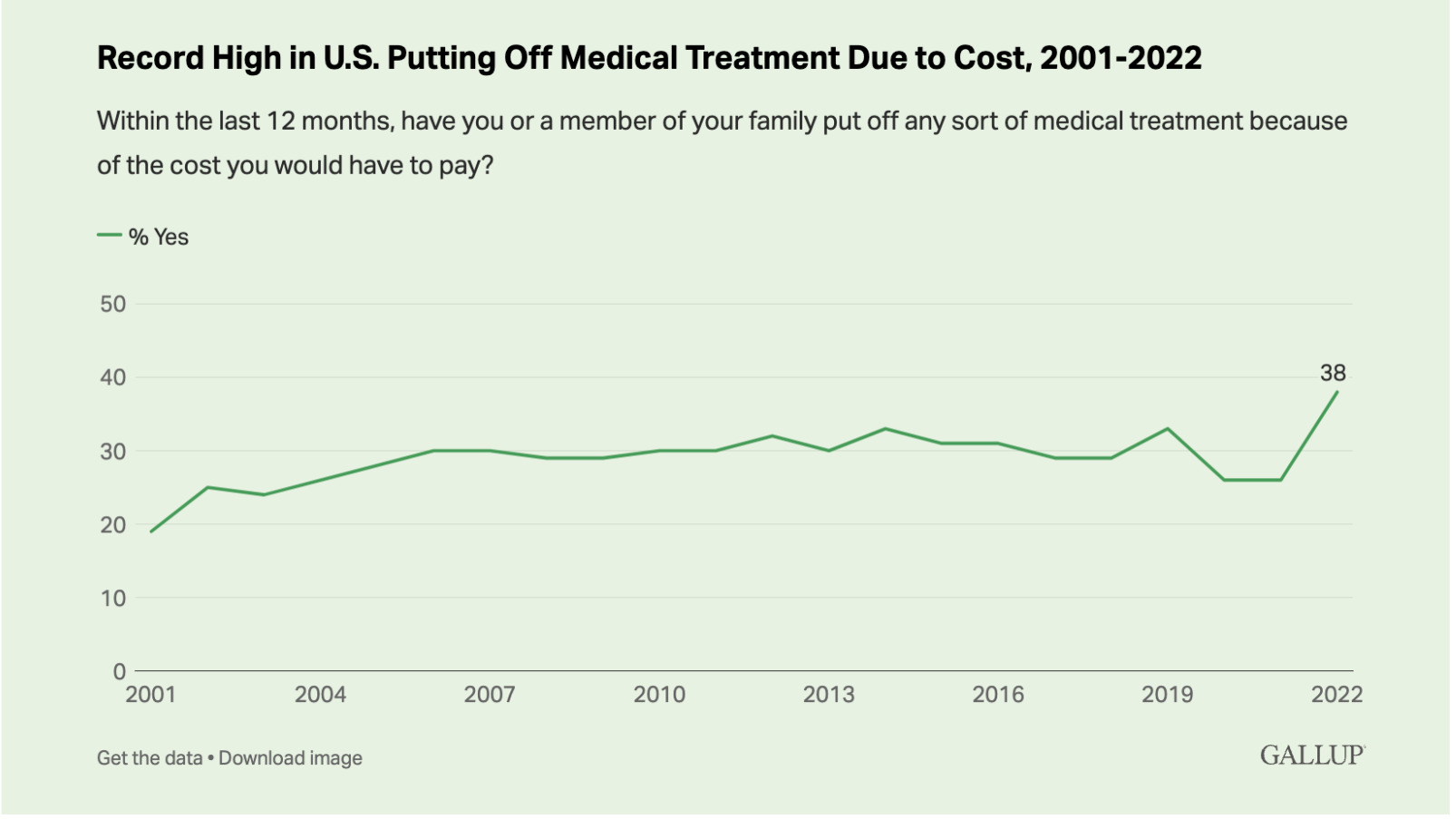
Star Wars Science

Flintstones Delivery

Patient Cost Sharing: Americans Do Not Care About Health Care Costs; They Care About What It Costs Them



- Deductibles – the most common form of patient cost sharing – is a 'blunt' instrument, in that patients pay out of pocket for ALL care regardless of clinical value
- Health care costs are among the leading causes of:
  - Personal debt
  - Personal bankruptcy
  - On-line fundraisers

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Inspiration (Still)

> 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, 1934-2024)

“Blunt” Cost-Sharing Worsens 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]

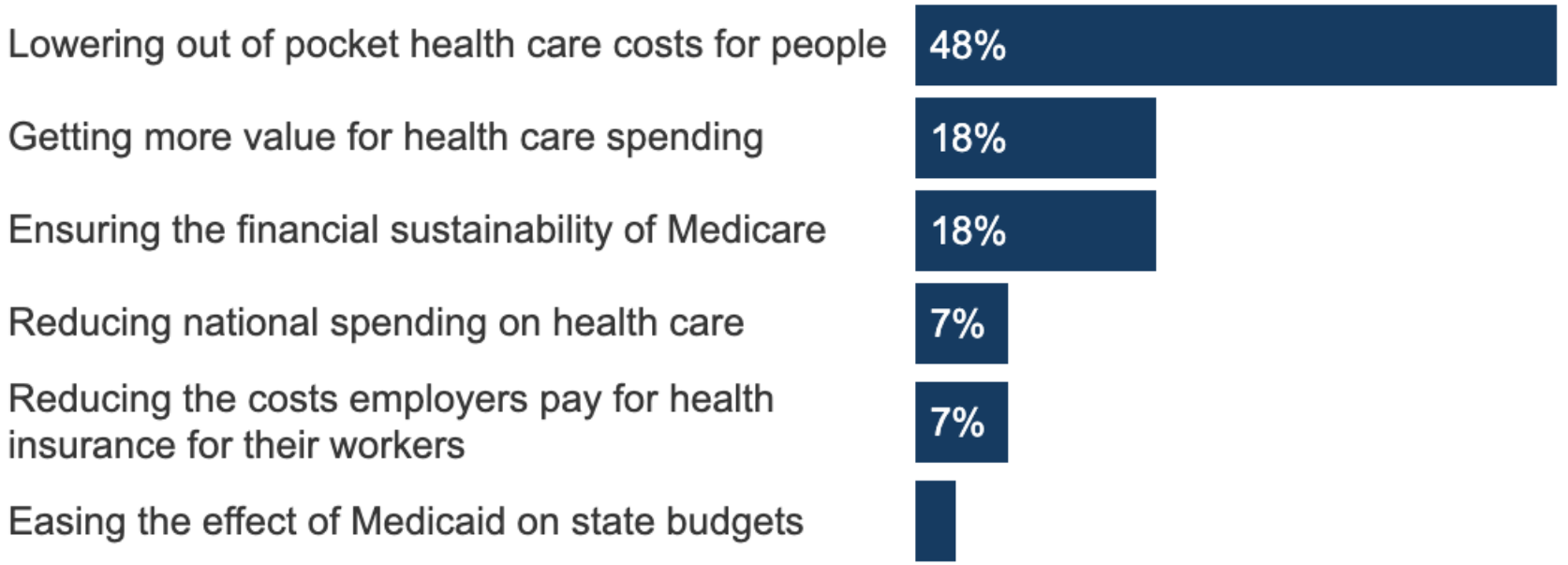
Cost-sharing worsens disparities and adversely affect health, particularly among economically vulnerable individuals and those with chronic conditions

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

Americans Do Not Care About Health Care Costs; They Care About What It Costs Them

Most Voters Say Out Of Pocket Costs Are Top Health Priority

Which of the following health care priorities do you think is most important for the country to address?



NOTE: Among registered voters. See topline for full question wording.
SOURCE: KFF Health Tracking Poll (Jan. 30-Feb. 7, 2024) • Get the data • PNG

KFF

Alternative to “Blunt” Consumer Cost-Sharing: A Clinically Nuanced Approach

A “smarter” cost-sharing approach that encourages consumers to use more high value services and providers, but discourages the use of low value ones

A Clinically Nuanced Alternative to "Blunt" Consumer Cost-sharing: Value-Based Insurance Design - More of the Good Stuff and Less of the Bad Stuff

- Sets consumer cost-sharing on clinical benefit – not price
- Little or no out-of-pocket cost for high-value care; higher cost-sharing for low-value care
- Implemented by hundreds of public and private payers
- Bipartisan political support
- Improves health outcomes
- Enhances equity

Value-Based Insurance Design: Aligning Incentives, Benefits, and Evidence in Oncology

Jonas A. de Souza, Mark J. Ratain and A. Mark Fendrick

***J Natl Compr Canc Netw* 2012;10:18-23**

Putting Innovation into Action: Translating Research into Policy

THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

ACA 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)

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ASSISTANT SECRETARY FOR PLANNING AND EVALUATION

ISSUE BRIEF

January 11, 2022

HP-2022-01

Access to Preventive Services without Cost-Sharing: Evidence from the Affordable Care Act

- Over 230 million Americans have enhanced access to preventive services
  - 150 M with private insurance – 58 M women and 37 M children
  - 61 million Medicare beneficiaries
  - Approximately 20 million Medicaid adult expansion enrollees
- The majority of studies showed increased use of fully covered services
- Studies that included socioeconomic status reported more substantial increases in utilization of preventive services in financially vulnerable patients, suggesting that the policy reduced disparities

BRAIDWOOD V BECERRA

A Texas Judge Just Invalidated The Preventive Services Mandate. What Happens Next?

Nicholas Bagley, A. Mark Fendrick

MARCH 30, 2023 10.1377/forefront.20230330.177353

Several outstanding questions remain, but it is possible that this ruling will mean that qualified payers will no longer have to provide first-dollar coverage for the 50+ services that have received an “A” or “B” rating from the U.S. Preventive Services Task Force (after March 2010) as well as those receiving future “A” or “B” rating


Cancer Screening

ACA Sec 2713: Selected Cancer Screenings Provided without Cost-Sharing

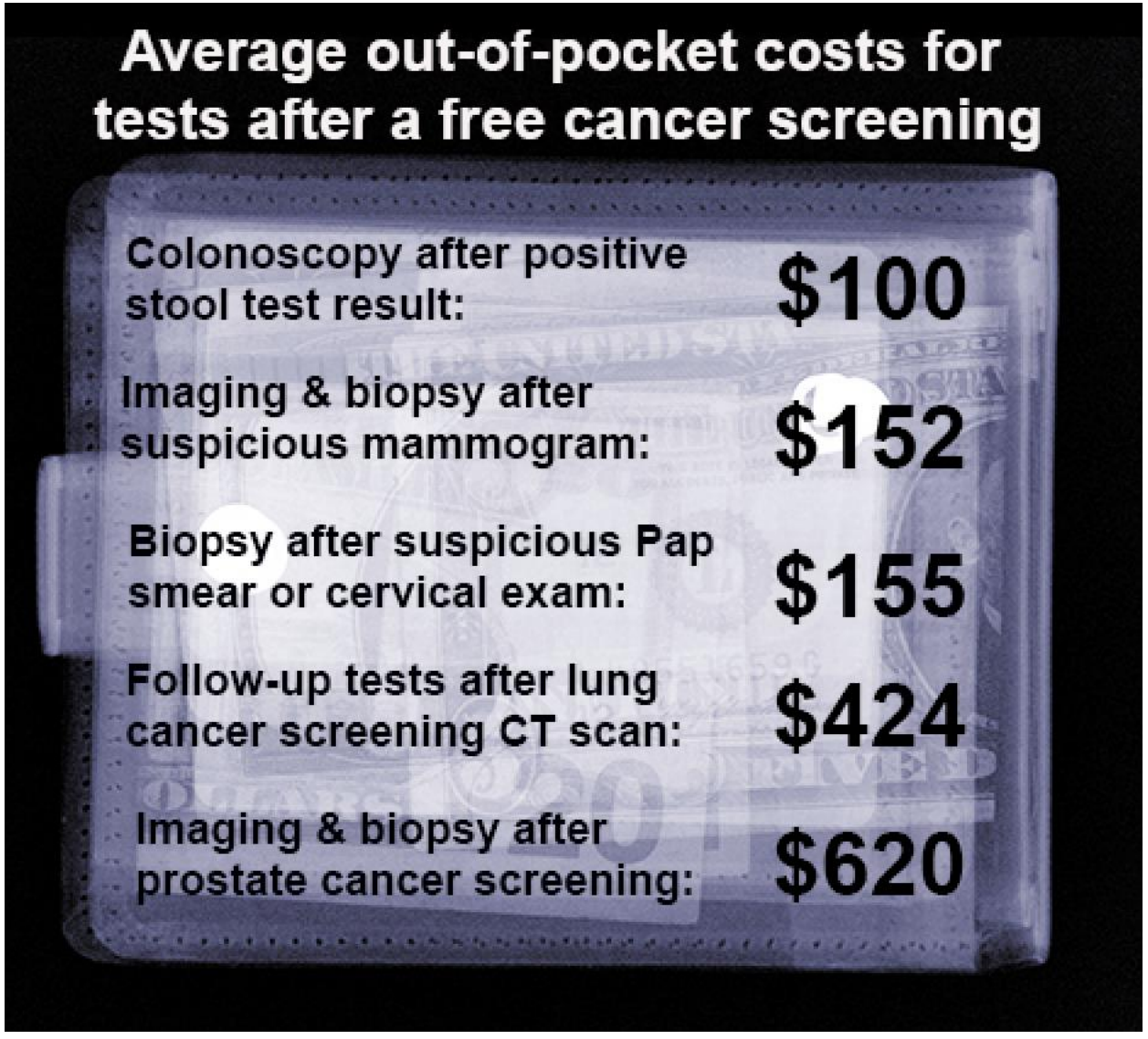
Cancer screening receiving an A or B rating from the United States Preventive Services Taskforce (USPSTF)

- Breast
- Cervical
- Colorectal
- Lung

Your Free Cancer Screen Shows Trouble: What If You Can't Afford the Follow-Up?

Although patients receive *initial* cancer screening test without cost sharing, they frequently to pay out of pocket for necessary diagnostic follow up testing

- Breast
- Cervical
- Colorectal
- Lung
- Prostate



- JAMA Network Open. 2021;4(8):e2121347
- Obstetrics & Gynecology. 2022;139(1): doi:10.1097/AOG.0000000000004582
- JAMA Network Open. 2021;4(12): doi:10.1001/jamanetworkopen.2021.36798
- JACR E-pub ahead of print. 2021.DOI:https://doi.org/10.1016/j.jacr.2021.09.015
- *Cancer*. 2024; 1-6. doi:10.1002/cncr.35392

RESEARCH ARTICLE https://doi.org/10.1158/2767-9764.CRC-23-0322

Impact of Eliminating Cost-Sharing by Medicare Beneficiaries for Follow-Up Colonoscopy After a Positive Stool-based Colorectal Cancer Screening Test

A. Mark Fendrick[1], David Lieberman[2], Jing Voon Chen[3], Vahab Vahdat[3], A. Burak Ozbay[3], and Paul J. Limburg[3]

Significance: A follow-up colonoscopy after a positive stool-based colorectal cancer screening test is necessary to complete the full screening process. Policies that remove cost barriers to completing colorectal cancer screening may lead to increases in overall participation rates and use of follow-up colonoscopy, improving clinical and economic outcomes.

FAQS ABOUT AFFORDABLE CARE ACT IMPLEMENTATION PART 51, FAMILIES FIRST CORONAVIRUS RESPONSE ACT AND CORONAVIRUS AID, RELIEF, AND ECONOMIC SECURITY ACT IMPLEMENTATION

January 10, 2022

Q7: Are plans and issuers required to cover, without the imposition of any cost sharing, a follow-up colonoscopy conducted after a positive non-invasive stool-based screening test or direct visualization test (e.g., sigmoidoscopy, CT colonography)?

Yes. A plan or issuer must cover and may not impose cost sharing with respect to a colonoscopy conducted after a positive non-invasive stool-based screening test or direct visualization screening test for colorectal cancer for individuals described in the USPSTF recommendation. As stated in the May 18, 2021 USPSTF recommendation, the follow-up colonoscopy is an integral part of the preventive screening without which the screening would not be complete.[31] The follow-up colonoscopy after a positive non-invasive stool-based screening test or direct visualization screening test is therefore required to be covered without cost sharing in accordance with the requirements of PHS Act section 2713 and its implementing regulations.

American Cancer Society Position Statement on the Elimination of Patient Cost-Sharing Associated with Cancer Screening and Follow-up Testing

- It is the position of the ACS that cancer screening should be understood as a continuum of testing rather than a single screening test
- Screening is a process that includes a recommended screening test and all follow-up tests described as diagnostic and judged to be integral and necessary to resolve the question of whether an adult undergoing screening has cancer.
- These tests should be covered without any patient cost-sharing consistent with the 2022 FAQ specifying no patient cost-sharing for follow-up colonoscopy after a positive non-colonoscopy colorectal cancer screening examination.
- Insurers must cover and should not impose cost-sharing for these recommended examinations, regardless of the patient's designated risk.

Cancer Screening Coverage
Community Oncology Alliance Position Statement

Community Oncology Alliance Position

COA supports eliminating cost sharing for all clinically indicated steps of screenable cancers recommended by the USPSTF up to, and including, the determination of a specific diagnosis. Eliminating cost sharing for only an initial screening is not sufficient to achieve the true purpose and potential clinical benefit of cancer screenings. COA advocates for an extensive re-examination of cancer screening coverage and further study, and the impact of cost-sharing on access, equity, and clinical outcomes.

Breast, cervical, colorectal, and lung cancer should be identified and codified as screenable cancers. A screening protocol and insurance design should be created that includes the core components of the screening process in order to motivate the target population to access screening and eliminate cost-sharing for the complete chain of screening tests to enable the immediate development of a specific staging and subsequent treatment plan without the need for further pathologic testing.


DEPARTMENT OF HEALTH & HUMAN SERVICES · USA
Medicare

High Out of Pocket Costs are Common and Impactful For Medicare Beneficiaries

- One-third of Medicare beneficiaries said it was somewhat or very difficult to afford health care costs, including half of people under age 65
- More than one in four Medicare beneficiaries said health care costs made it harder for them to afford food and utility bills in the past 12 months
- More than one in five Medicare beneficiaries said they or a family member delayed or skipped needed care because of the cost in the past 12 months

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Inflation Reduction Act of 2022 Includes Several V-BID Elements

While has been paid to the IRA's drug price negotiation provision, that's not where the real action is on improving patient affordability

- As of January 2023, Medicare Part D beneficiaries no longer have cost sharing for adult vaccinations recommended by the Advisory Committee on Immunization Practices (such as the shingles vaccine)
- Those using insulin now pay no more than $35 per month for their supply
- Starting in 2025, the IRA caps annual out-of-pocket spending for Medicare Part D beneficiaries to $2,000 per year
- Allows patients to spread their cost-sharing over 12 months

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RESEARCH REPORT

July 7, 2023

HP-2023-19

—Inflation Reduction Act Research Series— Medicare Part D Enrollee Out-Of-Pocket Spending: Recent Trends and Projected Impacts of the Inflation Reduction Act

In 2025, these IRA Part D drug-related provisions will lead to an estimated $7.4 billion reduction in out-of-pocket spending for 18.7 million enrollees per year (36% of part D enrollees), or an average savings of $400 per affected enrollee

COMMENTARY · MEDICAL COSTS

If you have insurance, you shouldn't be paying full price for insulin

BY MARK FENDRICK AND DAVID A. RICKS

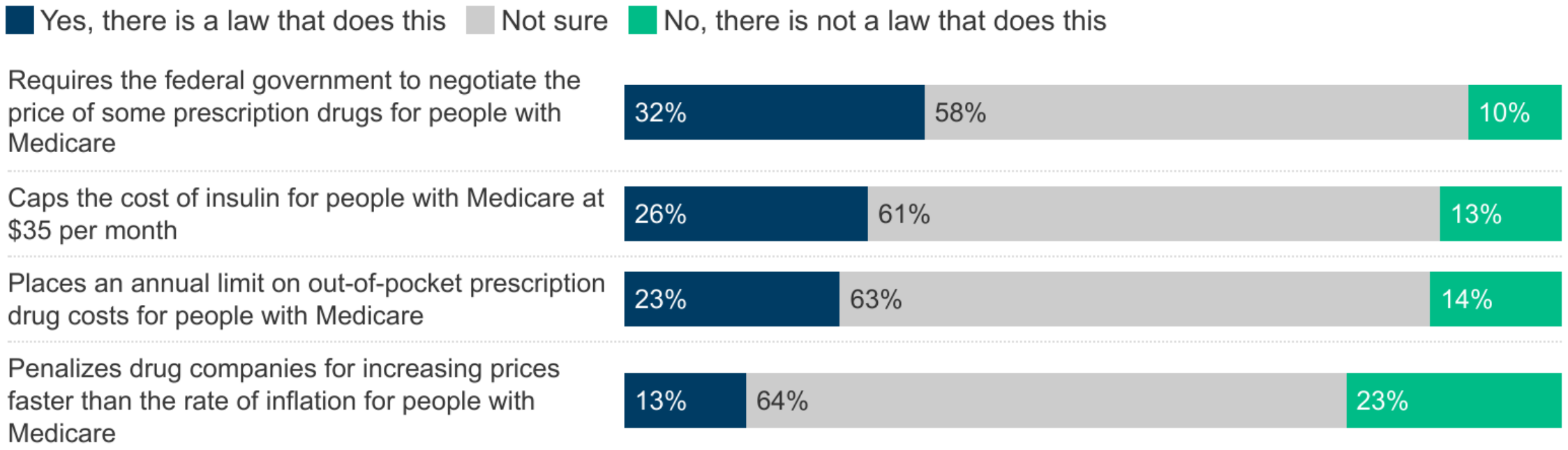
January 29, 2020 at 4:06 PM EST

We have succeeded in lowering the out-of-pocket cost for preventive care and insulin, why not essential oncology care?

Figure 12

Majorities Of The Public Do Not Know About Inflation Reduction Act Provisions

As far as you know, is there a federal law in place that...



NOTE: See topline for full question wording.
SOURCE: KFF Health Tracking Poll (Oct. 31-Nov. 7, 2023)

KFF

On Drug Price Negotiation: Put Patients First

- Hurdles to cancer patients receiving essential care long precede the drug price negotiation efforts undertaken by IRA and PDABs.
- When price is the sole consideration, a better, more expensive medication might seem like a poor choice compared to lower cost, but less effective alternatives.

On Drug Price Negotiation: Put Patients First

How To Make Sure The Inflation Reduction Act Works For All Patients

A. Mark Fendrick

AUGUST 24, 2023

10.1377/forefront.20230823.186201

- IRA requires negotiated medicines to be covered on Part D formularies (good for patients for whom these are the best choice)
- Patients with conditions treated by negotiated drugs but need an alternative treatment option may have deterred access:
    - Formulary placement
    - Utilization management (e.g., step-therapy, prior authorization)
    - Non-medical switching

On Drug Price Negotiation: Put Patients First

CMS Must Obtain Clinician Input Today To Prevent Part D Access Barriers Tomorrow

A. Mark Fendrick

DECEMBER 14, 2023

10.1377/forefront.20231213.586694

CMS and State PDABs ought to:

- Establish clinician advisory panels throughout the negotiation process.
    - Publish how that input was used after decisions are finalized.
- Monitor access to available treatment options for conditions treated by negotiated drugs

On IRA/PDAB Drug Provisions: Put Patients First

CMS Should Do More To Fulfill The IRA's Promise To Lower Drug Costs For Patients

A. Mark Fendrick

AUGUST 12, 2024

10.1377/forefront.20240809.62571

- The IRA includes valuable new benefits that are likely to enhance use of essential medications and ultimately reduce health care disparities and improve patient-centered outcomes.
- To optimize the impact of these policies, CMS and other stakeholders must act swiftly to raise awareness and ensure robust uptake.
- Stakeholders cannot turn a blind eye to the potential for unintended consequences that could undermine the law's key objective—better access to affordable medications that improve the lives of US seniors.

Funding for More Generous Coverage of High Value Oncology Care: Reduce Spending on Low Value Care

- Increase premiums – politically not feasible
- Raise deductibles and copayments – 'tax on the sick'
- Reduce spending on low value care

$345 BILLION

Examples include:

Vitamin D screening tests

Diagnostic tests before low-risk surgery

PSA screening for men 70 and older

Branded drugs when identical generics are available

Low-back pain imaging within 6 weeks of onset

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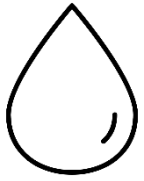
The Utilization and Costs of Grade D USPSTF Services in Medicare, 2007–2016

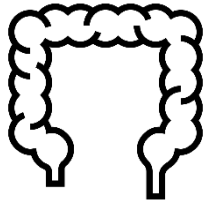
Carlos Irwin A. Oronce, MD, MPH[1,2], A. Mark Fendrick, MD[3], Joseph A. Ladapo, MD, PhD[4], Catherine Sarkisian, MD, MSPH[5,6], and John N. Mafi, MD, MPH[4,7]

The 7 most commonly ordered USPSTF D rated services are used over 30 million times a year at a cost to the Medicare program of over $500 Million annually



Prostate cancer screening ≥ 70 years

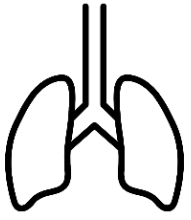
Cervical cancer screening > 65 years



Colon cancer screening >85 years

Cardiovascular screening in low risk patients

Asymptomatic bacteriuria screening



COPD screening

Vitamin D to prevent falls among older women

Enhancing Access and Affordability to Essential Oncology Services

- Reduce consumer cost-sharing on high-value, essential oncology services
  - Follow *Braidwood v Becerra* Case
  - Remind your Medicare patients about the new annual out-of-pocket drug cap and to enroll in the Medicare Prescription Payment Plan
  - Monitor drug access for conditions which include a negotiated drug
- Identify, measure and reduce low-value care to reduce waste and pay for more generous coverage of high-value care
- Implement clinically-driven payment reform, technologies and benefit designs that increase use of high-value services and deter low value care

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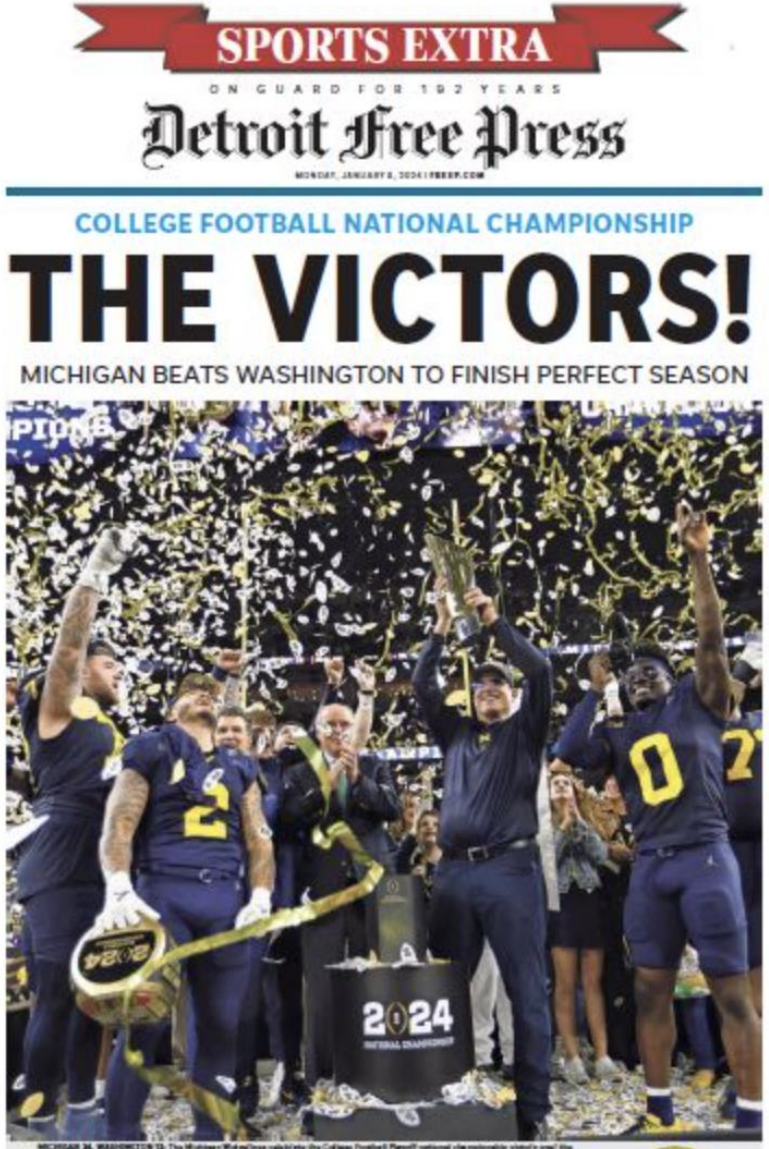
“If we don’t succeed then we will fail.”

Dan Quayle

Thank you and welcome to the BIG10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Detroit Free Press

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THE VICTORS!

MICHIGAN BEATS WASHINGTON TO FINISH PERFECT SEASON

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