Same Condition, Different Costs: Should Patients Pay Different Amounts?

Webinar
July 18, 2017
Average Worker Contributes Financially in Multiple Ways

2006

<table>
<thead>
<tr>
<th>Premiums</th>
<th>Deductibles</th>
<th>Cost-Sharing</th>
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<td>$8,508</td>
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<td>$2,973</td>
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Monthly Out-of-Pocket Cost-Sharing Varies Widely Based on Tier Placement

Kaiser/HRET Survey of Employer-Sponsored Health Benefits 2016. Assumes specialty drug cost $3,000/month
“What would happen if, instead, health plans offered more generous coverage of high-value care, but less generous coverage of those services that provide little or no health benefit?”

Today’s Discussion

• Is it acceptable to have different out-of-pocket costs for the same patients? When is it less acceptable?

• What are the trade-offs to consider making these decisions? From an ethical, legal, or actuarial perspective? From stakeholders’ perspectives?

• What is standing in the way of broader uptake of precision benefit designs?
Discussion

Mark Fendrick
Director
Center for Value-Based Insurance Design
University of Michigan

Cheryl Larson
Vice President
Midwest Business Group on Health

Helen Sherman
Chief Pharmacy Officer
Solid Benefit Guidance
Mark Fendrick

University of Michigan

Director, Center for Value-Based Insurance Design
View Dr. Fendrick’s slides on the V-BID Center website

www.vbidcenter.org

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Jennifer Graff
National Pharmaceutical Council
Vice President of Comparative Effectiveness Research
When is it less acceptable to have different cost-sharing for patients/groups of patients with the same or similar condition?

If we wish to align out-of-pocket patient costs with appropriateness, how do we pay for it?
Multi-Pronged Approach

White papers
- Ethics
- Economics
- Legal
- Payer, Employer, & Patient Perspectives

Expert Roundtable

External Dialogue and Dissemination
Does a One-Size Fits All Cost-Sharing Approach Incentivize Appropriate Medication Use?

Co-authors:
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* White Paper Authors

Roundtable panelists:
- Marc Boutin, JD (National Health Council)
- Doug Burgoyne, PharmD (VRx Pharmacy Services)
- Kim Dwyer (Advocate Health Care)
- Leslie Fish, PharmD (Fallon Community Health Plan)
- Mark Fendrick, MD (University of Michigan)
- Cliff Goodman, PhD (The Lewin Group);
- Alex Guerrero, PhD, JD* (University of Pennsylvania)
- Darin Hinderman, (Caterpillar)
- Louis Jacques, MD (ADVI)
- Steven D. Pearson, MD, MSc, FRCP (Institute for Clinical and Economic Review)
- Kenneth Schaecher, MD (SelectHealth);
- J. Russell Teagarden, DMH, MA* (Consultant)
- 1 additional national payer who wished to remain anonymous
When is higher cost-sharing for patients with the same condition less acceptable? (Select all that apply)
Roundtable Voting: *How acceptable are higher copays for patients with similar conditions?*

- **Step Therapy - Rheumatoid Arthritis**: 12% (Unacceptable), 35% (Neutral), 53% (Acceptable)
- **Dx Testing - Cystic Fibrosis**: 12% (Unacceptable), 29% (Neutral), 59% (Acceptable)
- **Side Effects - Fibromyalgia**: 6% (Unacceptable), 18% (Neutral), 76% (Acceptable)
- **Route/Frequency - Osteoporosis**: 6% (Unacceptable), 6% (Neutral), 88% (Acceptable)
Five Guiding Principles to Determine When Higher Out-of-Pocket Costs are Less Acceptable

1. “Try and fail” is important
2. Benefits are certain and significant
3. Costs must align with benefits
4. Don’t penalize for “bad luck”
5. Lower, but do not eliminate out-of-pocket costs
Principle 1. “Try and Fail” is Important

✔ ✔ Rheumatoid arthritis try and fail prior step therapy with lower cost treatments
✔ Side effects after trying a treatment
Preference to avoid side effects prior to treatment
Principle 2. Benefits Should Be Certain and Significant

Test Results = Certain Benefits

Importance of benefits
- 70% vs. 20% improvement in rheumatoid arthritis scores

Functional outcomes rather than surrogate endpoints
- Lung exacerbations or infections vs. FEV1
Principle 3. Costs Align with Clinical and Patient Benefits

☑☑ Greater Costs = Greater Benefits
☑ Greater Costs Offset with Other Costs?
  • Adherence → Fewer Fractures and Hospitalizations ≠ Costs

Costs align with benefits

If the treatment costs are balanced with better effectiveness and safety, then cost-sharing should be lower.
Principle 4. Don’t Penalize Patients for “Bad Luck”

✔ ✔ Cystic fibrosis

✔ Biology
  • Disease Severity
  • Comorbidities
  • Tolerance with side effects

Preferences

Don’t penalize for “bad luck”

If patients need higher-cost treatments based on their biology or genetics, then cost-sharing should be reduced.
Principle 5. Lower (but not eliminate) Out-of-Pocket Costs

✔️✔️ Preserve ability to encourage lower-cost treatments
  • Rheumatoid arthritis

✔️✔️ Lower but not eliminate difference
  • Reduce solely-preference outcomes

Preference = ↑out-of-pocket costs
Helen Sherman

*Solid Benefit Guidance*

Chief Pharmacy Officer
Payer Perspective

• Copays should be based on the value of medications
• Evidence needed on effectiveness, safety, and value.
• Consequences of raising premiums or copays for lower-tier medications.
• Logistic and real-world challenges/constraints
Cheryl Larson

*Midwest Business Group on Health*

Vice President
Employer Perspective

• Goal is to maintain a healthy, satisfied, and productive workforce.
• Employers have a role in educating employees about benefits and available programs.
• Evidence needed on effectiveness, safety, and value – employers continue to wait for drug studies on comparative effectiveness.
employer perspective

- When able, employers will absorb costs of medically appropriate care; value-based models share the outcome value between the consumer and employer.

- Employer use of HDHP and higher copays and coinsurance can:
  - Support employer cost management efforts in the short-term
  - Encourage consumerism and patient understanding of drug costs
  - Lead to consumers not seeking needed care
  - Impact consumer health
View the online employer tool kit here.

View the employer case study here.
DISCUSSION
Potential Solution to Cost Related Non-Adherence of Essential Services: Value-Based Insurance Design (V-BID)

- Bipartisan support to incorporate V-BID principles:
  - Expand Medicare Advantage V-BID Model Test to all 50 States (S 870; HR 1995)
  - TRICARE Demonstration (2017 and 2018 NDAA)
  - HSA-HDHP reform to allow chronic disease services to be covered on a pre-deductible basis (HR 5652; Draft Executive Order)
For more information, please visit
www.npcnow.org

Thank you!