Value-Based Health Care: The Role of Pharmaceuticals

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OVERVIEW

- Three approaches to incentive design for drugs
  - Consumer driven health plans (CDHP)
  - Value-based insurance design (VBID)
  - Value-based health care (VBHC)
- Value for specialty drugs and vaccines
- This summit: structure and goals

Why the Rising Focus on Out-of-Pocket Payment?

- Continued growth in medical costs, faster than growth in GDP, productivity, wages
- Retreat from provider incentives (e.g., capitation)
- Increasing role of consumer as decision-maker
  - Increasing direct-to-consumer advertising
  - Ideology of “consumer-directed health care”
- Success of tiered formularies (consumer incentives) in reducing costs to insurers and consumers

Consumer-Driven Health Plans (CDHP)

- Consumers choose more wisely when spending their own money ("moral hazard")
- Direct payment "empowers" consumers, reduces paternalism and cost-unconscious demand
- Self-rationing is better than rationing by others
  - Critique of provider incentives in managed care
- RAND study (1970s) found major cost reductions and no major adverse health effects of cost-sharing

Consumer-Driven Health Plans: Product Design

- High-deductible health plan (HDHP)
- Tax-favored reimbursement/savings account
- Hence most preventive, primary care services, and drugs are paid out-of-pocket
- Advocates reject managed care networks, payment incentives, medical management

Consumer-Driven Health Plans: Comparison to Auto Insurance

- Consumer-driven health plan paradigm models health insurance on auto insurance
- Auto insurance imposes deductible to limit low-cost claims (administrative burden)
- It does not cover oil changes and other “preventive” interventions even though these are effective
- Auto insurance is more costly, not less costly, for drivers with history of claims (by analogy, there is no special treatment in CDHP for chronically ill enrollees)

Value-based Insurance Design (VBID)

- Consumers often make poor choices
  - Example: refrain from taking effective lipid-lowering and hypertension control medications if pay OOP
  - Example: refrain from taking appropriate screening (e.g., mammography) tests
- Insurance design should promote access/use of effective and cost-effective treatments
- VBID criticizes CDHP cost sharing provisions as penny wise but pound foolish

Value-based Insurance Design: Product Design

- "Donut hole" models in private sector
  - CDHP or PPO with first-dollar coverage for effective treatments and drugs
    - Preventive services (pap smear, vaccinations, mammography)
    - Cost effective drugs (lipids, hypertension, etc.)
    - Physician visits (limited number of PCP visits per year)
- Restructure formularies to assign particularly effective drugs to Tier 1 (regardless of cost)

Value-based Health Care (VBHC)

- Both consumers and physicians are key decision-makers and need to face appropriate incentives
  - Blend of CDHP and VBID principles
- Incentives for providers (e.g., payment methods and medical management) need to be coordinated with incentives for consumers (e.g., cost sharing)
- “Choice architecture” matters

Value-based Health Care: Product Design

- Network design: “high performance networks”
  - Selective contracting, COE, P4P, episode payment
- Medical management
  - Wellness, acute care coordination, DM, CM
- Benefit design
  - Evidence-based formularies
  - Cost sharing creates incentives for consumer cooperation with network design and medical mgmt.

Value-Based Health Care: Product Design (continued)

- Benefit design and OOP payment rewards consumer participation in other programs
  - Lower OOP if use high-performance network providers
  - Lower OOP if participate in wellness, care coordination, disease management, case management programs
- More generally, the components of insurance design should promote consumer choices that reward efficient performance by providers of care

Special Problems with Specialty Drugs

- Features of specialty drugs (mostly biologics):
  - Often very toxic; patient education is imperative
  - Patients are very ill; care management programs are imperative
  - Special handling and distribution is imperative
  - Often infused or injected; site of care is important
  - Often covered under “medical” rather than “pharmacy” benefit
    - Different provider payment (buy & bill) and consumer cost sharing than for oral drugs
    - Part B rather than Part D for Medicare
  - Very expensive

Specialty Drugs in Contemporary Benefit Designs

- If covered by medical benefit, often no cost sharing
  - Sometimes 20% coinsurance
  - Special out-of-pocket maximum for drugs?
- Under pure HDHP, full coverage above deductible
- Under tiered formulary, in tier 3
- Increasingly, in tier 4 or 5: High copay (e.g., $500 per month) or coinsurance (25%, 33%)

Perverse Incentives for Specialty Drugs

- Patients either face too little cost sharing or too much cost sharing for specialty drugs
- Coinsurance and 4th tier placement are punitive for high-cost drugs
  - The high costs of these drugs are what “insurance” is designed for
- Most importantly, the extent of cost sharing is not linked to whether the patient is an appropriate candidate for the drug
- Difficult to define “appropriate”:
  - On-label? On-protocol? Prior auth? Step therapy? CED?

Needed: VBID for Specialty Drugs

- VBID was pioneered for primary care drugs that treat diabetes and other chronic conditions
- It can and should be applied to specialty drugs
  - Low cost sharing when drug is taken appropriately
  - No coverage when drug is taken inappropriately
  - High cost sharing in between, e.g., when the evidence on appropriateness is equivocal and more research is needed

Needed: VBHC for Specialty Drugs

- Appropriate benefit design is only the first step
- Specialty drugs need special treatment, and benefit design needs to be coordinated with:
  - Care management and patient education programs
  - Provider network contracting (e.g., centers of excellence)
  - Physician payment methods
  - Distribution and handling (specialty pharmacy)

This Summit

- Plenary panel: framing the issues
- Breakout sessions: deeper dives into two key areas
  - Biopharmaceuticals
  - Vaccines
- Beyond the summit
  - Identification and dissemination of best practices
  - Improvement in benefit designs: Medicare, commercial
  - Improvement in the system of health care for patients suffering from severe yet treatable conditions