

ADVANCES IN DRUG DEVELOPMENT

Current Developments in Oncology Drug Research

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The Impact of Value-Based Insurance Design on Oncology Drugs



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H&O Why are prescription drug expenditures increasing in the United States?

MF Drug expenditures are going up because we are seeing a combination of the introduction of new—often expensive—drugs, greater utilization of existing drugs, and higher drug prices across the board. But to me, the bigger questions are these: How much healthier are prescription drugs making us? And how does the additional health we are getting from these added expenditures on drugs compare with benefits from expenditures in other health care sectors?

The amount we spend on drugs is only part of the story. We should remember that pharmaceuticals account for only 10% to 15% of the health care dollar. Unlike other health care sectors, prescription drugs require proof of safety and efficacy from 2 separate trials before their approval for use. Thus, I have great confidence that the pharmaceutical portion of spending contributes to individual and population health at least as much as the other aspects of health care expenditures. From a pure value perspective, we probably should be spending more on prescription drugs, not less.

H&O What is value-based insurance design (V-BID), and how did you become interested in it?

MF My interest in V-BID began with the growing problem of cost-related nonadherence to high-value clinical services. We saw that large numbers of people were not following evidence-based health recommendations, either because they

were uninsured or because their high insurance deductible or copayment discouraged them from getting the medical care they needed. Approximately 1 in 4 insured Americans skips recommended clinical services because of cost.

Not only are Americans being asked to pay more and more for their health care, they are being asked to pay high out-of-pocket costs for things that physicians beg them to do—just as much as for the services their doctor might tell them to avoid. As for drug costs, the copay might be the same for a lifesaving drug that treats cancer, depression, diabetes, or heart disease as for a drug that treats toenail fungus or hair loss.

With V-BID, we adjust the cost-sharing structure so that patients pay for the amount of health that is produced, not the acquisition cost. Specifically, patients pay less for the drugs or services that produce the best health and more for those services that have not been shown to be beneficial. V-BID programs are designed with the tenets of clinical nuance in mind. These tenets recognize that (1) medical services differ in the amount of health produced and (2) the clinical benefit derived from a specific service depends on the consumer using it, as well as on when and where the service is provided.

H&O Who coined the term V-BID?

MF My colleague Michael Chernew, PhD (now at Harvard Medical School and previously at the University of Michigan), and I introduced the term *clinically nuanced benefit design* in the late 1990s to describe the concept of linking copay amounts to clinical benefit. When we

saw the interest in this topic, we expanded the concept to include all health care services. We settled on the term *value-based insurance design*.

H&O How many US health plans have adopted the principles of V-BID for drugs?

MF We estimate that more than 1000 employers and health plans have implemented V-BID programs for drugs. The recent annual Towers Watson/National Business Group on Health Employer Survey on Purchasing Value in Health Care suggested that more than 40% of large employers either had or planned to have a V-BID formulary by the end of 2015 (Figure).

H&O Have V-BID plans been shown to improve patient-centered outcomes or control health care cost growth?

MF It should come as no surprise that if you make people pay less for something, they will buy more of it. So, we have robust evidence that V-BID programs modestly improve adherence to drugs in high-value classes. That is not to say that cost is the only reason Americans do not take the drugs they should; there are multiple reasons for nonadherence. However, with V-BID we have been able to increase adherence by as much as 4 or 5 percentage points, as shown in a 2014 review of 76 plans published in *Health Affairs*.

We also have evidence supporting the idea that certain disease-specific V-BID programs will become cost-neutral if they continue for long enough—2 or 3 years for conditions such as coronary artery disease and diabetes. The programs are more likely to reduce costs if they are very well targeted. Our goal is to add efficiency and build a preventive, not reactive, health care delivery system. I believe that V-BID programs give more health for the money than just about any other health reform alternative.

H&O Could you talk about the plan from the Center for Medicare and Medicaid Innovation to test V-BID in Medicare Advantage plans?

MF We were incredibly pleased to see that after 8 years of advocacy, the Center for Medicare and Medicaid Innovation of the Centers for Medicare & Medicaid Services (CMS) announced a demonstration to implement V-BID principles in Medicare Advantage plans in 7 states. This demonstration waived a provision from the 1965 Medicare bill that required every Medicare beneficiary to have the same benefits.

Allowing flexibility in plans is important because it results in more targeted, clinically nuanced care. We feel it

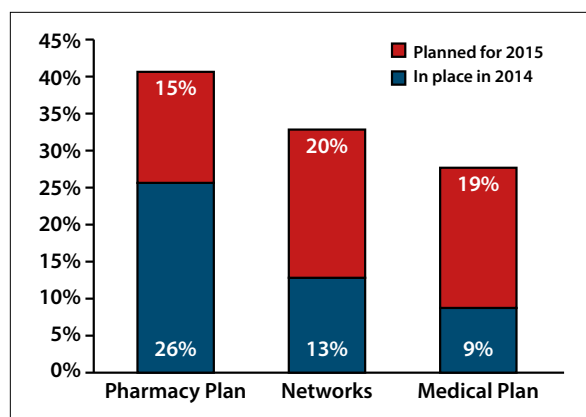


Figure. Increases in value-based insurance design.

Source: 19th annual Towers Watson/National Business Group on Health Employer Survey.

is intuitive that people with diabetes need better benefits for eye examinations than those who do not have diabetes, and people with heart disease need easier access to certain medications than people who take those medications for less-serious conditions. After explaining this to multiple stakeholders, we were able to assemble a broad coalition supporting the idea of clinical nuance in plan design. I feel very strongly that if we are going to incentivize providers to encourage their patients to do certain things, we should make it easy for those patients to do those things.

For example, if clinicians are going to be evaluated on how well they manage blood sugar, blood cholesterol, blood pressure, and eye examinations in a patient with diabetes, the patient should be enrolled in a health plan that makes it easy to access the relevant visits, tests, and medications.

H&O What is the status of the use of these programs in Medicare Advantage plans?

MF We are very excited to see multiple plans rolling out V-BID demonstration models on the launch date of January 1, 2017. These pilot programs are scheduled to run for 5 years.

H&O What special concerns exist regarding insurance coverage of oncology drugs?

MF Clinical formularies traditionally have not used clinical nuance to determine reimbursement for oncology drugs. For example, cost-sharing levels for drugs that cure cancer are often the same as the levels for drugs that have never been shown to provide a cure.

With oncology, we have drugs that work much better for one type of cancer than for another. We also have situations in which we could use molecular diagnostics or other clinical attributes to identify a higher or lower likelihood

of success for a particular therapy. It seems reasonable that if a drug works 50% of the time in one situation, 25% of the time in another situation, and 5% of the time in a third situation, the copay should be higher in the 5% scenario than in the 50% scenario. The person who is unlikely to benefit is not denied access to the drug, but taking it requires a higher out-of-pocket cost. This is a rational way to allocate resources.

H&O Could you talk about the concept of dynamic benefit design?

MF Dynamic benefit design is based on the fact that for most chronic clinical conditions, the efficacy of interventions, including drugs, changes over time. Although I strongly support the use of lower-cost generic drugs as first-line agents, we often need to use multiple and more expensive therapies as time goes on. Chronic myeloid leukemia is an example of a disease that can be treated initially with a lower-cost drug but often requires more expensive targeted agents as it progresses. This common clinical circumstance was my inspiration for a dynamic benefit design I refer to as “reward the good soldier.” That is, the patient should be encouraged to first use the low-cost agent. However, when the clinical situation calls for a second-line, higher-cost agent, the patient will need to pay more. In the dynamic model, patients who are diligent about following the protocols—the “good soldiers”—will be rewarded with a lower cost-share for the expensive agent only when that agent becomes necessary. In other words, benefits should not be static because clinical medicine, and particularly cancer care,

changes over time. I have received positive feedback from many oncology colleagues and payers about this “reward the good soldier” concept because it commits to policies that encourage first-line therapies, acknowledges that clinical scenarios may require multiple treatment options, and enhances access to effective therapies when clinically appropriate.

H&O Is there anything that you would like to emphasize?

MF I think we need to focus less on lowering health care spending, which seems to be the main focus of health care deliberations in this country, and more on what we are getting for our money. The more that the dialogue is about what we are getting for the money rather than just the amount we are spending, the better off we will all be. We have to keep individual and population health at the forefront of this health care cost discussion.

Suggested Readings

- Center for Value-Based Insurance Design. <http://vbidcenter.org>.
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