Practical Solutions for High Cost-Sharing In the United States

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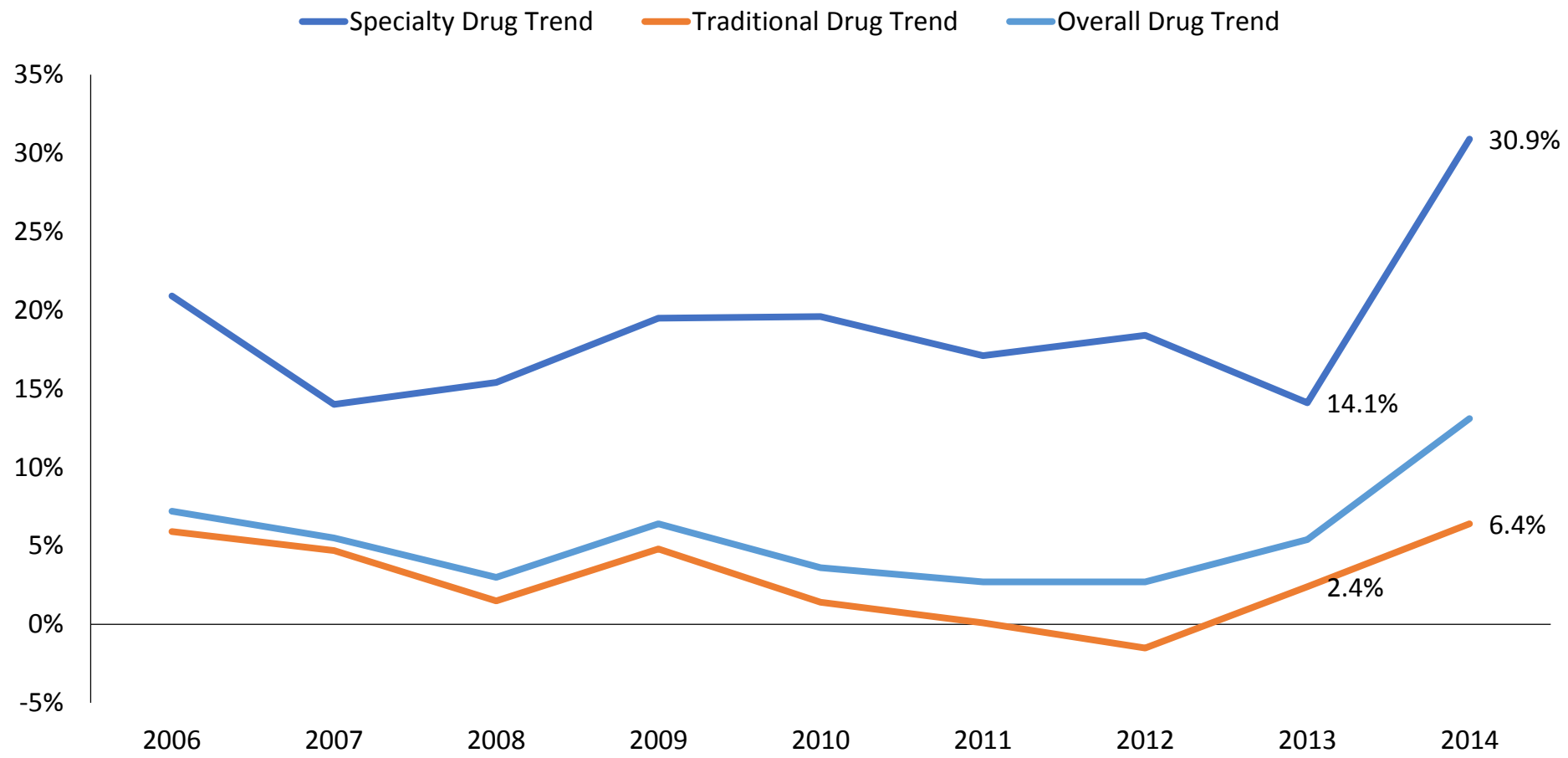
Outline

- High prices for prescription drugs
- Cost-sharing after US health reform
- Cost Sharing for Rx: A Powerful Policy Lever to Use with Care

Costly new specialty drugs are a major driver of increased health spending

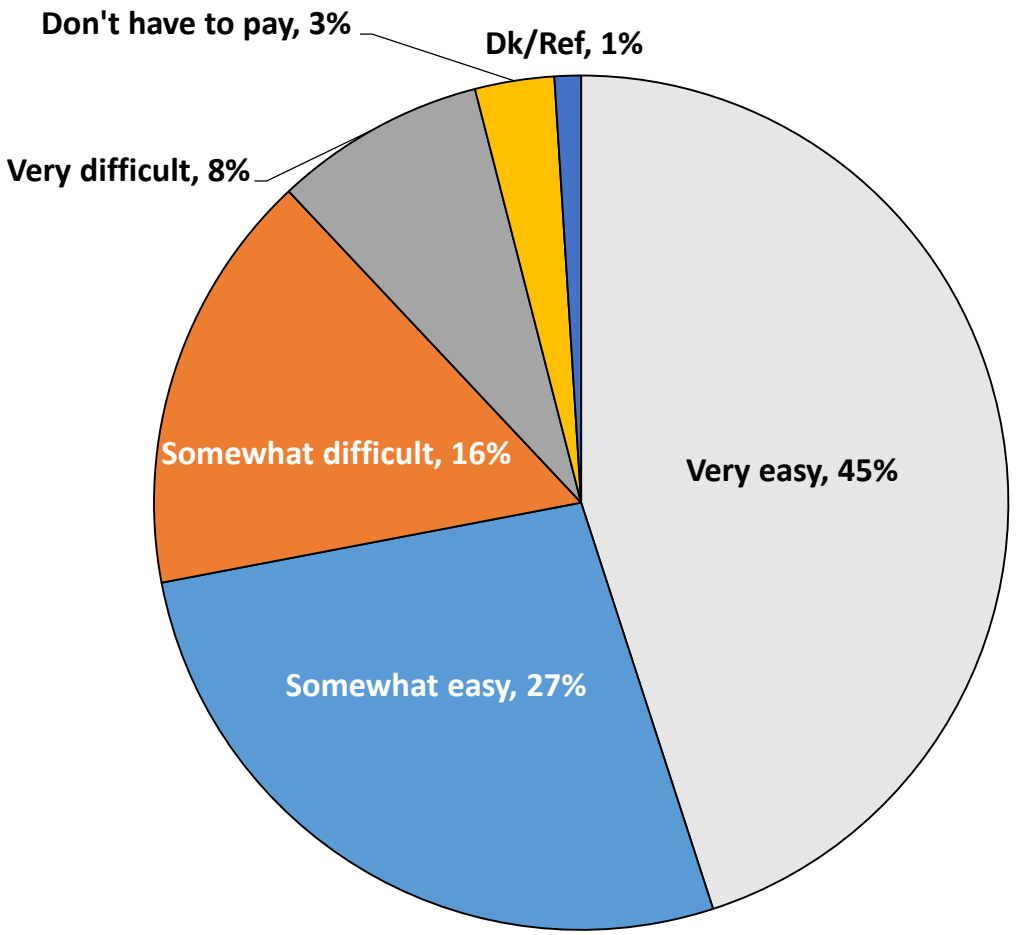


Source: Express Scripts 2014 Drug Trend Report and Year in Review. Available at http://lab.express-scripts.com/drug-trend-report/ and http://lab.express-scripts.com/drug-trend-report/introduction/year-in-review

Express Scripts drug spending growth trend by therapy class, 2006 -2014

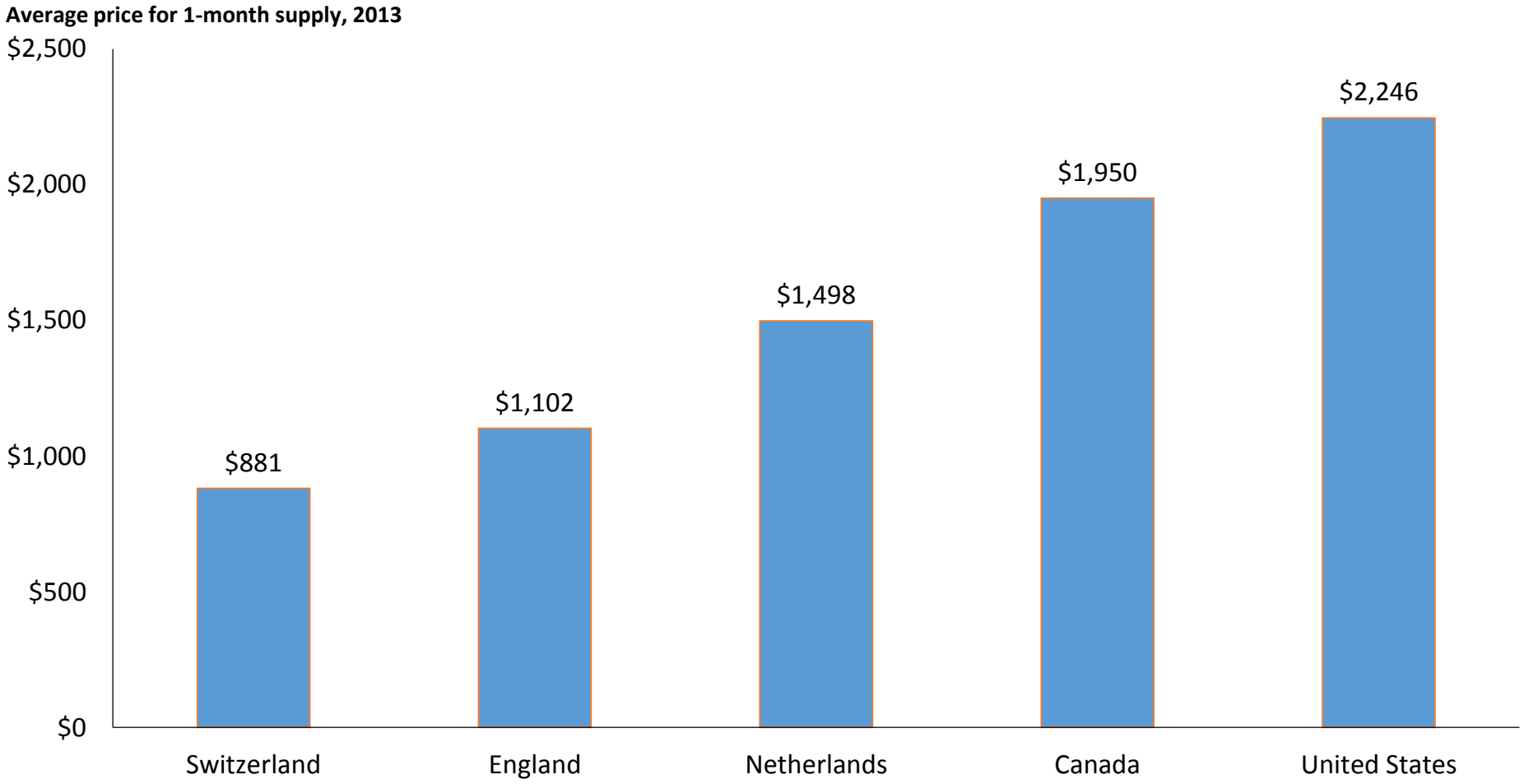
Most people taking Rx drugs say they can afford their treatment, but about 1 in 4 have a difficult time affording their medicine

Among those who are currently taking Rx medicine, percent who report ease or difficulty affording the cost of their prescription medications



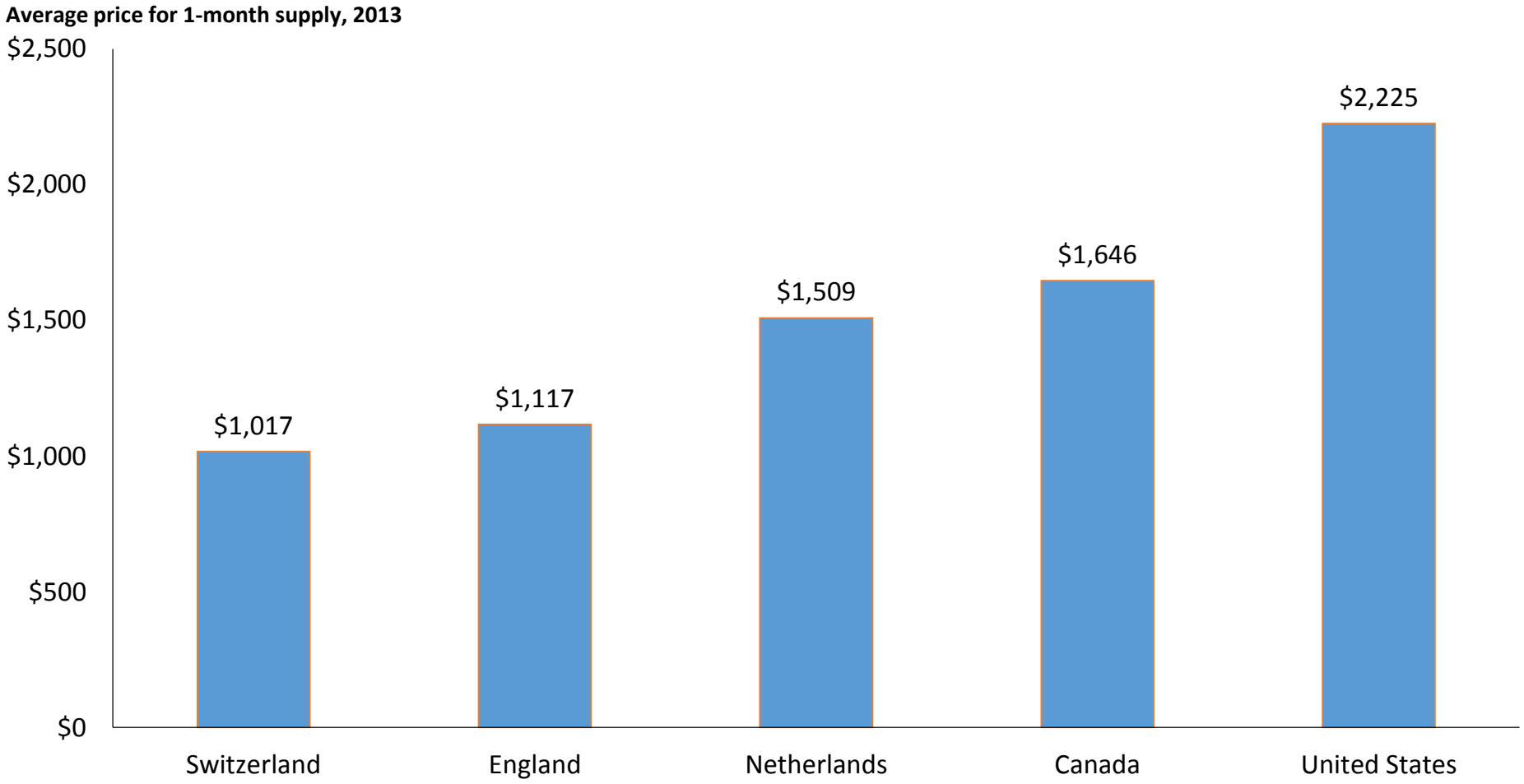
Source: Kaiser Family Foundation Health Tracking Poll (conducted Aug 6 – 11, 2015)

The average price of Humira is about 15% higher in the U.S. than in Canada



Source: International Federation of Health Plans **Notes:** U.S. average prices are calculated using commercial claims data from Truven MarketScan Research databases. Methods and sources for comparable countries can be found here: http://www.ifhp.com/1404121

The average price of Enbrel in the U.S. is about 35% higher than in Canada



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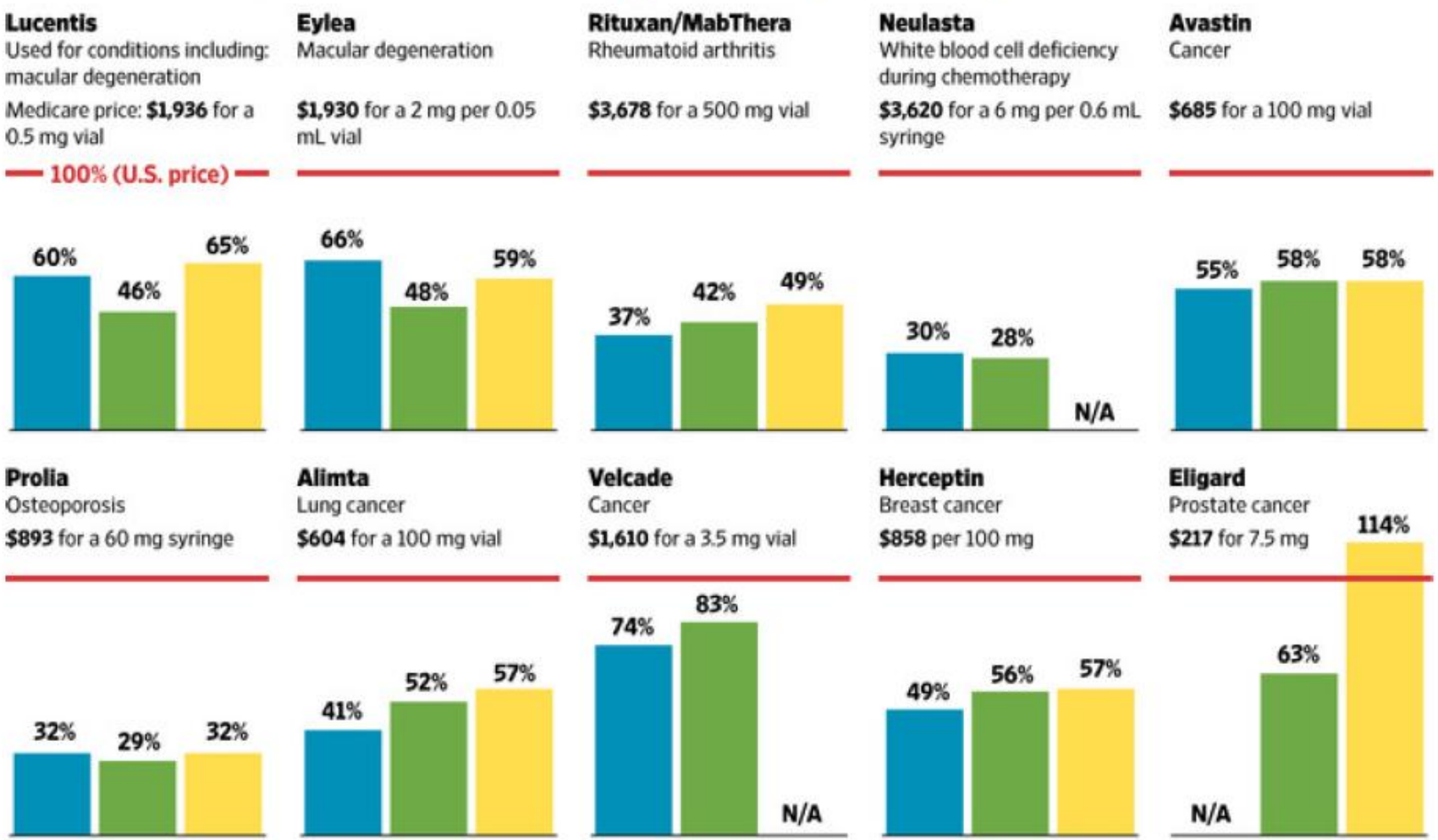
Same Drug, Higher Price

Here are prices the government health systems of England, Norway and Ontario, Canada, paid for some of the biggest brand-name drugs by Medicare Part B expenditure, for which pricing was available in multiple countries.

Price as a percentage of U.S. Medicare price in: England Norway Ontario



Note: Medicare beneficiaries are responsible for paying 20% of prices listed here. Medicare itself covers 80%. Prices listed reflect a temporary 2% discount imposed by federal spending cuts known as budget sequestration. All prices are for third quarter of 2015; foreign prices were converted to U.S. dollars at July 1, 2015, exchange rates. Top drugs were determined by Medicare Part B payments to doctors' offices and medical practices in 2013, the latest year for which data were available. Norwegian prices include 25% Value Added Tax levied on pharmaceuticals. England's National Health Service says prices listed here are 'indicative' and may vary in some circumstances.

Sources: WSJ analysis of data from the Centers for Medicare & Medicaid Services; the Norwegian Medicines Agency and the Norwegian Drug Procurement Cooperation; the NHS Business Services Authority; and Ontario's Ministry of Health and Long-Term Care

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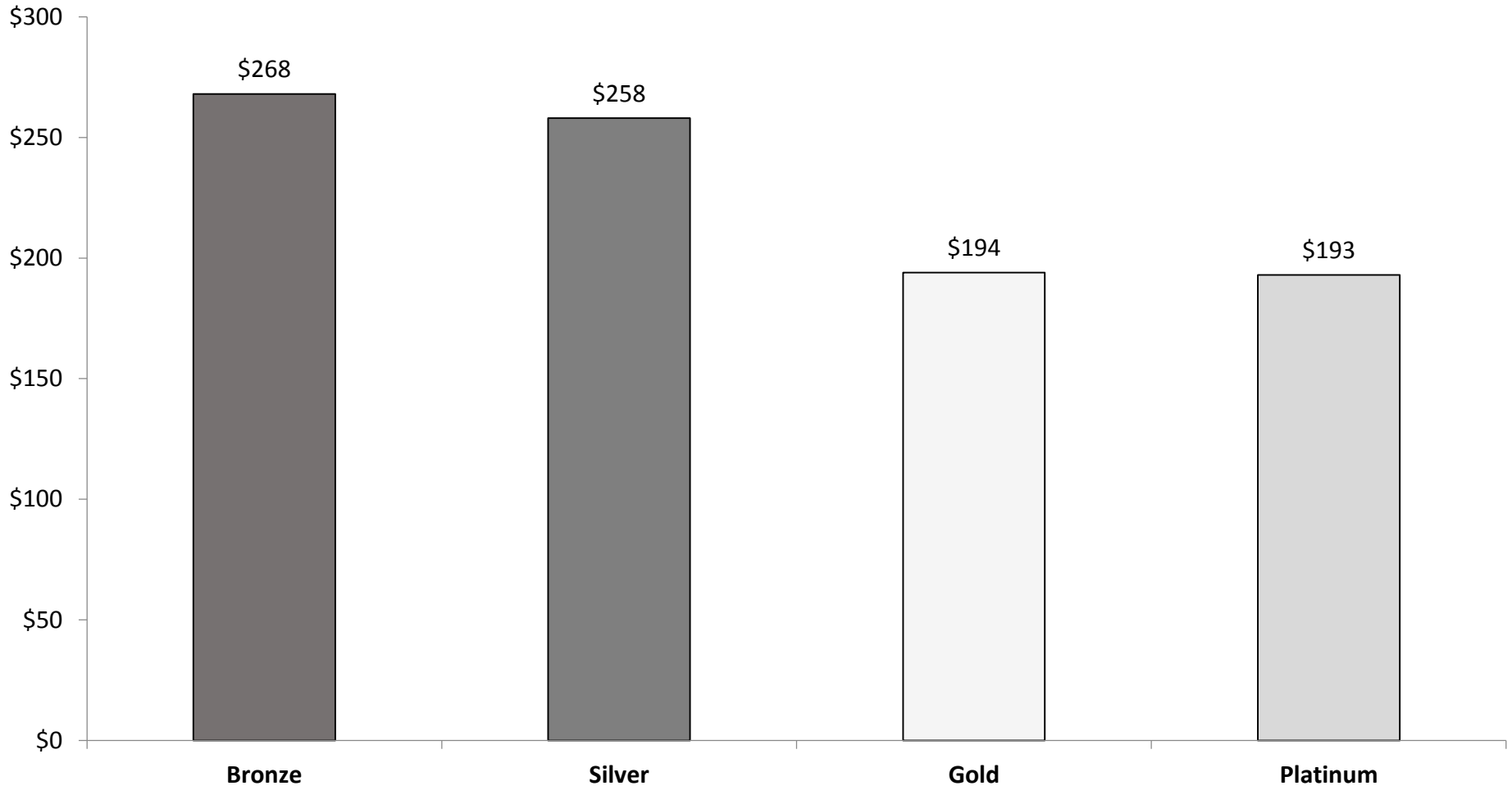
Prescription Drug Cost Sharing

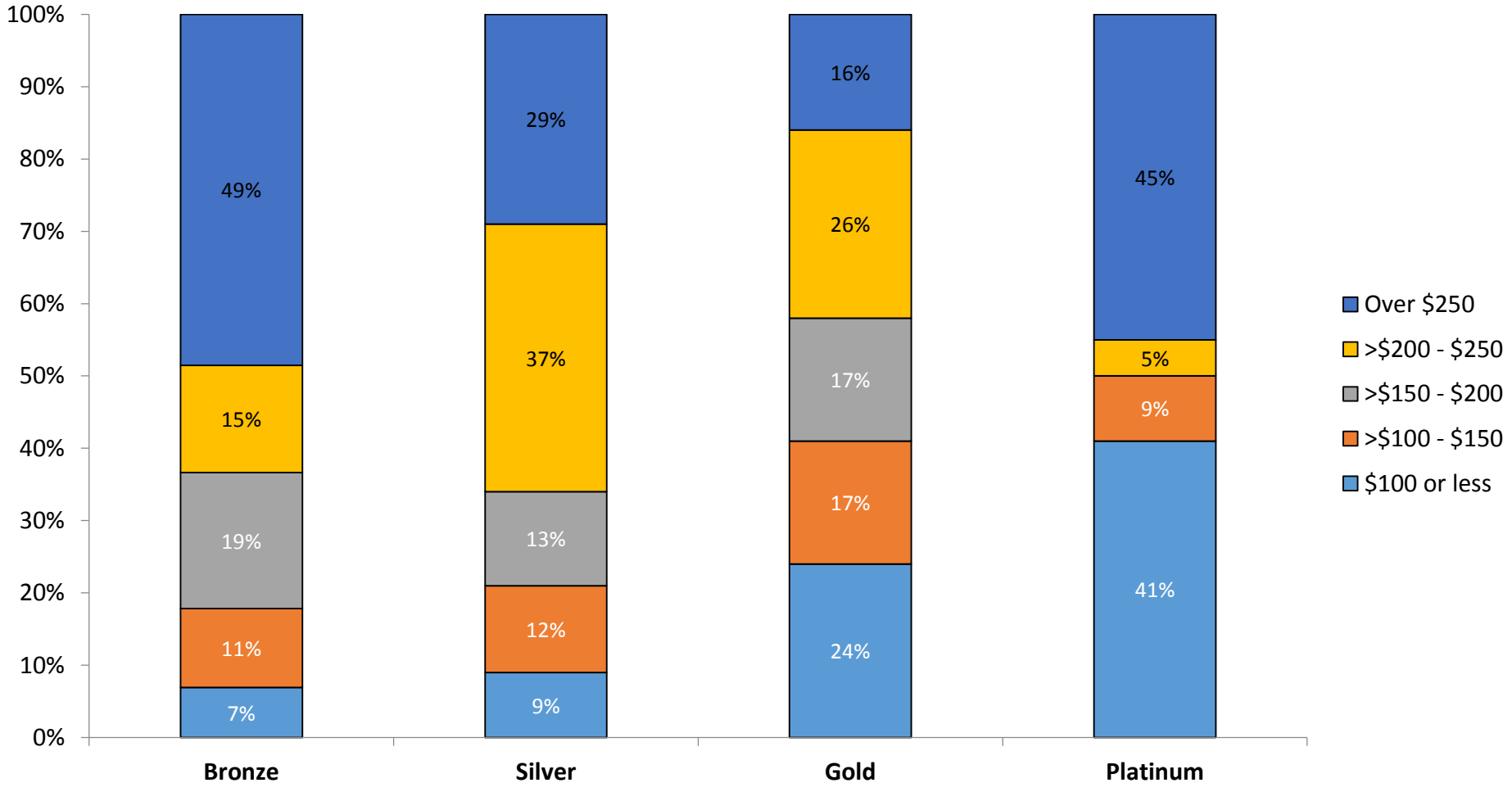
Cost sharing in the US

- Insurance plans typically require some form of cost sharing (also called out-of-pocket costs)
- These expenses, which are in addition to the amount an enrollee spends on his or her monthly premium, come in a variety of forms:
  - Copayments: set dollar amounts for covered services (e.g. $20 per general physician visit)
  - Coinsurance: a percentage of the allowed cost for covered services (e.g. 20% of the allowed cost for a specialist visit)
  - Deductibles: set dollar amounts that enrollees must pay before their plan starts to cover the service or a group of services (e.g. $200 drug deductible before drug coverage begins)
  - Often, some combination thereof.

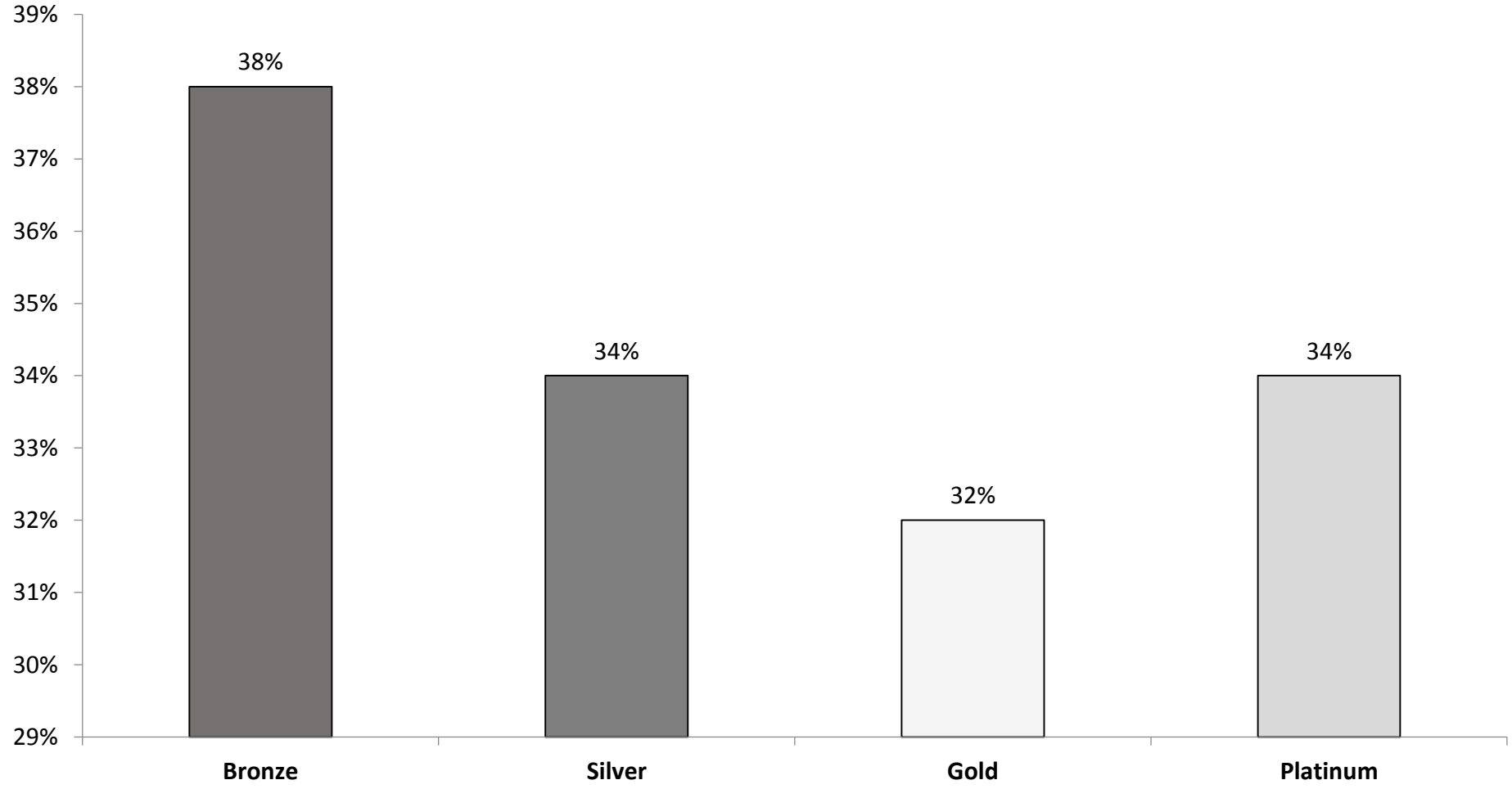
Average Copayment for Specialty Drugs (includes plans with 'copayment' or 'both copayment & coinsurance')



Distribution of Copayment Amounts for Specialty Drugs (includes plans with 'copayment' or 'both copayment & coinsurance')



Average Coinsurance Rates for Specialty Drugs (includes plans with 'coinsurance' or 'both copayment & coinsurance')



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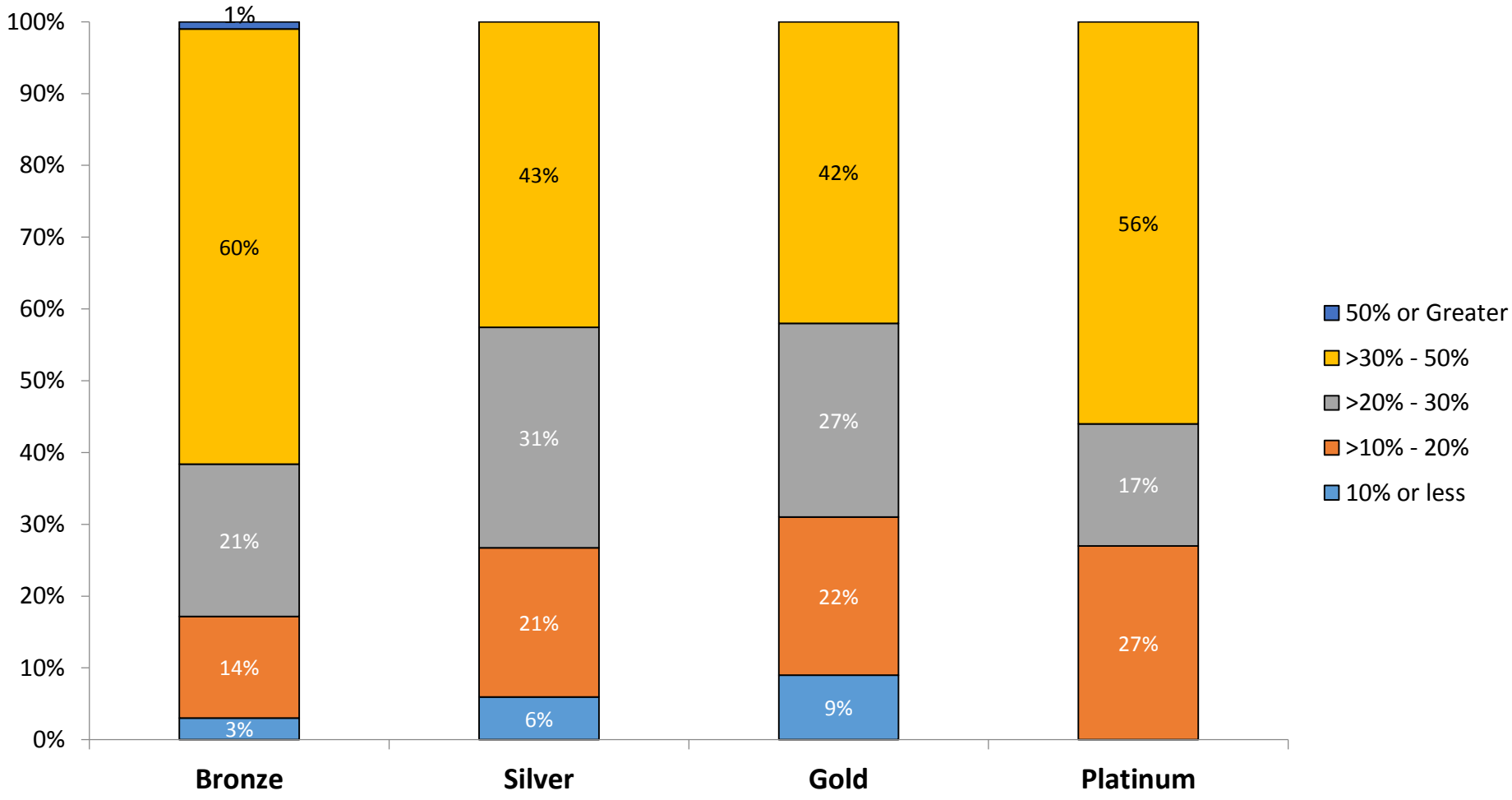
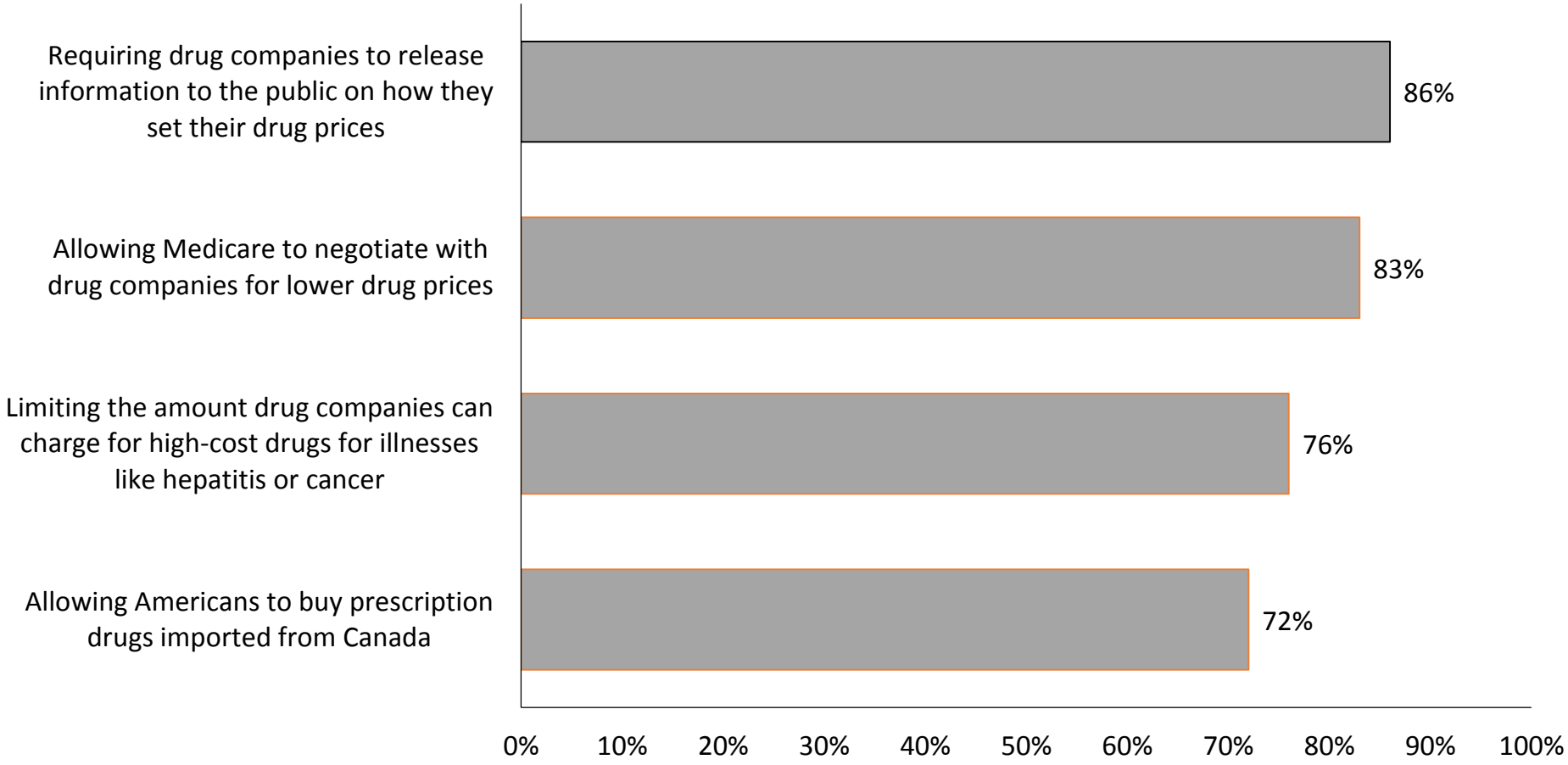


Most Americans favor action to keep drug prices down

Percent who say they favor each of the following in keeping prescription drug costs down:



Source: Kaiser Family Foundation Health Tracking Poll (conducted August 6-11, 2015)

Policy Solutions Are Needed

- As policy makers and insurers search for ways to control cost growth, they have frequently turned toward cost-sharing as a cost-containment mechanism.
- Recent data show that insurers and, subsequently, employers, have steadily shifted the cost of healthcare to beneficiaries

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- A literature review in 2012 found that increases in cost sharing led to decreases in medication adherence.

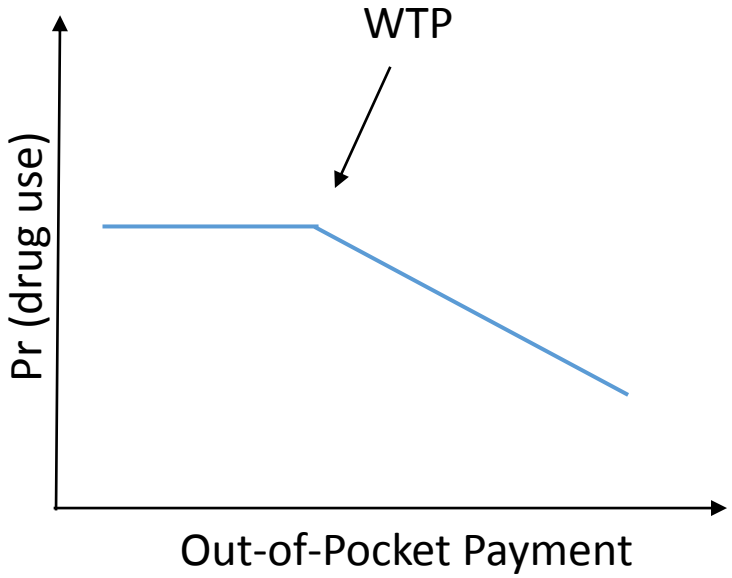
Association between Cost Sharing and Disease Modifying Treatments (DMTs) in Multiple Sclerosis

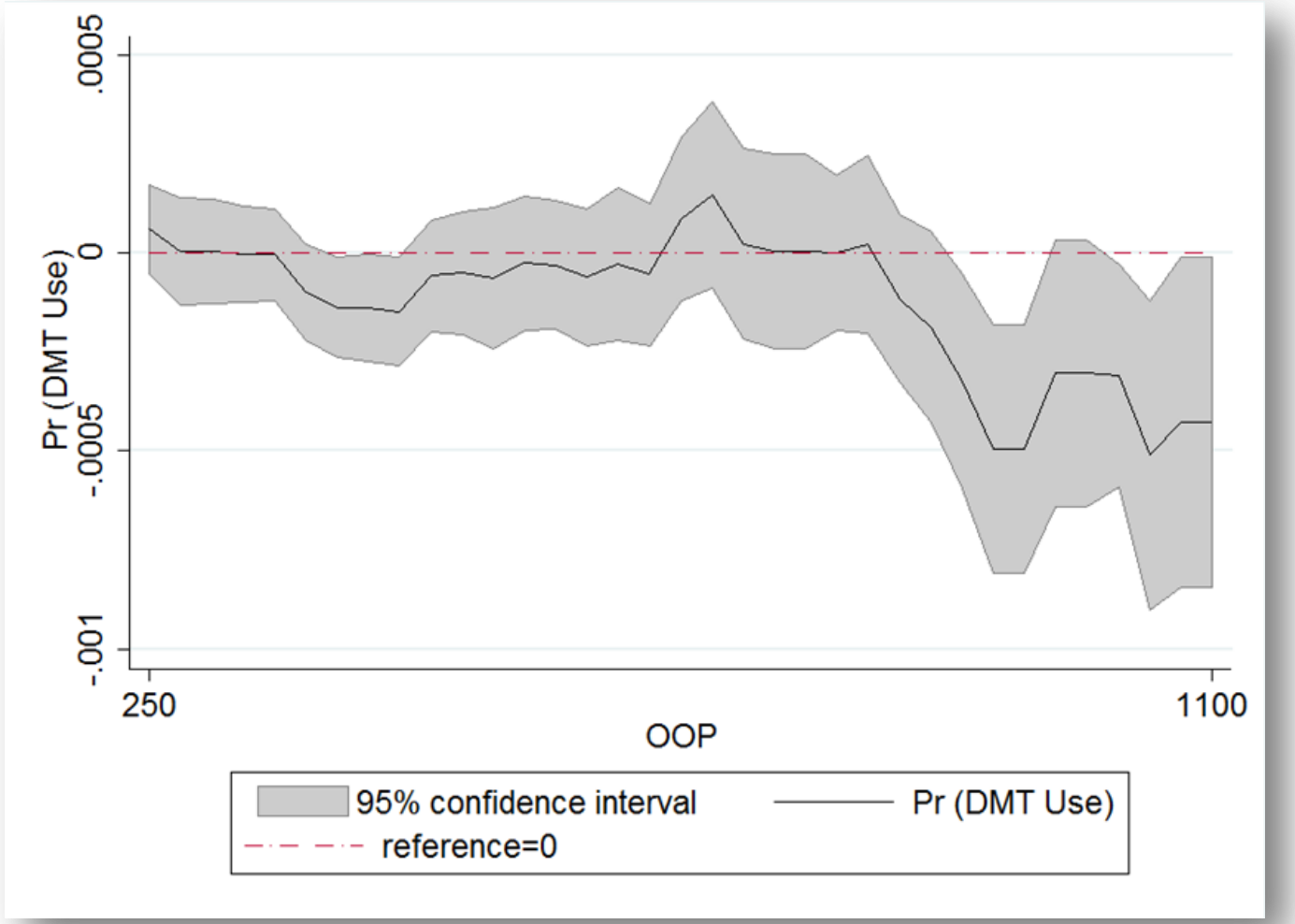
Objective:

To explore the existence of a classic economic concept: willingness to pay (WTP) threshold for DMT utilization and adherence.

Hypothesis:

MS patient are insensitive to the OOP payment if their OOP payment is below the WTP threshold, while the health outcomes may be compromised above the WTP threshold.

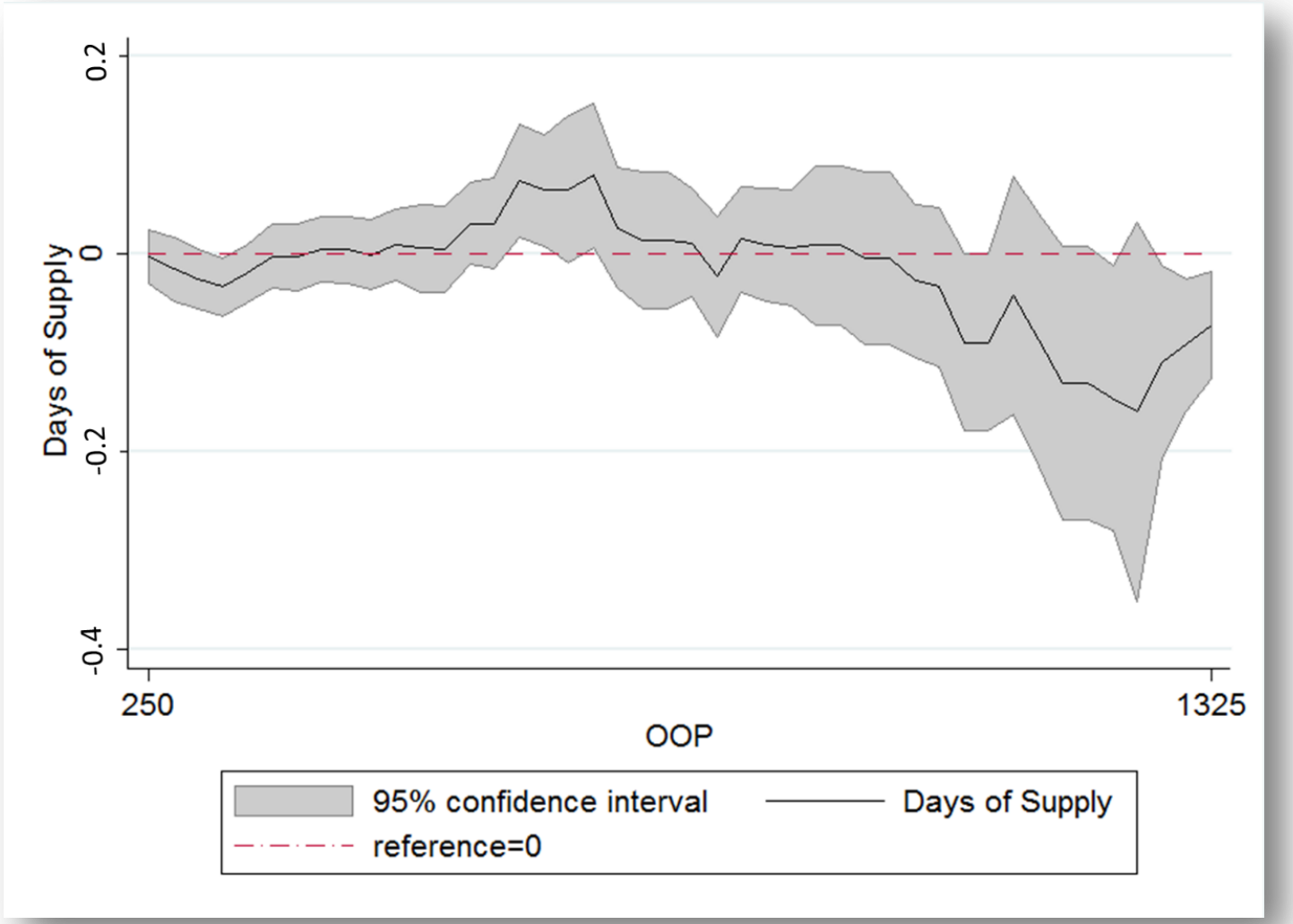




- Y axis is the change of the probability for using DMT
- X axis is the annual OOP payment.

- A flat line from 0 can be observed until the OOP payment reached to a certain threshold, and then the probability of initiating DMT decrease as the OOP keep rising.

Existence of the WTP threshold for DMT utilization.

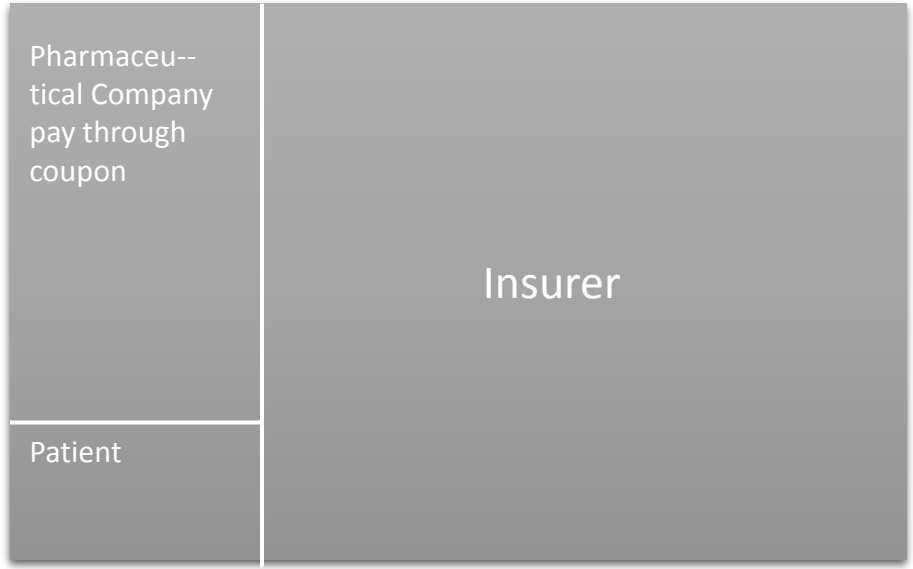


- Existence of the WTP threshold for DMT adherence

Coupon Policy In Private Sector

Starting from 2010, there was an sharply spreading trend for the coupon policy offered by major DMTs manufacturers (e.g., Copaxone, Betaseron, Tysabri, etc.)

Before 2010



After 2010

Solution 1: pooling with other drug type

- A recent actuarial analysis (2013) indicated that the cost of eliminating Medicare Part D specialty tiers could be offset by implementing relatively modest increases in traditional 3-tiered co-payment.

- It is a rational strategy for the private insurance company follows similar logic and try to shift the copay amount from MS DMTs to other common drug classes under the same health plan, as it will be likely to cause only a modest increase in their copays, considering MS as rare disease in the US population.

- A small increase in copay for common drugs is unlikely to discourage the drug initiation, as the cost-sharing component is very low in those drug class.

- *However, what/how to do, given that specialty drug category is projected 1/3 total Rx cost?*

Solution 2: Value-Based Insurance Designs

- Currently, the main stream of drug cost sharing plan such as Medicare part D policies is one-size-fits-all, wherein cost sharing is directly a function of the medication cost.

- However, the number of value-based insurance design is increasing: in 2017, the CMS will be initiating the Medicare Advantage Value-Based Insurance Design (VBID) model in seven states: Arizona, Indiana, Iowa, Massachusetts, Oregon, Pennsylvania, and Tennessee, and it may keep expanding to other states over time.

- *Is there any value difference? What is the value framework?*

State Efforts to Reduce Cost Sharing for Rx

- Monthly caps on drug costs:
  - California (all Rx)
  - Delaware, Louisiana, and Maryland (specialty tier)
- Annual cap on drug costs: Maine and Vermont
- Liming formulary flexibility: New York (prohibit specialty tier)
- Health plan benefit design (using copayment instead of coinsurance)

Summary

- High-cost drugs can impose a crushing burden on some of our sickest, most vulnerable citizens.

- Caps on cost-sharing aim to ease this burden and help people access critical treatments by spreading some of the costs across healthy and sick alike.

- As debate over how best to manage this trade-off continues, the experiences of states taking early action should be closely monitored.