



# Patient Out of Pocket Costs Taskforce (SSB 6569)

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# Introductions

Name

Organization

Role

- Breaks
- Bathroom
- Parking
- Safety



- Start on time and end on time
- “Parking Lot” to help us stay focused and on track
- Iterative process
- Goal is not consensus
- All voices count
- Loose “agenda” - go where the conversation takes us but w/ a keen eye toward our deliverables
- We will make room at end to get input on the next meeting



# The Plan For Today

- Welcome & introductions
- Meeting Ground Rules
- Purpose - recap
- Last Meeting – brief refresher
- Deeper dive, multiple perspectives
- WORKING LUNCH
- Determine next steps

## SSB 6569: Patient Out-of-Pocket Costs Taskforce Purpose Statement

- The purpose of the Patient Out-of-Pocket Costs Taskforce is to realize the intent of the legislature as expressed in SSB 6569 by developing a list of policy options or recommendations related to prescription drug out-of-pocket costs to be presented to the Washington State Legislature in a report by December 1<sup>st</sup>, 2016.
- These policy options may not represent the views of every member of the group and do not need to represent taskforce consensus. Rather, the report will provide legislators with (a) more information about policy options that have been considered or implemented in other states and (b) specific feedback from Washington stakeholders on the positives and negatives of each option. If taskforce members are able to reach consensus, the final report may include recommendations as well.

# Meeting Rhythm

-  **Meeting 1** – Discuss the factors and impacts related to patient out-of-pocket costs generally, but with a specific focus on the tie-in with prescription drugs. Begin considering next steps by brainstorming policy options.
-  **Meeting 2** – Provide a high-level overview of policy options that other states have considered or implemented to address prescription drug out-of-pocket costs. Provide time and resources for taskforce members to learn more about these policy approaches and share initial opinions and reactions. Determine which policy options should be considered during Meeting 3.
- **Meeting 3** – Conduct an in-depth discussion of the policy options selected during the second meeting. Discuss the technical considerations or issues that each approach would entail. Document the advantages and disadvantages raised by taskforce members in response to each policy option.

MEMORY LANE

# Factors Influencing OOP Costs

- Rising cost of healthcare / medications
  - No cost transparency for consumers
- Insurance plan design (Deductibles, Copays & Coinsurance)
  - Difficult for consumers to understand
- Unforeseen medical problems
  - Difficult for consumer to predict
- Medication formularies
  - Limited transparency and understanding by consumers

# Impacts of OOP Costs

- Greater impacts to individuals with lower incomes and individuals with poorer health
- Poor health outcomes → decreased productivity in work force
- Decrease healthcare utilization
- Delayed care
- Increased stress
- Premium Mitigation

???

Thinking  
through  
the  
options







# Presentation 1: Sarah Kwiatkowski

*Washington State Office of the Insurance  
Commissioner*

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# Overview of State Laws and Regulatory Actions: Patient Access to Prescription Medications

*Presentation to SSB 6569 Patient Out-of-Pocket Costs Taskforce*

September 9, 2016



OFFICE of the  
**INSURANCE  
COMMISSIONER**  
WASHINGTON STATE

# Issue Summary and Overview

# Diverse State Approaches

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- Standardized benefit design
- Limiting formulary flexibility
- Dept. of Insurance Review and Approval Authority and Process
- Transparency & Consumer Information

# Standardized Benefit Design

# What is standardized benefit design

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Design of plan developed by either the Dept. of Insurance or the marketplace (exchange)

- A plan designed by DOI/marketplace and that issuers participating in the marketplace are *required* to offer
- In the federally-facilitated marketplace standardized benefit design is *optional*

Plans have defined (or identical) cost-sharing parameters (deductibles, co-payments, and co-insurance) within each metal level

# Example: Covered California

Key benefits	Bronze 60	Silver 70	Gold 80	Platinum 90
	Benefits in Blue are Subject to Deductibles		Copays in Black are Not Subject to any Deductible and Count Toward the Annual Out-of-Pocket Maximum	
Individual Deductible	<b>\$6,000</b> medical deductible <b>\$500</b> pharmacy deductible	<b>\$2,250</b> medical deductible <b>\$250</b> pharmacy deductible	no deductible	no deductible
Family Deductible	<b>\$12,000</b> medical deductible <b>\$1,000</b> pharmacy deductible	<b>\$4,500</b> medical deductible <b>\$500</b> pharmacy deductible	no deductible	no deductible
Preventative Care Copay <sup>1</sup>	no cost	no cost	no cost	no cost
Primary Care Visit Copay	<b>\$70</b> <sup>2</sup>	\$45	\$35	\$20
Specialty Care Visit Copay	<b>\$90</b> <sup>2</sup>	\$70	\$55	\$40
Urgent Care Visit Copay	<b>\$120</b> <sup>2</sup>	\$90	\$60	\$40
Tier 1 (most generics) Drug Copay	<b>100%</b> up to <b>\$500</b> per script after deductible	\$15	\$15	\$5
Lab Testing Copay	\$40	\$35	\$35	\$20
X-Ray Copay	<b>100%</b> of your plan's negotiated rate	\$65	\$50	\$40
Emergency Room Facility Copay	<b>100%</b> of your plan's negotiated rate	<b>\$250</b>	\$250	\$150
High cost and infrequent services (e.g. Hospital Stay)	<b>100%</b> of your plan's negotiated rate	<b>20%</b> of your plan's negotiated rate	HMO Outpatient Surgery - \$600 Hospital - \$600/day up to 5 days PPO — 20%	HMO Hospital - \$250/day up to 5 days PPO — 10%
Hospital Stay Physician Fee	<b>100%</b>	<b>20%</b> of your plan's negotiated rate	<b>HMO — \$55</b> <b>PPO — 20%</b>	<b>HMO — \$40</b> <b>PPO — 10%</b>
Tier 2 (preferred brand) Drug Copay after Pharmacy Deductible (if any)	<b>100%</b> up to <b>\$500</b> per script after deductible	<b>\$50</b>	\$50	\$15
Tier 3 (non-preferred brand) Drug Copay after Pharmacy Deductible (if any)	<b>100%</b> up to <b>\$500</b> per script after deductible	<b>\$70</b>	\$70	\$25
Tier 4 (specialty drugs) cost-share after Pharmacy Deductible (if any)	<b>100%</b> up to <b>\$500</b> per script after deductible	<b>20%</b> up to <b>\$250</b> per script after deductible	20% up to \$250 per script after deductible	10% up to \$250 per script
Maximum Out-of-Pocket For One	\$6,500	\$6,250	\$6,200	\$4,000
Maximum Out-of-Pocket For Family	\$13,000	\$12,500	\$12,400	\$8,000

<sup>1</sup> in-network only

<sup>2</sup> First 3 visits each year are not subject to the deductible

# Policy Goals of Standardization

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- Streamline consumers' shopping experiences and make comparing plans easier
- Design plans to be more affordable
- Can also curb the setting of cost-sharing structures that discourage enrollment by sicker people

# Actions that Impact Drug Tiering

# What is Drug Tiering?

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- First, what is a formulary?
  - In WA, a formulary means a listing of drugs used within a health plan. (WAC 284-43-0160)
- Tiers
  - Drugs on a formulary grouped into tiers. The tier determines a consumer's portion of the drug cost.
- Specialty Tier
  - A category of drugs within a tier in a drug formulary for which a beneficiary's cost-sharing is greater than tiers for other tiers
- Specialty Drug
  - Can be high-cost prescription medications used to treat complex, chronic conditions; often require special handling

# Potential Policy Options – Drug Tiers

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## Limiting number of drug tiers

- MA, NY, & VT limit the number of drug tiers through standard benefit design

## Prohibiting specialty tiers

- NY enacted a statute that prevents issuers from charging cost-sharing that exceed amount for non-preferred brands

# Drug tiers, continued

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## Defining specialty tier/drug

- DE and MD define defines criteria for what it means to be a specialty drug
- CA has standard definition of formulary tiers

## Barring issuers from placing all or most drugs for the same condition on any specialty tiers

- DE (part of a larger bill)
- CA bill that prohibits formulary design that discourage enrollment by sick individuals & regulatory action that requires issuers to place at least one medication on Tiers 1-3 when multiple treatment are available for chronic conditions

# Transparency & Consumer Information

# Examples of States' Efforts

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- Requirement that carriers post formularies on public part of website (see [WAC 284-43-5100](#))
- Providing information about benefit structure, including tiering and prior authorization requirements (see [WAC 284-43-5170](#))
- Searchable formularies
- Information on exceptions process (see [WAC 284-43-5170](#); [WAC 284-43-5040](#))

# Value Based Insurance Design & Consumer Protections

# What is VBID?

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Targets: High-value care is care that provides the best health results for a particular patient at the right price.

"Value-based insurance design" promotes the timely use of high-value care by changing the cost-sharing patients pay for certain services based on the clinical and cost-effectiveness of that care

# Consumer Protections

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- Require it be evidence-based
- Include consumer cost-sharing protections such as low-cost sharing for prescription drugs and access to an exception process

# Questions?

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# Discussion

## At your table

- What ideas feel like they have merit for us?
  - How does it (they) impact outcomes?
  - What benefits might we expect?
  - What are the potential draw backs?
- What ideas might be worthy of a deeper dive at the next meeting?

## Large Group

- Pros, Cons, Want More Information







# Presentation 2: Kirsten Axelsen *Pfizer*

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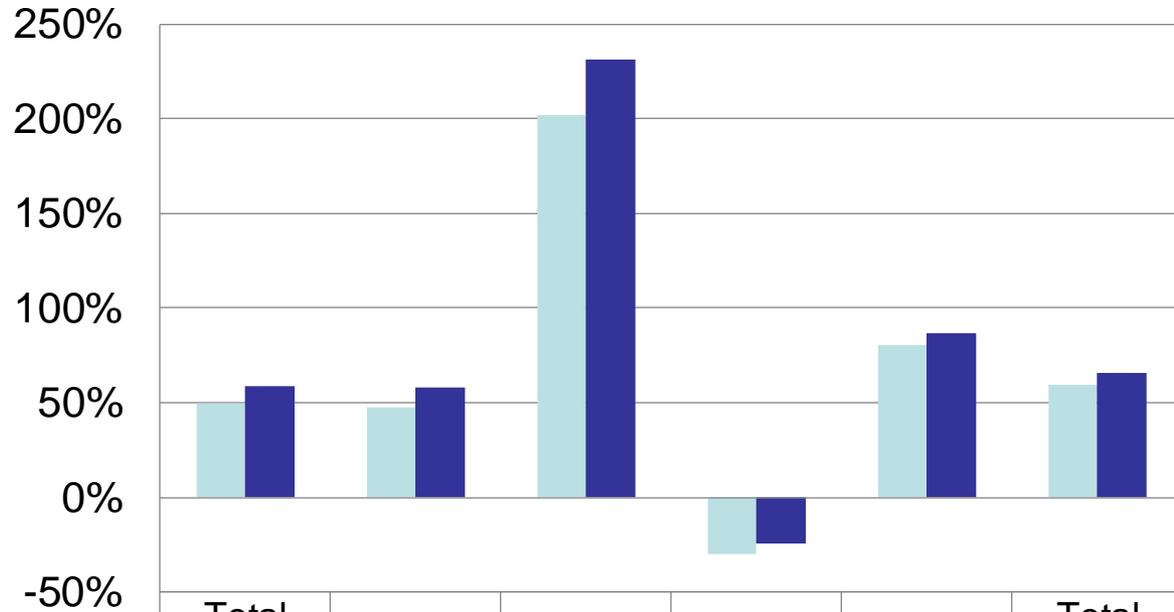
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# **Healthcare Expenditures & Prescription Medicines:** *Addressing Out-of-Pocket Cost Barriers*

*Washington State SSB 6569 Task Force*  
*August 3, 2016*

# Cost Sharing: Deductible, Co-Insurance, Co-Pay

## Change in Spending 2014 vs 2005

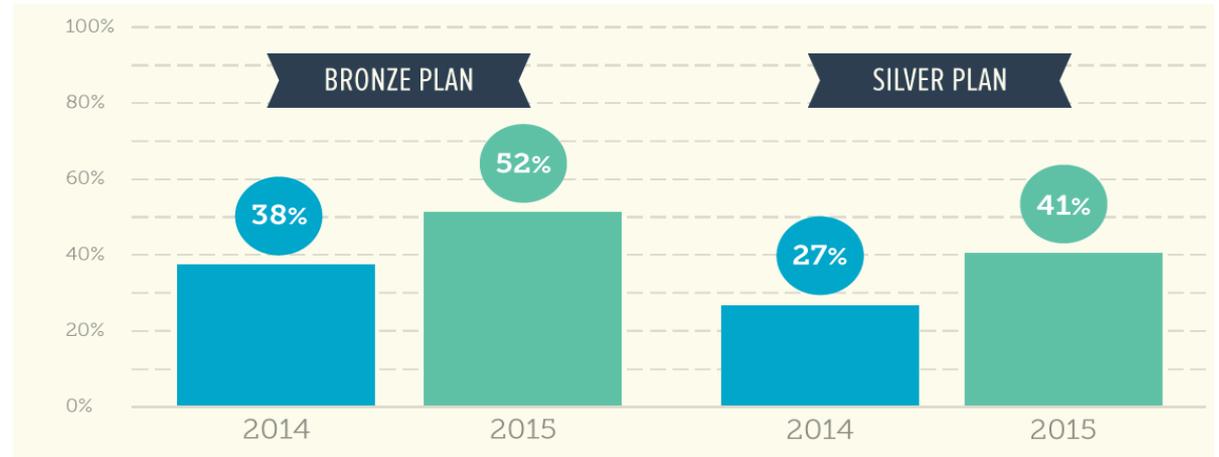


	Total benefit costs	Paid by insurers	Deductibles	Copayments	Coinsurance	Total cost sharing
■ Total Population	49%	48%	202%	-30%	81%	59%
■ Top 15% Spenders	59%	58%	231%	-24%	86%	66%

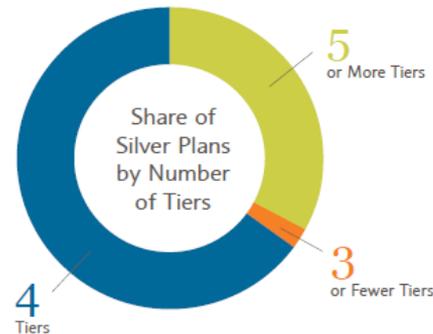
Adapted from Kaiser Family Foundation analysis of Truven Health Analytics MarketScan Commercial Claims and Encounters Database, 2004 – 2014\*Includes enrollees with total spending (including claims paid by the insurer and out-of-pocket costs) in the top 15% in each year. In 2014, enrollees in the top 15% had total costs that exceeded \$6,717.

# Co-Insurance and Tiers Increasing

**Percentage of exchange plans with co-insurance >30% in specialty tier**

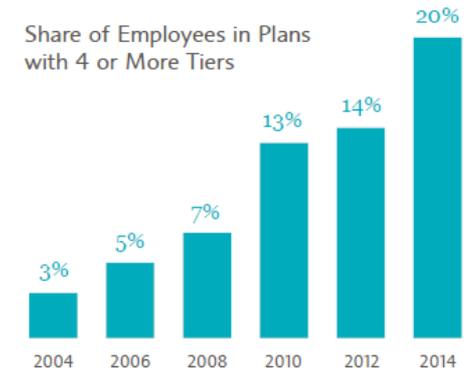


*...is the norm for plans in Health Insurance Exchanges*



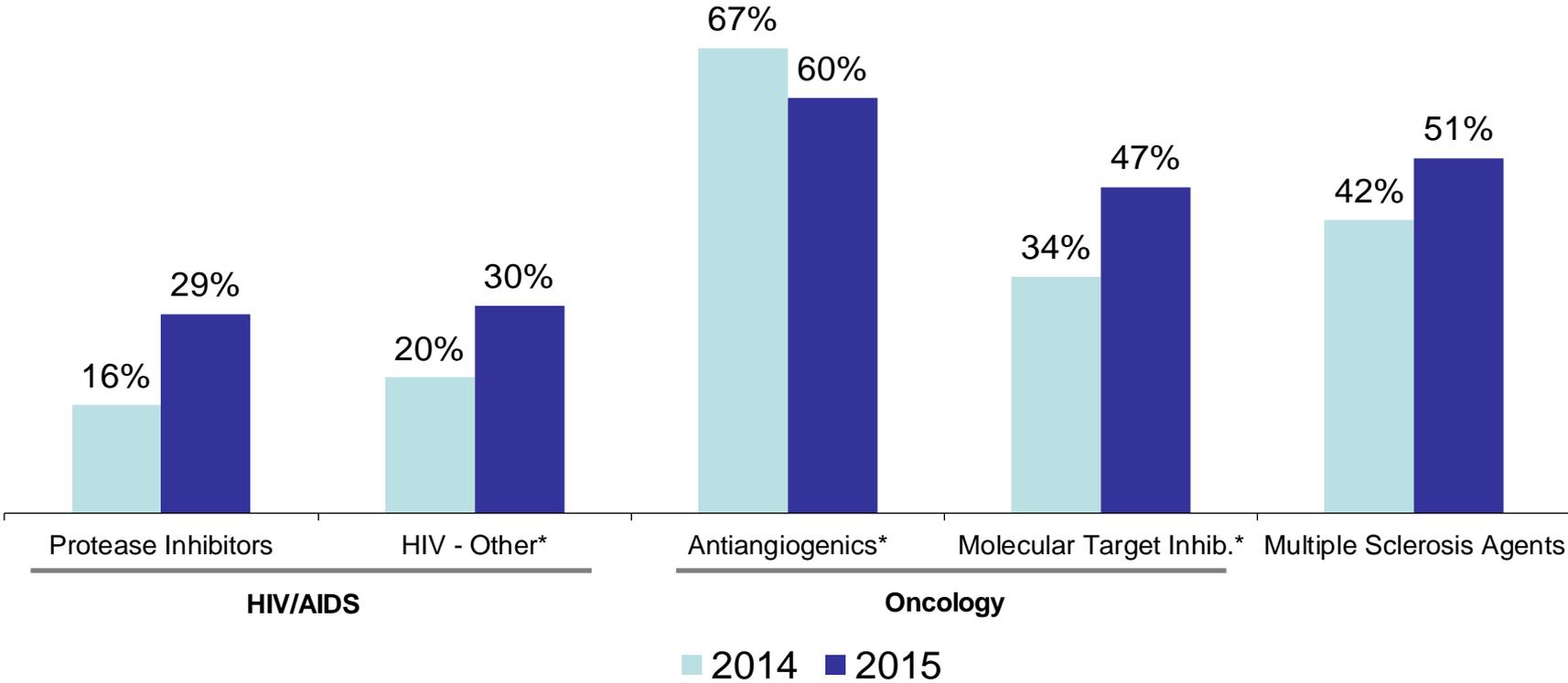
**Plans with 4+ tiers increasing**

*...and is becoming more common in employer plans*



# Adverse Tiering Common

**Percentage of Silver plans placing all drugs in the class on the specialty tier, 2014 and 2015**

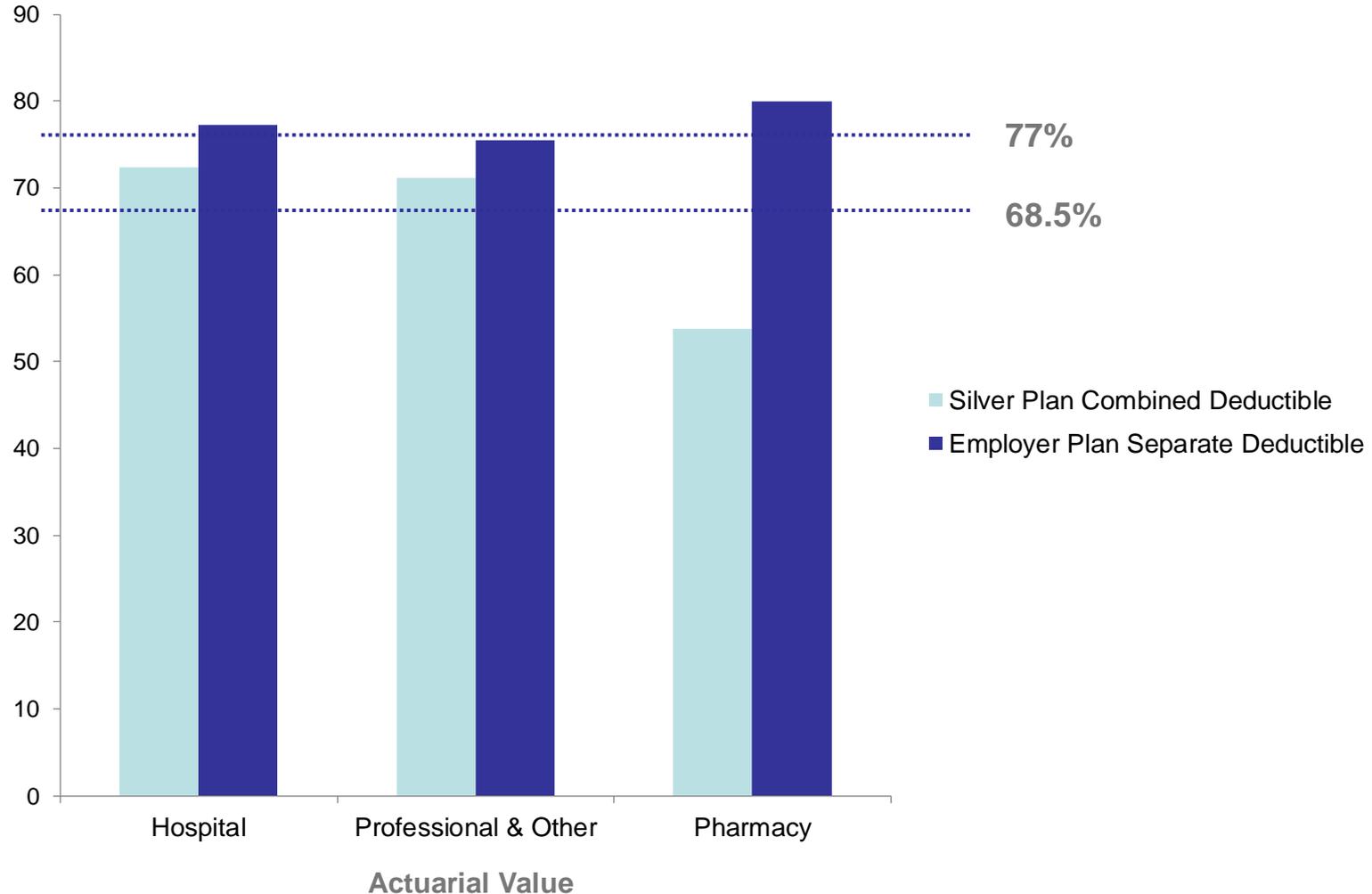


\*There are no generic drugs available in the class. All products are single-source.  
 Note: Coverage is weighted according to unique plan-state combinations. Sample includes silver plans in 6 states (FL, GA, IL, NC, PA, and TX) relying on HealthCare.gov, and CA and NY.  
 Source: Avalere Health PlanScape®, a proprietary analysis of exchange plan features, February 2015. This analysis is based on data collected by Managed Markets Insight & Technology, LLC.

# Implication: Patients Pay a Higher Share of Cost for Medicines Than Other Services in ACA Plans



## Percentage of Cost Paid by Insurer in a Typical Silver Plan



# Premium Increases: Drivers

## Average Dollar Increase in Per Member Per Month Premiums, by Benefit Category, 2016 Individual and Small Group Plans



- Medicines are responsible for \$3.29 or around of the 17.5% premium growth—roughly the same as their contribution to their cost structure

# Consumer Representatives to the NAIC Report



CONSUMER  
RECOMMENDATIONS

## Consumer Recommendations on Copays and Coinsurance

State and federal insurance regulators, marketplace officials, and state lawmakers should:

- Prohibit or limit the use of coinsurance for drug coverage and/or adopt fixed copays for all drug tiers.
- Establish maximum levels of cost-sharing per prescription and per month and consider limiting monthly cost-sharing for any drug to no more than 1/12 of the plan-specific annual out-of-pocket maximum.
- Require formularies to disclose the actual dollar cost-sharing amount for a given medication under a particular plan.
- Require plans to offer drug benefits that, at a minimum, meet the plan's overall actuarial value level and disclose the actuarial value of their prescription drug benefit coverage.
- Encourage insurers that offer cost-sharing reduction plans to meet actuarial value targets by reducing cost-sharing for specialty drugs in addition to lowering deductibles and annual out-of-pocket maximums.

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**Patient Access and Use of Medicines:**  
*State Policies to Address Co-Pay*

# Enacted Policies Addressing Rx Cost-Sharing

## Legislation

- ❖ **Post-Deductible Copay Caps**
  - CA - \$250/\$500 per 30 day Rx
  - DE - \$150 per 30 day Rx
  - LA - \$150 per 30 day Rx
  - MD - \$150 per 30 day Rx
- ❖ **Lower Annual Rx Maximum Out of Pocket (MOOP)**
  - Maine - \$3,500 Rx annual MOOP for drugs with co-insurance
  - Vermont – Annual Rx MOOP equals the minimum deductible amount for HDHP (\$1,300)
- ❖ **Prohibition on “Specialty Tiers”**
  - New York – Only 3 Rx tiers allowed

## Regulation

- ❖ **CA – Copay Caps**
  - Tier 4 drugs in Exchange plans capped at \$250 or \$500 (Bronze plans) per 30 day supply, after deductible is met
- ❖ **CO / MT – Fixed Copay Requirement / Pre-deductible Plans**
  - A subset of plans must offer flat copays
  - Some of the subset must have no Rx deductible
- ❖ **MA – Fixed Copays in Exchange**
  - In 2016, the MA Health Connector requires plans to use fixed copays ranging from \$20 - \$225
- ❖ **MA, VT – Limit Rx Tiers**
  - Exchange plans are limited to three (3) Rx tiers
- ❖ **CA, CT, DC – Separate Rx Deductible**
  - Standard plans in Exchanges have a separate, relatively low drug deductible
  - CA limits separate Rx deductible to \$500 or \$1000 for Bronze plans

# Policy Impact Research: Elimination of “Specialty” Tiers



## ❖ Milliman study of commercial plans<sup>1</sup>

- Modeled removal of specialty tiers from a typical commercial plan
- Findings similar to a study on eliminating specialty tiers in Medicare Part D<sup>2</sup>
- Conclusion: Cost fully offset by raising preferred and non-preferred copays by \$5 or \$10, depending on the baseline design

**Figure 2: Sample Actuarially Equivalent Benefit Designs in the Context of Prescription Drug Cost Reduction**

Scenario 1: Three- and Four-Tier Structures, No Adverse Selection Assumed

Current Plan	Actuarial Equivalents to Current Plan		Plan Savings from Either Actuarial Equivalent Relative to Current Plan
	Three-Tier Benefit Structure <sup>a</sup>	Four-Tier Benefit Structure <sup>b</sup>	
<b>Lower Copay Plan</b> <b>\$8 / \$20 / \$40</b> <i>Annual Cost to Specialty Patient<sup>c</sup></i>	<b>\$8 / \$25 / \$45</b> <b>\$300–\$540</b>	<b>\$8 / \$20 / \$40 / 5%</b> <b>\$1,800</b>	<b>3%</b>
<b>Higher Copay Plan</b> <b>\$12 / \$30 / \$50</b> <i>Annual Cost to Specialty Patient<sup>c</sup></i>	<b>\$12 / \$40 / \$60</b> <b>\$480–\$720</b>	<b>\$12 / \$30 / \$50 / 10%</b> <b>\$3,600</b>	<b>6%</b>

a. Generic / preferred / non-preferred

b. Generic / preferred / non-preferred / specialty (coinsurance)

a, b. Mail-order copayment twice the retail copayment

c. Annual patient cost assumes \$3,000 specialty drug per month with second, third, and fourth-tier cost-sharing

<sup>1</sup> Milliman, “Specialty Tiers: Benefit Design Considerations for Commercial Payers,” October 2013. Available at <http://us.milliman.com/uploadedFiles/insight/2013/Benefit%20design%20considerations%20for%20commercial%20payers.pdf>.

<sup>2</sup> Milliman, “Specialty Tiers: Benefit Design Considerations for Medicare Part D.” June 25, 2013. Available at: <http://us.milliman.com/uploadedFiles/insight/2013/specialty-tiers.pdf>.

# Policy Impact Research:

## Co-Pay “Caps” / Lower Rx MOOP



### ❖ Pre-deductible co-pay “caps”

- Methods: Milliman<sup>1</sup> modeled pre-deductible caps of \$100, \$150, and \$200 per Rx (30-d supply), for typical Silver Exchange plans and three CA Exchange plans
- Findings: Premium increases would be 0.5% or less with few benefit design changes (e.g., \$5 increase in PCP copays) for all but bronze plans, which would require larger design changes to stay under 0.5%
- Findings: Members with high spending on specialty drugs would be expected to save between \$80 - \$2,300 per year in OOP cost; little change in OOP for other members

### ❖ Lower Rx maximum out of pocket (MOOP)

- Methods: Milliman<sup>1</sup> also modeled establishing an Rx MOOP at 20% of total MOOP (e.g., \$1,310 for an individual in 2017), similar to Vermont
- Conclusion: Premium increases would be 0.5% or less with minimal or no design changes for all but Bronze plans, which could increase by 4.6% for a typical Bronze plan

<sup>1</sup> Milliman, “Pharmacy Cost Sharing Limits for Individual Exchange Benefit Plans: Actuarial Considerations,” March 5, 2015. Available at <http://www.ils.org/sites/default/files/National/USA/Pdf/Milliman%20Report%20on%20Prescription%20Cost%20Sharing%20Limits%20for%20Exchange%20Plans.pdf>.

# Policy Impact Research:

## Co-Pay “Caps” / Lower Rx MOOP



- ❖ Milliman<sup>1</sup> modeled premium impact of caps or lower Rx MOOP:

Possible Actions a Plan may Take to Offset Increased Plan Costs						
Scenario	California Standard Platinum Plan	California Standard Gold Plan	California Standard Silver Plan	California Standard Bronze Plan	Typical Silver Exchange Plan	Typical Bronze Exchange Plan
<b>Monthly per-prescription cap, applied pre-deductible (\$200)</b>						
Estimated % Increase in Premium	0.1%	0.3%	0.3%	1.6%	0.3%	1.6%
Possible actions a plan may take minimize premium increase to 0.5%	No action required	No action required	No action required	Increase out-of-pocket maximum by \$350	No action required	Increase out-of-pocket maximum by \$350
<b>Annual Rx OOP max set at % of total annual OOP max (20%)</b>						
Estimated % Increase in Premium	0.2%	0.8%	0.9%	4.8%	0.9%	4.6%
Possible actions a plan may take minimize premium increase to 0.5%	No action required	Increase PCP copay by \$5	Increase PCP copay by \$5	Cannot minimize premium increase to 0,5% under ACA out-of-pocket limits	Increase PCP copay by \$5	Cannot minimize premium increase to 0,5% under ACA out-of-pocket limits

\* Assuming plan applies 15% load for retention and that all loadings are included in this retention

<sup>1</sup> Milliman, “Pharmacy Cost Sharing Limits for Individual Exchange Benefit Plans: Actuarial Considerations,” March 5, 2015. Available at <http://www.ils.org/sites/default/files/National/USA/Pdf/Milliman%20Report%20on%20Prescription%20Cost%20Sharing%20Limits%20for%20Exchange%20Plans.pdf>.

### ❖ Colorado Model<sup>1</sup>

- Each issuer offers one plan per metal level with fixed co-pays and no Rx deductible
- 25% of plans must offer fixed copay Rx benefit design, and those co-pays can be no more than 1/12 of the out of pocket maximum
- Prohibition on placing all drugs on the highest tier for a condition

### ❖ Research

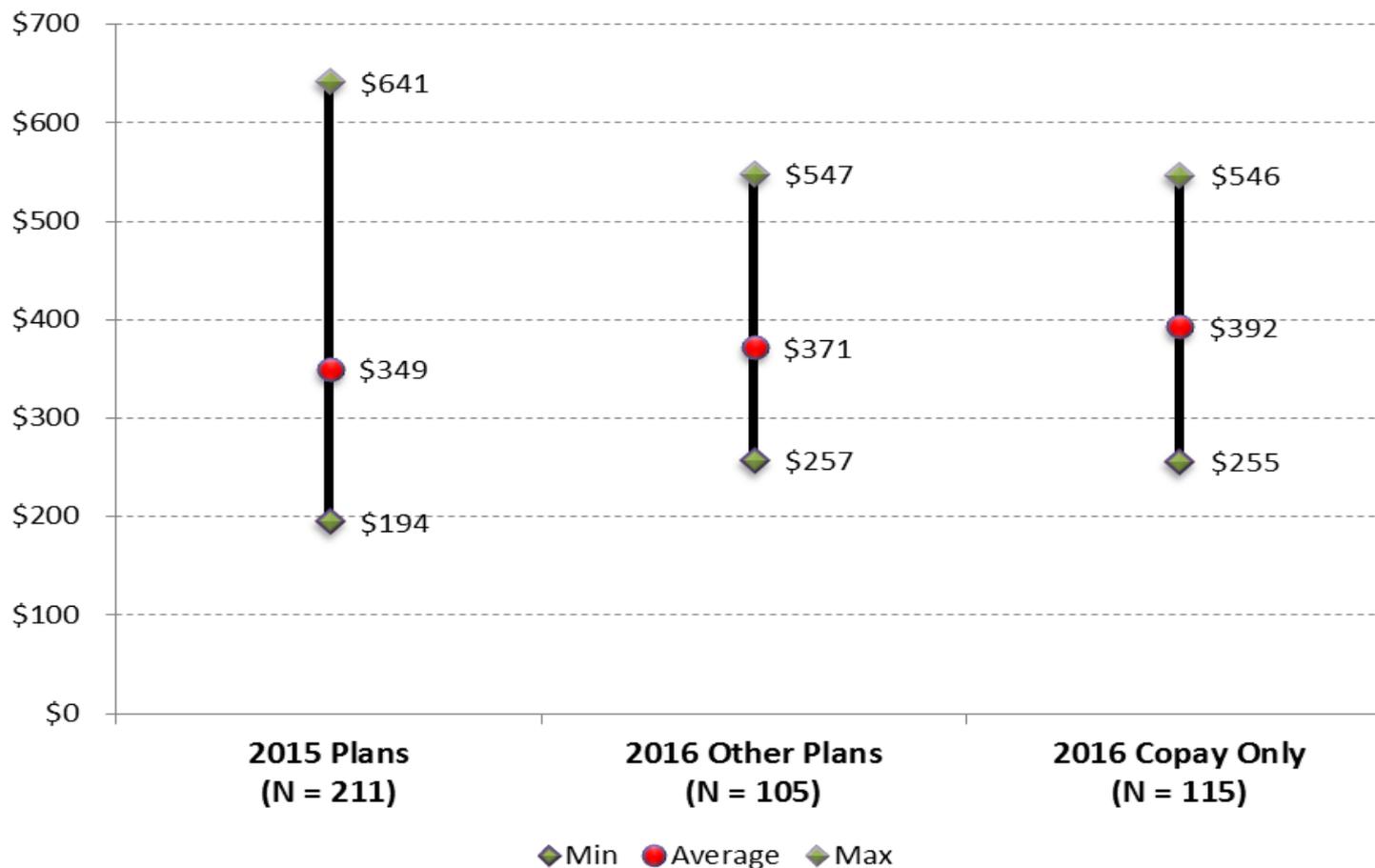
- The Moran Company examined issuer participation, change in Silver plan premiums, and benefit designs before and after implementation (2015-16)

### ❖ Findings

- # of issuers / plans were similar before and after implementation
- 2016 premiums were similar between copay-only and other plans
- Rx deductibles were significantly lower for copay-only than other plans
- Cost sharing did not shift appreciably higher for benefit categories

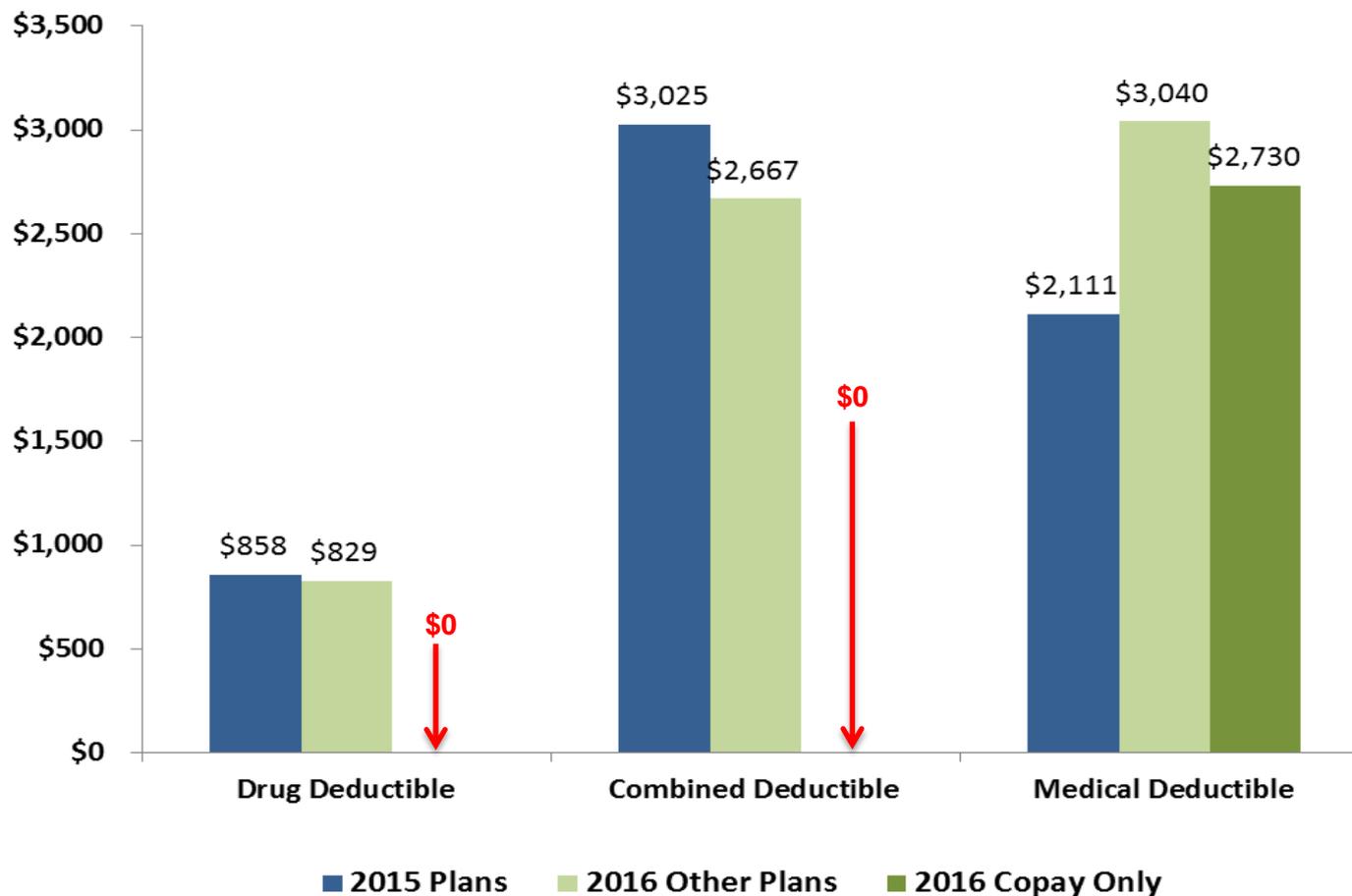
<sup>1</sup> The Moran Company, "Initial Findings from Colorado Insurance Landscape Analysis 2016." Prepared for PhRMA, August 2016. Available at: <http://phrma.org/sites/default/files/pdf/colorado-exchange-deliverable-highlights.pdf>.

## Impact on Premiums



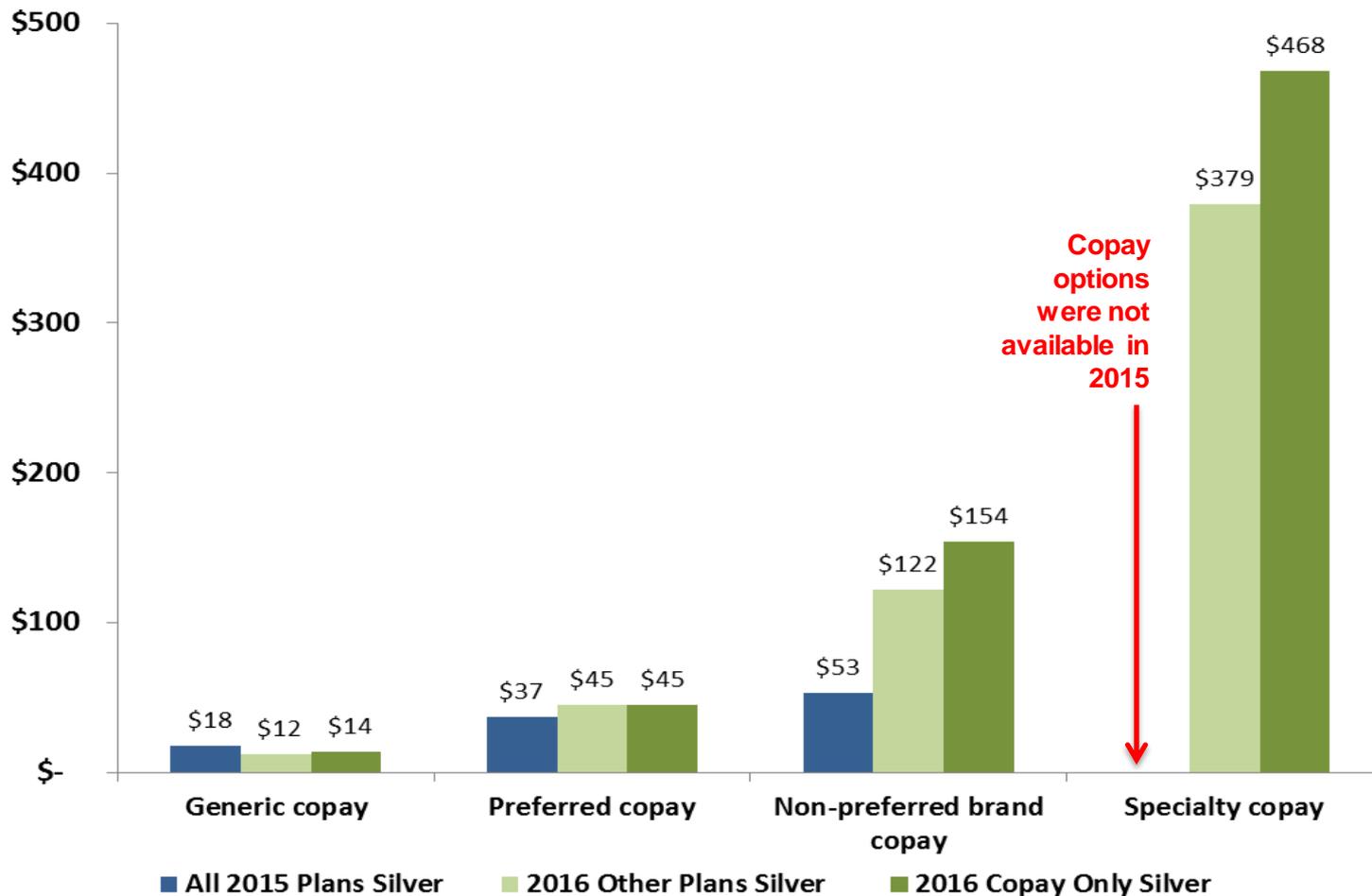
<sup>1</sup> The Moran Company, "Initial Findings from Colorado Insurance Landscape Analysis 2016." Prepared for PhRMA. August 2016. Available at: <http://phrma.org/sites/default/files/pdf/colorado-exchange-deliverable-highlights.pdf>.

## Silver Plan Deductibles



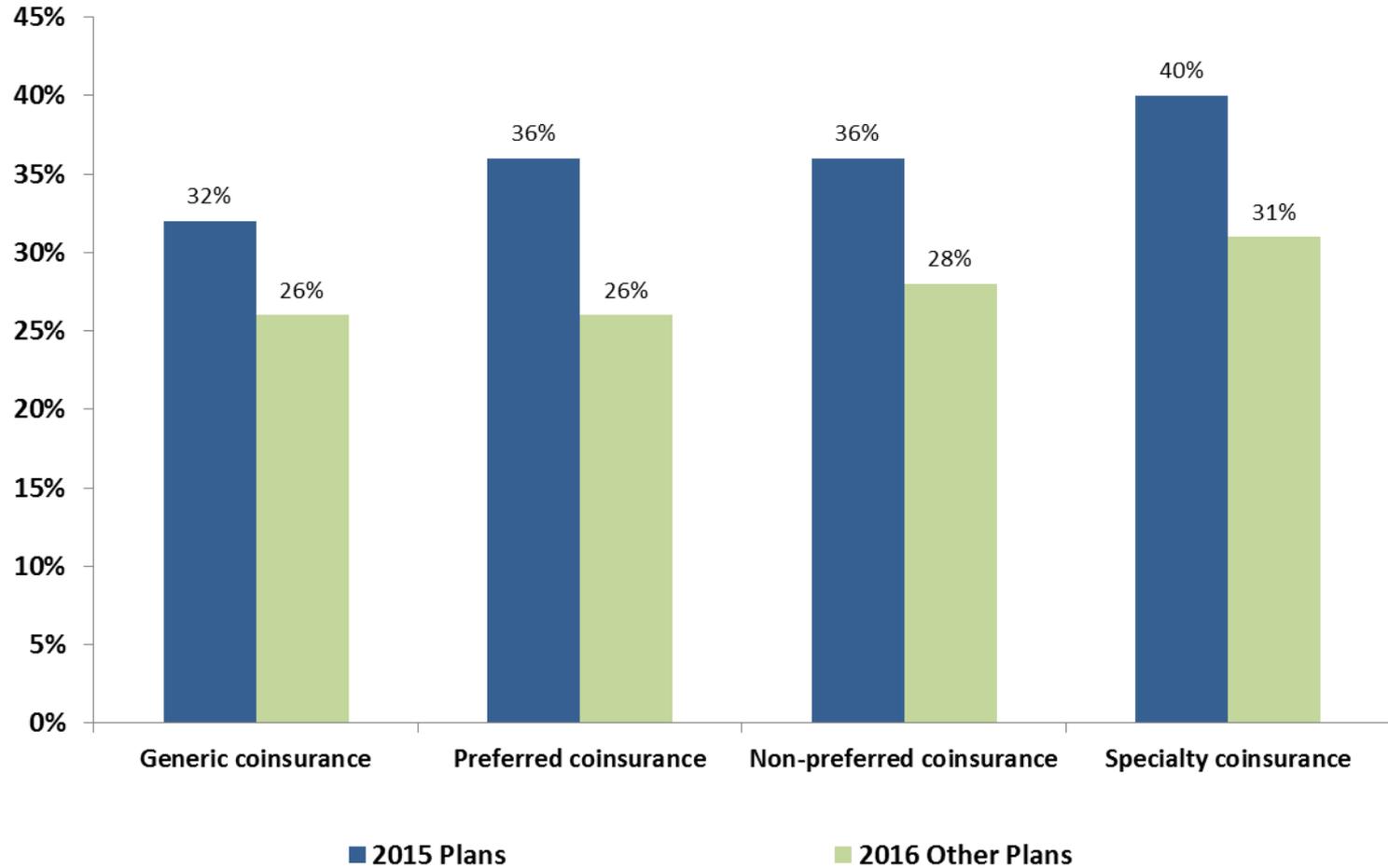
<sup>1</sup> The Moran Company, "Initial Findings from Colorado Insurance Landscape Analysis 2016." Prepared for PhRMA. August 2016. Available at: <http://phrma.org/sites/default/files/pdf/colorado-exchange-deliverable-highlights.pdf>.

## Silver Plan Copays



<sup>1</sup> The Moran Company, "Initial Findings from Colorado Insurance Landscape Analysis 2016." Prepared for PhRMA. August 2016. Available at: <http://phrma.org/sites/default/files/pdf/colorado-exchange-deliverable-highlights.pdf>.

## Silver Plan Coinsurance



<sup>1</sup> The Moran Company, "Initial Findings from Colorado Insurance Landscape Analysis 2016." Prepared for PhRMA. August 2016. Available at: <http://phrma.org/sites/default/files/pdf/colorado-exchange-deliverable-highlights.pdf>.

# Discussion

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## Large Group

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**KEEP  
CALM  
AND  
MAKE**

**New Friends**



# Presentation 3: Julie Cooper

## *Premera Blue Cross*

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# PRIVATE SECTOR: HEALTH PLAN AND PURCHASER TRENDS IN ADDRESSING OUT- OF-POCKET COSTS

MATERIALS FOR THE PATIENT OUT-OF-  
POCKET COSTS TASK FORCE

SEPTEMBER 9, 2016

*This is not an exhaustive list of policy options, but intended to provide a high level overview of the array of efforts to address high out-of-pocket costs consumers face, focused on prescription drugs.*

# POLICY OPTIONS

## **Value-Based Designs**

- Outcomes-Based/Value-Based Drug Formulary Design
- Value-Based Contracting Agreements
- Employer Solutions

## **Transparency Efforts**

- Drug pricing transparency
- Cost estimator tools and other technologies
- All Payer Claims Database
- Drug coupons and co-pay cards

## **Patient Education**

# VALUE-BASED DRUG FORMULARY DESIGN

- Payers in many other countries routinely use sophisticated value-based decision making principles when designing formularies
- Value-Based Formulary Design (VBFD) seeks to encourage the appropriate use of **high-value care**
- VBFD recognizes that:
  - Medical services differ in the benefit provided
  - Clinical benefit of certain medical services differ between the patient, provider and site of care
- Applied to drugs, VBFD attempts to structure a formulary that reflects the value of drug rather than cost
  - Seeks to align co-pay for drugs with their value in hopes of obtaining better clinical outcomes and economic benefit
- To date, most value-based plans have targeted chronic medical conditions such as diabetes, hypertension, hyperlipidemia, and asthma

# VALUE-BASED DRUG FORMULARY DESIGN

## ANTHEM: OUTCOMES BASED DRUG LIST APPROACH (EXAMPLE)

- Links pharmacy and medical data in order to improve outcomes and better manage total health care cost
- Designed to consider both the complete burden of disease and to utilize the formulary to improve patient outcomes
- Pharmacy and Therapeutics Committee (includes Clinical Review and Value Assessment) combines clinical evaluation and overall value to decide which medications are on the formulary
  - The internal drug information team gathers and critically reviews all available clinical data, including: Published literature; FDA documents; and manufacturer information
  - Internal analyses are reviewed by external pharmacoeconomic specialists before being ranked to dictate tier placement for each drug, followed by careful consideration of real-world outcomes and total costs
    - Tier 1 drugs are usually generics and members pay the lowest coinsurance
    - Tier 2 and Tier 3 drugs often have brand names or are more expensive generics and members can expect to pay slightly more
    - Tier 4 drugs are mostly specialty drugs and members will pay the highest copay amounts

# VALUE ASSESSMENT FRAMEWORK

- **Institute for Clinical and Economic Review (ICER):** independent non-profit research institute that produces reports comparing how well different treatment options work for different kinds of patients and analyzes costs across the system in short and long term
- Goal is to help support discussions of how to achieve the broader goal of improving patient outcomes while making health care more affordable for patients
- Calculates a “value-based price benchmark” based on evidence of how much better it is improving patients’ lives
- **Education/Informed Decision Making:** ICER is also focused on developing guides to help patients and clinicians make high value healthcare choices

# VALUE-BASED CONTRACTING AGREEMENTS

- Value-based contracting agreements are contracts in which the health plan pays for drugs based on their effectiveness
- Contracts that link drug payment to health outcomes are common in the U.K. and other European countries

## Recent Examples

- Novartis agreed to pay-for-performance contract agreements with Aetna and Cigna for Novartis' heart drug Entresto
  - Contract agreements tie the financial terms to how well the drug improves the relative health of the plan's customers
- The discounted amount Aetna and Cigna will pay for Entresto depends on whether the medication reduces hospitalizations for their commercially insured patients with congestive heart failure
- In exchange, Novartis will gain volume, and Entresto will become a preferred drug, subject to prior authorization, on Aetna and Cigna's formularies

# EMPLOYER PURCHASER INITIATIVES

## Frequently Used Approaches/Tools

- Step therapy, prior authorization, quantity limits, tiering, site of care steerage, and freestanding or PBM specialty pharmacy

## Solutions to improve patient medication adherence

- Proper patient onboarding and ongoing support
- Adding specialty administration to on-site clinics
- Emerging technology - Bluetooth capabilities on the pill container; Pill sensors; mobile technology and apps
- United Health Care – ScriptHub Plus smartphone app pilot project
  - Designed to ensure medication adherence
  - When patients fail to take medicines, health plans can get hit with additional costs
  - When a physician has prescribed a medication, the app offers the price for the drug under the patient's insurance plan at the location requested
  - The app also offers other options, including mail-order, drug information and potentially cheaper alternatives the patient can discuss with the doctor

# RX PRICING TRANSPARENCY

## State Legislation

- At least 14 states introduced bills to require prescription drug manufacturer transparency such as disclosure of how much is spent on research, manufacturing and marketing to justify their prices
  - CA, CO, LA, MA, MN, NJ, NY, NC, OR, PA, TX, VT, VA, WA
- Three states passed bills that require health plans to provide product price and access to transparency
  - AR, SD, TX

# COST ESTIMATOR MEMBER TRANSPARENCY TOOLS

- Helps enrollees **compare out-of-pocket costs** for a number of common procedures across different providers
  - e.g., enrollee can compare knee arthroscopy at VM, Multicare, etc and view quality scores
- WA law requires health plans to provide transparency tools including cost estimator and quality information, including Rx costs

The screenshot shows the UnitedHealthcare myHealthcare Cost Estimator interface. At the top, it displays the UnitedHealthcare logo and the user's remaining deductible: Individual \$100, Family \$3,000, and HSA \$244. The main heading is "myHealthcare Cost Estimator" with navigation links for "Start over", "Prescription estimates", "What is it?", and "How it works". The current procedure is "Care Estimate: Knee Arthroscopy With Meniscus Surgery". The "Your Out-of-Pocket: Based on Your Plan" is \$968, and the "In-Network Cost: Market Average" is \$5486. The "Health Plan Pays: \$4,518" is also shown. Below this, there are icons for various steps: Home (\$40), Initial Office Visit with PCP Smith (\$40), Office Visit with Specialist for Evaluation Gordon (\$111), Select MRI Facility (\$474), Repair or Removal of Meniscus Step 4 (\$4,388), Physical Therapy Step 5 (\$300), Follow-up Office Visit Smith (\$40), and Final Estimate. The search criteria are "Knee MRI" with a search radius of 25 Miles and 5 facilities selected. The search results show 4 facilities ranging from \$287 to \$502. The first facility is a Hospital at 1234 40th Ave, Manhattan, NY 10002, with a Local Average of \$474, This Facility cost of \$287, Health Plan Pays of \$33, and Out-of-Pocket of \$254. The second facility is a Diagnostic Imaging center at 1234 45th Ave, Manhattan, NY 10002, with a Local Average of \$649, This Facility cost of \$382, Health Plan Pays of \$119, and Out-of-Pocket of \$263.

(Source: <https://www.uhc.com/news-room/2014-news-release/2014-news-release-archive/health4me-app-available-to-all>)

# TRANSPARENCY TOOLS

## Emerging Technology

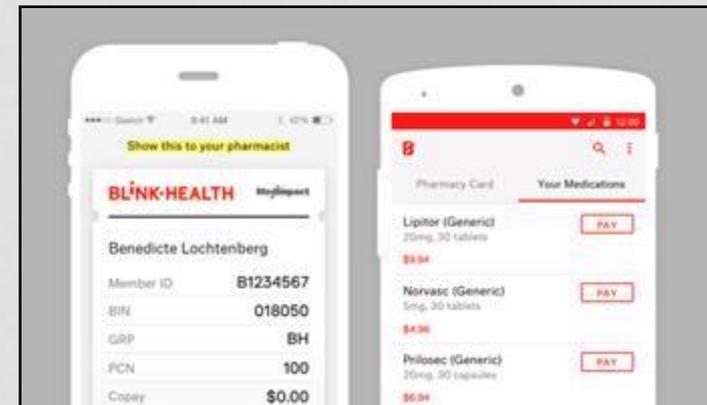
- United Healthcare – Health4Me mobile app
  - Helps users find nearby providers, manage prescriptions, check their claims, and provides patients with cost estimates and quality data
- National Comprehensive Cancer Network
  - Developing a comparison tool to help patients compare the costs and benefits of various cancer therapies
  - The tool will score different medication options on a one-to-five scale based on five measure: price, effectiveness, safety, quality, and consistency of clinical data



# TRANSPARENCY TOOLS

## Emerging Technology

- Truveris – OneRx mobile app
  - Helps patients calculate their prescription drug co-pays based on their insurance coverage as well as any available deals, such as manufacturer coupons and pharmacy discounts
- Blink Health – Website and mobile app
  - Specific to generic drugs only; Blink Health allows customers to pay for their drugs online, then pick up the prescription at nearly any pharmacy, no insurance required
- GoodRx – Website and mobile app
  - Collects drug prices at pharmacies around the country and connects consumers to coupons to help them pay



# TRANSPARENCY

## **All-Payer Claims Database (APCD)**

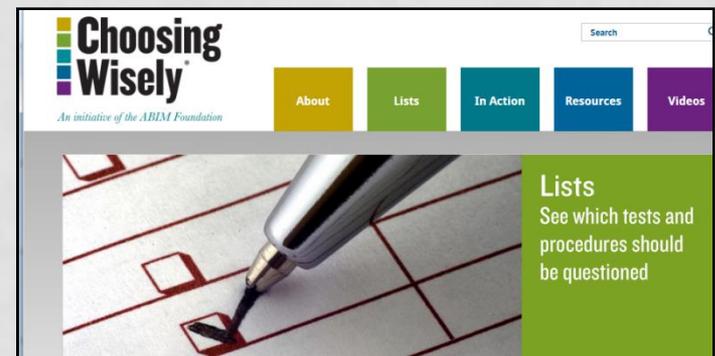
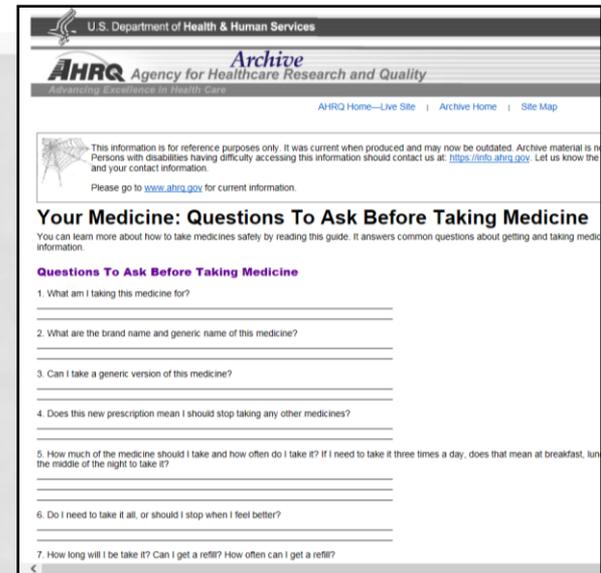
- Collects medical claims, pharmacy claims, dental claims (typically, but not always), and eligibility and provider files from private and public payers
- Allows states and other stakeholders to understand the cost, quality, and utilization of healthcare
- CO's APCD: provides a consumer facing search capability to look up price and quality information for select hospital-based services
- At least 18 states have enacted APCDs while more than a dozen others have considered such a law or program

# DRUG COUPONS AND CO-PAY CARDS

- Manufacturers attempt to subsidize consumers' out-of-pocket costs via drug coupons and co-pay cards
- While coupons may be helpful to consumers and immediate out-of-pocket costs, coupons can distort and skew plan formularies that lead to higher overall costs across the system
- Federal government plans (Medicare and Medicaid) ban the use of coupons as kickbacks under federal law
- MA: was the only state that prohibited use of coupons; recently loosened restrictions

# AN INFORMED PATIENT : BETTER DECISIONS AND CARE

- **Agency for Healthcare Research and Quality (AHRQ):** common list of questions that a patient can ask their doctor to learn about alternatives including generics
- **Choosing Wisely:** encourages conversations between provider and patient using evidence based recommendations
- Information sharing before a prescription is written can impact patient and prescriber choices



(Source: <http://www.choosingwisely.org/>)

(Source: <http://archive.ahrq.gov/patients-consumers/diagnosis-treatment/treatments/safemeds/yourmedques.html>)

# DISCUSSION

# Discussion

## At your table

- What ideas feel like they have merit for us?
  - How does it (they) impact outcomes?
  - What benefits might we expect?
  - What are the potential draw backs?
- What ideas might be worthy of a deeper dive at the next meeting?

## Large Group

- Pros, Cons, Want More Information

*Dácil Ridolfi*



# Planning for Meeting #3

## Conversation Starters

- Are there any other policy options that should be considered?
- What are the most promising ideas you've heard today?



Plus



Delta

