V-BID

Probing the public's views on VBID

Report II

Funding for this project was provided by the Robert Wood Johnson Foundation.

For questions or more information, please contact the core project team:

Thomas M. Reischl, PhD, Susan Morrel-Samuels, MA, MPH, Caroline Kusi, BA
Prevention Research Center of Michigan, University of Michigan School of Public Health
reischl@umich.edu; sumosa@umich.edu; ckusi@umich.edu

Kaden Milkovich, MPA
Center for Value-Based Insurance Design, University of Michigan School of Public Health
kmilkovi@umich.edu

Mary Ellen Benzik, MD
Integrated Health Partners, Battle Creek, MI
mebstork@aol.com

Executive Summary

There is a growing body of evidence suggesting that Value-Based Insurance Design (V-BID) plans can improve health outcomes and may reduce health care costs. Because of these promising research results, a growing number of insurance companies and employers are interesting in implementing V-BID programs. With this growing interest, however, is an increasing concern about how employees and health insurance consumers will understand and judge V-BID approaches. Will consumers be wary of tailored co-pay schemes that incentivize selected health care protocols? Will consumers view V-BID approaches as taking away decision-making power from doctors and patients? Will V-BID approaches be viewed as too expensive or as an unfair burden for consumers who won't directly benefit from tailored incentives?

This report supplements an earlier report on the public's views about value-based insurance design (see Swinburn et al., 2012). Both reports provide analyses and summaries of focus group discussions of health insurance scenarios that feature value-based insurance design (V-BID) ideas such as (A) reduced co-pays for effective treatments of chronic diseases like diabetes, (B) higher co-pays for unnecessary health care such as early MRI scans for acute back pain, and (C) discontinued insurance coverage for ineffective or potentially dangerous health care such as an ineffective cancer medication with life-threatening side effects.

The two focus group discussions for this second report occurred in Battle Creek (Michigan) with 19 participants (9 in one group, 10 in the other group). Recruitment targeted a mixed-age group of those currently receiving health insurance through an employer. Before beginning the discussions, the participants viewed a brief PowerPoint presentation about health plans. The discussions that followed the slide presentation were structured in three parts. First, the lead moderator read a scenario aloud. Second, the moderator asked participants to indicate their agreement with series of statements related to the scenario which were written on a flip chart. Participants "voted" by placing a colored dot under the statement that was most reflective of their own opinion. Following the voting, the moderator asked each participant to describe the reasons for his or her opinion. Lastly, the moderator led an open discussion about the scenario in question. After the focus group discussions, participant's completed a survey about their concerns regarding health insurance and their impressions of the V-BID approaches they discussed during the focus group.

Based on these initial discussions and reviews of the transcripts, the researchers developed a set of thematic codes to identify the diversity of opinions about V-BID approaches held by the focus group participants. These themes are categorized into two broad groups: reasons for favoring or not favoring V-BID approaches.

After each focus group discussion, each participant completed a survey about their concerns regarding health insurance and their final impressions of the V-BID approaches they discussed during the focus group.

The results of this second set of focus group discussions described in this report revealed a wide variety of ideas and opinions about V-BID approaches in health insurance plans. While there were more thematic codes for the participants' unfavorable impressions of V-BID approaches than for favorable impressions, this difference should not be interpreted as the participants' general impressions of V-BID approaches. The post-discussion surveys indicated that most of the participants left the discussions with favorable impressions of V-BID approaches.

The favorable impressions of V-BID approaches included:

- The potential for V-BID approaches (especially lower co-payments and lower out-of-pocket costs) to serve as incentives for patients seeking health care and adhering to medical regimens.
- The potential for V-BID approaches to serve as disincentives for ineffective or unnecessary or harmful health care.
- The potential for health care providers with professional knowledge (e.g., doctors) to have more decision making power in determining diagnostic and treatment procedures.
- The potential for reducing health care costs.

The unfavorable impressions of V-BID approaches included:

- Health care benefits should be distributed according to standards of fairness instead of on the effectiveness of health care treatments.
- People should take personal responsibility for their own health care and incentives (e.g., no co-payments) may reduce this personal responsibility.
- V-BID incentives (e.g., no co-payments) for some employees and patients may increase costs for others.
- V-BID components may lead to greater scrutiny and discrimination against employees who use expensive health care treatments.
- V-BID disincentives for ineffective health care may be unfair to patients who hold out hope for positive results (even if there is clear research evidence that the treatments are ineffective).
- Evidence about the effectiveness of health care treatments should not be trusted and should not determine which treatments should be encouraged and discouraged.
- Patient should have the power to decide about their own health and health care, including power when diagnosing health problems, when choosing the elements of health plans and key health care treatment decisions, and in treatment decisions.
- V-BID plans may not save money in the long term because health care costs are rising and doctors have incentives for increasing health care costs.

These results suggest that the participants understood the potential advantages of V-BID approaches including those that are incentives for effective care (e.g., no co-payments) and disincentives for ineffective care (e.g., higher co-payments). These themes also suggest that participants also understood how V-BID approaches such as incentives and disincentives may lead to better health outcomes and lower health care costs.

The participants also held a variety of concerns that lead them to mistrust or disagree with V-BID approaches. V-BID approaches encroached on some participants' sense of fairness, personal responsibility, health privacy rights, hopes for positive outcomes, and patient freedom to choose health care. Other participants were concerned about higher health care costs either for everyone or for some employees if V-BID approaches are used.

Probing the Public's Views on Value-based Insurance Design (V-BID)

Introduction

This report supplements an earlier report on the public's views about value-based insurance design (see Swinburn et al., 2012). Both reports provide analyses and summaries of focus group discussions of health insurance scenarios that feature value-based insurance design (V-BID) ideas such as (A) reduced co-pays for effective treatments of chronic diseases like diabetes, (B) higher co-pays for unnecessary health care such as early MRI scans for acute back pain, and (C) discontinued insurance coverage for ineffective or potentially dangerous health care such as an ineffective cancer medication with life-threatening side effects.

The earlier report explained that V-BID is a new approach to health benefits design, with growing popularity among employers and policymakers. V-BID programs use incentives to help lower barriers to highly effective medical treatments and services and to increase disincentives for ineffective health care. V-BID programs rely on prevailing judgments about the research evidence of effectiveness of medical care to determine which treatments and services are deemed effective and ineffective.

There is a growing body of evidence suggesting that V-BID plans can improve health outcomes and may reduce health care costs by reducing long-term health complications. One example of such a V-BID approach is offering diabetics free or reduced rates on needed medications, insulin, and doctor's visits. Recent studies suggested this approach improved medication compliance, health outcomes for patients with diabetes, and health care cost savings.

Because of these promising research results, a growing number of insurance companies and employers are interesting in implementing V-BID programs into their health insurance plans. With this growing interest, however, is an increasing concern about how employees and health insurance consumers will understand and judge V-BID approaches. Will consumers be wary of tailored co-pay schemes that incentivize selected health care protocols? Will consumers view V-BID approaches as taking away decision-making power from doctors and patients? Will V-BID approaches be viewed as too expensive or as an unfair burden for consumers who won't directly benefit from tailored incentives? Great—really informative.

Summary of First Focus Group Study Report

The earlier report (Swinburn et al., 2012) summarized the discussions of five focus groups in Calhoun County (Michigan) during January and February of 2012. There were 47 participants in these discussion groups (8-10 participants per group) and all participants had a health insurance plan through a local employer. A few participants had Medicare coverage and an employer-based supplemental health insurance plan.

The analysis of the first five focus group discussions was organized to summarize discussion themes within three scenarios. The first scenario was about a 45-year old male middle-class office worker with diabetes who is starting to find it difficult to afford the rising out-of-pocket medical costs associated with managing his chronic disease. The focus group participants were invited to discuss their ideas about health plans that have no co-payments for medical care for patients with chronic diseases like diabetes to make it easier to adhere to medical regimens known to produce better health outcomes. The scenario expresses that while this V-BID approach will be more expensive for an employer, it is expected that no-copays will reduce long-term health complications and health insurance could become less costly for everyone.

The analysis of comments made about the first scenario suggested that the primary reason participants liked the no-copay approach was **the potential long-term cost savings** and the financial benefit for those with chronic illness. Those participants who expressed conditional support or who did not support the no co-pay approach (A) questioned whether this approach **actually did save money**; (B) suggested this approach **cover a broader range of chronic diseases** (not just diabetes); (C) argued that this approach should **require individual responsibility for self-care**; and (D) believed this approach should **account for participants' ability to pay**.

The second scenario was about a 50-year old mail high school teacher who had recently hurt his back while doing some home improvement work. He disagrees with his doctor that the back injury was acute and would quickly heal within a couple weeks. The teacher wants his doctor to order an expensive MRI scan, but his doctor believes the MRI scan is unnecessary. The focus group participants were asked to discuss their ideas about health insurance plans requiring that patients pay a higher co-pay for health care that medical experts believe is unnecessary (like this premature MRI scan).

The analysis of comments about the second scenario noted that participants who liked the higher co-pay approach for unnecessary care cited the **cost savings** and that **patients shouldn't insist on health care** that their doctor thinks is unnecessary. Those participants who did not favor higher co-pays for unnecessary care directly disagreed; they suggested that **more expensive diagnostic procedures may be needed** to rule out serious problems and that **patients should have the right to question their doctor's judgment**.

The third scenario was about a 48-year old woman with advanced breast cancer whose health care included an expensive drug that had recently lost its FDA approval because recent studies determined the drug was ineffective for breast cancer treatment and had a high risk of dangerous side effects (heart disease, stroke). The participants discussed their reaction to the V-BID approach to discontinue paying for this expensive drug even though this woman believe the drug was working for her.

The participant's comments about the third scenario included support for discontinuing insurance payments for this drug citing the importance that **insurance companies pay only for treatments that are effective** and that **doctors should not offer false hope** to patients by using ineffective treatments, especially those with **risky side effects**. Those participants who did not favor the discontinuation of insurance payments for this expensive drug argued that even though the drug is ineffective, the **patient's grave situation** warrants the continuation payments for this drug treatment.

The first report also provided a summary of the coded discussion comments including three themes associated with V-BID approaches that represent incentives for effective health care ("carrots") including:

- **Cost Savings**. This theme covered statements about the potential for V-BID to reduce the cost of health insurance.
- **Individual Responsibility**. Some participants expressed the importance that patients should be responsibility for their own care and that V-BID approaches should not discourage individual responsibility.
- **Fairness**. Many participants expressed that was unfair to offer incentives only to diabetics.

The focus group participants reactions to the V-BID incentives (such as no-copays for diabetes medicines and health care visits) included the potential cost saving benefits if the incentives encouraged more effective

health care and self-care. Other participant reactions suggested that the V-BID incentives may discourage individual responsibility for health care and self-care. Some participants expressed opinions that offering incentives only to one group of persons with a chronic illness (e.g., diabetics) would be unfair to those with other health problems.

Summary themes for the V-BID disincentive ("sticks") were also included in the first report. These included:

- **Determining value**. Participants were concerned about who determines the value of health care when these determinations limited access to health care.
- **Looking for compromise**. When considering barriers to ineffective or unnecessary health care, the participants often expressed a desire to find a compromise solution so that patients could have some power or recourse when certain forms of health care is discouraged.
- **Value means more than clinical outcomes**. Some participants noted the importance of hope and sense of control in addition to the value placed on health outcomes.

Some participants expressed concerns about who determines the value of various forms of health care and whether this determination should be done by review panels or health care providers with little knowledge of a specific patient's health needs. Other participants wanted patients to have some power or recourse to question decisions to not reimburse for health care that patients want. Finally, some participants questioned whether clinical outcomes of health care should be the only criteria for determining the value of health care; other outcomes such as giving hope to patients should also be considered.

Purpose of a Second Focus Group Study

After the first five focus groups were completed, the investigators set a goal to conduct two additional focus group discussions with a new set of discussion facilitators and data analysts. The chief advantage of conducting a new set of focus group discussions with new personnel is the possibility that new researchers will be open to hearing new ideas and summarizing focus group transcripts in new ways. Allowing new researchers the chance to facilitate discussions using the same study protocols and to examine the participants comments with a fresh perspective allows for comparing and contrasting the discussion themes and for highlighting a greater diversity of reactions to V-BID approaches. The second set of focus groups offered another opportunity: to discuss V-BID approaches with a group of participants who had been offered a health insurance plan with V-BID components.

What follows is a description of second study of how health care consumers understand and evaluate V-BID approaches to health care. The study protocols were very similar to the first study, but the facilitators and the analysts were different from the first study.

Approach

Recruitment for discussion groups was led by healthcare practices and employers in Calhoun County, Michigan, that are a part of the Integrated Health Partners collaborative. Emails and letters were sent to employees and patients, and flyers were posted at practices. Participants were offered a $100 stipend to attend either an early afternoon session from 3:30pm-5:30pm or an early evening session from 6:00pm-8:00pm. The recruitment excluded those working in the healthcare field (because their expertise may unduly influence the conversation about high- and low- value care). Recruitment targeted a mixed-age group of

those currently receiving health insurance through an employer. Participants called or emailed the recruitment contact to sign up for the focus groups and received reminder calls/emails one week before the groups were scheduled to occur as well as the business day before.

Two discussion groups were held in Calhoun County, Michigan in September, 2012. Both of the groups took place in Battle Creek (population 50,000). Each discussion group lasted two hours and included 9-10 participants. A total of 19 individuals participated in the focus groups.

Each discussion followed the same format:

- Introduction of facilitators, participants, and basic ground rules for the discussion.
- Introductory presentation on the high cost of healthcare.
- Presentation and discussion of three value-based scenarios (provided in the following section).
- Participants publicly voted individually at the end of each scenario and then discussed their choices with the group. Participants were encouraged to debate their perspectives, and the facilitator probed for differences in views when new information was provided.
- Following the discussion, participants completed a brief anonymous survey.
- A note-taker recorded all relevant comments in each session on a flip chart. Discussions were also audio-recorded and transcripts were reviewed to augment the meeting notes.

Focus Group Session Methods

Both focus groups were conducted on the same day (September 13, 2012) at a university building in downtown Battle Creek. Each group lasted two hours. Group one had ten participants, and group two had nine participants. Participants were greeted and asked to sign a consent form. Each group was led by two moderators. The lead moderator presented scenarios and facilitated discussion, while the second moderator provided an initial presentation on "High Value Health Care" and recorded discussion points on flip charts. The discussions were also audio-recorded and the recordings were professionally transcribed.

Before beginning the discussions, the participants introduced themselves and viewed a brief PowerPoint presentation (see Appendix XX). The presentation defined common insurance terms such as "co-payment" and "deductible", presented information about the rising costs of health care, and introduced the basic concepts underlying "high-value health care". The presentation defined the goals of high-value health care as encouraging the use of effective health care services and discouraging the use of ineffective health care services.

The discussions that followed the slide presentation were structured in three parts. First, the lead moderator read each scenario aloud. Second, the moderator asked participants to indicate their agreement with series of statements related to the scenario which were written on a flip chart. Participants "voted" by placing a colored dot under the statement that was most reflective of their own opinion. Following the voting, the

moderator asked each participant to describe the reasons for his or her opinion. Lastly, the moderator led an open discussion about the scenario in question. We include each scenario, the results of the participants' votes on the polling statements, and the discussion questions below:

Scenario 1: Controlling Diabetes

Diabetes has become one of the most common chronic diseases in this country, and now about 11% of people in the US over the age of 20 have this condition. To avoid or delay serious health problems, people with diabetes must:

- see their doctor regularly to check their health status
- maintain proper diet and regular exercise
- take medication or insulin injections every day, if prescribed by their doctor.

Diabetes can cause problems such as nerve damage and poor circulation, which often leads to kidney failure or heart disease, blindness, strokes or amputations. Besides the harm to patients and their families, these complications are also very expensive to treat and may make it difficult to work or live independently. The key to controlling diabetes is early diagnosis, careful control of blood sugar and a commitment to regular medical care and monitoring.

Robert. Robert is a 45 year old middle-class office worker, married with two children. He was born with diabetes and has been on insulin nearly his whole life. He has been very responsible about maintaining his health. Like most people with health insurance, Robert has co-payments for his medications, testing equipment, doctors' visits, etc. With a chronic disease, Robert's medical out-of-pocket expenses are high, because he must use services continuously. If Robert cuts back on his medications, testing or visits to save money, he is likely to develop more serious (and costly) complications. But as co-payments have increased over time, Robert finds it difficult when these medical costs are more than he can handle.

Encouraging effective medical care. Some employers and health insurance companies are trying to design health plan coverage that makes it easier for people with chronic illnesses, like Robert, to be as healthy as possible.

One option is to have no co-payments for medical care needed for chronic conditions like diabetes. (For all other medical care, however, patients would have the usual co-payments.) The theory is that with fewer barriers – such as frequent, pricey co-payments – people with chronic illnesses will be more likely to stick with the care they need and would develop fewer complications. Thus, those patients are more likely to use fewer health care dollars, stay employed longer, and be more likely to remain independent. Although this "no co-payments" plan will be more expensive for the company, it expects to make it up with healthier employees. If this works well – if less is spent on complications of chronic diseases – health insurance could become less costly for everyone in that health plan.

Polling Statements:

Your company has asked you – as an employee who is part of the company health plan – to help decide if this is a sensible approach for the company to take. **What is your initial reaction?**

I agree that there should be no co-payments for medical care of chronic illnesses.

Group 1: 3 votes; 30%

Group 2: 4 votes; 44%

I disagree; all co-payments should be the same regardless of the medical problem.

Group 1: 0 votes; 0%

Group 2: 2 votes; 22%

I think a different approach is better.

Group 1: 7 votes; 70%

Group 2: 3 votes; 33%

Discussion Questions:

After the votes were posted on paper, the facilitator reviewed them for confirmation and additional perspectives and posed the following questions:

1. Why did you respond the way you did? What aspects of this example did you think were most important in your decision?
2. What would you change in this example that would change your response to it?
3. If you do not think that 'no co-payments' is useful way to encourage compliance, would you change your mind if research showed that it worked?
4. Diabetes was the example given as a chronic condition but this could also apply to any chronic disease, such as asthma, high blood pressure, heart disease, arthritis, cancer survivors, AIDS/HIV. Are there particular characteristics of a 'chronic disease' that you think warrant this level of support? Or do they all?
5. Are there other characteristics of employees that might make a difference, such as low-income employees, those with very hard-to-manage conditions?

Scenario 2: Dealing with Low Back Pain

More than 75% of the population will have low back pain at some time in their life; it is one of the most common reasons people visit their doctor. Low back pain is usually caused by strain on the back's muscles and ligaments from heavy lifting or just a wrong movement. While it can be terribly painful, it is usually a short-term ('acute') problem that goes away after a few days or weeks. But it can greatly interfere with work and recreation.

After examining the patient, the doctor might prescribe physical therapy, medications or exercises to reduce inflammation and pain. If a more serious problem is suspected, then the doctor does more extensive testing, including an MRI, a high-tech scan that can see internal parts of the spine. But for the usual symptoms of low back pain, it is very rare that an MRI will show anything meaningful, and expert guidelines recommend that MRIs not be done unless more serious signs are evident. In recent years, however, doctors have been ordering far more MRIs than are medically necessary, and many policy experts believe that this over-use is one reason why health care costs are so high.

Harvey

Harvey is a 50 year old high school teacher in good health. But recently he strained his back while doing some home improvement work. The pain was quite severe and Harvey was worried that this would interfere with his teaching job. His doctor said he had 'acute' low back pain that would heal by itself in a couple weeks. In the meantime, his doctor prescribed muscle relaxants, pain medication, and physical therapy to learn the exercises he needed to do. But Harvey believes that something more should be done and wants his doctor to order an MRI scan to see what is happening with his back. Though Harvey believes he needs it, his doctor does not think that the MRI will help.

Discouraging unnecessary care

Health policy experts are seeking ways to discourage the over-use of tests, medications, surgeries and other services that medical evidence has shown to be unnecessary, wasteful and even harmful.

One option is to increase the amount that patients have to pay if they want a test that has been proven to have little if any benefit for their situation. For example, if a patient normally has a $50 co-payment for getting an MRI that actually costs $1,800, he would pay a much higher share of the cost if he wanted the test (like Harvey does) when there is no medical reason for it. This might cause patients to think twice before they insist on a test that is not medically indicated. And if fewer of these unnecessary tests are done, experts believe that health care costs will not continue to rise so fast.

Polling Statements:

Your company has asked you – as an employee who is part of the company health plan – to help them decide if it is a good idea to charge higher co-payments for unnecessary care. **Which statement is closest to your opinion?**

Yes, patients should pay more if the test or treatment they want is not necessary.

Group 1: votes 2; 20%

Group 2: votes 8; 89%

No, patients should pay the same amount for all tests or treatments that they get.

Group 1: votes 2; 20%

Group 2: votes 1; 11%

I think there is another way to do this.

Group 1: votes 6; 60%

Group 2: votes 0; 0%

Discussion Questions:

After the votes were posted on paper, the facilitator reviewed them for confirmation and additional perspectives and posed the following questions:

1. Why did you respond the way you did? What aspects of this example did you think were most important in your decision?

2. What might change your mind about this example? (what details written here would need to change for you to change your mind?)
3. Your response is based on the patient insisting on the test even if the doctor didn't think it was needed. Would your response be any different if the doctor was the one who thought the test should be done even though it was contrary to accepted expert practice guidelines?

Scenario 3: Treating Advanced Breast Cancer

Breast cancer is one of the most common cancers in the US today. Each year about 240,000 new cases of breast cancer are diagnosed. Of these, 12% (about 29,000) are advanced cases, where the cancer has already spread to other parts of the body.

When the cancer has not spread, the chances for a cure are very good: 90% of women will be cured with treatments like chemotherapy, radiation and/or surgery. But when the cancer has spread, only 15-20% of women will live longer than five years. Medical science has been searching for a better treatment for stopping or slowing breast cancer after it has spread to others parts of the body.

A false hope. Recently, there was great hope that *Drug A* – which was helpful for other cancers – might also prove successful in treating advanced breast cancer. It was approved for use by the FDA on a trial basis for advanced breast cancer. Though scientists were not expecting that it would be a cure, they hoped it would enable patients to live longer or make them more comfortable.

But after years of studying thousands of patients, researchers recently concluded that *Drug A* did not help advanced breast cancer patients: it did not slow the tumors, extend patients lives or give them a better quality of life. Its only impact was to increase their chances of getting heart disease or stroke. With this evidence, the FDA ruled that *Drug A* would no longer be approved for advanced breast cancer. But some patients and doctors were unhappy with this decision, saying it was unfair to patients now taking the drug who were still hopeful.

Patricia. Eight months ago, Patricia, a 48 year old homemaker with two children, was diagnosed with advanced breast cancer. Her cancer doctor had immediately started her on a standard cancer drug along with *Drug A.* Despite this new evidence that *Drug A* does not work for her type of cancer, Patricia is convinced that it is helping to control the growth of her cancerous tumors. She is now worried that her health plan will stop paying *Drug A's* yearly cost of $100,000. Patricia argues that even the smallest chance that this drug could save or extend a few lives is worth its risks and high cost.

Polling Statements:

Your company has asked you – as an employee who is part of the company health plan – to help them decide if your health plan should continue to pay for Drug A for advanced breast cancer. **Which statement below is closest to your view?**

The health plan should continue to cover the cost of Drug A for advanced breast cancer, just as it did previously.

Group 1: votes 4; 40%

Group 2: votes 1; 11%

The health plan should cover only some of the cost; because Drug A is not effective, if patients want it they should pay more than just an average co-payment.

Group 1: votes 0; 0%

Group 2: votes 0; 0%

The health plan should not cover Drug A for advanced breast cancer, because it doesn't work and will just make health insurance more expensive for everyone.

Group 1: votes 6; 60%

Group 2: votes 8; 89%

Discussion Questions:

After the votes were posted on paper, the facilitator reviewed them for confirmation and additional perspectives and posed the following questions:

1. Why did you respond the way you did? What aspects of this example did you think were most important in your decision?
2. What might change your mind about this example? (what details written here would need to change for you to change your mind?)
   - Another disease but cancer
   - Non life-threatening
3. If Patricia hadn't already started on Drug A, would you feel differently about allowing her to use the drug?
4. Before it was revoked by the FDA, Drug A was being given to 18,000 women with advanced breast cancer at a cost of $1.8 Billion each year. Does this affect the way you view this case?
5. This example did not say what Patricia's doctor thought about whether Drug A was working for her or not. If her doctor agreed that Drug A was helping her, then should insurance continue to pay for it? If he doesn't think it is working – but doesn’t want Patricia to lose hope so he is supporting her – should insurance continue to cover it?

It is noteworthy that there were differences between the two groups in their responses to the written statements concerning the scenarios. The moderators observed that the responses in group one may have been influenced by the fact that several of the participants were firefighters whose contracts had recently renegotiated, resulting in a much larger deductible for their health insurance. These participants were vocal about their dissatisfaction with their new insurance plans. The recent experience with a reduction in benefits seemed to provide a context in which the scenarios were viewed as taking away coverage and choice from individuals.

Focus Group Data Analyses

The analysis of the focus group transcripts began with study personnel reading the transcripts and generating ideas for thematic codes and sharing code ideas with each other. Based on these initial discussions, we began to define a set of thematic codes with minimal shared conceptual meeting. The hope was to generate a comprehensive set of mutually exclusive codes that would identify the diversity of opinions about V-BID approaches held by the focus group participants.

A key decision made by the research team early in our discussions was that most of the participants' statements could be broadly conceived as being in favor of V-BID approaches or being against V-BID approaches. This is not surprising given that the opening questions for each scenario directly solicited opinions for liking or not liking V-BID approaches.

Our goal in the thematic coding was to assign a code to every meaningful statement that seemed to be directly or indirectly related to the V-BID approaches in each scenario. Some statements were not coded because the meaning of the statement was unclear or inaudible.

To capture the diversity of reactions to V-BID approaches described in the three scenarios, we organized the development of thematic codes into three broad categories:

- Reasons for liking V-BID approaches
- Reasons for not liking V-BID approaches
- Other concerns (that were directly related to how the participants thought about the V-BID approaches in the three scenarios).

The initial set of thematic codes and their definitions were revised as the coding ensued and after further review of the coding themes.

Reasons for Favoring V-BID Approaches

The analysis of the participants comments about the three scenarios revealed several reasons for having a favorable impression of value-based insurance design elements. A listing of the thematic codes associated with these favorable impressions is listed in Table 1 below.

Several participants in both focus groups noted that having no co-pays for treatments known to lead to good health outcomes would be **an incentive for seeking and using health care** (No co-pay incentive). Example quotes for this theme were:

> "I think it would encourage people with diabetes or another kind of disease like, for instance, Crohn's, my daughter has Crohn's, to see their provider more often, perhaps stay on top of the latest treatments and medicines…"

> "…It would encourage people more. Like you say, if you don't have the money to go and you don't have a co-pay to go, you tend to lag back or you might, "Oh, I gotta pay this instead of
>
> going to get my medication," or something. But without that worry, you would be more inclined to go and get whatever check up…"

"… I feel like the no co-payment would be good 'cause I think that would help them prevent it leading to a more serious condition. And then--in that it would keep the cost down that way."

On the other hand, several participants noted favorable opinions for **disincentives for ineffective or unnecessary care**. Example quotes included:

"But if he's demanding something that is not necessary in the long run and all due care was given to that point then, yes, I think that perhaps he should bear the cost of something that is going to offset the entire programming."

"And I understand what you're saying, [name], but think about it on her side. How many times we got somebody going to the emergency room or to this or going to all these great lengths for a common cold. It's ridiculous..."

"Like it's not fair for them to keep paying money to something that clearly they said didn't work. And if that's the case, they should take it off the market."

Other participants were favorable to V-BID elements because they were **disincentives for harmful treatments.** Example quotes included:

"Mm-hmm, but not if it's going to cause heart problems or a stroke. I mean, from a women's point of view, that could be very--that'd be very serious too, you know? "

"It doesn't do anything to prevent it and you're causing more problems. Personally, I wouldn't

think I wanted any more problems."

"No, not to give somebody something that's doing them no good and it's doing them harm. No."

Another reason for favoring V-BID elements was that it made sense to have key medical **treatment decisions made by those with medical expertise** rather than by patients' treatment preferences. Example quotes included:

"But I still think for the most part these doctors are pretty darn good at what they do in terms of diagnosing the problem and I did not ask for the extra treatment. So it was given to me, prescribed by the doctors, which I feel is much different than my asking for it."

"You would trust your doctor because you have that relationship."

"I would be--I guess I would be dumbfounded if I walked in to my doctor and said, "I need an MRI," and he said, "Okay."

A last theme that expressed a favorable rationale for V-BID approaches was the idea that there may would be **cost savings** with this kind of health insurance. We identified only one quote with this idea:

"I think that's how it works because usually it's not seeing it that makes you oppose it. How are they gonna do that? That's the first thing you think about when somebody say, "Well, how are they gonna do that? Where are they gonna take it out of?." They might not come right around for it, but it's gonna come from somewhere. You just think it skeptically….That's usually what everybody's out

for at the end of the day, you're worried about how it's gonna affect your bottom line at the end of the day. And if it's proved, I think we go for it."

Table 1. Focus Group Themes Covering Reasons for Favoring V-BID Approaches

1. **No co-pay incentive.** This theme is used to code statements that suggest that patients will be more likely to seek health care and adhere to medical regimens because the cost barriers are reduced or eliminated.
2. **Disincentive for ineffective care.** This theme code is used for statements that favor V-BID disincentives for ineffective or unnecessary health care.
3. **Disincentive for harmful treatments.** This theme is used for statements suggesting that disincentives for harmful treatments are justified.
4. **Decisions based on physician expertise.** This theme is used to code statements that physicians are competent in what they do and are able to determine an appropriate diagnosis and treatment plan that avoids unnecessary and ineffective treatment.
5. **Cost savings associated with value-based approaches.** This theme is used to code statements that suggest that value-based elements have the potential for reducing health care costs.

Reasons for Skepticism about V-BID Approaches

Perhaps because the V-BID approaches described in the three scenarios seemed like new ideas to many of the participants, there was a greater variety of opinions that conveyed skepticism about the V-BID approaches. The list of reasons for skepticism about V-BID approaches are listed in Table 2 below.

One reason for skepticism was an overriding concern about health **care benefits being distributed unfairly** to only one group of employees (patients) and without regard to ability to pay. Example quotes included:

> "And then there's also the potential that any of us could have a chronic illness or we could get an injury and we'll be in that same boat. So I think that it's fair to have the balance that co-payment for everybody, one set co-payment for everyone."
>
> "So, yeah, I agree. It's hard to single out diabetes and say, okay, now dump co-pays for diabetes, but if you have high cholesterol [you do not qualify for the benefit]"

A second reason for being skeptical is the belief that providing health benefits without out-of-pocket co-pays or deductibles might reduce the sense of **personal responsibility patients have for self-care**. This rationale asserts that patients may not take medicines or make health care appointments if they have no financial commitment for reaching health outcome goals. Some participants suggested a different approach where lower or no out-of-pocket costs was a reward for enhanced self-care and health care compliance. Example quotes include:

> "I just felt that there had to be some way to make the individual do what he was supposed to. I mean, so many times you have people, "I'm a diabetic and I don't have to pay for anything but I'm still not doing what I'm supposed to be doing."

> "…And, you know, if you're doing what--like you say you're doing, what you're supposed to do and you're keeping yourself healthy but if because you have diabetes you're off from work and, yeah, you know, no co-pay then…"

> "Yeah, I think the accountability is--you know, holding someone accountable for how well they're taking care of themselves or whatever, in order to get this ..."

A third reason for being skeptical about V-BID approaches (especially reduced or no copays or out-of-pocket costs) is the **increased costs to other employees and patients** participating in the health plan. Several participants doubted that there will be a long-term cost savings. Example quotes included:

> "A company could have 15 employees, 20 of them could have a chronic disease. So company costs could rise so high that the other 45 people wouldn't be able to afford it. So I haven't changed my mind."

> "Cause I think everyone else will agree with the idea of it. We all like the idea, but as skeptics and employees we wonder how are they gonna pull this off?"

A similar concern is that V-BID approaches that encourage the use of health care is that some patients will **overuse health care services** causing further increases in costs for everyone in the insurance plan. Example quotes included:

> "I mean, in this scenario I think it's because it's fairly typical that there are probably more MRIs needed so that is worth thinking about."

Some participants worried that V-BID approaches could lead to **discrimination of employees** who use expensive health care treatments. This concern may be broader than any specific reservations about V-BID plans and apply to any kind of managed care approaches. But it is part of how some participants thought about the idea that health care decisions are reviewed and approved by health plans selected by employers. Example quotes included:

> "…And I wouldn't want to see the company so inhibited by cost that now they're letting people go. And now my husband doesn't have a job because the company can't support that many people because of the extra. So I don't know exactly what the answer is, but that was kind of the reason I was thinking I don't--that makes me a little nervous."

> "It would concern me if it went to--what--a no co-pay thing. It might lead to employers screening potential new hires to have [inaudible] family have a chronic illness? Yes or no? More likely to not hire people with chronic illness because they increase cost."

A different concern expressed by some participants about V-BID approaches reducing or denying health plan reimbursements for ineffective health care may **revoke patients' hopes** associated with that health care.

Some participants placed a high value on a patients' beliefs or expectations of specific health care procedures or medications even if research studies suggest the treatments are ineffective. Example quotes included:

> "I don't want to take hope from nobody, especially when they have cancer."
>
> "I--whether you think this--'cause most of the psychological, if they ain't gonna live more than five years anyway. I don't want to take hope from nobody."
>
> "If she thinks it's gonna help, don't take that away."

Some participants cited a **mistrust of evidence regarding the effectiveness of health care treatments** and that health care decisions should not be determined by health care treatment studies. Example quotes included:

> "If it does some people some good but most people it doesn't work, then you're gonna lose out just on the law of averages because they're gonna say, "Well, statistically, it doesn't help people." But maybe it helps some people. So again, you're discriminating against those people."
>
> "And 20 years from now they say, oh, we realize now that this was a bad drug."
>
> "Not every smoker dies from lung cancer. These things are not definitive. So that was the only reason why I play advocate, 'cause it's not definitive and some of the doctors they say, "Hey, what's up with that? Why is this going away? Some of my patients are getting along fine on this." And now that some other way has come through or some new drug is out that we want to promote we gonna prove this one bad and this is the new drug and sometimes you as a patient you've been on this drug, it's working for you, and they then just strip it of you and they tell you have no other option to use it no more and they had you hooked on it now. And it's working for you."

Another broad concern about V-BID approaches is the **loss of individual patients' control and health care choices**. Our analysis used three sub-themes under this broader theme: (a) loss of patients' decision power when **determining a diagnosis of health problems**, (b) loss of patients' decision power to make treatment because of **managed care elements of health plans**, and (c) loss of patients decision power because **health care decisions are made by providers**.

Example quotes for concerns regarding the **loss of patient control over health diagnoses** included:

> "[The patient knows] their body better than doctor. And there could be something seriously wrong with them and if they want a particular test, they shouldn't have to pay more. With all the malpractice and everything going on."
>
> "I think there are times when a patient knows."

Example quotes for concerns regarding the **loss of patient control over treatment decisions** included:

> "And who's making that decision on what the chronic disease is."
>
> "Would it be the healthcare provider or the healthcare company who would determine what a chronic illness is? Who's gonna make that decision?"

"Who is gonna make the decision, is it chronic and stuff because the government is making too many decisions as to what, you know, like what our deductible is and all that other."

Example quotes for concerns regarding the **loss of patient control over health care decisions made by providers** included:

"I mean, you can say what you think should happen and it doesn't always if the doctor doesn't agree with you. So that's just my--I think you should--you kind of have an idea if there's something wrong. Go to the doctor."

So just having more confidence with that patient/doctor relationship and educating your doctors more so they have the confidence to listen to that patient. That to me would be more of an educational thing instead of saying, "Okay, the last doctor you had was messed up and didn't do something and you had all these circumstances in your family where it was negative and then it turned out to be something like her." Well, she's not gonna trust that doctor so why should she have to pay for her past experiences with the wrong doctors.

Some participants expressed **mistrust of research on value-based insurance approaches** suggesting this approach will save health care costs. Example quotes included:

"Where is the--where are the numbers that show that that treatment has been quality treatment"

"I mean, if it's been done and it's proven and as long as you get the cooperation it'll work."

A final concern about V-BID approaches was the **increased out-of-pocket costs** for patients because of doubts that V-BID plans will save money and that health care costs will keep rising. Example quotes included:

I'm just thinking that the--when you're talking about a family and probably most of the employees are supporting a family, that it may become too much, that way you're not recouping the cost in the end."

"So yes, it might be a short term cost, but it is eventually won't be there."

"Well I think they charge co-pays. I mean, I have--I called to have an appointment to see if they'll do a referral. Well, you got to come back in and talk to us first. That's another co-pay."

"So I think the doctor's office, they get off on charging a co-pay."

"I realize it takes a lot of cutting here and there, but like I said, I think they need to start with the insurance companies and with the medical profession before they start cutting our care because it's not us that are making the costs so high. I don't care if they say prescriptions are high, this and that. It's the doctor that's prescribing the prescriptions and if they go back to basics, maybe they don't have to."

Table 2. Focus Group Themes Covering Reasons for Skepticism about V-BID Approaches

1. **Fairness of benefits**. This theme is used to code statements that suggest health care benefits should be distributed according to standards of fairness instead of on the effectiveness of health care treatments.

2. **Personal Responsibility**- This theme is used to code statements that people should take personal responsibility for their own health care and incentives (like no copays) may reduce this personal responsibility. Other statements suggest that incentives should be earned by demonstrating personal responsibility for one's health care.

3. **Cost of services**. This theme is used to code statements that suggest that value-based incentives will increase costs for *other employees and patient.*

4. **Overutilization of services**. This theme is used to code statements that suggest value-based incentives will lead to overutilization of health care services causing costs to increase for everyone in insurance pool.

5. **Potential discrimination.** This theme is used to code statements that value-based elements in health plans will lead to greater scrutiny of employee health records and employers may begin to discriminate against employees who use expensive health care treatments.

6. **Denying patient hope.** This theme is used to code statements that suggest ineffective health care should continue for patients who hold out hope for positive results even if there is clear research evidence that the treatments are ineffective or potentially dangerous.

7. **Mistrust of Evidence.** This theme is used to code statements that suggest that the evidence about the effectiveness of health care treatments should not be trusted.

8. **Loss of individual choice**. These themes are used to code statements that suggest patient should have the power to decide about their own health and health care. This code has three sub-codes based on decisions points in health care such as diagnosis and treatment choices.

   a. **Misdiagnosis**. This theme is used to code statements that suggest patients should have more decision making power when diagnosing a health problems.
   b. **Managed Care**. This theme is used to code statements that suggest patients should have more decision making power about the elements of health plans and key health care treatment decisions.
   c. **Patient/doctor control over services**- This theme is used to code statements that suggest patients should have more decision making power in treatment decisions along with their providers and health plan staff.

9. **Mistrust of research on value-based insurance approaches.** This theme is used to code statements that suggest that we should not trust the research on the effectiveness of value-based approaches.

10. **Increased out of pocket costs/cost-sharing.** This theme is used to code statements that suggest that value-based insurance plans will not save money in the long term because health care costs are rising and doctors have incentives for increasing health care costs.

Other Concerns

We also identified meaningful responses that were not directly relevant to favorable or unfavorable impressions of V-BID approaches to health insurance plans. These responses were highlighted because they represented concerns about health plans that may influence how the participants thought about V-BID approaches. A summary of other concerns are listed in Table 3 below.

Some focus group participants expressed other concerns that were not related to V-BID approaches but were related to health care and health plans. One concern was that some believed they had **limited choices in their health plans**. Example quotes included:

> "Most physicians in this area doesn't accept Blue Care or Blue Choice. Like my physician doesn't. So I'm sticking with traditional and [inaudible] my doctor provides."

> "I'm on Medicare. I have city insurance and I have to buy my own drug coverage."

Another general concern was about **rising health care costs**. Example quotes included:

> "Yeah. 'Cause once you retire, I know this I'm retired, it's like everything is cut in half and just a little bit off. And the cost, co-pay and everything, goes up and it's really--there's no balance there. Everything goes up except your coverage. And it's--I mean, it's not funny because it's really"

> "Well, another article I read just in the last week in the Wall Street Journal, this trend of hospitals buying doctor's practices, almost universally costs increase when that happens. But it's hard for the doctors to be--'cause most doctors aren't good business people. I get that. But the cost of hospital owned doctor's office is going up."

Table 3. Other Concerns.

1. **Limited choices in health plans.** This theme is used to code statements that patients have limited choices in their health plans.
2. **General concerns about health care costs.** This theme is used to code statements that patients have limited choices in their health plans.

Post Discussion Surveys

After each focus group discussion, each participant completed a survey about their concerns regarding health insurance and their final impressions of the V-BID approaches they discussed during the focus group.

General Concerns about Health Insurance Costs

Two questions asked participants about how concerned they were about the risking costs of health insurance. The responses on both questions suggested a high level of concern. The first question was "How concerned are you (for yourself or family) about the rising cost of health insurance?" All of the participants were either "somewhat concerned" (26%) or "very concerned" (74%). No participants indicated that they were "not at all concerned" or "I haven't given it any thought."

The participants gave similar responses to the second question, "How concerned are you (for the country in general) about the rising costs of health insurance?" All of the participants were either "somewhat concerned" (21%) or "very concerned" (79%). No participants indicated that they were "not at all concerned" or "I haven't given it any thought."

Reactions to V-BID Approaches

In general, the participants indicated support for V-BID approaches for health insurance plans. The participants were asked the following question:

> *Today we discussed value-based health care, where the goal is to encourage people to use treatments and services that work well to keep them healthy – and to discourage them from using treatments and services that bring little if any benefit to their health.*
>
> *This means that patients have:*
> - *little or no co-payments for very effective treatments AND*
> - *higher co-payments for treatments that do not bring a proven benefit.*
>
> ***What is your reaction to this type of value-based health care?***

The participants checked one of four responses to this question. A slight majority (53%) responded that this type of value-based health care should be used most of the time and (37%) noted this type of health care should be used some of the time. One participant (5%) thought this type of health care should only be used rarely and no one thought this should never be used. One participant did not answer this question.

Count (%)	Response
10 (53%)	This should be used most of the time
7 (37%)	This should be used some of the time
1 (5%)	This should only be used rarely.
0 (0%)	This should never be used.

The participants also responded to a more specified questions about V-BID approaches that are incentives for effective health care. They were asked,

> *Imagine your company was thinking about lowering co-payments only for those medical services that have been proven to work well for patients with chronic illnesses (like the example with Robert, the diabetic).* ***Would you support this plan?*** *Indicate on a scale of 1-5.*

Most of the participants were supportive of this plan, but there were some who did not support the plan. Five participants (32%) checked the "highly support" response while three participants (16%) checked the "not support" response. On the five-point scale, the average rating was 3.58 (SD=1.43).

Count (%)	**Response**
3 (16%)	1 – Not Support
1 (5%)	2
3 (16%)	3
6 (32%)	4
6 (32%)	5 – Highly Support

The participants responded to another question that asked specifically about health plans raising co-payments for ineffective health services:

> *Imagine your company was thinking about raising co-payments only for those medical services that have been proven to not work well (like the example with Harvey and the MRI for low back pain).* ***Would you support this plan?*** *Indicate on a scale of 1-5.*

The participants checked one of five responses (1-5 scale) to this question indicating their level of support for this plan. There was mixed support for this plan. Only four (21%) checked the "highly support" response option. The same number of participants (21%) checked the "not support" response. On the five-point scale, the average rating was 3.32 (SD=1.46).

Count (%)	**Response**
4 (21%)	1 – Not Support
1 (5%)	2
3 (16%)	3
7 (37%)	4
4 (21%)	5 – Highly Support

The participants were also asked "Does your employer offer a health insurance plan that includes high-value based components, such as varying or eliminating co-payments for certain services." Even though this group of participants were invited to the focus group because their employer (or a family member's employer) had

offered a health insurance plan with value-based components, only one participant (5%) replied that they had been offered such a health insurance plan. Most of the respondents (13, 68%) replied that they had not been offered such a plan. And five other participants said they were unsure.

Finally, the participants had the chance to provide their reactions to the focus group discussion with replies to the question, “What is your reaction to participating in this discussion today?” The research staff sorted the responses in to thematic categories. The participants’ reactions are listed below within the thematic categories:

Interesting and Enjoyable Discussion (9 comments)

“Was pleased with the discussion and outcome.”

“Very Educational.”

“Interesting.”

“I think this was good, but also Obama Care needs to be discussed. I'm not for it but thank you for having me. May God give you wisdom.”

“Really enjoyed how the scenarios brought our personal and professional values.

“Thought it was a good discussion group and informative.”

“This was the second discussion group I have been to. Very interesting conversation! It's nice to discuss a subject that everybody has part.”

“This was very informative. Broadened my outlook on health care. This should be conducted often.”

“This was most enlightening. I do believe that a survey of consumers as opposed to providers gives more dimension to healthcare.”

Diverse People and Opinions (3 comments)

“Interesting Discussion. Good mix of participants. Time went by faster than expected.”

“Very informative and interesting and hearing others' points of view. I hope all we shared will be put to good use.”

“Interesting points of view from a diverse group of people. A lot of agreement on the 3 issues.”

Difficult Issues to Discuss (3 comments)

“My knowledge on the subjects discussed was very little to offer. I understood that it was a discussion about diabetes.

“The examples were cut and dry. Real situations often aren’t.

"I have a new appreciation for the difficult place that insurance companies, individuals are when it comes to making health care.

Hopes for Health Care Change (2 comments)

"Hopefully small group discussions like this will help to change the way health care is run.

"I support the efforts to discuss and research to find a better way to get a handle on healthcare costs.

Mixed Feelings and Unsure (2 comments)

"I like the discussion but have mixed feelings about issues."

"Unsure."

These reactions suggest that most participants enjoyed the discussion though some thought some of the issues were difficult to discuss.

Conclusions

The second set of focus group discussions described in this report revealed a wide variety of ideas and opinions about V-BID approaches in health insurance plans. Our analysis focused on ideas that indicated (a) favorable impressions and (b) unfavorable impressions of V-BID approaches. This analytic choice reflected our reactions immediately after facilitating the discussions.

While there were more thematic codes for the participants' unfavorable impressions of V-BID approaches than for favorable impressions, this difference should not be interpreted as the participants' general impressions of V-BID approaches. The post-discussion surveys indicated that most of the participants left the discussions with favorable impressions of V-BID approaches.

We suggest that the larger number of thematic codes for unfavorable impressions was due to the greater variety of ideas and opinions about the concerns the participants had about V-BID approaches and, perhaps, about health insurance trends in general. The participants expressed their high levels of concern in their responses to the post discussion survey. We also suggest that it may be easier for health care insurance consumers to articulate concerns about insurance plans than it is to articulate advantages of these plans. With those thoughts in mind, we highlight the ideas and opinions expressed in these two focus group discussion.

The favorable impressions of V-BID approaches included:

- The potential for V-BID approaches (especially lower co-payments and lower out-of-pocket costs) to serve as incentives for patients seeking health care and adhering to medical regimens.
- The potential for V-BID approaches to serve as disincentives for ineffective or unnecessary or harmful health care .
- The potential for health care providers with professional knowledge (e.g., doctors) to have more decision making power in determining diagnostic and treatment procedures.
- The potential for reducing health care costs.

These themes suggest that the participants understand the potential advantages of V-BID approaches including those that are incentives for effective care (e.g., no co-payments) and disincentives for ineffective care (e.g., higher co-payments). These themes also suggest that participants also understand how V-BID approaches such as incentives and disincentives may lead to better health outcomes and lower health care costs.

The unfavorable impressions of V-BID approaches included:

- Health care benefits should be distributed according to standards of fairness instead of on the effectiveness of health care treatments.
- People should take personal responsibility for their own health care and incentives (e.g., no co-payments) may reduce this personal responsibility.

- V-BID incentives (e.g., no co-payments) for some employees and patients may increase costs for others.

- V-BID components may lead to greater scrutiny and discrimination against employees who use expensive health care treatments.

- V-BID disincentives for ineffective health care may be unfair to patients who hold out hope for positive results (even if there is clear research evidence that the treatments are ineffective).

- Evidence about the effectiveness of health care treatments should not be trusted and should not determine which treatments should be encouraged and discouraged.

- Patient should have the power to decide about their own health and health care, including power when diagnosing a health problems, when choosing the elements of health plans and key health care treatment decisions, and in treatment decisions.

- V-BID plans may not save money in the long term because health care costs are rising and doctors have incentives for increasing health care costs.

These themes suggest that the participants hold a variety of concerns that lead them to mistrust or disagree with V-BID approaches. V-BID approaches encroached on some participants' sense of fairness, personal responsibility, health privacy rights, hopes for positive outcomes, and patient freedom to choose health care. Other participants were concerned about higher health care costs either for everyone or for some employees if V-BID approaches are used.

Other concerns expressed in the focus group discussions underscored participants' dismay with their experience of more limited choices in their health insurance plans and in the rising costs of health care.

Integration with the First Set of Focus Group Discussions

There are several content themes identified from the second set of focus group discussion that were also identified in the first set of focus group discussions. The key themes identified in the first report were:

Regarding V-BID Incentives:

- **Cost Savings**. This theme covered statements about the potential for V-BID to reduce the cost of health insurance.

- **Individual Responsibility**. Some participants expressed the importance that patients should be responsibility for their own care and that V-BID approaches should not discourage individual responsibility.

- **Fairness**. Many participants expressed that was unfair to offer incentives only to diabetics.

Regarding V-BID Disincentives:

- **Determining value**. Participants were concerned about who determines the value of health care when these determinations limited access to health care.

- **Looking for compromise**. When considering barriers to ineffective or unnecessary health care, the participants often want to find a compromise solution so that patients could have some power or recourse when certain forms of health care is discouraged.

- **Value means more than clinical outcomes**. Some participants noted the importance of hope and sense of control in addition to the value placed on health outcomes.

We also noted participant's concerns about cost savings, individual responsibility, fairness, and determining the value of health care options. We did not identify themes that suggested participants were seeking compromise solutions, however.

It is worth noting that the similar sets of results were noted even though different data analysts and different analytic approaches were used in both studies. The first study focused on the themes related to the different type of V-BID components (e.g., incentives, disincentives). The second study focused on themes related to how V-BID components were evaluated (e.g., favorable, unfavorable).

Methodological Cautions

Focus group methods require that researchers are highly involved in the data collection and data analysis. In this study, the researchers were highly involved in facilitating the discussion among the focus group participants. Before we started the discussions, we presented some key concepts about health insurance and about value-based insurance ideas. We also were active in facilitating the focus group discussions. For instance, the facilitator often asked follow-up questions or made interpretive statements to solicit more discussion. This level of involvement may have exerted considerable influence on what was discussed. The facilitator tried to used active listening techniques (e.g., repeating statements, reflection statements, open-ended questions) to solicit comments from the participants and to ensure that all participants had the opportunity to express their ideas and opinions.

In addition to possibly influencing the discussions, the researchers were highly involved in identifying content themes that summarized key ideas noted in the discussion transcripts. The development of themes requires the researchers to seek and interpret meaning in the content of the participant's comments. After the themes are developed, members of the research team make judgments about how specific quotes fit or do not fit the evolving theme definition. Coding discussion text is usually an iterative process of reading text and theme development until the researchers are reasonably satisfied that the final set of themes can be used to classify most of the meaningful text.

Because of this level of researcher involvement in facilitating the discussion "data" and in the "data" classification, the results of this study should be considered with the appropriate methodological cautions. Another set of researchers may have solicited different ideas and opinions and documented different sets of discussion themes. In the end, we are reasonably confident that we identified most of the important content themes related to the purpose of this study: to determine how health care consumers think about V-BID approaches. Our confidence is bolstered by the similarity of our results to the first focus group study.