

Probing the public's views on V-BID

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Executive Summary

Value-based insurance design (V-BID) is an approach to designing healthcare benefits based on the recognition that medical tests, treatments or services can vary greatly in their benefit relative to their cost.

The goal of V-BID is to use incentives (usually higher or lower co-payments) to encourage medical care that is ‘high-value,’ where there is ample evidence of patient benefit. V-BID also can be used to discourage the use of medical care that is ‘low-value,’ where the evidence of benefit is insufficient to justify the use of communal resources. When used responsibly, V-BID can redistribute healthcare resources in a way that provides more health for the dollars spent.

As V-BID has grown in popularity, it is important to learn how the general public perceives this new approach to the use of variations in cost-sharing as a mechanism to achieve better health outcomes and more responsible use of resources. A pilot project of five small-group discussions, with 8-10 participants each, in Calhoun County, Michigan provides an initial step to identify public values related to the use of V-BID in employer-based insurance coverage. Project participants reviewed and discussed different scenarios depicting three contemporary medical situations. In each scenario, participants were asked to respond not as patients or consumers, but as ‘social decision-makers’ responsible for advising their employer on a health benefit plan design.

Participants expressed concerns about healthcare costs and quality and were generally open to changes in their health plan to foster more effective care. They showed guarded optimism about the potential for V-BID to guide the careful use of resources and were supportive of V-BID programs in concept, assuming the V-BID program saved money. Although ‘carrot’ approaches—those that lowered patient out of pocket costs for high-value services—were favored broadly (assuming they were effective), participants had greater reservations about ‘stick’ approaches—those that increased copayment for low-value services. Use of disincentives may be appropriate but in more narrow circumstances than use of positive incentives. The ‘stick’ approach also raised concerns about who determines what constitutes high- and low-value, and participants struggled if the authority of the physician was questioned. Many had different views of ‘fairness’ and offered ideas for compromise when it was difficult to conceive a plan that suited all individual circumstances.

Participants voiced a range of values and perspectives that may be helpful in developing, communicating, implementing and evaluating V-BID approaches that have the support of employees and health plan members.

Introduction

Value-based insurance design (V-BID) is a new approach to health benefits design, with growing popularity among employers and policymakers. V-BID programs (also known as value-based benefits or value-based design) use incentives to help lower barriers to medical treatments and services that are proven to be effective, providing a high level of health impact for the money spent. V-BID programs can also provide disincentives to health treatments or services where there is little evidence of health impact, often by increasing the cost to the patient. This ‘clinical nuance’ in benefit design, rather than pricing the co-pay for all treatments and services the same, aims to create more efficient spending of healthcare resources, producing better health outcomes for those in V-BID plans.

Studies have measured the change in outcomes of existing V-BID plans, and this evidence has shown noteworthy success (a full listing of clinical studies on V-BID is available at www.vbidcenter.org). Diabetes is thought to be the most common area for a V-BID approach by offering diabetics free or reduced rates on needed medications, insulin, and doctor visits. A recent study of such a V-BID program in diabetes, coupled with disease management, showed that the approach saved money for the health plan, while increasing medication compliance and health of diabetics.¹ This result—cost savings and improved health—has led to rapid growth in V-BID among employers and plan designers. A recent survey showed 73% of health care opinion leaders support V-BID.²

However, while the clinical and outcomes evidence on V-BID is growing, little is known about how the general public perceives V-BID: is it a worthwhile, credible approach to healthcare benefits design—or—is it an unfair, discriminatory way to put greater cost burden on health plan members? In this project, we asked participants to be social decision-makers: responding to V-BID examples as ‘advisors’ to their employer on the criteria they believe are essential for supporting or rejecting V-BID as a new component of coverage.

Limited in its sample size, we view this project as a pilot: an important first step in understanding how the general public regards value-based approaches. Findings from this pilot, and future research, can improve value-based approaches, both those currently in place and those being developed.

¹ Gibson TB, Mahoney J, Rangel K, Cherney BJ, McElwee N. Value-Based Insurance Plus Disease Management Increased Medication Use and Produced Savings. *Health Affairs*, January 6, 2011. 30:1; 100-108.

² Davis K, Guterman S, Stremikis K. Health Care Opinion Leaders’ Views on Transparency and Pricing. The Commonwealth Fund, October 2010. 1415 (102).

Approach

To explore individuals' responses to value-based approaches, this project used a discussion tool to focus on contemporary clinical examples of both 'carrot' and 'stick' types of V-BID. 'Carrot V-BID' incentivizes actions that have a considerable impact on health; this was illustrated by a scenario of reduced co-payments for diabetics on their diabetes-related medical care. 'Stick V-BID' discourages actions where evidence suggests there is little impact on health for the expenditure. This was illustrated with two scenarios: 1) of a patient paying more than the usual co-payment when requesting an MRI for lower back pain that the physician felt was unwarranted; and 2) of a cancer patient requesting continuation of 'Drug A,' a treatment for advanced breast cancer that recently was found to be ineffective. The discussion tool was piloted with a test group in Sacramento, California, and revised to clarify facts of the scenarios.

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 \$50 stipend for each of the four evening sessions, and a \$75 stipend for the one daytime session. The recruitment excluded those working in the healthcare field (because their expertise may unduly influence the conversation about high- and low- value care) and those receiving Medicaid (because of their limited experience with co-payments). Recruitment targeted a mixed-age group of those currently receiving health insurance through an employer. A few participants also had Medicare coverage and a majority of participants were 50 or older.

Five discussion groups were held in Calhoun County, Michigan in January and February, 2012. Four of the groups took place in Battle Creek (population 50,000), and the fifth was held in Marshall (population 7,500). Each discussion group lasted two hours and included 8-10 participants. A total of 47 individuals participated in the project.

Each discussion followed the same format:

- Introduction of facilitators, participants, and basic ground rules for the discussion.
- Introductory presentation on the rising costs of healthcare to lay a foundation for why new approaches are needed.
- Presentation and discussion of three value-based scenarios (provided in the following section). Participants 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. Discussions were also audio-recorded and transcripts were reviewed to augment the meeting notes.

Scenarios

The following section includes each of the three scenarios, along with participants' voting responses. Dominant themes expressed by participants are summarized following each scenario with quotes that typified their perspectives.

Controlling Diabetes—a ‘carrot V-BID’ approach

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.

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? (N = 47)

51%—I agree that there should be **no co-payments** for medical care of chronic illnesses

17%—I disagree; all co-payments should be the same regardless of the medical problem

32%—I think a different approach is better: _____

Responses to Scenario #1

Participants supported 'no co-payments for chronic illness'.

This support was based on two perspectives:

1. The potential for cost-savings.

- *"Most of those (maintenance) visits are short, they are simple and they are more cost effective because the insurance companies aren't going to be paying down the road."*
- *"If you can get [individuals with chronic illness] to go in to the doctor on a regular basis, instead of waiting until they are in this acute position where everything is out of control, then, that could maybe decrease the overall healthcare costs."*
- *"If the people are in fact healthier and are present at work, it goes beyond the insurance costs because you don't have other employees having to pick up that work when people are gone."*

2. Desire to financially help those with chronic illness.

- *"I think it balances out and I think it is right, personally, that we pay a little bit more to help balance out those costs [of chronic illness]."*
- *"It's going to be pretty hard for these people to make it (financially) once they make all of the necessary co-pays."*

Participants supported but with a conditional response.

These caveats included such things as:

1. Only if the program saved money.

2. Offer discounts for a broader range of diseases: Many participants would not be comfortable with a program that targeted only diabetes and suggested that a wide range of chronic diseases (and other routine maintenance care) should be included, so that everyone ("even the healthy people") could benefit.

3. Require individual responsibility: Many participants felt it would not be fair to offer a benefit without insisting on individual accountability. They said those benefitting from V-BID, like Robert, should need to demonstrate doing their part with healthy behaviors in order to continue to receive the benefit.

- *"I want to make sure if you are getting this, you are doing what you are supposed to be doing."*

4. Account for participants' ability to pay: This topic came up frequently, with mixed impressions. Most participants felt a V-BID discount should be available only to those who cannot afford their healthcare, while others felt the wealthy should not be penalized and excluded from a V-BID benefit.

Participants did not support this 'carrot' approach.

Their reasons centered on three areas:

1. Everyone is responsible for their own health.
 - *"If you are not willing to take care of yourself why should everyone else have to foot the bill for you?"*
2. Participants felt it was unfair to subsidize care for one illness over another.
 - *"I just don't know how you would fairly just zero in on one specific disease and say that that disease across the board would get some kind of discount."*
3. Did not believe it had potential to save money and feared that the reduced co-payments would be unaffordable for a small employer.

Other ideas proposed by participants in the initial voting:

1. Cap incentives to discourage overuse of healthcare by diabetics.
2. Apply V-BID incentives to a wider range of chronic diseases, or to everyone for all preventive care, so that everyone benefits.
3. Preclude V-BID discounts for those whose diabetes is a result of lifestyle choices:
 - *"Something that happens as a result of something that you choose to do or choose not to do, then I don't think they should have the benefit of the reduced co-pay."*
 - *"If somebody finds themselves with that disease because of a poor lifestyle... I don't know if the rest of us should pay for that."*
4. Provide more healthy diet and exercise incentives to make V-BID incentive programs unnecessary.

General discussion on the diabetes scenario

In follow-up discussions, the potential for cost savings was a key factor in how participants viewed the V-BID program. Many suggested they would not be supportive if the plan later was found not to save money. Similarly, many of those who felt all co-pays should be the same might consider a V-BID if it proved to save everyone money. A small number of participants felt the V-BID program would be the right thing to do, regardless of the cost, and would be willing to pay more to provide this program to their diabetic colleagues.

Participants also considered whether all diabetics should receive the discounts or if Type 2 diabetics, where lifestyle choices played a role in their chronic illness, should be treated differently. Participants expressed a mixed response; some felt that those with Type 2 diabetes should be excluded from a V-BID benefit, while others felt uncomfortable judging lifestyle choices (one participant asked, "does this mean we wouldn't treat a car crash victim if they were a bad driver?").

MRIs for low back pain—a ‘stick V-BID’ approach

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.

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? (N=47)

49%—Yes, patients should pay more if the test or treatment they want is not necessary.

23%—No, patients should pay the same amount for all tests or treatments that they get.

28%—I think there is another way to do this: _____

Responses to Scenario #2

Patients should pay more for a test or treatment that is not necessary.

Participants said this strategy would avoid wasteful spending and suggested doctors, not patients, should decide what treatments are needed:

- *“Sometimes [a test] is just not necessary and you waste a lot of money because you have a feeling [you need something more].”*
- *“A patient shouldn’t be allowed to strong arm a doctor into a treatment that isn’t needed.”*

Patients should not be charged more even when evidence did not support the use of the MRI.

Participants believed that physicians are not always right and that patients sometimes know best.

- *“You have to have these tests done just to rule out certain things. So, I think my co-pay shouldn’t be different than someone else’s co-pay just because I wanted to be cautious.”*
- *“Patients need to be proactive and they need to stop letting doctors control the situation. If you are still having the pain, why not get the MRI?”*

There is some concern about the role of health insurance; they believe that these decisions should be between the patient and physician and do not want the health plan making these decisions. Some participants also suggested the ‘value’ of a test may be more than its clinical impact; providing peace of mind to a worried patient has value, too.

Participants proposed other ideas.

1. A patient is entitled to a second opinion before having to pay more. If both doctors agree the test is unnecessary, then the patient should have to pay more.
2. There should be an option to proceed ‘at your own risk’. If the MRI shows no further problem, the patient should pay the full cost. If it does show a problem, the MRI should be fully covered.

General Discussion

Wider discussion in this session centered on physician accountability and whether coverage decisions should be determined at the discretion of a physician, or whether an evidence-based standard should be used. Most agreed that if physicians denied a patient request for a test, patients could easily seek out a different physician until one agreed to order. Despite this, most felt that the physician discretion, not evidence-based guidelines, should be the deciding factor on whether or not a test is warranted. Evidence-based standards cannot account for the uniqueness of each patient or situation and the physician should be able to treat the patient as he/she thinks is best.

Drug A for advanced breast cancer—a ‘stick’ approach to V-BID

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.

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? (N=47)

17%—The health plan should continue to cover the cost of Drug A for advanced breast cancer, just as it did previously.

28%—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.

55%—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.

Responses to Scenario #3

Participants thought Drug A should not be covered.

These participants said they trusted the FDA findings and thought it would be wasteful to cover a treatment where the evidence showed no impact:

- *“If the FDA didn’t approve it, there must be compelling reasons why. So, if it’s not working, I don’t think insurance should cover it.”*

When asked if the high cost of the medication was a significant factor in their decision, many said they would not feel differently even if Drug A were cheaper.

- *“I wouldn’t want to cover \$1 for this drug—it doesn’t work.”*

Participants often said they felt it would be wrong to provide a medication that offered false hope:

- *“A doctor’s obligation and responsibility is not to tap into your hope, it is to provide healing.”*
- *“My belief is that it would be wrong to provide a medication to someone that could have very serious side effects, when you know it’s not going to do any type of treatment for that disease.”*

Participants thought some of the cost of Drug A should be covered.

Some participants wanted to compromise and help those facing a difficult situation. These participants generally accepted that Drug A was ineffective, but felt it very difficult to deny resources to a patient in this grave situation.

Participants thought the employer should continue to cover Drug A.

These participants emphasized the value of hope to a patient, and said a medication can have a greater impact than just on clinical outcomes:

- *“If the patient is convinced it is helping them, a lot of times that is what is going to get you through. If you have hope and you feel like this medicine is helping you that is almost half the battle.”*
- *“You can’t put a price tag on hope.”*

Nearly all of these participants also felt that coverage should be continued for those already on the medication, but said it should not be offered to new patients. Rather, hope should be found in other treatments for new patients.

General Discussion

When considering the physician’s opinion whether or not to provide Drug A to Patricia, most participants said the physician’s opinion would not change their views. In an interesting contrast to Scenario 2, most participants felt that FDA evidence had greater weight than physician discretion in this case. When asked about this difference, some expressed that the Drug A testing provided a clear answer as to the effectiveness of the product. This seemed different than standards for getting an MRI for back pain, where the evidence would be less clear or compelling. Participants believed that each case is different, and with interventions that are sometimes useful and sometimes not, the physician perspective becomes more important.

Key themes impacting perception of V-BID

Key themes for 'carrot V-BID'

Cost savings: Many supported the diabetes V-BID program because they thought it could reduce costs; those that did not support it were skeptical that it would reduce the cost of health insurance. When asked if the cost saving assumption were either proven or disproven in time, many participants changed their views with the change in the assumption about cost.

Individual responsibility: Participants' views varied on how they might customize a V-BID program. Some wanted to only reward those that were doing their part to stay healthy, while others thought that the employer ought to help with few strings attached.

Fairness: Among those in favor of V-BID in the diabetes program, many felt it was unfair to only offer discounts to diabetics, even if that area were the only one to save money. Most thought such a program needed to be applied to many areas of chronic disease and to preventive care more broadly so that all (including the healthy) could benefit.

Key themes for 'stick V-BID'

Determining 'value': physician or evidence? When disincentives were being considered, participants were especially concerned about how value is determined. Interestingly, the response was different in the two scenarios. In the MRI for back pain example, participants did not want clinical standards regarded as rigid rules, feeling that they may not necessarily apply for every patient. They thought that the physician should decide what treatments a patient receives. Yet, in the Drug A example, many felt the evidence set forth by the FDA should be the deciding factor, even if the physician felt differently.

Looking for compromise: Many chose 'another approach' when it was an option. Participants were reluctant to identify an absolute solution that worked for each unique patient and situation. Instead, they often sought a compromise, such as offering the patient a second opinion in the case of the MRI. Since the 'stick' approach represented 'take-aways', participants tended to apply this approach more narrowly than the 'carrot' approach.

Value means more than clinical outcomes: Participants valued hope and peace of mind and felt that clinical evidence was not giving that its just due.

Results of post-discussion survey

Results from the post-discussion survey show that participants are very concerned about rising health insurance costs, and after the discussion most thought V-BID should be used some or most of the time (see Figure 1). Despite the objections to V-BID noted in the qualitative findings, participants seem to be supportive in general. Since much of the discussion was oriented to improving or modifying the V-BID examples they were given, it may well be that their concluding decisions reflect an assumption that their changes in V-BID would be adopted.

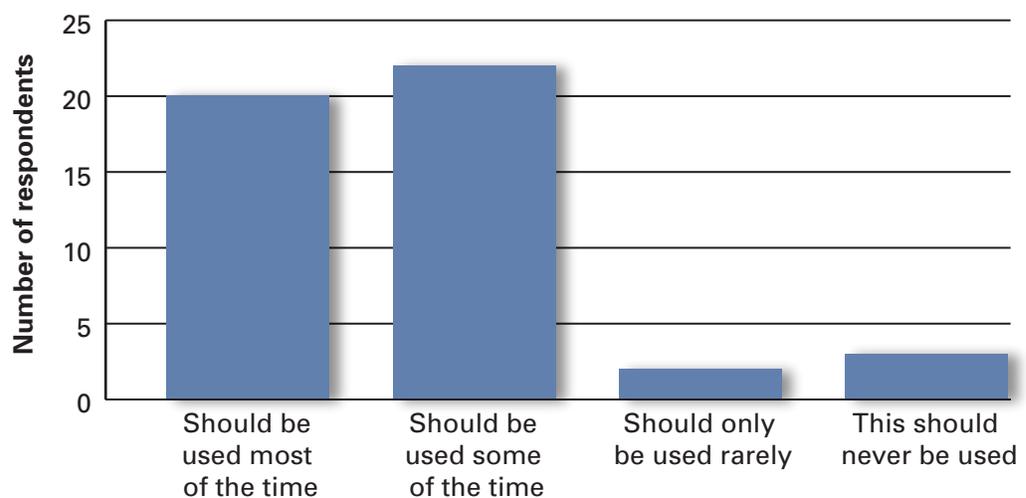
FIGURE 1

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 (n=47):



To see if participants' responses differed depending on which approach was used—carrot or stick—we also asked two separate questions:

1. 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 (not support) -5 (highly support)
2. 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 (not support) -5 (highly support).

The average response to the carrot version was 3.87 while the stick version was 3.58.

Conclusions

These pilot discussions signify some enthusiasm regarding value-based approaches as a tool to help reduce the growing costs of healthcare. Participants grasped the potential of the V-BID concept and were willing to consider value-based applications.

Responses varied considerably on what would be needed to make V-BID a fair approach. Not surprisingly, perceptions of fairness reflect widely divergent views and values. For example, while some participants felt that diabetics receiving V-BID discounts should need to show a certain level of personal responsibility for their health, others felt that the discounts should be helping those struggling the most to adhere to their medications and manage their condition. Others questioned whether a V-BID discount should be offered to those whose lifestyle choices may have contributed to their chronic disease. These differing perspectives highlight the tensions that surround many aspects of health care reform: strategies for improving quality and value are not without controversy and conflicting individual and societal values.

Participants proposed many different (and sometimes conflicting) ways to make V-BID programs more acceptable. Participants wanted ‘carrots’ applied broadly (to more than just a few chronic diseases) and ‘sticks’ applied narrowly. Cost savings was key—there was little support for a V-BID program that would not save money. Individual responsibility was an important consideration for most, but participants had different views on what this should mean.

The ‘value’ of medical interventions is a new concept for most consumers and a difficult one to accept if it threatens the authority of patients and doctors to make independent decisions. In one stick example, evidence of low-value was not the deciding factor, and patients felt that the physician should make the call in each unique situation. Yet in the other stick example, FDA evidence was enough to determine that something was ‘low-value’ and over-riding the decision of the physician was justified.

The findings from this small study offer issues and questions that might well be pursued with additional deliberative discussions with the general public:

- Most participants were supportive of some form of V-BID, but the discussions around fairness, determining value, and individual responsibility were divisive. Additional studies could shed light on how the public resolves some of these tensions when faced with health plan models that use these different approaches and their cost implications for consumers.
- One of the most complex issues is the tension between physician authority and medical evidence. Notwithstanding the “Drug A” example, the public is reluctant to allow a physician’s treatment decision to be overruled by others—even when that treatment decision is contrary to solid research. This is a particularly vital issue for ‘stick V-BID’.

We hope to be able to continue this research to help those implementing V-BID create better and more effective programs and to make the most of the potential for V-BID as a tool in healthcare improvement.