Potential Role for Value-Based Insurance Design in Cancer Care

Summit on Optimizing High Value Cancer Care

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Improving Care and Bending the Cost Curve
Shifting the discussion from “How much” to “How well”

- The past several decades have produced remarkable technological and therapeutic innovations for the prevention and treatment of cancer, resulting in impressive reductions in morbidity and mortality.
- Regardless of these clinical advances, cost growth remains the principle focus of health care reform discussions.
- Despite unequivocal evidence of clinical benefit, substantial underutilization of high-value cancer services persists across the spectrum of clinical care.
- Given that there is no disagreement that there is enough money in the current system, stakeholders should shift the focus from how much - to how well - we spend.
Dealing with the Health Care Cost Crisis
Interventions to Control Costs

• Information Technology
• Payment Reform
• Make Beneficiaries Pay More
  – For today’s discussion, it is important to distinguish between the total cost of care and the portion of costs of care paid by the consumer
The Problem: "One Size Fits All" Cost Sharing

Cost sharing for medical services and providers are the same for...

High value services:
- Strong evidence base
- Enhance clinical outcomes
- Increase efficiency

&

Low value services:
- Weak evidence base
- Minimal or no clinical benefit
- Increase inefficiency

...despite evidence-based differences in value.
A growing body of evidence demonstrates that increases in patient cost-sharing leads to decreases in non-essential and essential care which, in some cases, leads to greater overall costs.
“I can’t believe you had to spend a million dollars to show that if you make people pay more for something they will buy less of it.”

Barbara Fendrick (my mother)
Value-Based Insurance Design: Aligning Cost-sharing with Clinical Benefit – not Purchase Price

- Ideally, patient copayments would be used to encourage the use of high-value services and discourage the use of low-value services.
- Cost-related non-adherence is particularly problematic in clinical oncology.
A New Approach: Clinical Nuance

1. Services differ in clinical benefit produced

2. Clinical benefits from a specific service depend on:
   - Who receives it
   - Who provides it
   - Where it's provided
The Solution: Clinically-Nuanced Cost Sharing

Low Cost Sharing to encourage High value services

High Cost Sharing to discourage Low value services
Value Based Insurance Design: “Carrot” Programs Improve Adherence Without Increasing Costs

- July 2013 *Health Affairs*:
  - Systemic review of 13 studies of incentive-only drug programs
  - “consistently associated with improved adherence”
  - Lower patient out of pocket costs
  - No significant increase in total spending by payers

Joy L. Lee, Matthew Maciejewski, Shveta Raju, William H. Shrank, and Niteesh K. Choudhry
*Health Aff* July 2013 vol. 32 no. 7 1251-1257
Value-Based Insurance Design
Implications for Use of “Clinical Nuance” in Oncology

• Screening
  – Targeted screening based on cancer risks
• Diagnostics
  – Molecular diagnostics to determine prognosis or predict response to therapy
• Treatments
  – By indication
  – Based on results of diagnostics
• Providers
  – Centers of excellence

“Lowe's is offering employees incentives in the form of reduced out-of-pocket costs to come to the Cleveland Clinic for heart procedures.”
Value Based Insurance Design: Provisions in the Patient Protection & Affordable Care Act

• Coverage of Primary Preventive Services
  – Sec. 2713 prohibits cost sharing for >60 evidence-based preventive services
  – Approximately 105 million Americans have received expanded coverage
• Implementation of “nuanced” cancer related recommendations challenging
  – Screening (colonoscopy, CT for lung)
  – Treatment (chemoprevention for high risk breast cancer)
• Clinically indicated follow-up of preventive care not included
The CMS recently finalized rules (CMS-2334-F) giving Medicaid programs greater flexibility to vary cost-sharing for drugs as well as certain outpatient, emergency department, and inpatient visits.

States may vary cost-sharing for a particular outpatient service in accordance with who provides the service and/or where it is delivered.

States may target cost-sharing to specific groups of individuals based on clinical information (e.g., diagnosis, risk factors).
V-BID in Healthy Michigan Legislation

Health plans permitted to:
- Reduce required contributions to an individuals health savings account if “healthy behaviors are being addressed, as based on uniform standards developed by DCH in consultation with health plans.”
- Waive co-pays "to promote greater access to services that prevent the progression and complications related to chronic diseases.”

Department of Community Health to “design and implement a co-pay structure that encourages the use of high-value services, while discouraging low-value services such as non-urgent Emergency Department utilization.”

DCH to implement a pharmaceutical benefit that utilizes co-pays at appropriate levels allowable by CMS to encourage the use of high-value, low-cost prescriptions.

[Section 105D(1)(5)]

[Section 105D(1)(e)]
Section 226 (a) The commissioner shall by regulation determine which medical services, treatments and prescription drugs shall be deemed high-value cost-effective services for the purposes of this section. The determination of high-value cost-effective services shall rely on the recommendations of the Barrier-Free Care Expert Panel established by subsection (c). Any service, treatment or prescription drug determined by the commissioner to be a high-value cost-effective service by regulation promulgated prior to July 1 of a year shall be deemed a high-value cost-effective service for the purposes of subsection (b) effective on January 1 of the following year. In determining medical services, treatments and prescription drugs to be deemed high-value cost-effective services, the commissioner may limit the effect of the determination to people with one or more specific diagnoses or risk factors for a disease or condition.
“(D) Changes in coverage.—The Secretary, in consultation with experts in the field, shall establish a process for qualified BCPs to submit value-based Medicare coverage changes that encourage and incentivize the use of evidence-based practices that will drive better outcomes while ensuring patient protections and access are maintained."
Many initiative are restructuring provider incentives:

- Payment reform
  - Global budgets
  - Pay-for-performance
  - Bundled payments
  - ACOs
- Tiered networks
- Health information technology
Unfortunately, “supply-side” initiatives have historically paid little attention to consumer decision-making or the “demand-side” of care-seeking behavior:

- Shared decision-making
- Literacy
- Benefit design
• The alignment of supply- and demand-side incentives can improve quality and achieve savings more efficiently than either one alone.
Aligning “Supply-Side” and “Demand-Side” Incentives BlueShield of California’s “Blue Groove” Plan

- Combines wellness programs, advanced member engagement, Value-Based Insurance Design, and high-performing provider networks

- Qualify for lower co-payments only if you have one or more conditions and use a high-value provider:
  - End-stage renal disease
  - Congestive Heart failure
  - Coronary artery disease
  - Cancer
  - Diabetes
  - Hypertension
  - Osteoarthritis

- Aligns clinical goals of supply-side (ACO) and demand-side (V-BID) initiatives
• The use of “clinically nuanced” incentives [and disincentives] to encourage [and discourage] patient and provider behavior to redistribute medical expenditures will produce more health at any level of health expenditure

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