

Grounding Coverage in Value

A Paradigm for Linking Quality and Costs

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One of the fundamental shortcomings of the U.S. healthcare system is the consistent inability to implement effective interventions into routine practice.¹ To overcome this deficiency, substantial expenditures are made on a variety of quality improvement efforts, many with unknown or marginal benefit.^{2,3} Although performance measurement, disease management, pay for performance, and other quality-enhancement tools strive to overcome the underutilization of effective services, the prevailing trend in health insurance benefit design—increasing cost-sharing for the patient—has worked largely in opposition to these efforts.⁴ Rising cost-sharing, enacted chiefly through copayments and deductibles, multitiered formularies, and consumer driven health plans, is designed to curtail the overutilization of healthcare interventions often associated with mounting healthcare costs.

In an industry commanding \$1.9 trillion annually (16% of the U.S. gross domestic product),⁵ it is equally fascinating and frustrating to observe how aggressively these 2 trends (quality improvement and cost containment) have developed concurrently yet entirely incongruously, creating a marked conflict of incentives in the healthcare marketplace—improve quality by increasing utilization of effective services (which almost always leads to added costs) OR constrain costs by decreasing utilization typically without regard to clinical merit.

In an era in which healthcare cost concerns are allegedly crippling the competitiveness of American industry but where quality of care is universally recognized to be below acceptable standards, it is unclear which path—the quality improvement or the cost containment—is the correct one. My answer is both . . . and neither. Improving quality is a noble goal, yet constraining cost growth may be an absolute requirement for making progress in other social goals—rising living standards, affordable government budgets, and care for the 45 million uninsured.⁶ Our current “one-size-fits-all” approaches to quality improvement and cost containment inherently conflict. Although we reward providers for increasing beta blocker use after myocardial infarctions, we penalize patients by increasing their copay for the very beta blocker we are giving physicians the incentive to prescribe.

VALUE—THE OFT-FORGOTTEN SYNERGY BETWEEN QUALITY AND COSTS

What is the right balance between quality and costs? The answer is to reject both paradigms as absolute and to recognize the common theme: value—put simply, the clinical benefits achieved for the money we spend. Our goal should be to provide services that are worth the cost—spending more where that is justified and less where we are not achieving appropriate returns.⁷ Focusing on value will require a more nuanced investment in health technologies and a willingness to redesign some of our most common healthcare financing mechanisms to respond to differences in the value (rather than solely the cost)

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of services being financed. Such a realignment of incentives, although desirable, will require rigorous evaluation to ensure such policies provide incentives for value as designed.

In this issue of *Medical Care*, Mah and colleagues examine the impact of a health plan coverage change specifically designed to improve quality.⁸ Using a rigorous longitudinal study design, they examine the impact of reducing patient cost-sharing for diabetes-monitoring equipment on racial disparities in diabetes self-management practices. Although the provision of free glucose monitors increased initiation of blood glucose self-monitoring overall and appeared to do so more in blacks than whites, this relative increase in self-monitoring quickly waned over time. Although the findings were not striking, the suggestion that removing financial barriers to effective therapies might be a viable policy lever to improve quality and reduce disparities provides an important justification for further such studies.

“CLINICALLY SENSITIVE” BENEFIT DESIGN— BALANCING COSTS AND QUALITY

Increases in patient cost-sharing, although meant to reduce utilization of low-value care, assume that patients can distinguish between essential and nonessential therapies. Yet, the preponderance of evidence suggests that patients, in response to “one-size-fits-all” cost-sharing, decrease the use of both excess and essential therapies alike^{9–11} and have poorer health outcomes as a result.^{9,10} Rather, the ideal benefit design would base out-of-pocket costs on a targeted assessment of benefit. Thus, the more clinically beneficial the therapy for the patient, the lower that patient’s cost share would be. This concept has been proposed under many different names: benefit-based copays, value-based benefits, value-based insurance design and, most recently, “clinically sensitive” benefit design.^{12–14} Regardless of the name, the concept is the same: redesign benefits to encourage the use of high-value care while discouraging the use of low-value or unproven services.

Not surprisingly, the cost pressures placed on American industry have led the medical sector to experiment with innovative benefit design approaches. Although most employers have moved to high cost-sharing,¹⁵ some have experimented with encouraging value-based care. In an effort to reduce high-cost claims, Fortune 500 employer (and self-insurer) Pitney Bowes lowered medication copays for asthma and diabetes medications in 2001, reporting to the *Wall Street Journal* a \$1 million savings from reduced complications.^{16,17} The Asheville Project, which waived copays on diabetes medications and supplies for Asheville city employees who enrolled in a pharmacist case management program, has shown long-term improvements in glycemic control and reductions in the rate of healthcare cost growth.¹⁸ Building on these early reported successes, other payers have touted such value-based benefit redesigns as the long-awaited solution to improving return on investment in health care. CIGNA HealthCare, for example, is developing a 4-tier formulary option it terms the “tiered clinical utility” approach, with “lifesaving” drugs on the lowest copay tier and “lifestyle” drugs on the highest copay tier.¹⁹ Other efforts have been

more modest such as the state waivers of copays for secondary preventive services, including diabetes monitoring equipment described by Mah.⁸ Although these clinically sensitive benefit designs hold promise for improving the value of care, there have been few prospective, controlled evaluations of these more targeted benefit designs.

In this context, the study by Mah and colleagues represents a major advance in the field by acknowledging that cost-sharing may be an important tool—rather than just a barrier—to improve appropriate healthcare utilization and potentially reduce disparities in care. As cost-sharing continues to rise,¹⁵ the financial barriers posed by copays will continue to limit the access to effective services of those who stand to benefit the most—individuals with multiple chronic conditions and those with limited financial resources. Further studies of the impact of more targeted cost-sharing arrangements on quality of care and on disparities in care will be critical as we move forward. It is only with such studies that we will be able to demonstrate the importance of linking financial incentives and quality improvement initiatives in a consistent, synergistic manner if we are to achieve the outcome of high-quality equitable care at a reasonable price.

“CLINICALLY SENSITIVE” PERFORMANCE MEASUREMENT—BALANCING QUALITY AND COSTS

Just as the “one-size-fits-all” approach to benefits fails, so does the “one-size-fits-all” approach to quality improvement. Performance measurement sets, clinical practice guidelines, and other quality improvement tools recommend and track the utilization of evidence-based therapies for specific chronic diseases. However, the benefit of these therapies relies substantially on the underlying risk of the patient, and not all patients will benefit to the same extent.²⁰ This focus on specific therapies for individual diseases may be particularly poorly suited to our current practice environment in which multiple chronic comorbidities is the norm.²¹ Indeed, by failing to acknowledge heterogeneity of patient risk (and therefore benefit), current performance measurement and reward systems may increase utilization above appropriate levels. As Mah and colleagues point out, although copay relief may have improved race-related diabetes self-monitoring practices, it appeared to do so in the group of patients—noninsulin-requiring type II patients with diabetes—with the least evidence of benefit from such practices.²² To improve on current performance measurement, what is needed is to incorporate a better understanding of which groups of patients (along a continuum) are most likely to benefit from therapies; this information, as it develops, can then be used in the restructuring of benefits to maximally improve the value of care.

CONSIDERATIONS

The impact of value-based benefits on the medical system is difficult to know. Although some studies suggest that more appropriate utilization of evidence-based therapies may lower healthcare costs and improve quality of care,^{23,24} this is unlikely to be uniformly true. Referred to as a “dominant

strategy” in the cost-effectiveness world or “positive return on investment” in the business world, the expectation of financial savings from any quality improvement tool is unrealistic. A much more reasonable forecast is that healthcare costs will continue to rise, although perhaps at a more moderate rate. Relatedly, it is important to recognize that the primary return on investment in health care is good health (not money saved), so any true return on investment must incorporate health improvements. If value-based benefits are evaluated in this framework, it is reasonable to expect and demand a positive return on investment.

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