Changing the Health Care Cost Discussion from “How much” to “How well”

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Session Outline

- Problem: "One size fits all"
- Solution: “Clinical Nuance”
- Approach: Identify the "Good Stuff" and the "Bad Stuff"
Improving Care and Bending the Cost Curve

- The past several decades have produced remarkable innovations resulting in impressive improvements in individual and population health.
- Regardless of these advances, cost growth remains the principle focus of health reform discussions.
- Despite clear evidence of clinical benefit, high-value services are underused across the entire spectrum of care.
- Billions of dollars are spent on services that provide no clinical benefit and may cause harm.
- Given systematic underuse, overuse and misuse, the cost discussion should change from how much to how well our health care dollars are spent.
Problem: Misguided Financial Incentives for Clinicians and Consumers

- Ideally, reimbursement models and consumer cost-sharing would be set to encourage the clinically appropriate use of health care services.
- Fee for service payment and an archaic “one-size-fits-all” approach to consumer cost sharing fails to acknowledge the differences in clinical value among medical interventions.
Impact of Increases in Consumer Cost-Sharing on Health Care Utilization

A growing body of evidence concludes that increases in consumer cost-sharing leads to a reduction in the use of essential care, which worsens health disparities, and in some cases leads to greater overall costs.

Cost-sharing Affects Mammography Use by Medicare Beneficiaries

Trivedi A. NEJM. 2008;358:375-383
High Copays Reduce Adherence to Appropriate Medication Use

Change in Days Supplied for Selected Drug Classes When Copays Were Doubled

- Diabetes: -25%
- High Cholesterol: -34%
- Hypertension: -26%

- When copays were doubled, patients took less medication in important classes. These reductions in medication levels were profound.
- Reductions in medications supplied were also noted for:
  - NSAIDs 45%
  - Antihistamines 44%
  - Antiulcerants 33%
  - Antiasthmatics 32%
  - Antidepressants 26%
- For patients taking medications for asthma, diabetes, and gastric disorders, there was a 17% increase in annual ER visits and a 10% increase in hospital stays.

ER = emergency room.

Effects of Increased Copayments for Ambulatory Visits for Medicare Advantage Beneficiaries

Copays increased:

- from $7.38 to $14.38 for primary care
- from $12.66 to $22.05 for specialty care
- remained unchanged at $8.33 and $11.38 in controls

In the year after copayment increases:

- 19.8 fewer annual outpatient visits per 100 enrollees
- 2.2 additional hospital admissions per 100 enrollees
- Effects worse in low-income individuals and beneficiaries with chronic illness

Rising copayments may worsen disparities and adversely affect health, particularly among patients living in low-income areas.

Solutions Are Needed to Enhance Efficiency

- Targeted solutions are necessary to better allocate health expenditures on the clinical benefit - not the price or profitability – of services
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
Clinical Nuance: Short Term Cost Savings Require “Carrots” and “Sticks”

- An opportunity exists for a cost-saving reallocation - within any health budget - through increasing use of high-value interventions and simultaneously reducing the use of services that offer no clinical benefit
Implementing Clinical Nuance: Value-Based Insurance Design

- Sets consumer cost-sharing level on clinical benefit – not acquisition price – of the service
- Mitigates concerns over cost-related non-adherence of high value clinical services
- Successfully implemented by hundreds of public and private payers
- Broad stakeholder support
Value-Based Insurance Design
Broad Multi-Stakeholder Support

- HHS
- CBO
- SEIU
- MedPAC
- Brookings Institution
- The Commonwealth Fund
- NBCH
- PCPCC
- PhRMA
- AHIP
- National Governor’s Assoc.
- Academy of Actuaries
- Bipartisan Policy Center
- Kaiser Family Foundation
- NBGH
- National Coalition on Health Care
- Urban Institute
- RWJF
- IOM
- US Chamber of Commerce

Lewin. JAMA. 2013;310(16):1669-1670
Evidence Supporting Value-Based Insurance Design:

- Most V-BID programs focus on removing financial barriers “carrots” to high-value prescription drugs used to treat chronic conditions (e.g., diabetes, asthma, heart disease)

- Evidence review
  - Improved adherence
  - Lower consumer costs
  - No increase in total spending
  - Reduction in health disparities

1 Health Affairs. 2013;32(7):1251-1257
2 Health Affairs. 2014;33(5):863-70
Emerging Best Practices in V-BID Implementation

An evaluation of 76 V-BID plans \(^1\) identified program features that had significant impact on improvement in medication adherence:

- Magnitude of reduction in cost-sharing levels
- Targeting of high-risk individuals
- Offered with a wellness program
- Avoided disease management
- Used mail-order prescription delivery

Evidence for Value-Based Insurance Design: MI-FREEEE: Better Quality Without Higher Costs

- Assessed impact of elimination of consumer cost-sharing for preventive medications for Aetna commercial plan members with history of myocardial infarction (i.e. heart attack) 1
- Random assignment by plan sponsor to either elimination of cost-sharing or usual cost-sharing levels
- “Enhanced prescription coverage improved medication adherence and rates of first major vascular events and decreased patient spending without increasing overall health costs.” 1

Evidence for Value-Based Insurance Design: MI-FREEE: Reducing Health Care Disparities

The MI-FREEE study assessed impact of elimination of consumer cost-sharing for preventive medications for Aetna commercial plan members with history of myocardial infarction (i.e. heart attack) ¹

Among MI-FREEE subjects who self-identified as being non-white, the elimination of cost-sharing ²

- Significantly reduced rates of a post-MI vascular event or revascularization
- Reduced total health care spending by 70 percent

Need for Savings Drives Momentum for “Stick” V-BID Programs

- “Carrot” programs do not lead to immediate cost savings
- Programs that discourage use of low-value services are increasingly being explored
- Oregon Public Employees
  - Higher cost sharing on selected imaging and diagnostic studies led to 15% - 30% decreased use
Growing Momentum to Identify Wasteful Medical Spending

- Available evidence suggests that significant opportunities exist to save money without sacrificing high-quality care
  - The Congressional Budget Office has concluded that up to 30 percent [approximately $700 billion] of the $2.5 trillion in annual health care spending is unnecessary

- Removing waste and unnecessary care from the system will help achieve the “Triple Aim”
  - Improve health outcomes
  - Enhance the patient experience by reducing harm
  - Lower cost to consumers and third party payers
Challenge of Identifying Low-Value Services: Clinical Nuance Revisited

- Although there is urgency to bend the health care cost curve, cost containment efforts should not produce avoidable reductions in quality of care.
- Many services identified as high-value in certain clinical scenarios are considered low-value when used in other patient populations or delivery settings.
  - Coronary artery stenting
  - Imaging for back pain
  - Colorectal cancer screening using colonoscopy
Health Waste Calculator: Capitalizing on Momentum to Identify Waste

- VBID Health collaborated with Milliman to create a new health care analytic solution powered by Milliman’s MedInsight software.
- The Health Waste Calculator is a standalone software tool designed to help health care organizations leverage clinically nuanced principles by identifying wasteful services.
- The tool identifies and quantifies the use of unnecessary or harmful clinical services, including those defined by initiatives such as the U.S. Preventive Services Task Force and Choosing Wisely.
Barriers to V-BID in HSA-qualified HDHPs

- IRS guidance documents specifically exclude from the definition of preventive care those services or benefits meant to treat “an existing illness, injury or condition.
- Confusion persists about what services can and cannot be covered outside of the deductible.
Applying V-BID to Specialty Medications

- Impose no more than modest cost-sharing on high-value services
- Reduce cost-sharing in accordance with patient- or disease-specific characteristics
- Relieve patients from high cost-sharing after failure on a different medication
- Use cost-sharing to encourage patients to select high-performing providers and settings
HR 5183/S.2783: Bipartisan “V-BID for Better Care Act of 2014”

- Directs HHS to establish a demonstration program to test V-BID in MA for beneficiaries with chronic conditions
- MA plans may lower cost-sharing to encourage the use of specific, evidence-based medications or services and/or specific high-performing providers
Using Clinical Nuance to Align Payer and Consumer Incentives: As Easy as Peanut Butter and Jelly

Many “supply side” initiatives are restructuring provider incentives:

- Payment reform
  - Global budgets
  - Pay-for-performance
  - Bundled payments
  - Accountable care
- Tiered networks
- Health information technology

AJAC. 2014;2(3);10.
Unfortunately, “supply-side” initiatives have historically paid little attention to consumer decision-making or the “demand-side” of care-seeking behavior:

- Benefit design
- Shared decision-making
- Literacy

AJAC. 2014;2(3);10.
The ultimate test of health reform will be whether it improves health and addresses rising costs. Adding clinical nuance to payment reform and consumer engagement initiatives can help improve quality of care, enhance patient experience, and contain cost growth by removing waste.

AJAC. 2014;2(3);10.
Questions?

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Health Waste Calculator: Capitalizing on Momentum to Identify Waste

- *Waste Calculator* algorithms process claims or electronic health record data to quantify potentially wasteful services.
- For each potentially inefficient service, the *Calculator* provides a degree of appropriateness for care:
  - A *wasteful* score, flags a cause for concern as the service should not have been delivered.
  - A *likely to be wasteful* score, indicates the need to question the appropriateness of service rendered.
  - A *necessary* score, suggests appropriate services were administered by the health care provider.
- Milliman benchmarks are bundled into the reporting package to improve the comparative analysis process.