

## Value-Based Insurance Design: A “Clinically Sensitive” Approach to Preserve Quality of Care and Contain Costs

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One of the perks that accompany editing *The American Journal of Managed Care* is that we can describe our vision for the *Journal* and the healthcare system from time to time. Over the past several months, not a day has passed without some criticism in the media, the US Congress, or the business community of the current US approach to healthcare delivery: millions uninsured or underinsured, safety concerns, underuse of recommended care, and most notably, how skyrocketing healthcare costs impede the ability of American companies to compete in the global marketplace. The 2006 New Year appears to be an equally provocative time, as healthcare consumerism continues to rise and the Medicare prescription drug benefit makes its much-heralded January 1 launch. This ongoing healthcare (r)evolution stirs various healthcare stakeholders' emotions, ranging from tremendous confidence to extreme anxiety. No matter where you might be sitting on this veritable roller coaster, the *Journal* looks forward to documenting the experience of this topsy-turvy ride. It remains our goal to provide timely and pertinent information on relevant topics and be a forum for discussion of the critical issues shaping the healthcare system.

Independent of the level of optimism or skepticism regarding the future of the present structure, increases in healthcare expenditures are an indisputable reality. Innovations to improve the quality of healthcare—interventions, such as drugs and devices, or enhancements to their delivery, for example, information technology and plan design—continue to be produced at a break-neck pace. How to pay for these advances remains the most challenging and troubling concern. A fundamental tension exists between the insatiable quest for the magic bullet that produces longer and healthier lives and the reality that Americans consume more resources to achieve these incremental benefits.

As long as health insurance remains a benefit of employment for many workers in this country, employers will continue to be more intimately drawn into the deliberations. Thus, we at the *Journal* intend to increas-

ingly engage the human resources personnel, actuaries, benefit design consultants, and the employer community in the *Journal's* efforts. Frequently, the first comment after a disappointing earnings statement is how the healthcare cost burden is negatively impacting a firm's bottom line. Given this obvious strain on the US employer, is it time to seriously reconsider the current employer-based system of health insurance? Although some analysts have espoused such a dramatic change, it appears Americans aren't ready to completely jettison this longstanding and well-accepted approach to providing health benefits. What seems more likely is incremental change to the employer-based healthcare benefit. Given the tall order to control cost growth while improving quality, we feel these innovative benefit packages should incorporate a range of features that promote effective and efficient delivery of care.

Healthcare benefit design is certainly a dynamic area. Rising healthcare costs have spawned efforts to redesign benefit packages to control costs and increase the value of healthcare dollars spent. Momentum has gathered behind two trends. The first focuses primarily on impacting the *cost* of care, and uses financial incentives to alter patient and provider behavior. Examples of these mechanisms include health savings accounts, consumer-driven health plans, and pharmaceutical coverage policies with increased patient cost-sharing provisions. Consumerism in its many forms has certainly become the darling of the benefit design arena. While rigorous evaluative data on these plan designs are scarce, proponents hope that lower-premium, high-deductible health plans will reduce expenditures, at least in the short run. Despite these potential cost reductions, we are not convinced that having the individual patient weigh the benefits and costs of

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medical interventions will lead to the desired clinical outcome, especially for patients who cannot become adequately informed. To clarify for our readers the potential impact on both clinical and economic outcomes of innovative benefit design, we encourage submissions of articles that formally evaluate redesigned benefit packages.

Increased cost sharing has become the norm for individuals with any type of health insurance, even those with the most generous benefits. For the most part, the amount of cost sharing has been based solely on the cost—not the value—of the intervention. That is, for low-cost services such as generic drugs, there is usually a low cost share, while for high-cost services such as branded pharmaceuticals, the converse is true. If one believes that the value of medical services may vary by indication and by patient group, an approach that ties the copay amount exclusively to the acquisition price may require some rethinking. A growing body of evidence demonstrates that increases in cost shifting leads to decreases in both essential and nonessential care. Benefit design packages that impose the same level of cost sharing for all services discourage the use of valuable—and perhaps cost-saving—services just as much as these packages discourage the use of wasteful, cost-ineffective, services. We believe that there is substantial benefit to the addition of nonprice elements into the equation.

The second trend in healthcare benefit design focuses on the *quality* of care, and usually uses tools to directly manage clinical care. Examples of these benefit features include disease management initiatives that span interventions aimed at both patients and providers, and pay-for-performance programs that give financial incentives to physicians if their patients achieve certain prespecified end points. The data evaluating pay-for-performance initiatives are just emerging and suggest marginal benefit.<sup>1</sup> Evidence suggests that disease management programs improve desirable health outcomes in such conditions as congestive heart failure or diabetes; however, convincing evidence has not yet been found that these programs reduce spending.<sup>2</sup>

Increased patient cost-sharing and disease management initiatives have been rapidly adopted. Yet it is underappreciated that greater patient expense and successful disease management inherently conflict with one another. Greater cost sharing at the point of service makes it relatively more difficult for individuals to purchase recommended services. Thus, it should be intuitive that “across the board” increases in cost sharing make it less likely for those individuals enrolled in disease management programs to meet their quality and cost metrics. From an economic perspective, the status

quo makes little sense and should be discarded. Instead, we strongly believe that aligning various financial and nonfinancial incentives, such as copay relief for services recommended by disease management, is more likely to achieve desired outcomes.

While we argue that high levels of cost sharing may be ill-advised in certain circumstances, it is absurd to completely ignore the need for interventions to constrain cost growth. Increased cost sharing—a well-established way to decrease utilization—seems inevitable given the inability for other mechanisms to bring about real cost growth constraint. Yet, instead of the current “one size fits all” approach, we propose a cost-sharing system that is “clinically sensitive.” We support a system of cost sharing that tailors copayments at the point of service to the evidence-based value of specific services for targeted groups of patients. This approach, “value-based insurance design,” is just a new name for the “benefit-based copay” concept that we first introduced for prescription drugs in this *Journal* in 2001 (long before we became co-editors).<sup>3</sup> In this new paradigm, patients’ out-of-pocket costs are no longer set on price alone, but on the cost/quality trade-off in a particular clinical set of circumstances: no or low copayment for interventions of highest value, such as angiotensin-converting enzyme inhibitors for individuals with diabetes mellitus<sup>4</sup> and lipid-lowering therapy for an individuals with a history of myocardial infarction,<sup>5</sup> and higher cost sharing for interventions with little or no proven health benefit, such as total body computer tomographic scanning. Smarter benefit packages can be designed that combine the health focus of disease management programs with the prevailing view that increased cost sharing is the preferred way to address concerns about healthcare spending growth.

We cannot deny legitimate challenges exist that are associated with implementing a health insurance option incorporating value-based insurance design. An obvious concern would pertain to the ability of an employer or a health plan to selectively lower employee contributions for specific interventions or selected patient groups. The widely reported experience of Pitney Bowes, whose initial intervention provided copay relief for drugs used to treat asthma and diabetes, has demonstrated that such an approach is feasible, acceptable to employees, and produces both clinical and economic returns. Thanks to the tireless efforts extolling the virtues of such a benefit design by Jack Mahoney, MD, and David Hom of Pitney Bowes, this value-based model has now been adopted by over 20 employers (and counting) nationwide.

Another potential difficulty in implementing a value-based insurance plan is the accurate classification of

individuals into disease groups. While this task may seem daunting, the evolution of disease management programs and other information technology advances suggests that much of the work has already been done for a set of important clinical conditions. Moreover, advances in risk adjustment systems can be used to facilitate payments and categorization systems. The Medicare disease management demonstrations exemplify such systems, in that the contractors take financial and clinical risk for populations suffering from specific chronic conditions. We believe that a clinical focus will allow better measurement of the reasons for cost growth and the value achieved for the extra spending. For this reason it will also facilitate pay-for-performance systems, because performance measures are best understood on a disease level. The disease management industry, for whatever its strengths or weaknesses, does focus attention on specific clinical entities and patterns of care across the spectrum of providers. In our opinion, patient-targeting approaches, such as those used in disease management programs, will allow the successful integration of nonfinancial clinical tools with financial levers such as cost sharing.

We are quite confident that reductions in cost sharing will increase the utilization of certain highly valued, yet underused services. Controlled investigations are ongoing to answer this question in the near future. In certain circumstances, we also project that these health advantages will translate into total cost savings.<sup>4</sup> We feel that the cost-saving examples are more likely to be the exception, and not the norm. However, cost

saving should not be the goal of any healthcare intervention; such a standard is both unrealistic and unnecessary. Savings notwithstanding, we do feel that a value-based insurance design would improve the market basket of clinical services provided when compared to similar expenditures made in currently available programs. These improvements would be achieved through the encouraged use of valued services and the implementation of higher cost sharing and resultant decreased use of those interventions of low or unproven efficacy.

Such a value-based system is unlikely to be a panacea for the healthcare crisis. Undoubtedly, technologic advances will continue to generate upward pressure on costs and the ability of individuals and their employers to afford them. Yet, the adoption of a healthcare benefit design that ensures value will allow more efficient management of the resources flowing into the system and generate improved health outcomes for the dollars spent, which, after all, is the collective goal.

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