Changing the Health Care Cost Discussion from "How Much?" to "How Well?"

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Learning Objectives

1. Examine the relationship between cost-sharing and patient adherence.

2. Explain the concept of “clinical nuance” which recognizes that: (1) medical services differ in the benefit provided; and (2) the clinical benefit derived from a specific service depends on the patient using it, as well as when and where the service is provided.

3. Introduce Value-Based Insurance Design - a program where cost-sharing is based on an intervention’s clinical benefit - not cost - to prioritize patients’ out-of-pocket expenditures.

4. Review existing evidence on Value-Based Insurance Design programs.

5. Overview of V-BID implementation in public and private payers.
<table>
<thead>
<tr>
<th>Factor</th>
<th>Odds ratio (and 95% CI)</th>
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</thead>
<tbody>
<tr>
<td><strong>Environmental</strong></td>
<td></td>
</tr>
<tr>
<td>Dim lighting</td>
<td>1.6 (0.8–2.5)</td>
</tr>
<tr>
<td>Warm room temperature</td>
<td>1.4 (0.9–1.6)</td>
</tr>
<tr>
<td>Comfortable seating</td>
<td>1.0 (0.7–1.3)</td>
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<tr>
<td><strong>Audiovisual</strong></td>
<td></td>
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<tr>
<td>Poor slides</td>
<td>1.8 (1.3–2.0)</td>
</tr>
<tr>
<td>Failure to speak into microphone</td>
<td>1.7 (1.3–2.1)</td>
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<tr>
<td><strong>Circadian</strong></td>
<td></td>
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<tr>
<td>Early morning</td>
<td>1.3 (0.9–1.8)</td>
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<tr>
<td>Post prandial</td>
<td>1.7 (0.9–2.3)</td>
</tr>
<tr>
<td><strong>Speaker-related</strong></td>
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<tr>
<td>Monotonous tone</td>
<td>6.8 (5.4–8.0)</td>
</tr>
<tr>
<td>Tweed jacket</td>
<td>2.1 (1.7–3.0)</td>
</tr>
<tr>
<td>Losing place in lecture</td>
<td>2.0 (1.5–2.6)</td>
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Note: CI = confidence interval.
Translating Research into Policy: Shifting the discussion from “How much” to “How well”

- Innovations to prevent and treat disease have led to impressive reductions in morbidity and mortality.
- Regardless of these advances, cost growth is the principle focus of health care reform discussions.
- Despite unequivocal evidence of clinical benefit, substantial underutilization of high-value services persists across the entire spectrum of clinical care.
- Attention should turn from how much to how well we spend our health care dollars.
For today’s discussion, our focus is on costs paid by the consumer, not the employer or third party administrator.

Ideally, consumer cost-sharing levels would be set to encourage the clinically appropriate use of health care services.

Instead, archaic “one-size-fits-all” cost-sharing fails to acknowledge the differences in clinical value among medical interventions.

Consumer cost-sharing is rising rapidly.
A growing body of evidence concludes that increases in consumer cost-sharing leads to a reduction in the use of essential services, worsens health disparities, and 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)
Cost-sharing Affects Mammography Use by Medicare Beneficiaries

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

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.

Medication Affordability After Medicare Part D Implementation

- Among elderly beneficiaries with four or more chronic conditions, the prevalence of cost-related non-adherence increased from 14% in 2009 to 17% in 2011, reversing previous downward trends.

- The prevalence among the sickest elderly of forgoing basic needs to purchase medicines decreased from 9% in 2007 to 7% in 2009 but rose to 10% in 2011.
Rising copayments worsen disparities and adversely affect health, particularly among economically vulnerable individuals and those with chronic conditions.
Effects of Increased Copayments for Ambulatory Visits for Medicare Beneficiaries

• Copays increased:
  • $7 for primary care visit
  • $10 for specialty care visit
  • remained unchanged in controls
• In the year after copayment increases:
  • 20 fewer annual outpatient visits per 100 enrollees
  • 2 additional hospital admissions per 100 enrollees
• Total cost higher for those with increased copayments

IBM to Drop Co-Pay for Primary-Care Visits

By WILLIAM M. BULKELEY

In an unusual bid to cut health-care costs, International Business Machines Corp. plans to stop requiring $20 co-payments by employees when they visit primary-care physicians.

The company said it believed the move would save costs by encouraging people to go to primary-care doctors faster, in order to get earlier diagnoses that could save on expensive visits to specialists and emergency rooms.

IBM said that the action applies to the 80% of its workers who are enrolled in plans in which the company self-insures—that is, programs in which it pays the health-care benefits, not insurers. The new policy doesn't cover IBM employees in health-maintenance organizations.

One of the nation's largest employers with 115,000 U.S. workers, IBM spends about $1.3 billion a year on U.S. health care. Its benefit practices are closely watched in the human-resources community, and its actions are sometimes trend-setters.
Unable to Afford Surgery, Farmer Amputates His Own Feet

By AMY QIN   MAY 14, 2014, 6:56 AM   1 Comments

For months, Liu Dunhe, a 44-year-old farmer in the southeastern province of Anhui, watched as what had begun as several seemingly innocuous blisters on his feet deteriorated into severe necrosis. By late April, his feet had become so rotten that he had already dug out several maggots from the dead, odorous flesh, according to a report in The Beijing News.

No longer able to withstand the torturous pain and unable to afford the out-of-pocket expenses for an operation, Mr. Liu decided that it was time for drastic measures: self-amputation.
Foregoing Preventive Care Due to Cost: A Bipartisan Problem

40% of Democrats and 41% of Republicans said cost is the number one reason they have not utilized preventive care.
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
Implementing Clinical Nuance: Value-Based Insurance Design

• Sets consumer cost-sharing level on clinical benefit – not acquisition price – of the service
  – Reduce or eliminate financial barriers to high-value clinical services and providers

• Successfully implemented by hundreds of public and private payers
Evidence Supporting Value-Based Insurance Design: Improving Adherence Without Increasing Costs

- Evidence review
  - Improved adherence
  - Lower consumer out-of-pocket costs
  - No significant increase in total spending

MI-FREEE: Better Quality Without Higher Costs

- Assessed impact of free access to preventive medications for Aetna members with history of MI

- Random assignment by plan sponsor

- “Enhanced prescription coverage improved medication adherence and rates of first major vascular events and decreased patient spending without increasing overall health costs.”

Full drug coverage:

- Reduced rates of a post-MI vascular event or revascularization among patients who self-identified as being non-white

- Reduced total health care spending by 70 percent among patients who self-identified as being non-white
Emerging Best Practices in V-BID Implementation

A 2014 *Health Affairs* evaluation of 76 V-BID plans reported that programs that:

- were more generous
- targeted high-risk individuals
- offered wellness programs

had greater impact on adherence than plans without these features.

Choudhry. N. *Health Affairs*. 2014;33(3).
Value Based Insurance Design
More than High-Value Prescription Drugs

- Prevention/Screening
- Diagnostic tests/Monitoring
- Treatments
- Clinician visits
- High performing networks
- PCMH
- Hospitals
“Lowe's is offering employees incentives in the form of reduced out-of-pocket costs to come to the Cleveland Clinic for heart procedures.”
Putting Innovation into Action:
Create Broad Multi-Stakeholder Support

- HHS
- CBO
- SEIU
- MedPAC
- Brookings Institution
- The Commonwealth Fund
- NBCH
- PCPCC
- Partnership for Sustainable Health Care
- Families USA
- AHIP

- National Governor’s Assoc.
- US Chamber of Commerce
- Bipartisan Policy Center
- Kaiser Family Foundation
- NBGH
- National Coalition on Health Care
- Urban Institute
- RWJF
- IOM
- PhRMA
- AARP
• V-BID included in the Patient Protection and Affordable Care Act
ACA Sec 2713: Selected Preventive Services be Provided without Cost-Sharing

- Receiving an A or B rating from the United States Preventive Services Taskforce (USPSTF)
- Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP)
- Preventive care and screenings supported by the Health Resources and Services Administration (HRSA)

Over 100 million Americans have received expanded coverage of preventive services
“Value-based insurance designs include the provision of information and incentives for consumers that promote access to and use of higher value providers, treatments, and services.”
Putting Innovation into Action: Translating Research into Policy

- Patient Protection and Affordable Care Act
- Medicare
- State Health Reform
- HSA-qualified HDHPs
HR 5183/S.2783: Bipartisan “V-BID for Better Care Act of 2014”

- Bill directs HHS to establish a demonstration program to test V-BID for beneficiaries with chronic conditions
- CMS issues RFI on role of V-BID in Medicare
• Patient Protection and Affordable Care Act
• Medicare
• State Health Reform
• HSA-qualified HDHPs
Value-Based Insurance Design
Growing Role in State Health Reform

- State Employees Benefit Plans
- State Exchanges
- CO-OPs
- Medicaid
Value-Based Insurance Design
Growing Role in State Health Reform

- State Employees Benefit Plans
  - Connecticut
  - Oregon
  - Virginia
  - South Carolina
  - Minnesota
  - Maine
  - New York
  - North Carolina
Implementing V-BID for State Employees: Connecticut State Employees Health Benefit Plan

• Participating employees receive a reprieve from higher premiums if they commit to:
  - Yearly physicals, age-appropriate screenings/preventive care, two free dental cleanings
  - If employees have one of five chronic conditions, they must participate in disease management programs (which include free office visits and lower drug co-pays)

• Early results:
  - 99% of employees enrolled and 99% compliant
  - Decrease in ER and specialty care
  - Increase in primary care visits
  - Increase in chronic disease medication adherence
CMS Rules Enable V-BID in Medicaid

Plans may vary cost-sharing for

- drugs, outpatient, inpatient, and emergency visits
- specific groups of individuals based on clinical factors
- an outpatient service according to where and by whom the service is provided

V-BID was prominently featured in Healthy Michigan Plan
V-BID Prominently Featured in Healthy Michigan Plan

- Sec 105D(1)(e), plans may waive consumer copayments, “to promote greater access to services that prevent the progression and complications related to chronic diseases.”

- Sec 105D(1)(f), assigned to “design and implement a copay structure that encourages the use of high-value services, while discouraging low-value services.”

- Sec 105D(5), assigned to “implement a pharmaceutical benefit that utilizes copays at appropriate levels allowable by CMS to encourage the use of high-value, low-cost prescriptions.”
Putting Innovation into Action: Translating Research into Policy

- Patient Protection and Affordable Care Act
- Medicare
- State Health Reform
- High Deductible Health Plans
HSA-qualified HDHPs: Too Much “Skin in the Game”?

- More than 25% of employers offer HDHPs
- 85% of enrollees in the individual marketplace purchased either silver or bronze HDHP plans
- Higher out-of-pocket costs hinder the use of evidence-based services (even when exempt from the deductible)
- HDHP enrollees with chronic diseases are more likely to go without care due to cost or experienced financial hardship due to medical bills
Barriers to V-BID in HSA-qualified HDHPs

- IRS guidance specifically exclude services meant to treat “an existing illness, injury or condition” from the definition of preventive care
- Many well-established quality metrics require the entire deductible to be met before coverage begins
- 90% of employers support expanding deductible-exempt definition to include chronic disease care
HVHP allows evidence-based, services that manage chronic disease to be deductible-exempt:

- Lower premiums than PPOs and HMOs; slight premium increase over existing HDHPs
- >40 million likely enrollees
- Vehicle to avoid “Cadillac tax”
- Substantially lower aggregate healthcare expenditures on a population level
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

Many “supply side” initiatives are restructuring provider incentives:

- Payment reform
  - Global budgets
  - Pay-for-performance
  - Bundled payments
  - Accountable care
- Medical homes
- 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:

- Benefit design
- Shared decision-making
- Literacy
Using Clinical Nuance to Align Payer and Consumer Incentives: As Easy as Peanut Butter and Jelly

- 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.
• The ultimate test of health reform will be whether it improves health and addresses rising costs

• V-BID should be part of the solution to enhance the efficiency of health care spending
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