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

A. Mark Fendrick, MD
University of Michigan Center for Value-Based Insurance Design

www.vbidcenter.org
amfen@umich.edu
@um_vbid
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
Role of Consumer Cost-Sharing in Clinical Decisions

• 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.

Health Affairs 2014. doi: 10.1377/hlthaff.2014.0792
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

- **2002**: 65.7% (Cost sharing) vs. 76.7% (Full coverage)
- **2003**: 69.7% (Cost sharing) vs. 77.5% (Full coverage)
- **2004**: 70.0% (Cost sharing) vs. 78.2% (Full coverage)

Trivedi A. *NEJM*. 2008;358:375-383
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.

Delayed Care Due to Costs, Overall and by Health Status
California, 2014

Have you delayed any of the following in the last 12 months because of the costs involved?
Base: All adults (n=1,548)

Yes to any of the below 40%

- Dental care 30%
- Regular physical or check up 19%
- Treatment that was recommended by a doctor 16%
- Care for a specific medical problem 16%
- Filling a prescription 11%
- Getting a medical device or equipment recommended by a doctor 10%
- Mental health services 7%
- Surgery 6%
- Treatment for drug or alcohol use 2%

Respondents delaying care by health status:
- Excellent or Very Good 35%
- Good 44%
- Fair or Poor 55%

Source: California General Public Survey, conducted by PerryUndem Research and Communication.

©2015 CALIFORNIA HEALTHCARE FOUNDATION
Effects of Increased Patient Cost Sharing on Socioeconomic Disparities in Health Care

Michael Chernew, PhD1 Teresa B. Gibson, PhD2 Kristina Yu-Isernberg, PhD, RPh3
Michael C. Sokol, MD, MS4 Allison B. Rosen, MD, ScD5, and A. Mark Fendrick, MD5

1Department of Health Care Policy, Harvard Medical School, Boston, MA, USA; 2Thomson Healthcare, Ann Arbor, MI, USA; 3Managed Markets Division, GlaxoSmithKline, Research Triangle Park, NC, USA; 4Managed Markets Division, GlaxoSmithKline, Montvale, NJ, USA; 5Departments of Internal Medicine and Health Management and Policy, Schools of Medicine and Public Health, University of Michigan, Ann Arbor, MI, USA.

• 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.
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
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
  - Reduced health care disparities

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
Translating Research into Policy

- V-BID included in the Patient Protection and Affordable Care Act
- Medicare
- State Health Reform
- HSA-qualified HDHPs
• 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 130 million Americans have received expanded coverage of preventive services
Putting Innovation into Action: Translating Research into Policy

- Patient Protection and Affordable Care Act
- **Medicare**
- State Health Reform
- HSA-qualified HDHPs
H.R.2570/S.1396: Bipartisan “Strengthening Medicare Advantage Through Innovation and Transparency”

- Directs HHS to establish a V-BID demonstration for MA beneficiaries with chronic conditions
- CMS issues RFI on role of V-BID in Medicare
Putting Innovation into Action: Translating Research into Policy

- 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
- State Innovation Models
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
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: Expanding the Deductible-Exempt “Safe Harbor”

- 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 may 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
Expanding the Deductible-Exempt “Safe Harbor”

• 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
V-BID HDHP Hybrid with “Smarter Deductibles”: High Value Health Plan

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 to move from volume to value.
Using Clinical Nuance to Align Payer and Consumer Incentives: As Easy as Peanut Butter and Jelly

- “Supply side” initiatives are restructuring provider incentives to move from volume to value

- Unfortunately, “demand-side” initiatives are moving consumers in the opposite direction
Using Clinical Nuance to Align Payer and Consumer Incentives: As Easy as Peanut Butter and Jelly

• “Supply side” initiatives are restructuring provider incentives to move from volume to value

• Unfortunately, “demand-side” initiatives are moving consumers in the opposite direction

• Adding clinical nuance can improve quality of care, enhance employee experience, and contain cost growth
Improving Care and Bending the Cost Curve

- V-BID should be part of the solution to enhance the efficiency of health care spending
- States can play an important role in the transition from volume to value

Discussion

University of Michigan Center for Value-Based Insurance Design

www.vbidcenter.org

@um_vbid

vbidcenter@umich.edu

Coalition for Smarter Healthcare

www.smarterhc.org