Invited Commentary

Precision Benefit Design—Using "Smarter" Deductibles to Better Engage Consumers and Mitigate Cost-Related Nonadherence

A. Mark Fendrick, MD; Michael E. Chernew, PhD

Increasing consumer cost-sharing (eg, deductibles, copayments) is a frequently used strategy to minimize the growth of health insurance premiums due to escalating health care expenditures. The 2016 National Health Interview Survey reports that 40.0% of those younger than 65 years with private health insurance are enrolled in a high-deductible health plan (HDHP), a sharp increase from 25.3% in 2010.[1] Similarly, a 2016 Kaiser Family Foundation survey shows that the average health plan deductible has increased from $818 in 2006 to $2069 in 2015.[2] People enrolled in plans with a deductible are required to pay the full cost of most medical care until the plan deductible is met.

Increases in health plan deductibles raise concerns that the proportion of household income dedicated to medical care will grow. In 2014, 23% of adults were underinsured (defined as out-of-pocket costs that were high relative to income) compared with 13% in 2005.[3] Another concern is that larger plan deductibles will cause consumers to forgo essential, high-value medical care.

Ideally deductibles would lead to a reduction in the use of only low-value care. To accomplish this goal, consumers must be able to distinguish between high-value and low-value clinical services, which is difficult. Thus, increased cost-sharing contributes to avoidance of both low- and high-value care. The study by Wharam and colleagues[4] in this issue of *JAMA Internal Medicine* adds to a large and growing body of evidence reporting that while consumer cost-sharing may not have large deleterious health effects on the general population, low income and very sick populations are particularly vulnerable to cost-related nonadherence. The authors found that persons with diabetes decrease the use of evidence-based interventions in response to increased deductibles, which likely results in worse health outcomes.[4] Vulnerable groups may not have the savings available to pay for needed care, potentially affecting the ability to purchase other essential services such as food or housing.

Related articles

Despite the limitations associated with current cost-sharing strategies, out-of-pocket payments may be helpful in establishing a consumer-centric system and reducing the cost of care by better engaging patients in their health care decision-making. Yet, commonly used instruments, such as deductibles, are blunt and impose the same financial barriers to high- and low-value clinical services.

Efforts are under way to develop more sophisticated cost-sharing strategies that can replace traditional approaches. An alternative benefit design that encourages the use of high-value care, while at the same time reduces wasteful spending, is needed. Specifically, value-based insurance design (V-BID) calls for lower cost-sharing for high-value services and higher cost-sharing for low-value services.[5] V-BID plans are designed with clinical nuance in mind, recognizing that the clinical benefit of a specific service depends on who receives it, who provides it, and where and when in the course of disease the service is provided. An example of using clinical nuance to make health plans more efficient is the evidence-based recommendation that individuals with diabetes mellitus undergo routine eye examinations. While it is not clinically appropriate for everyone to receive such examinations, the delivery of this evidence-based service to patients with diabetes is a frequently employed quality metric. In a nuanced design, cost sharing for eye examinations would be substantially lower for those with diabetes than for those without.

Implementation of clinically nuanced cost-sharing has been driven by private payers (private self-insured employers and commercial health plans). Also, the Patient Protection and Affordable Care Act (ACA) eliminated patient cost-sharing for certain primary preventive services approved by 1 of 4 committees.[6] In January 2017, the Centers for Medicare and Medicaid Services (CMS) launched the Medicare Advantage Value-Based Insurance Design Model, in which selected Medicare Advantage plans in designated states will be permitted to offer varied benefit designs for enrollees diagnosed with specified chronic conditions.[7] The available published evidence from private and public payers suggests that reductions in cost-sharing modestly increase the use of targeted high-value services and can reduce use of targeted low-value services.[8]

HDHPs coupled with health savings accounts (HSAs) are among the fastest-growing health plan types in the United States. Current Internal Revenue Service (IRS) regulations permit a "safe harbor" that allows coverage of specified primary preventive services prior to satisfaction of the plan deductible. However, IRS regulations designate that services meant to treat "an existing illness, injury, or condition" are excluded from predeductible coverage. It is important to note that many evidence-based services used to manage chronic illness—such as the diabetes mellitus quality metrics measured by Wharam and colleagues[4]—are not covered in HSA-HDHPs before the deductible is met.

Policy makers can change existing IRS regulations to support more clinically nuanced HSA-HDHPs and mitigate the growing concern of cost-related underuse of essential services used to treat common clinical conditions. Preferably, an HSA-HDHP would have the option to provide predeductible

coverage of high-value services used to manage chronic disease, while discouraging the use of wasteful care. By expanding predeductible coverage for essential care and directing high deductibles on to low-value services (eg, services identified by the Choosing Wisely initiative), this "High-Value Health Plan" (HVHP) would provide more effective coverage without fundamentally altering the original intent and spirit of consumer-directed plans. Quantitative analyses estimated that a novel HVHP, with predeductible coverage of evidence-based chronic disease services, would necessitate a modest increase in premiums and yield a slight increase in actuarial value compared with existing HSA-HDHPs. Simulation modeling suggests that the introduction of an HVHP would be a popular choice for consumers.[9]

Clinically nuanced—or smarter—deductibles might be a natural evolution of health plans, in that consumer cost-sharing would be reduced for the clinical services that are encouraged under many alternative payment models. As value-based reimbursement promotes the delivery of evidence-based, high-quality care, consumer-facing initiatives must encourage—not create barriers—to these high-value services. To better enable the synergies between value-based payment models and benefit designs, in July 2016, the bipartisan H.R. 5652 "Access to Better Care Act of 2016 " was introduced.[10] This bill gives HSA-qualified high-deductible health plans the ability to provide coverage for services that manage chronic disease prior to meeting the plan deductible. Given the priority role of HSAs as stated on page 2 of Donald Trump's Contract With the American Voter (https://assets.donaldjtrump.com/_landings/contract/O-TRU-102316-Contractv02.pdf), regulatory barriers must be removed to allow health plans the flexibility to best serve the health of enrollees.

Rising health care spending has created serious fiscal challenges that emphasize the need to better engage consumers in their health care decisions. Interventions that improve patient-centered outcomes while maintaining affordability are needed. The alignment of clinically nuanced health care provider-facing and consumer engagement initiatives is a necessary and critical step to improve quality of care, enhance patient experience, and contain cost growth.

ARTICLE INFORMATION

Author Affiliations: Center for Value-Based Insurance Design, University of Michigan, Ann Arbor (Fendrick); Department of Health Care Policy, Harvard Medical School, Boston, Massachusetts (Chernew).

Corresponding Author: A. Mark Fendrick, MD, Center for Value-Based Insurance Design, University of Michigan, 2800 Plymouth Rd, Ann Arbor, MI 48109 (amfen@umich.edu).

Published Online: January 9, 2017. doi:10.1001/jamainternmed.2016.8747

Conflict of Interest Disclosures: Dr Fendrick reported receiving personal fees from Merck, AstraZeneca, Trizetto, Amgen, Lilly, abbvie, Johnson & Johnson and Sanofi; grants from the National Pharmaceutical Council, PhRMA, the Gary and Mary West Health Foundation, the states of New York and Michigan, the Laura and John Arnold Foundation, the Robert Wood Johnson Foundation, and the Agency for Healthcare Research and Quality; and owning equity in Zansors, Sempre Health,Wellth, and V-BID Health. No other disclosures are reported. Dr Chernew reported having equity in V-BID Health; sitting on the board of advisors for The Commonwealth Fund, The National Institute for Health Care Management and Archway Health; grants from The Laura and John Arnold Foundation, The Commonwealth Fund, CareFirst BlueCross BlueShield and MedPAC; received payment for consultancy from Precision Health Economics, PhRMA, Paladin Healthcare Capital, Pfizer, McKinsey, University of Michigan, Anthem and the State of North Carolina; received speaking honoraria from ProHealth, Healthcare Research Analysts, AcademyHealth, Discern Health, Michigan State Medical Society, America's Health Insurance Plans, Mathematica Policy Research, DuPage Medical Group, Ontario Hospital Association, Deutsche Bank Group, Q1 Productions, Madinah Institute for Leadership and Entrepreneurship, Hartford Healthcare, and Teva; and has received payment for editorial services from Elsevier and Intellisphere.

REFERENCES

1. Cohen RA, Martinez ME, Zammitti EP. Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, January–March 2016. National Center for Health Statistics. https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201609.pdf Accessed November 1, 2016.

2. Claxton G, Rae M, Long M, Damico A, Whitmore H, Foster G. Health Benefits In 2016: Family Premiums Rose Modestly, And Offer Rates Remained Stable. *Health Aff (Millwood)*. 2016;35(10):1908-1917.

3. Collins S, Rasmussen P, Beutel S, Doty M. The Problem of Underinsurance and How Rising Deductibles Will Make it Worse. 2015. The Commonwealth Fund. http://www.commonwealthfund.org/publications/issue-briefs/2015/may/problem-of-underinsurance Accessed November 1, 2016.

4. Wharam JF, Zhang F, Eggleston EM, Lu CY, Soumerai S, Ross-Degnan D. Diabetes outpatient care and acute complications before and after high-deductible insurance enrollment: a Natural Experiment for Translation in Diabetes (NEXT-D) Study [published online January 9, 2017]. *JAMA Intern Med*. doi:10.1001/jamainternmed.2016.8411

5. Chernew ME, Rosen AB, Fendrick AM. Value-based insurance design. *Health Aff (Millwood)*. 2007;26(2):w195-w203.

6. Chen SC, Pearson SD. Policy framework for covering preventive services without cost-sharing: saving lives and saving money. *JAMA Intern Med*. 2016;176(8):1185-1189.

7. Center for Value-Based Insurance Design. The Evidence for V-BID. http://vbidcenter.org/the-evidence-for-v-bid-validating-an-intuitive-concept/. Accessed November 1, 2016.

8. Centers for Medicare & Medicaid Services. Medicare Advantage Value-Based Insurance Design Model. https://innovation.cms.gov/initiatives/vbid/. Accessed November 1, 2016.

9. Center for Value-Based Insurance Design. Health Savings Account-Eligible High Deductible Health Plans: Updating the Definition of Prevention. 2014. http://vbidcenter.org/wp-content/uploads/2014/07/HDHP-white-paper_final.pdf. Accessed November 1, 2016.

10. H.R. 5652: Access to Better Care Act. 2016. http://vbidcenter.org/wp-content/uploads/2016/07/HDHP-Bill.pdf. Accessed November 1, 2016.