



SCHOOL OF PUBLIC HEALTH

CENTER FOR VALUE-BASED INSURANCE DESIGN
UNIVERSITY OF MICHIGAN

Value-Based Insurance Design: Making Health Care Great (Again ;)

A. Mark Fendrick, MD

**University of Michigan Center for
Value-Based Insurance Design**

www.vbidcenter.org



@um_vbid

#VBID



Table 1: Risk factors for nodding off at lectures

Factor	Odds ratio (and 95% CI)
Environmental	
Dim lighting	1.6 (0.8–2.5)
Warm room temperature	1.4 (0.9–1.6)
Comfortable seating	1.0 (0.7–1.3)
Audiovisual	
Poor slides	1.8 (1.3–2.0)
Failure to speak into microphone	1.7 (1.3–2.1)
Circadian	
Early morning	1.3 (0.9–1.8)
Post prandial	1.7 (0.9–2.3)
Speaker-related	
Monotonous tone	6.8 (5.4–8.0)
Tweed jacket	2.1 (1.7–3.0)
Losing place in lecture	2.0 (1.5–2.6)

Note: CI = confidence interval.

Making Health Care Great (Again ;)

Outline

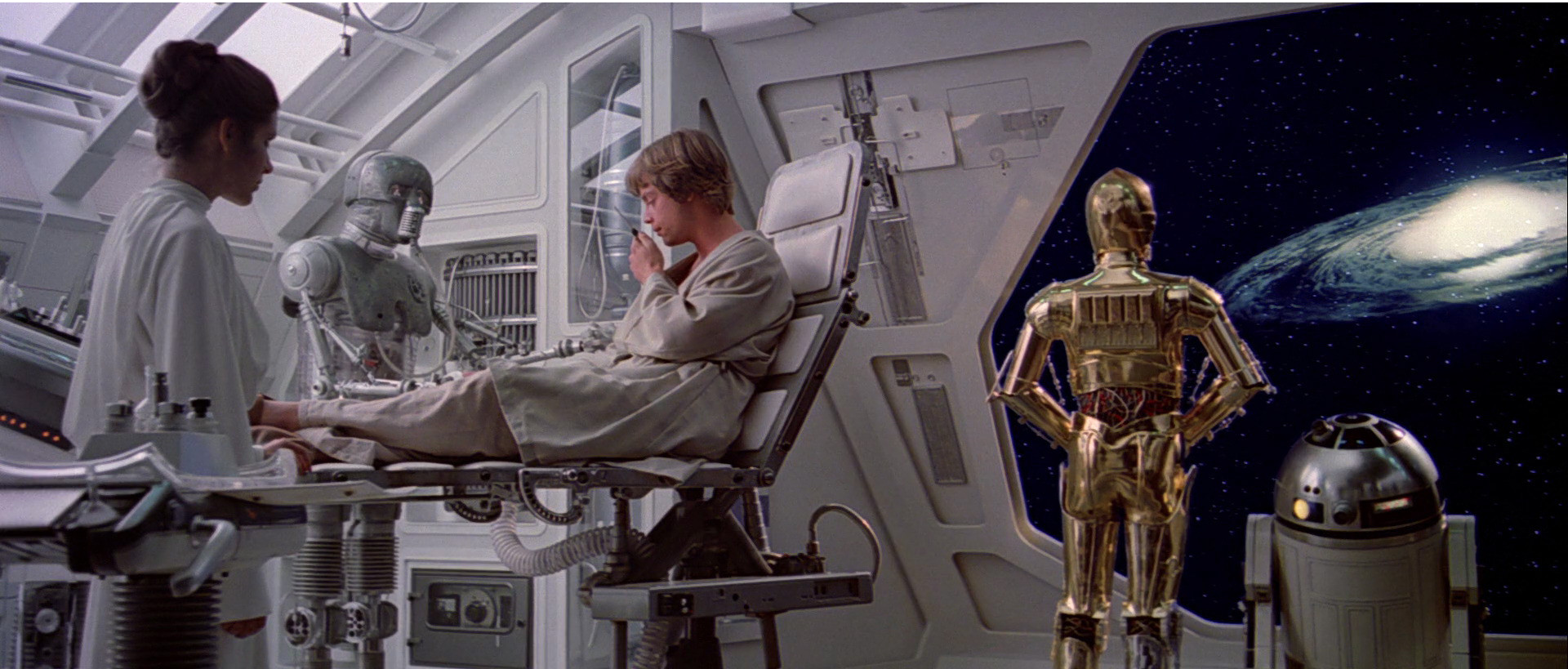
- **Impact of Consumer Cost-sharing**
- **Clinical Nuance**
- **Value-Based Insurance Design**
- **Translating Research into Policy**
- **Addressing Unnecessary Care**
- **Aligning Provider and Consumer Incentives**

Getting to Health Care Value

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, **cutting health care spending** is the principle focus of 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**

Star Wars Science



Flintstones Delivery



-BID

Getting to Health Care Value

Shifting the discussion from “How much” to “How well”

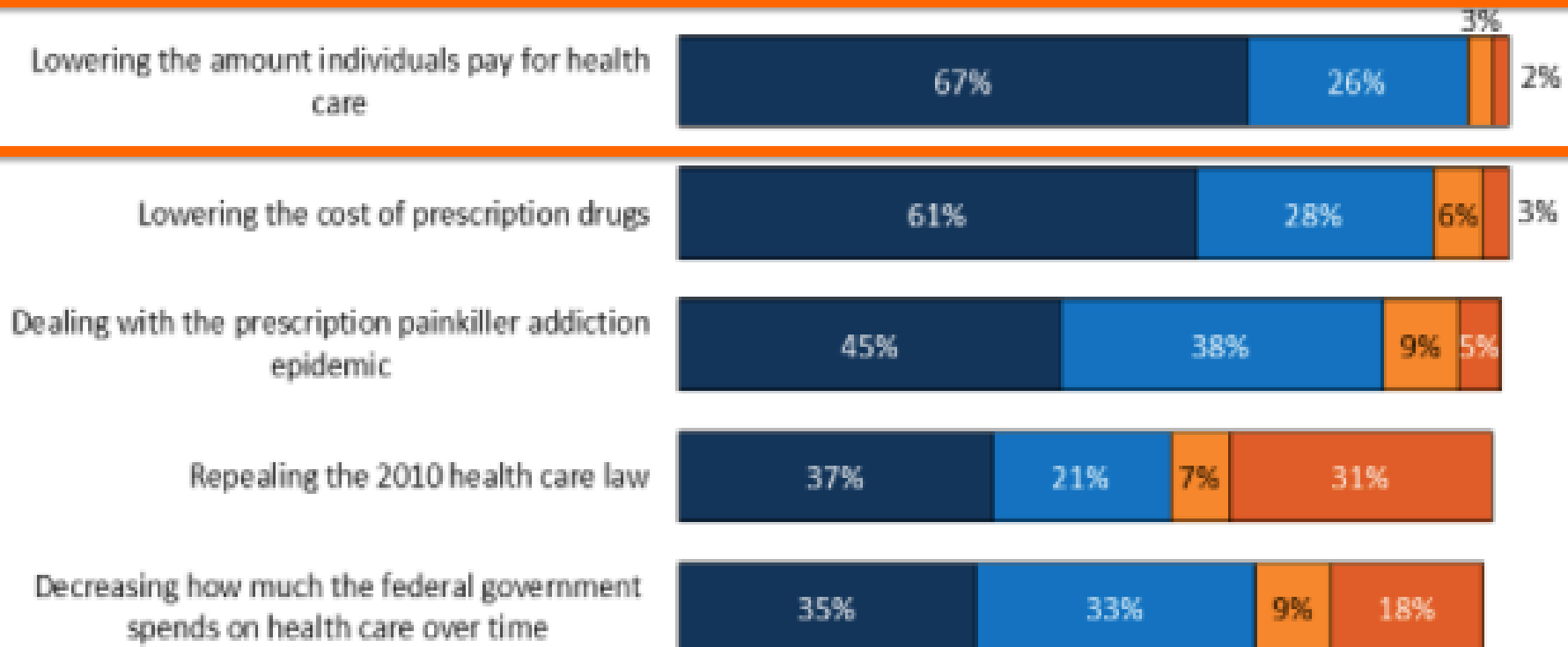
- **Moving from a volume-driven to value-based system requires a change in both how we pay for care and how we engage consumers to seek care**
- **Much of the deliberations is on alternative payment and pricing models**
- **Consumer engagement is an essential and important lever to enhance efficiency**
- **Consumer cost-sharing** is a common and important policy lever

Americans Do Not Care About Health Care Costs; They Care About What It Costs Them

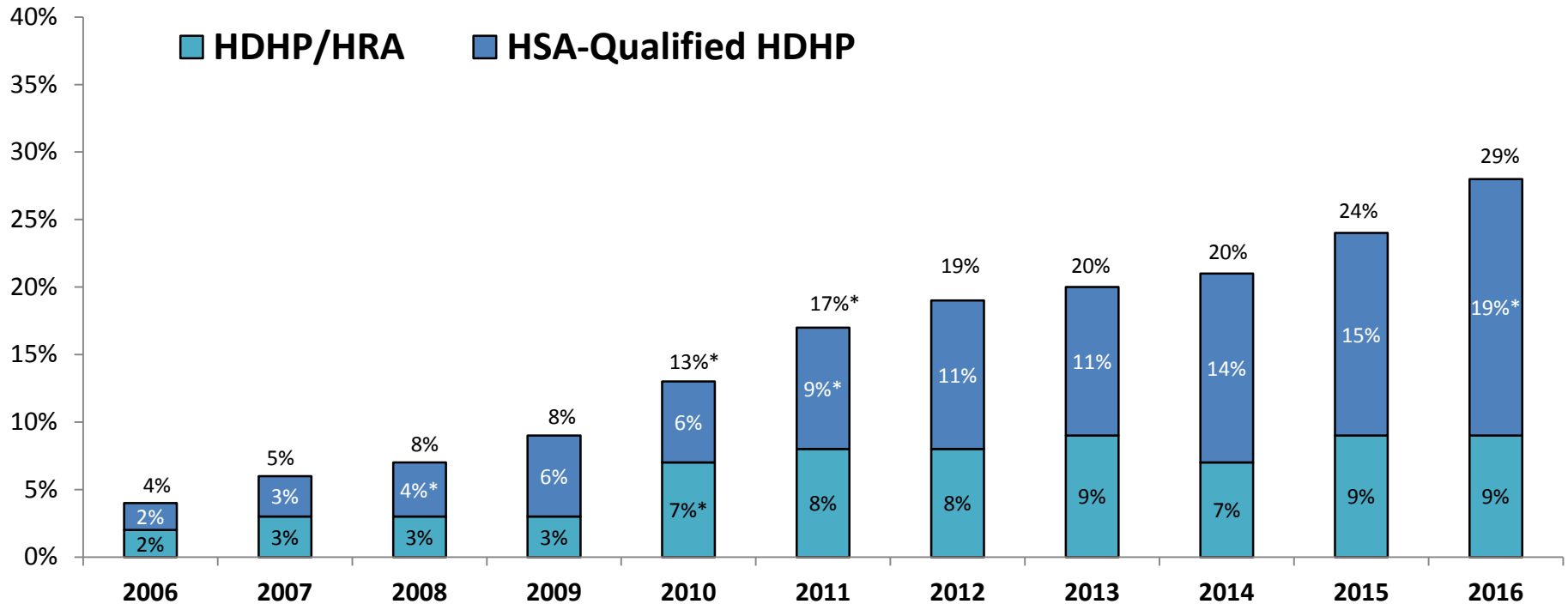
Lowering Out-of-Pocket Costs Is Top Health Care Priority

Should each of the following things Donald Trump and the next Congress might do when it comes to health care be a top priority, an important but not a top priority, not too important, or should it not be done?

■ Top priority ■ Important but not a top priority ■ Not too important ■ Should not be done



Percentage of Covered Workers Enrolled in an HDHP/HRA or an HSA-Qualified HDHP, 2006-2016



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).

NOTE: Covered Workers enrolled in an HDHP/SO are enrolled in either an HDHP/HRA or a HSA-Qualified HDHP. For more information, see the Survey Methodology Section. The percentages of covered workers enrolled in an HDHP/SO may not equal the sum of HDHP/HRA and HSA-Qualified HDHP enrollment estimates due to rounding.

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2016.




AHCA:


Additional Emphasis on Health Savings Accounts


- **HSA contribution limits for employers and individuals are essentially doubled**
- **HSAs will be able to reimburse over the counter medications**
- **Spouses may make ‘catch-up’ contributions**

HSAs to see explosive growth

By
Kathryn Mayer

 Print

 Email

 Reprints

Published
March 28 2017, 11:31am EDT

It's about time for health savinas accounts to take the spotlight. ↗

KHN Morning Briefing

Summaries of health policy coverage from major news organizations

FEB
23
2017

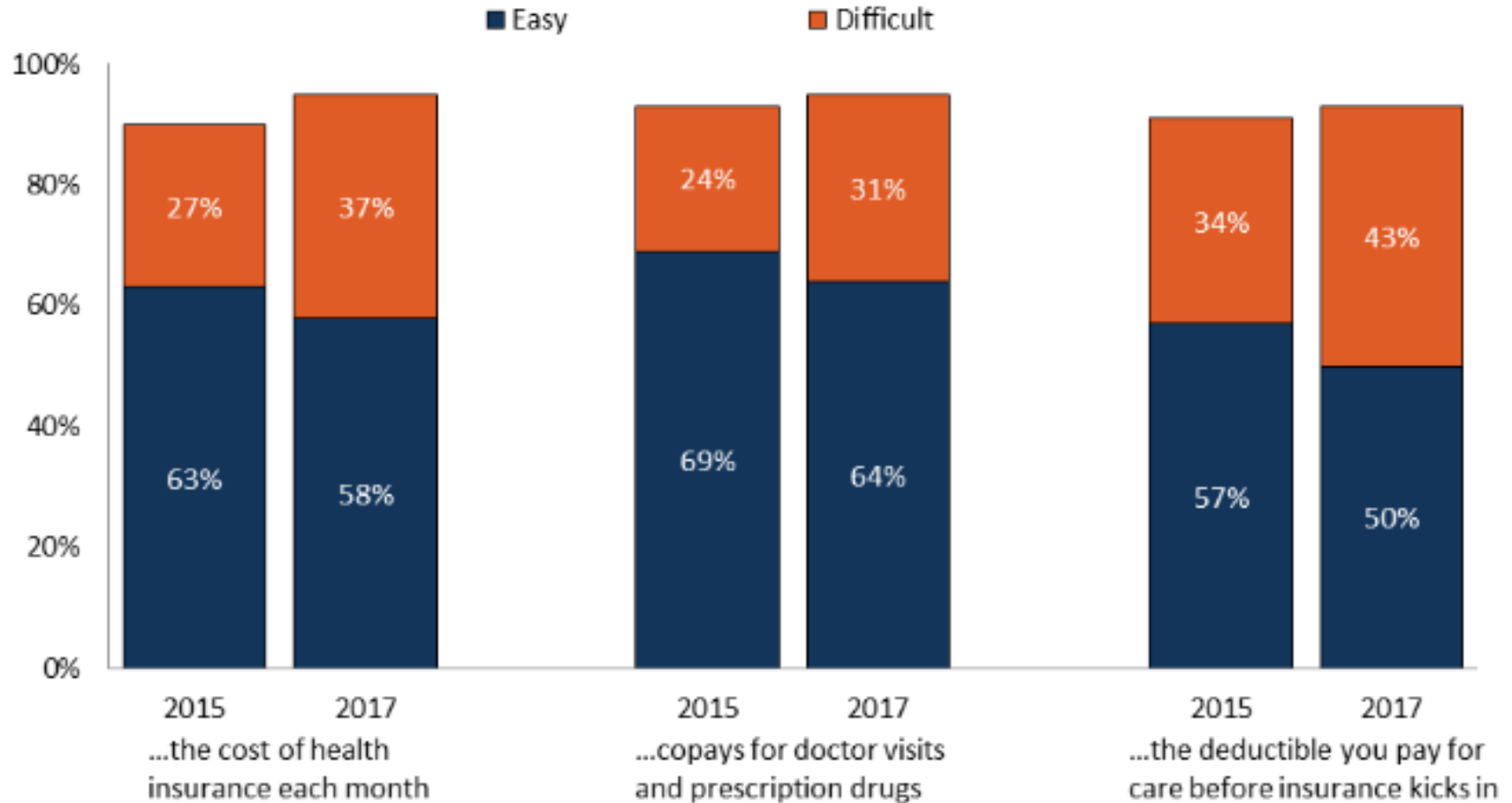
With HSAs, Republicans Want Americans To Have Some Skin In The Game

“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)

More Insured Americans Now Report Difficulty Affording Healthcare

AMONG THE INSURED: In general, how easy or difficult is it for you to afford to pay...



NOTE: Don't have to pay (Vol.) and Don't know/Refused responses not shown.

SOURCE: Kaiser Family Foundation Health Tracking Polls

Impact of Cost-Sharing on Health Care Disparities

Effects of Increased Patient Cost Sharing on Socioeconomic Disparities in Health Care

*Michael Chernew, PhD¹ Teresa B. Gibson, PhD² Kristina Yu-Isenberg, 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**

“Far Better, Far Less Expensive” Next Generation Plan Option 1



“It says our health insurance is being replaced by a series of tweets calling us losers.”

“Far Better, Far Less Expensive” Next Generation Plan Option 2: “Clinically Nuanced” Cost-Sharing

A “smarter**” cost-sharing approach that encourages consumers to use more high value services and providers, but discourages the use of low value ones**

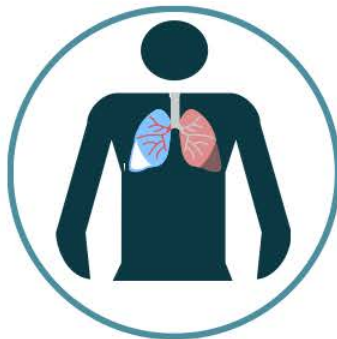
Understanding CLINICAL NUANCE

#1

Clinical Services Differ
in the Benefit Produced



Office
Visits



Diagnostic
Tests



Prescription
Drugs

#2

The Clinical Benefit Derived From a Service Depends On...



Who
receives it



Who
provides it



Where
it's provided

Clinical Nuance: Key Takeaway



What benefits one person...



...may harm another

Implementing Clinical Nuance

Value-Based Insurance Design

Sets cost-sharing to encourage greater utilization of high-value services and providers and discourage use of low-value care

- **Successfully implemented by hundreds of public and private payers**



THE WALL STREET JOURNAL
ONLINE

June 16, 2004

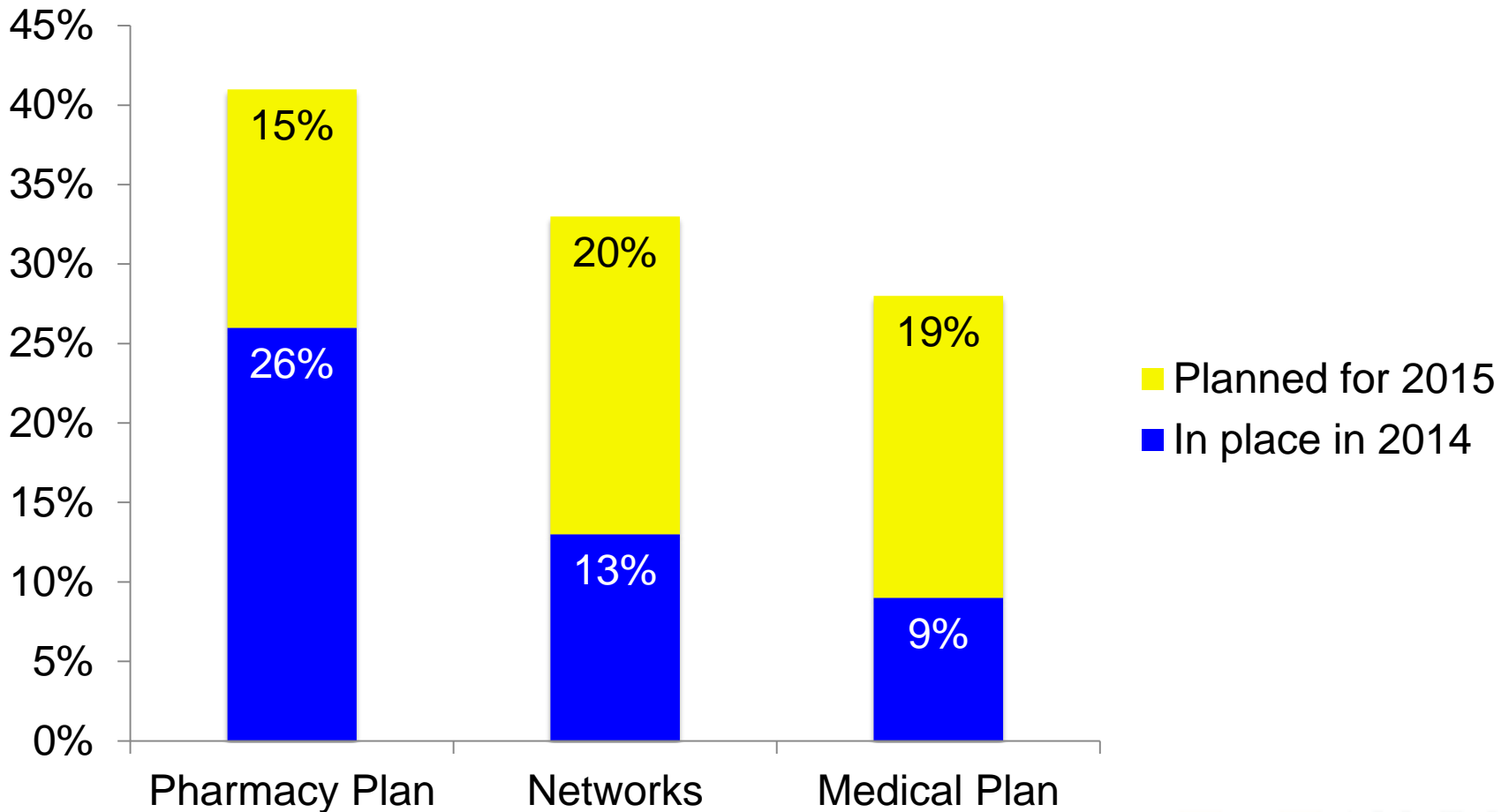
FOLLOW THE MONEY

**From 'One Size Fits All'
To Tailored Co-Payments**

June 16, 2004

University of Michigan researchers say a patient drug should depend on how much he or she will pay. The researchers say a move that would likely lower co-

V-BID Momentum Continues



Source: 19th Annual Towers Watson/National Business Group on Health Employer Survey



V-BID: Who Benefits and How?



CONSUMERS



Improves access

Lowers out-of-pocket costs



PAYERS



Promotes efficient expenditures

Reduces wasteful spending



PROVIDERS



Enhances patient-centered outcomes

Aligns with provider initiatives



Putting Innovation into Action

Broad Multi-Stakeholder Support

- **HHS**
- **CBO**
- **SEIU**
- **MedPAC**
- **Brookings Institution**
- **The Commonwealth Fund**
- **NBCH**
- **American Fed Teachers**
- **Families USA**
- **AHIP**
- **AARP**
- **National Governor's Assoc.**
- **US Chamber of Commerce**
- **Bipartisan Policy Center**
- **Kaiser Family Foundation**
- **American Benefits Council**
- **National Coalition on Health Care**
- **Urban Institute**
- **RWJF**
- **IOM**
- **PhRMA**

Putting Innovation into Action: Translating Research into Policy

- **Patient Protection and Affordable Care Act**
- **Medicare**
- **TRICARE**
- **HSA-qualified HDHPs**
- **High Cost Drugs**
- **State Health Reform**

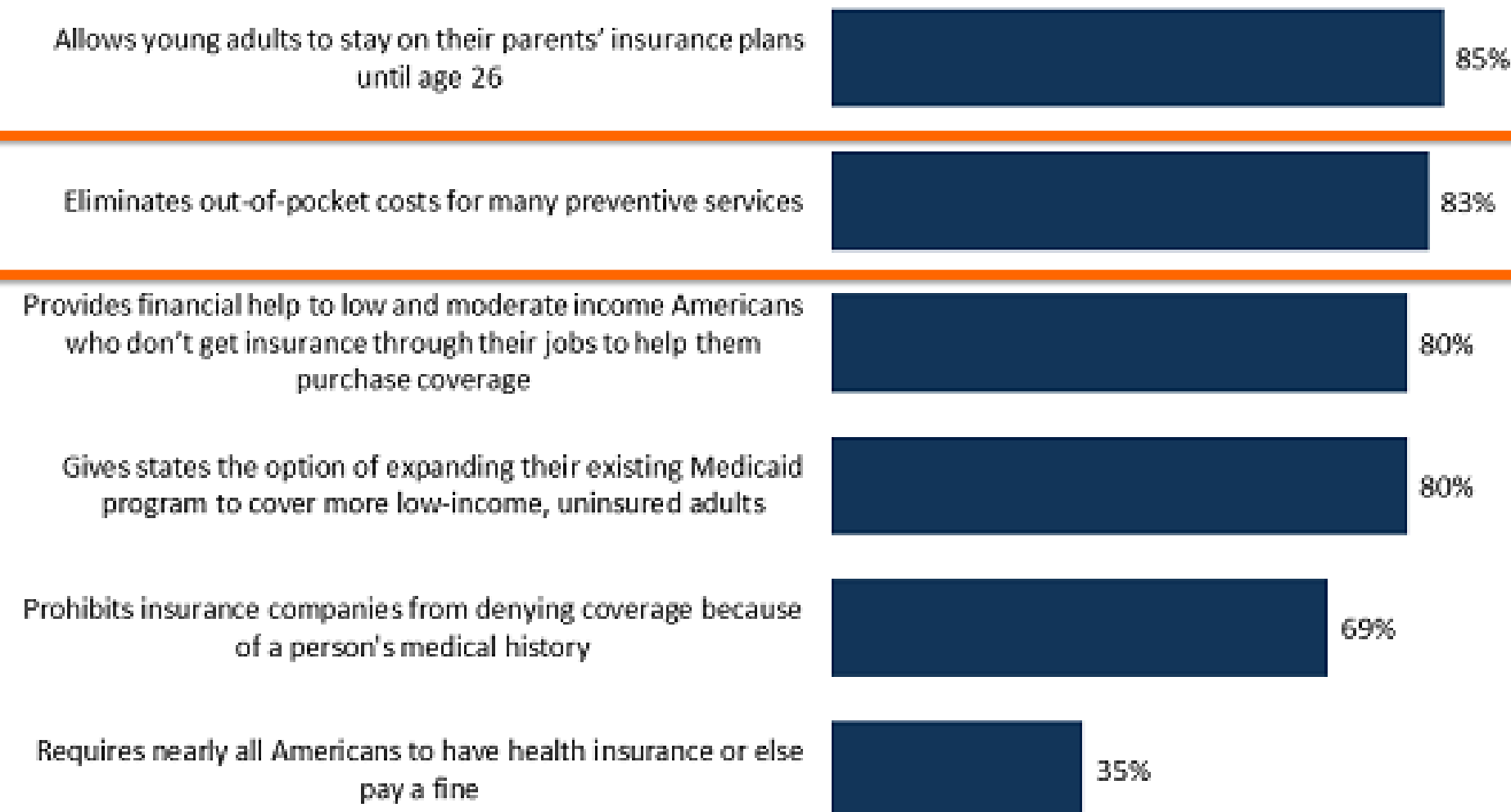
ACA Sec 2713: Selected Preventive Services be Provided without Cost-Sharing

- **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 137 million Americans have received expanded coverage of preventive services; over 76 million have accessed preventive services without cost-sharing

Majorities Favor Many Key ACA Provisions, But Not Its Individual Mandate

Percent who favor each of the following specific elements of the health care law:

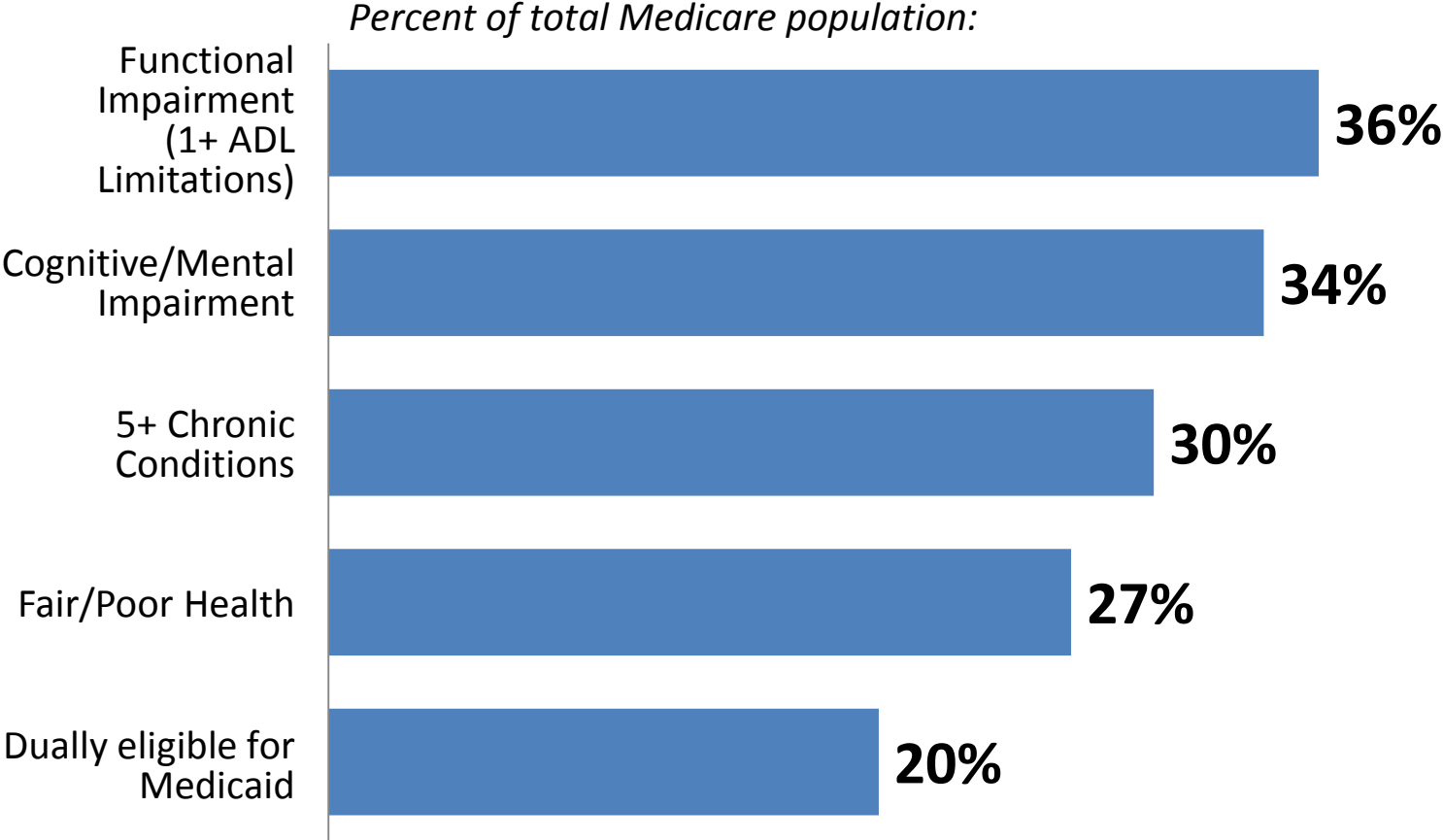


NOTE: Some items asked of half samples. Question wording abbreviated, see topline for full question wording.
SOURCE: Kaiser Family Foundation Health Tracking Poll (conducted November 15-21, 2016)

Putting Innovation into Action: Translating Research into Policy

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Many on Medicare live with functional limits, cognitive impairments, multiple chronic conditions, and fair/poor health



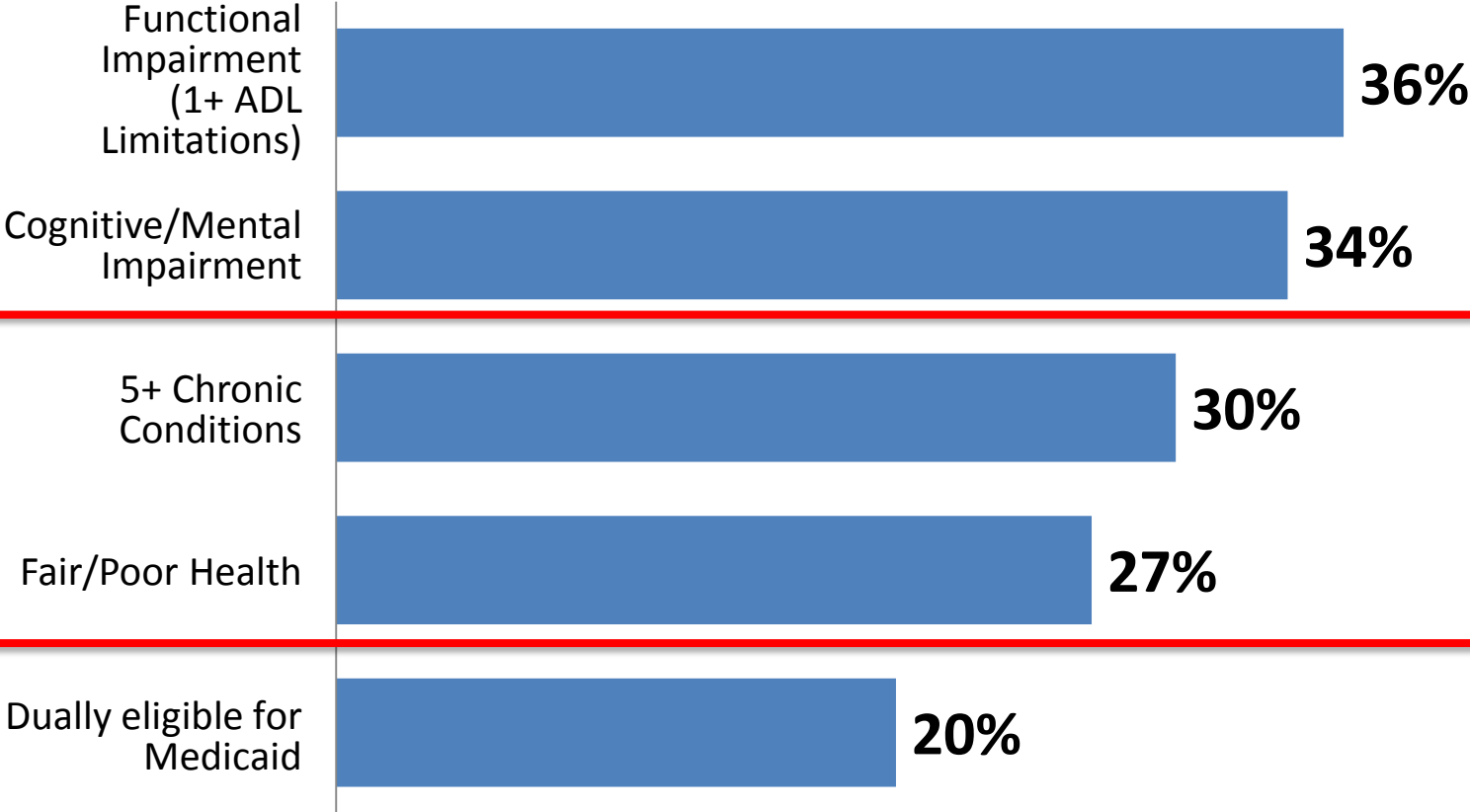
Medicare covered 57 million people in 2016

NOTE: ADL is activity of daily living.
SOURCE: Kaiser Family Foundation



Many on Medicare Live with Multiple Chronic Conditions, and Fair/Poor Health

Percent of total Medicare population:



Medicare covered 57 million people in 2016

NOTE: ADL is activity of daily living.
SOURCE: Kaiser Family Foundation



Medicare Beneficiaries Can Pay Thousands of Dollars Annually for Specialty and Other High-priced Drugs

Median annual out-of-pocket costs, 2016:

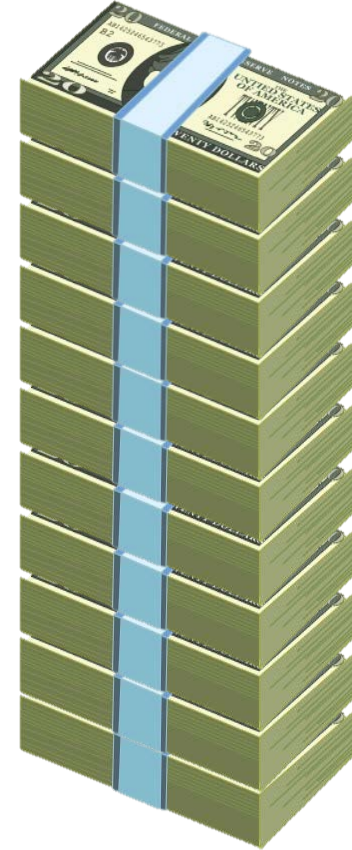
**HUMIRA:
\$4,864**



**SOVALDI:
\$6,608**



**REVLIMID:
\$11,538**



NOTE: Analysis includes 20 national and near-national stand-alone prescription drug plans in Baltimore, MD (zip code 21201) and reflects pricing at a Rite Aid pharmacy in this zip code.

SOURCE: Georgetown/Kaiser Family Foundation



Translating Research into Policy: Implementing V-BID in Medicare

Why not lower cost-sharing on high-value services?



The anti-discrimination clause of the Social Security Act does not allow clinically nuanced consumer cost-sharing.

"providers may not deny, limit, or condition the coverage or provision of benefits"

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**
- **Passed US House with strong bipartisan support in June 2015**

HR 2570: Strengthening Medicare Advantage Through Innovation and Transparency

114TH CONGRESS
1ST SESSION

H. R. 2570

IN THE SENATE OF THE UNITED STATES

JUNE 18, 2015

Received; read twice and referred to the Committee on Finance

AN ACT

To amend title XVIII of the Social Security Act with respect to the treatment of patient encounters in ambulatory surgical centers in determining meaningful EHR use, establish a demonstration program requiring the utilization of Value-Based Insurance Design to demonstrate that reducing the copayments or coinsurance charged to Medicare beneficiaries for selected high-value prescription medications and clinical services can increase their utilization and ultimately improve clinical outcomes and lower health care expenditures, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the “Strengthening Medicare Advantage through Innovation and Transparency for Seniors Act of 2015”.

SEC. 2. TREATMENT OF PATIENT ENCOUNTERS IN AMBULATORY SURGICAL CENTERS IN DETERMINING MEANINGFUL EHR USE.



CMS Announces Medicare Advantage Value-Based Insurance Design Model Test

A 5-year demonstration program will test the utility of structuring consumer cost-sharing and other health plan design elements to encourage patients to use high-value clinical services and providers.



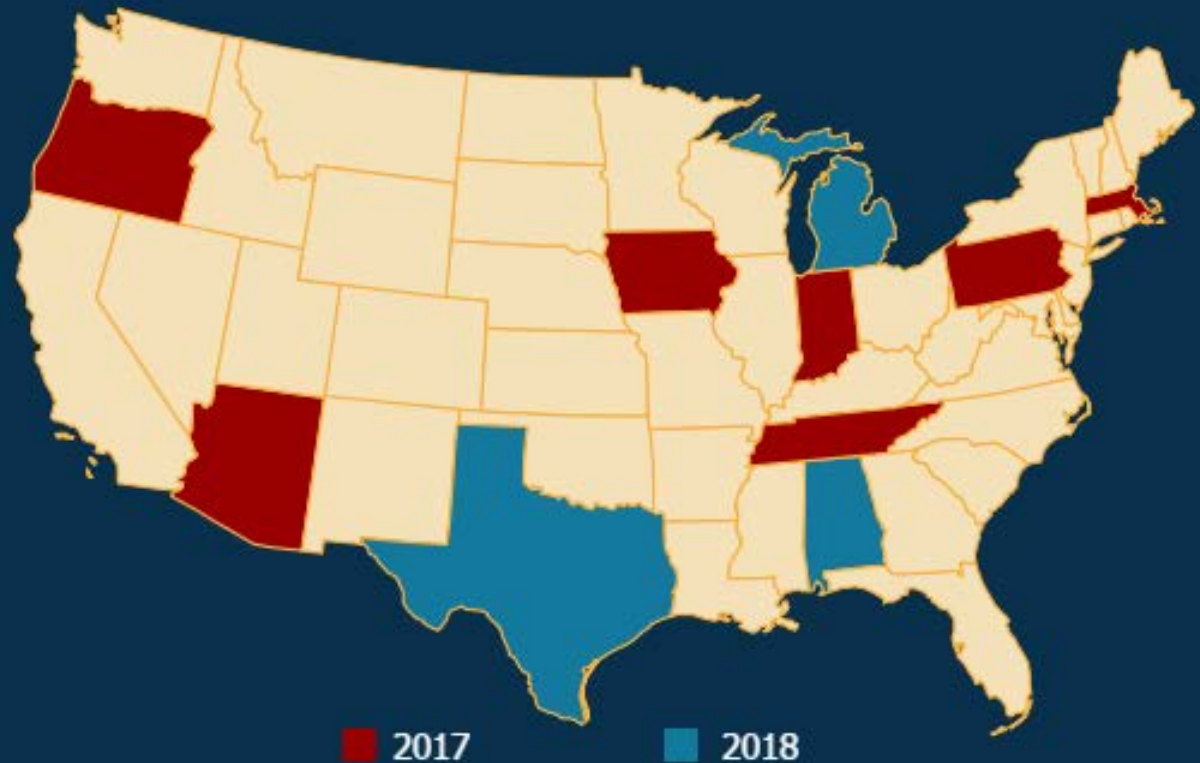
*Red denotes states included in V-BID model test

Projected Financial Impact of MA V-BID Program, Year 1

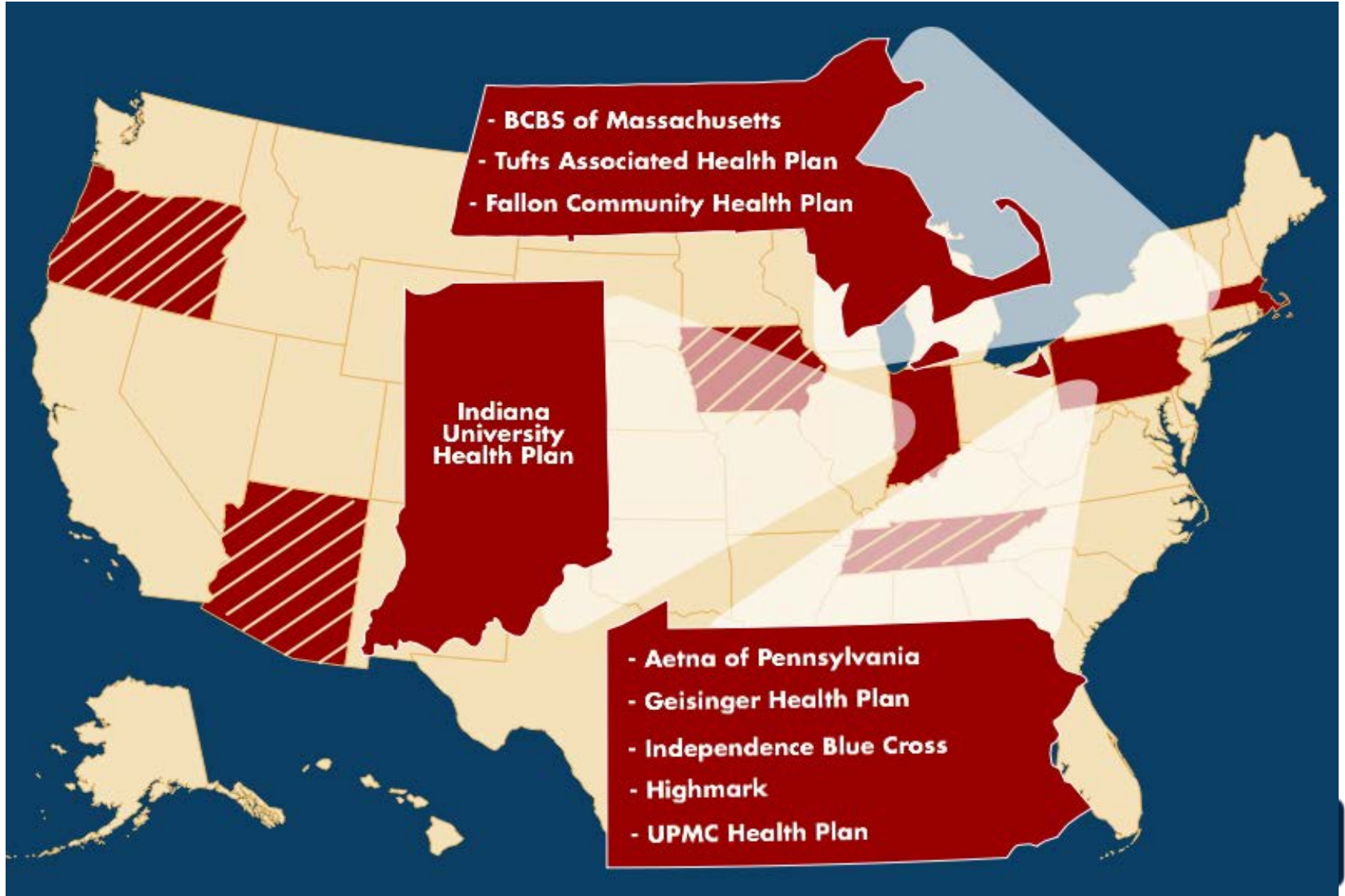
		Diabetes Mellitus	COPD	CHF
Cost Paid per Month (\$)	Member Cost Share	↓ \$21.64	↓ \$17.63	↓ \$12.73
	Plan Paid Amount	↑ \$24.56	↑ \$14.36	↓ \$0.56
	Total Societal Costs	↑ \$2.94	↓ \$3.27	↓ \$13.29

CMS Expands Medicare Advantage Value-Based Insurance Design Model Test

- Diabetes
- Congestive Heart Failure
- COPD
- Past Stroke
- Hypertension
- Coronary Artery Disease
- Mood Disorders
- Dementia
- Rheumatoid Arthritis



MA V-BID Model Test Plans Participating in Year 1



MA V-BID Model Test Plans Participating in Year 1

State	Plan	Clinical Condition(s)
Indiana	IUHP	CHF
Massachusetts	BCBS	Hypertension
	Fallon	Diabetes
	Tufts	COPD and/or CHF
Pennsylvania	Aetna	CHF
	Geisinger	COPD
	Highmark	Diabetes and/or COPD
	IBX	Diabetes & CHF
	UPMC	CHF & COPD or CHF & Diabetes

US House and Senate call for Expansion of MA VBID Demonstration to all 50 States

UNITED STATES SENATE
COMMITTEE ON FINANCE



[ABOUT](#) [HEARINGS](#) [LEGISLATION](#)

Hatch, Wyden, Isakson, Warner Release Proposals to Improve Treatment for Chronic Illness

Finance Committee Members Offer Bipartisan Legislative Language to Improve Chronic Care Outcomes in Medicare

115TH CONGRESS
1ST SESSION

H. R. _____

A BILL

To amend title XVIII of the Social Security to provide for national testing of a model of Medicare Advantage value-based insurance design to meet the needs of chronically ill Medicare Advantage enrollees.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

Putting Innovation into Action: Translating Research into Policy

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- Medicare
- **TRICARE**
- HSA-qualified HDHPs
- High Cost Drugs
- State Health Reform

Value-based insurance coming to millions of people in Tricare

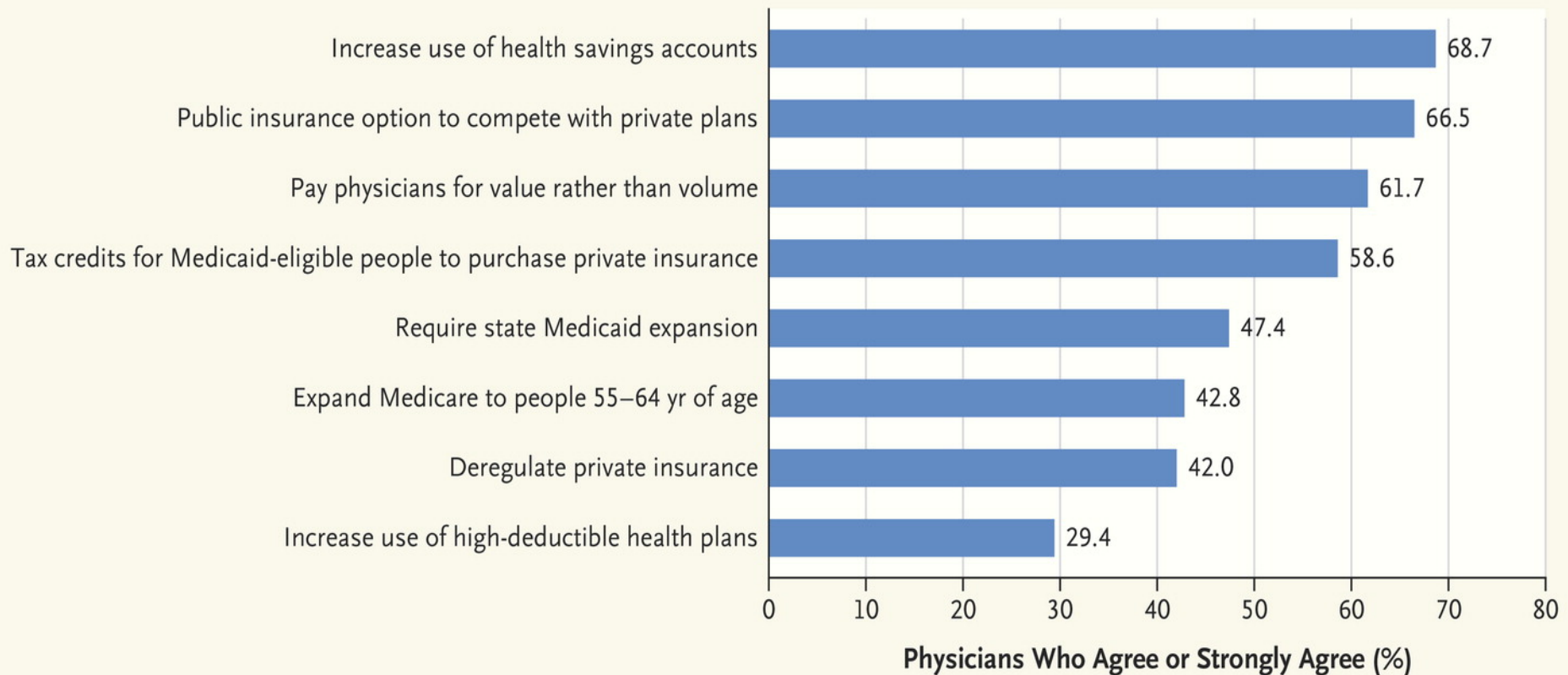
By [Shelby Livingston](#) | December 27, 2016

The annual defense bill signed last week by President Barack Obama included a pilot program to test value-based insurance coverage in Tricare, the U.S. Defense Department's health benefits program.

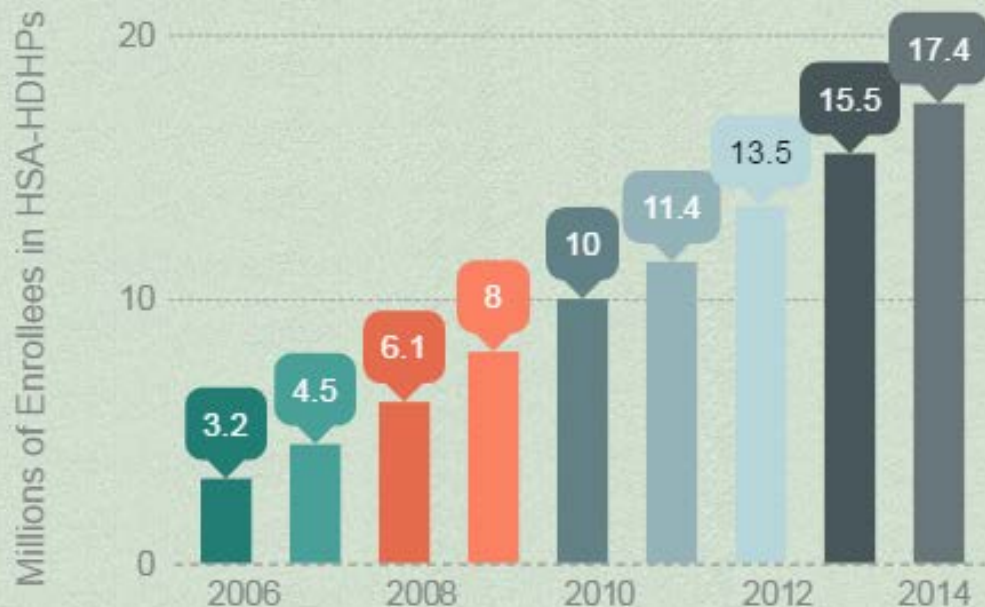
Putting Innovation into Action: Translating Research into Policy

- Patient Protection and Affordable Care Act
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NEJM Jan 2017, PCP Survey Responses Regarding Potential Health Reform



HSA-HDHP enrollment and out-of-pocket expenses continue to grow



Maximum Out-of-pocket expense 2006 to 2015

individual: \$5,000 to \$6,450

family: \$10,000 to \$12,900

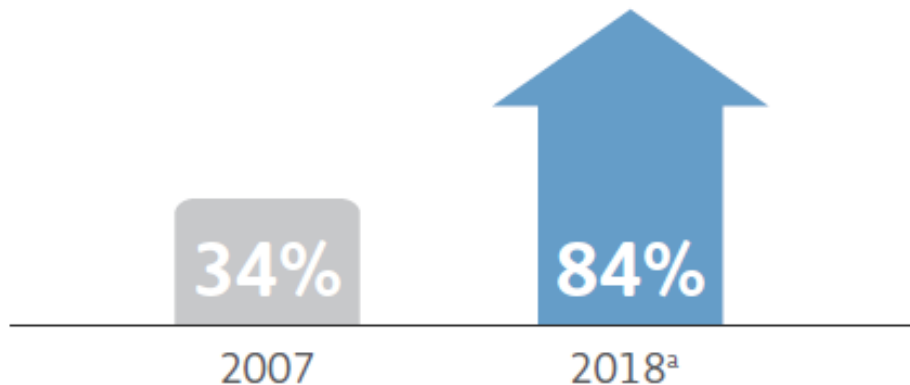
http://www.ahipcoverage.com/wp-content/uploads/2013/06/HSAinfographic_V9_FV.jpg

<http://kff.org/report-section/ehbs-2015-section-eight-high-deductible-health-plans-with-savings-option/>

<http://www.irs.gov/pub/irs-drop/n-04-2.pdf>

The percentage of employers turning to HDHPs has more than doubled over the past decade

Employers offering HDHPs



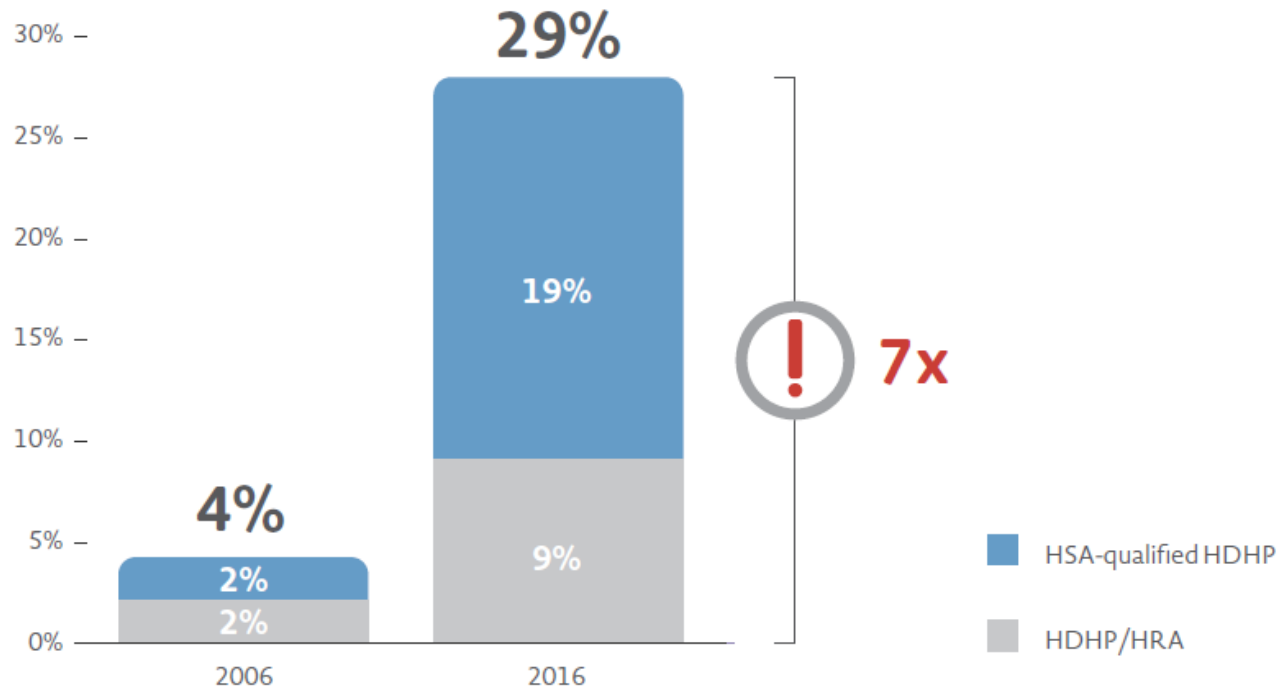
- This growth is **expected to continue**
- By 2018, **almost half of employers** expect to offer an HDHP as **the ONLY option**

^aEmployer projection.

Source: Benfield, a division of Gallagher Benefit Services, Inc. EMI Trends, 2016.

Nearly 30% of covered workers are enrolled in plans with high deductibles

Percentage of covered workers enrolled in an HDHP/HRA or HSA-qualified HDHP, 2006-2016^a



^aCovered workers enrolled in an HDHP/SO are enrolled in either an HDHP/HRA or an HSA-qualified HDHP. The percentage of covered workers enrolled in an HDHP/SO may not equal the sum of HDHP/HRA and HSA-qualified HDHP enrollment estimates due to rounding.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2016.

***IRS Safe Harbor Guidance allows zero
consumer cost-sharing for specific
preventive services***

INCLUDING:

- ✓ periodic health evaluations/screenings
- ✓ routine prenatal and well-child care
- ✓ child and adult immunizations
- ✓ tobacco cessation programs
- ✓ obesity weight-loss programs

www.irs.gov/pub/irs-drop/n-04-23.pdf

However, IRS guidance requires that services used to treat
"existing illness, injury or conditions"
are not covered until the minimum deductible is met



office visits



diagnostic tests



drugs

As HSA-HDHP enrollees with existing conditions are required to pay out-of-pocket for necessary services, they utilize less care, potentially resulting in poorer health outcomes and higher costs

Potential Solution:

High Value Health Plan

Flexibility to expand IRS
"Safe Harbor" to allow
coverage of additional
evidence-based services
prior to meeting
the plan deductible



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

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

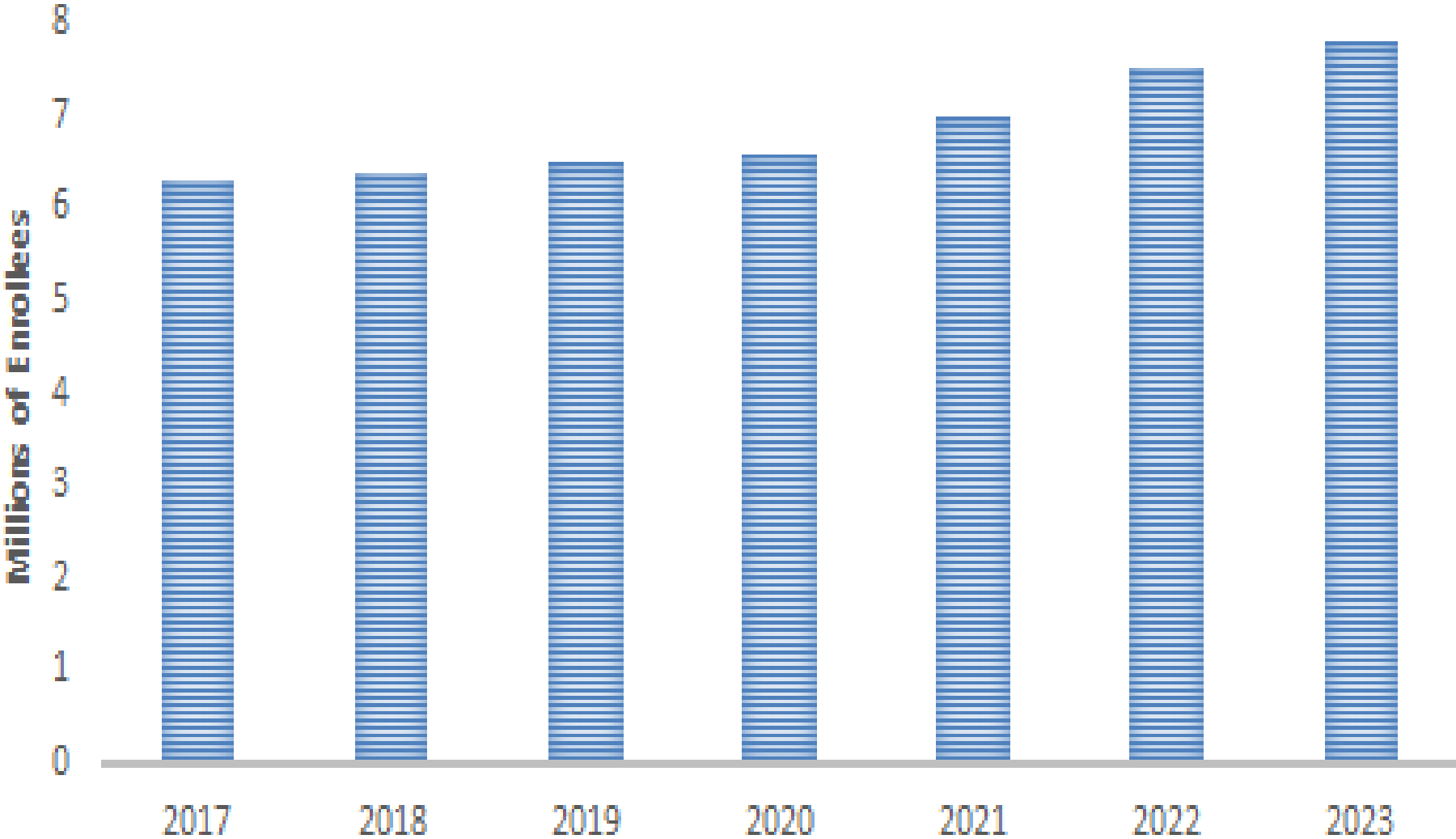
“To enable the continued growth of HSA-HDHPs, insurers need flexibility to provide pre-deductible coverage for high-quality services across the spectrum of clinical care.”



JAMA Internal Medicine



HVHP UPTAKE PROJECTIONS IN THE EMPLOYER MARKET (MILLIONS)



H.R. 5652: "Access to Better Care" Act

114TH CONGRESS
2D SESSION

H. R. 5652

IN THE HOUSE OF REPRESENTATIVES

Bipartisan legislation amends IRS Code to allow HDHPs the flexibility to provide coverage for services that manage chronic disease prior to meeting the plan deductible.

Are high-value health plans the wave of the future?

January 25, 2017

By Tracey Walker

- **Pre-deductible coverage of additional evidence-based services to leads to better clinical outcomes**
- **Aligns with provider payment reform incentives**
- **Lowers premiums compared to most PPO and HMO plans**
- **Substantially reduces total health care spending**
- **Provides millions of Americans a plan option that better meets their clinical and financial needs**



NOW READING: **The Latest**

Academics, industry groups lobby
for more flexible ...

Slideshow How 7 NAHU
delegations lobbied Congress ...

5 ways to rein in medication

Academics, industry groups lobby for more flexible high- deductible plans

Putting Innovation into Action: Translating Research into Policy

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Motivation for "Precision" Benefit Design

- Advances in precision medicine may specify immediate use of targeted therapies, nullifying recommendations for use of standard first line treatment
- The natural history of chronic conditions often necessitates multiple therapies to achieve desired clinical outcomes
- Current consumer cost-sharing levels are fixed and do not reflect the varying nature of clinical conditions
- Increasing out-of-pocket costs for alternative therapies may prevent consumers from accessing recommended treatment

Why Precision Benefit Design?

**Joe, Jill, and Bob have the
same clinical condition**



HELLO
My name is

Joe



HELLO
My name is

Jill



HELLO
My name is

Bob

Bob tested positive for a specific marker

"GOOD SOLDIER"



Complies with treatment steps
required by health plans

To effectively treat their condition, Jill and Bob need alternative therapy



Joe and Jill take first line therapy as prescribed; Bob's positive test result makes him a candidate for targeted treatment

For Joe, this medication effectively treats his condition

Unfortunately for Jill, first-line medication is not effective

For Bob, first-line medication is not clinically indicated, and targeted therapy is recommended



V-BID

Status Quo

Administrative challenges and higher cost-sharing required to obtain alternative medications



Barriers to access and increased out-of-pocket costs lead to non-adherence

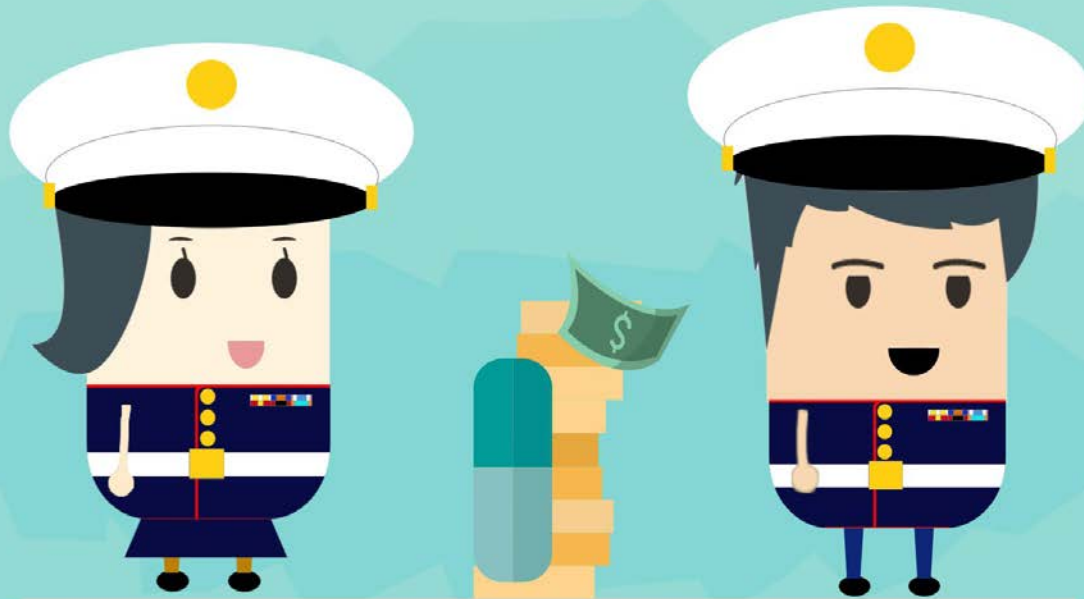


"Reward the **GOOD SOLDIERTM"**

A benefit design that removes administrative barriers and lowers cost-sharing for those who diligently follow the required steps for their condition, but require an alternative treatment option

Reward the Good Soldier™

Removes barriers and lowers cost-sharing to enhance access to alternative medications



Precision benefit design reflects varying nature of condition

Reward the Good Soldier™

A Precision Approach to Consumer Cost-sharing

- ✓ Commits to established policies that encourage lower cost, first-line therapies
- ✓ Enhances access to effective therapies when clinically appropriate
- ✓ Increases access to recommended treatments by removing administrative barriers and lowering cost-sharing
- ✓ Supports precision medicine initiatives by encouraging use of targeted therapies when clinically indicated

Putting Innovation into Action: Translating Research into Policy

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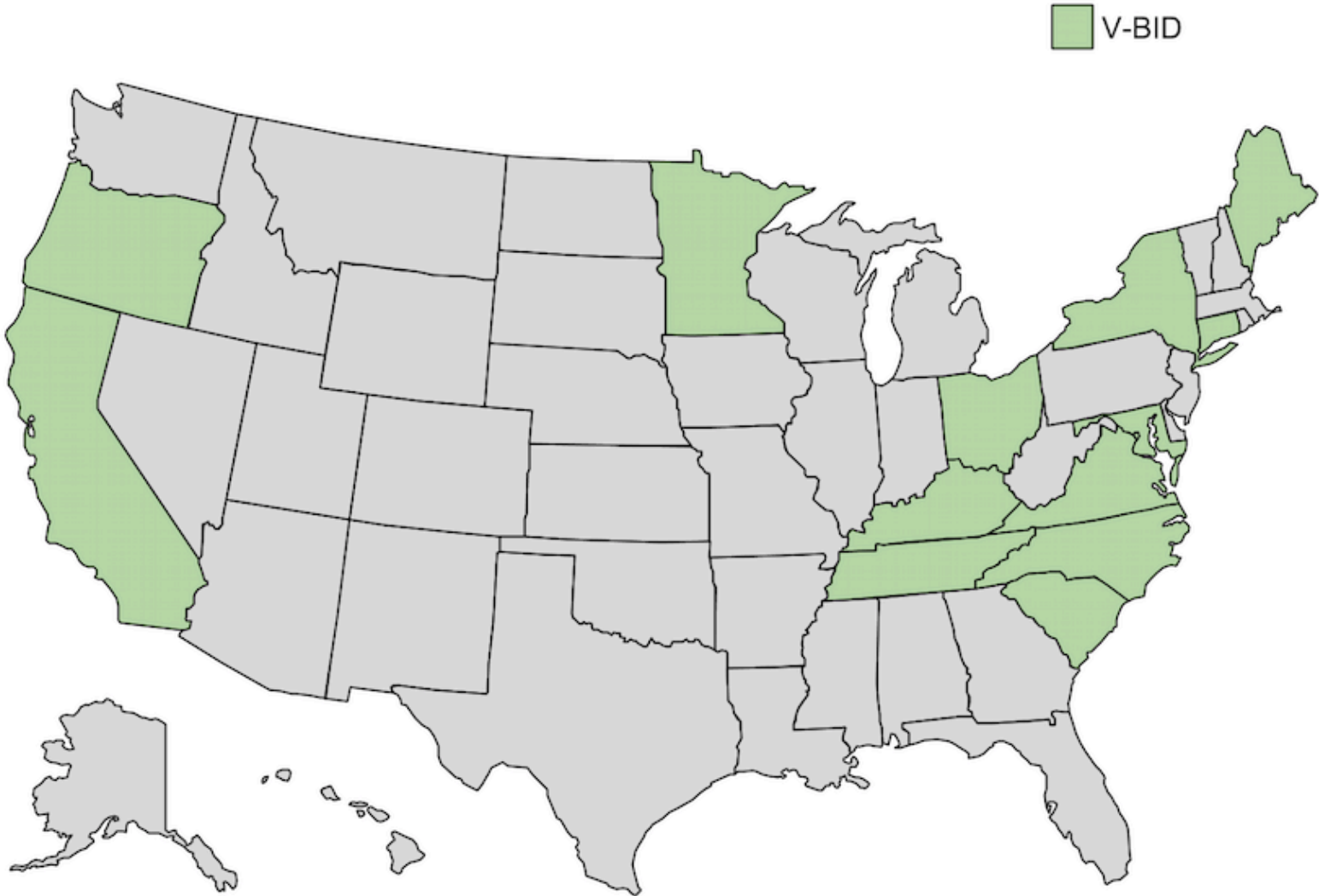
Getting to Health Care Value

V-BID Role in State Health Reform

- **Medicaid – Healthy Michigan Plan**
- **State Exchanges – Encourage V-BID (CA, MD)**
- **State Innovation Models – NY, PA, CT, VA**
- **State Employee Benefit Plans**

Value-Based Insurance Design

Growing Role in State Employee Plans

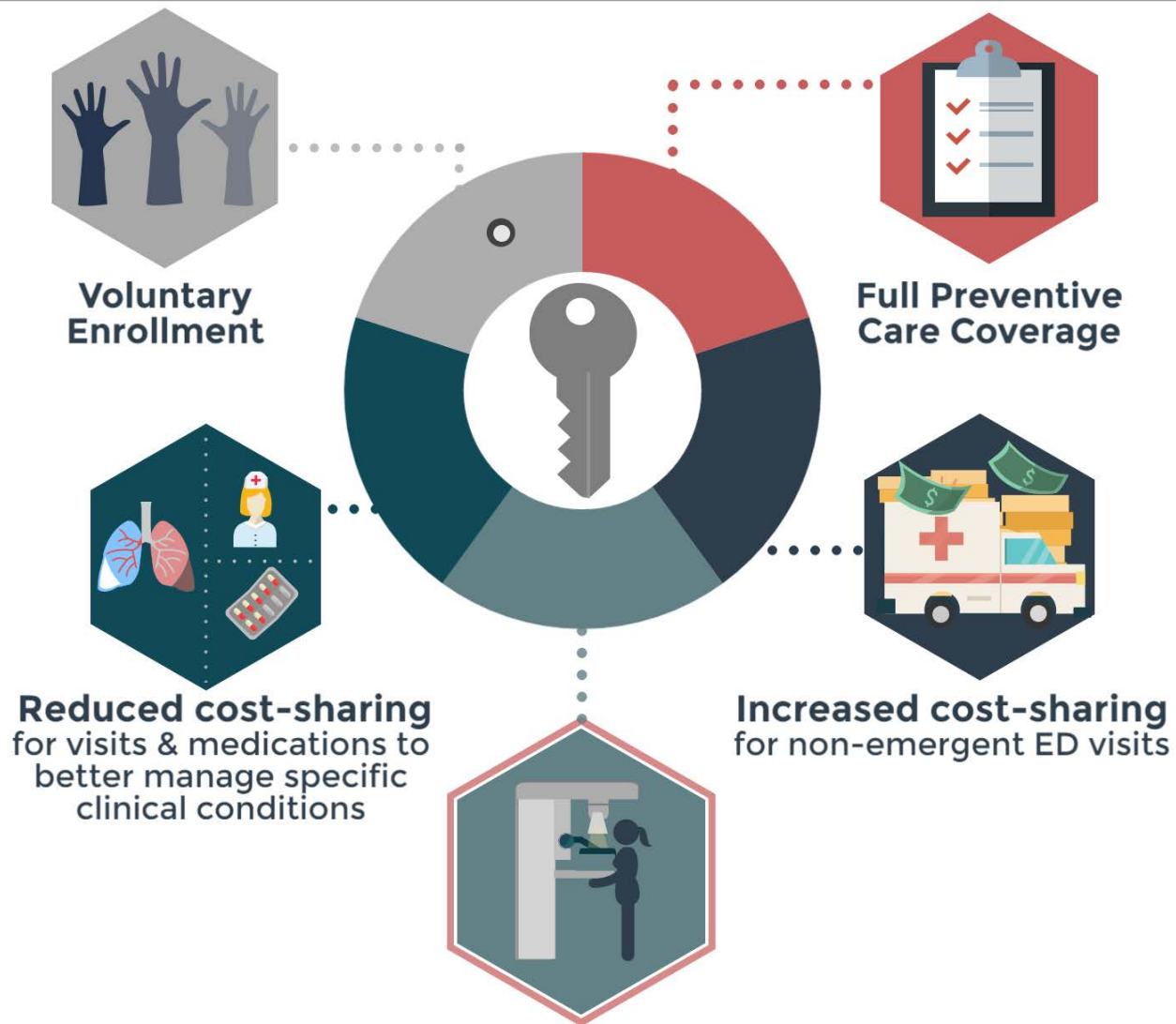


By Richard A. Hirth, Elizabeth Q. Cliff, Teresa B. Gibson, M. Richard McKellar, and A. Mark Fendrick

Connecticut's Value-Based Insurance Plan Increased The Use Of Targeted Services And Medication Adherence

Key Features of the HEP

Align out-of-pocket costs with healthy behaviors

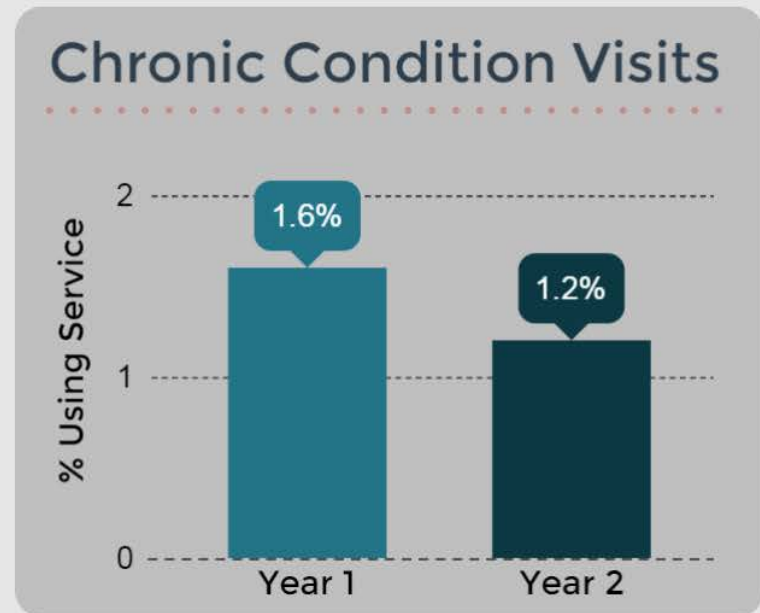


Participatory Requirement:

to maintain enrollment, members must complete age-appropriate preventive care & recommended chronic disease services

HEP Impact: 2 Year Results

[1] Office Visit Increases

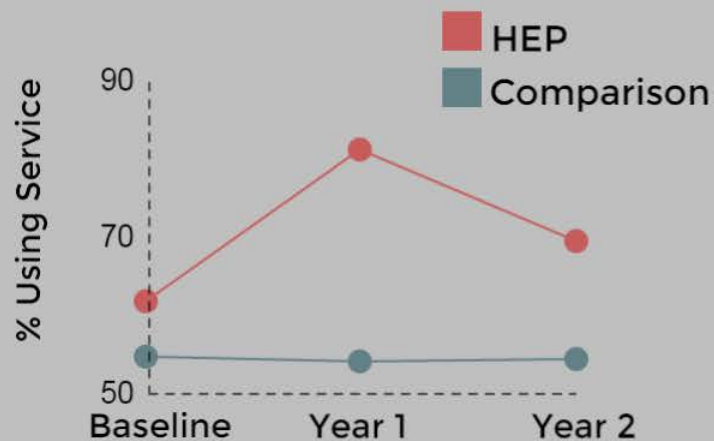


Relative change for HEP members compared to enrollees in control states

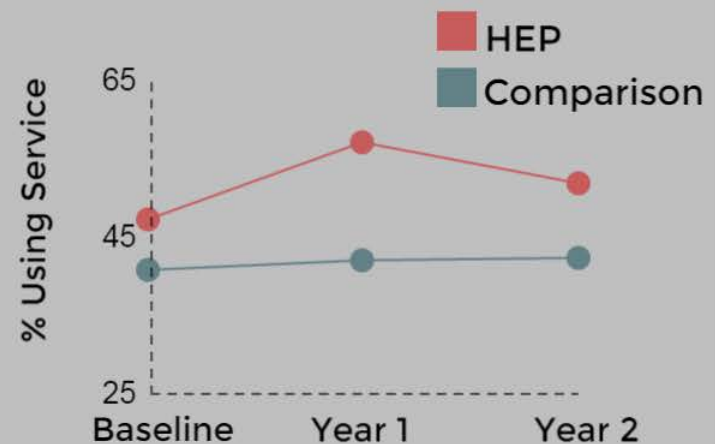
HEP Impact: 2 Year Results

[2] Preventive Care Utilization

Lipid Screening

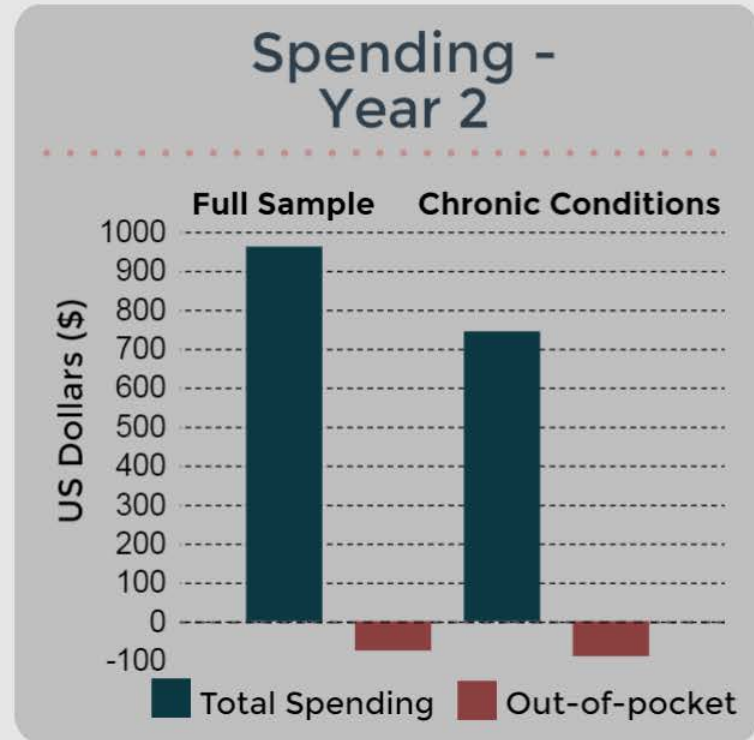
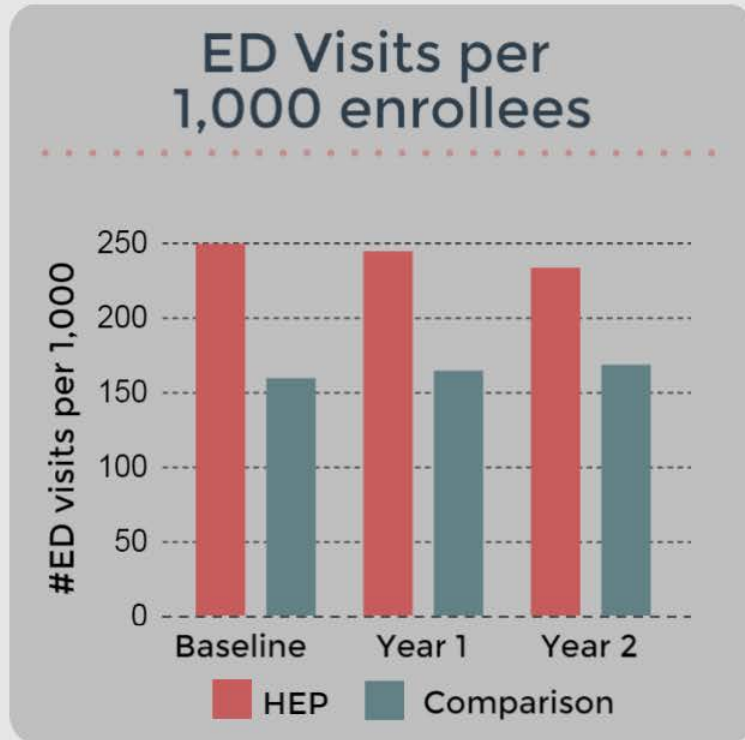


Mammography



HEP Impact: 2 Year Results

[3] Resource Use



Health Affairs. 2016;35(4):637-46.

Getting to Health Care Value

Focus Cost-Sharing Increases on Unnecessary Care

- **It is counter-intuitive to impose high levels of cost-sharing on those services that are identified as health plan quality measures**
- **Thus, instead of imposing blunt, price-driven cost-sharing increases on **all** services, consider high cost sharing on **only those services that do not make people healthier****

Our Health Care Spending

TOTAL

Hospitals,
Clinical Services,
Insurance,
Equipment,
Drugs

\$2.6 TRILLION

\$765 BILLION

\$340 BILLION

WASTE

Excess
Administration,
Fraud, & Low-
Value Care

LOW-VALUE CARE

We spend \$340 billion a year on services that don't make us healthier. These services are unnecessary, inefficient, or both.

ACA Sec 4105: Selected No-Value Preventive Services Shall Not Be Paid For

SEC. 4105. EVIDENCE-BASED COVERAGE OF PREVENTIVE SERVICES IN MEDICARE.

(a) **AUTHORITY TO MODIFY OR ELIMINATE COVERAGE OF CERTAIN PREVENTIVE SERVICES.**—Section 1834 of the Social Security Act (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:

“(n) **AUTHORITY TO MODIFY OR ELIMINATE COVERAGE OF CERTAIN PREVENTIVE SERVICES.**—Notwithstanding any other provision of this title, effective beginning on January 1, 2010, if the Secretary determines appropriate, the Secretary may—

“(1) modify—

“(A) the coverage of any preventive service described in subparagraph (A) of section 1861(ddd)(3) to the extent that such modification is consistent with the recommendations of the United States Preventive Services Task Force; and

“(B) the services included in the initial preventive physical examination described in subparagraph (B) of such section; and

“(2) provide that no payment shall be made under this title for a preventive service described in subparagraph (A) of such section that has not received a grade of A, B, C, or I by such Task Force.”

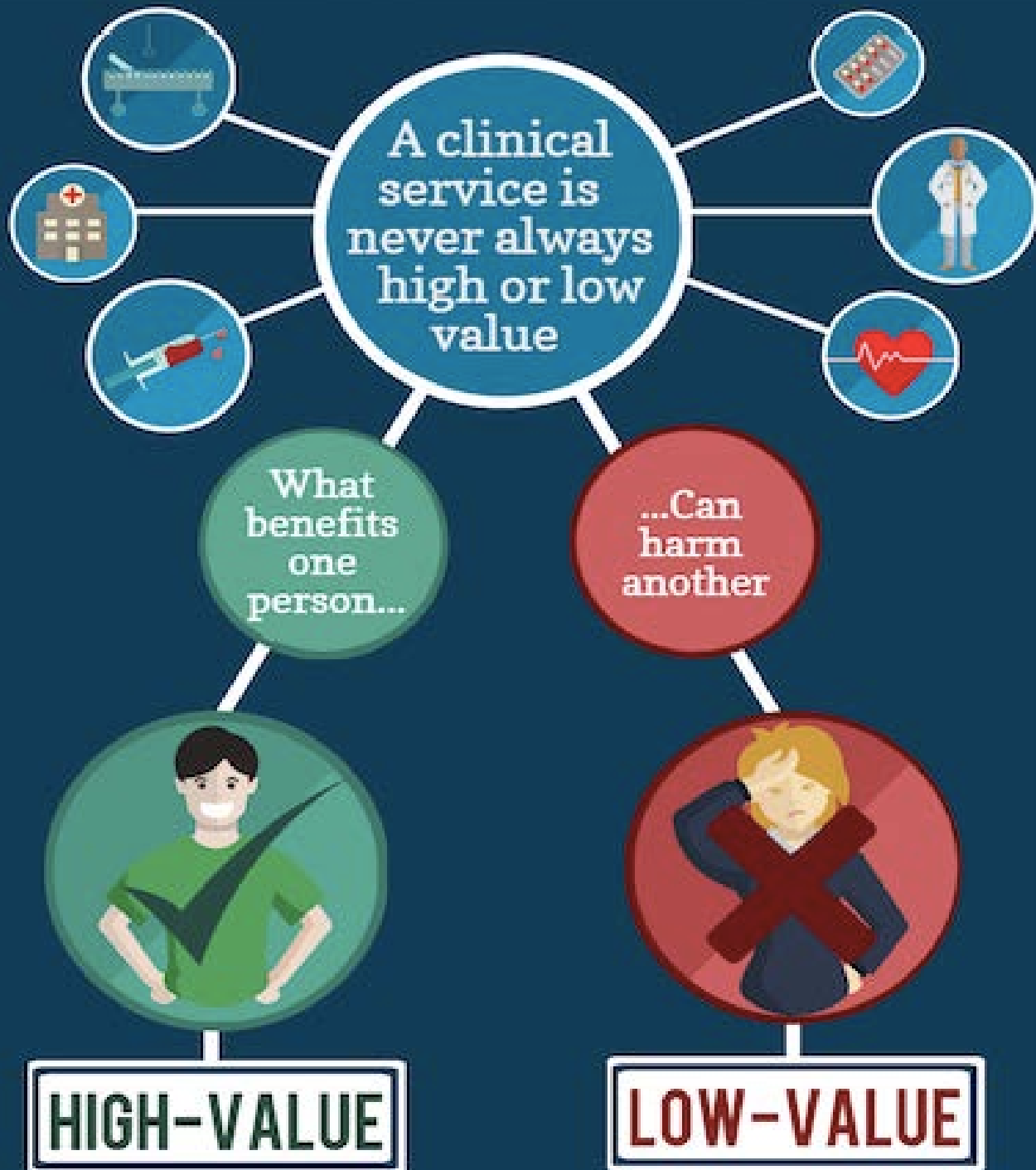
(b) **CONSTRUCTION.**—Nothing in the amendment made by paragraph (1) shall be construed to affect the coverage of diagnostic or treatment services under title XVIII of the Social Security Act.

**HHS granted
authority to not
pay for USPSTF
'D' Rated Services**



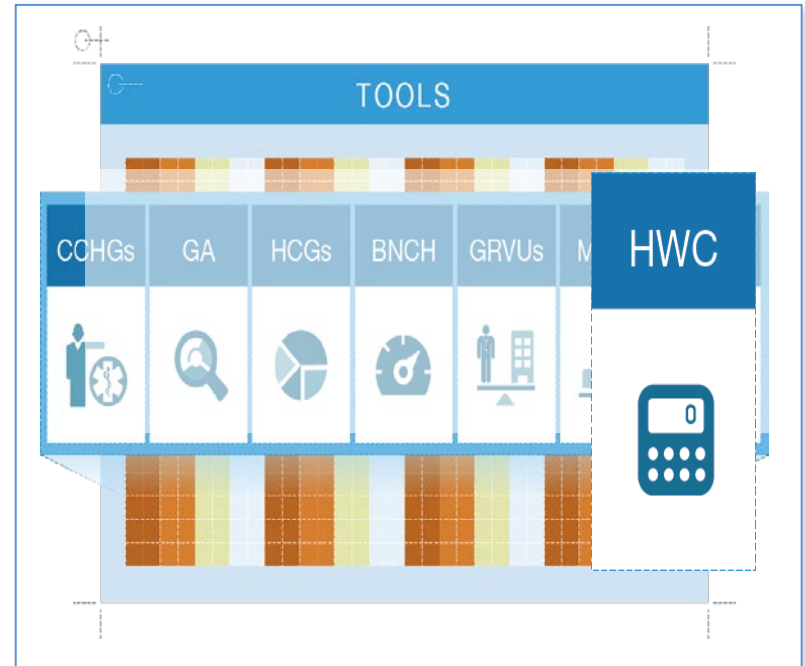
Identifying and Removing Unnecessary Care

- **Key stakeholders—including a large number of medical professional societies—agree that discouraging consumers from using specific low-value services must be part of the strategy**
- **Unlike delay for cost offsets from improved quality, savings from waste elimination are **immediate and substantial****
- **Identification, measurement, and removal of unnecessary care has proven challenging**



Identifying and Removing Unnecessary Care: Milliman Health Waste Calculator

- **Collaboration between Milliman and V-BIDHealth**
- **Measure potentially unnecessary services**
- **Analyze cost savings potential**
- **Discover ways to improve quality and patient safety**
- **Generate actionable reports and summaries**



Commonwealth of Virginia Unnecessary Care Initiative

Clinical Measure	Total Services Measured	Low Value Index (%)	Low Value Services (#)	Unnecessary Spending (\$)
Baseline labs for patients undergoing low-risk surgery	571,600	79%	453,447	\$184,781,018
Stress cardiac or advanced non-invasive imaging in the initial evaluation of patients w/o symptoms	219,878	13%	27,817	\$185,997,938
EKGs or other cardiac screening for low-risk patients w/o symptoms	2,268,194	6%	147,423	\$60,499,385
Routine Pap tests in women 21–65 years of age	199,865	81%	161,539	\$37,558,706
PSA-based screening for prostate cancer in all men regardless of age	313,011	42%	132,793	\$31,501,675

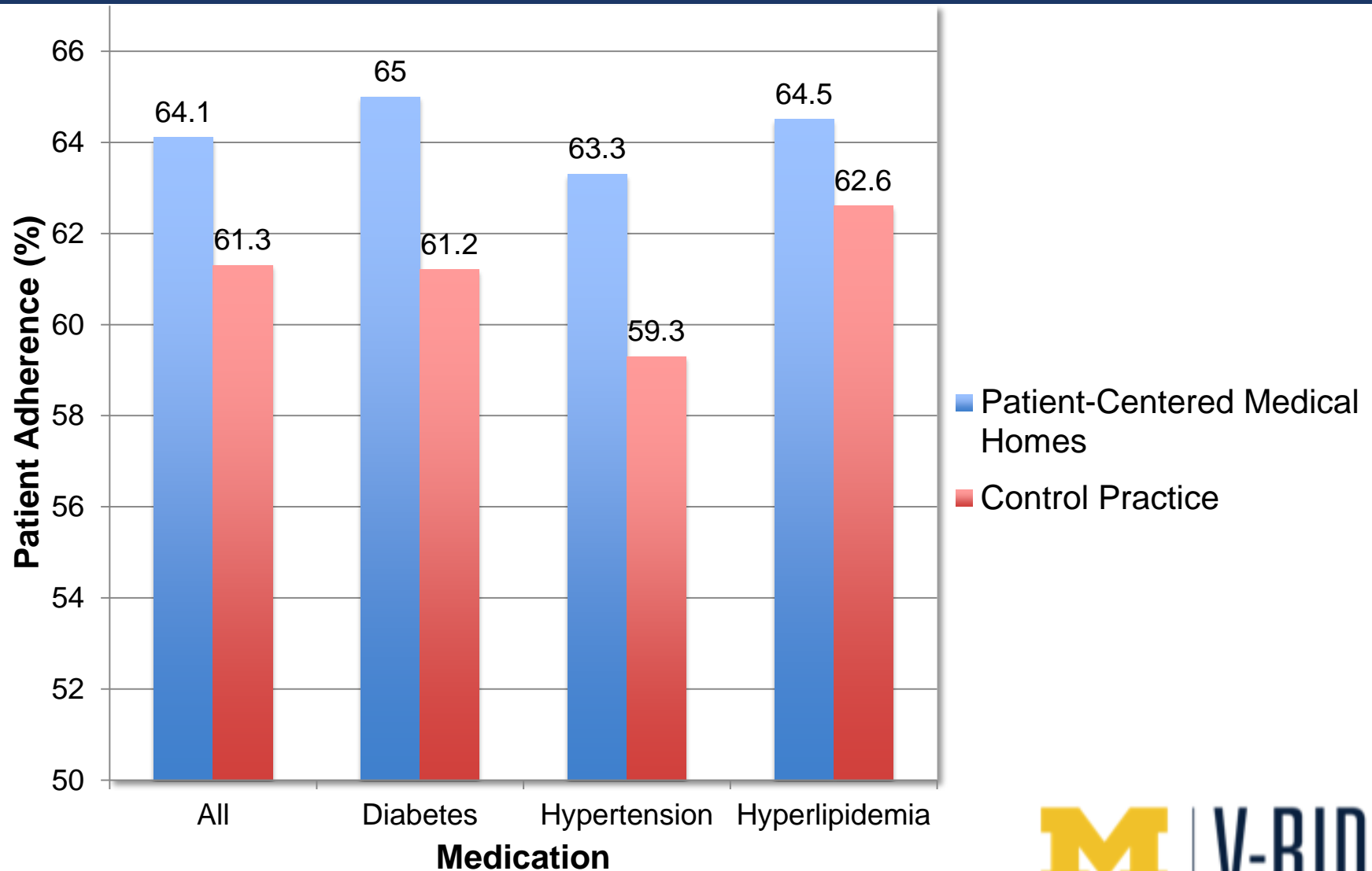
Aligning Payer and Consumer Incentives: As Easy as Peanut Butter and Jelly

Many “supply side” initiatives are restructuring provider incentives to move from volume to value:

- **Medical Homes**
- **Accountable Care**
- **Bundled Payments**
- **Reference Pricing**
- **Global Budgets**
- **High Performing Networks**
- **Health Information Technology**



Association Between Patient-Centered Medical Homes and Adherence to Chronic Disease Medications

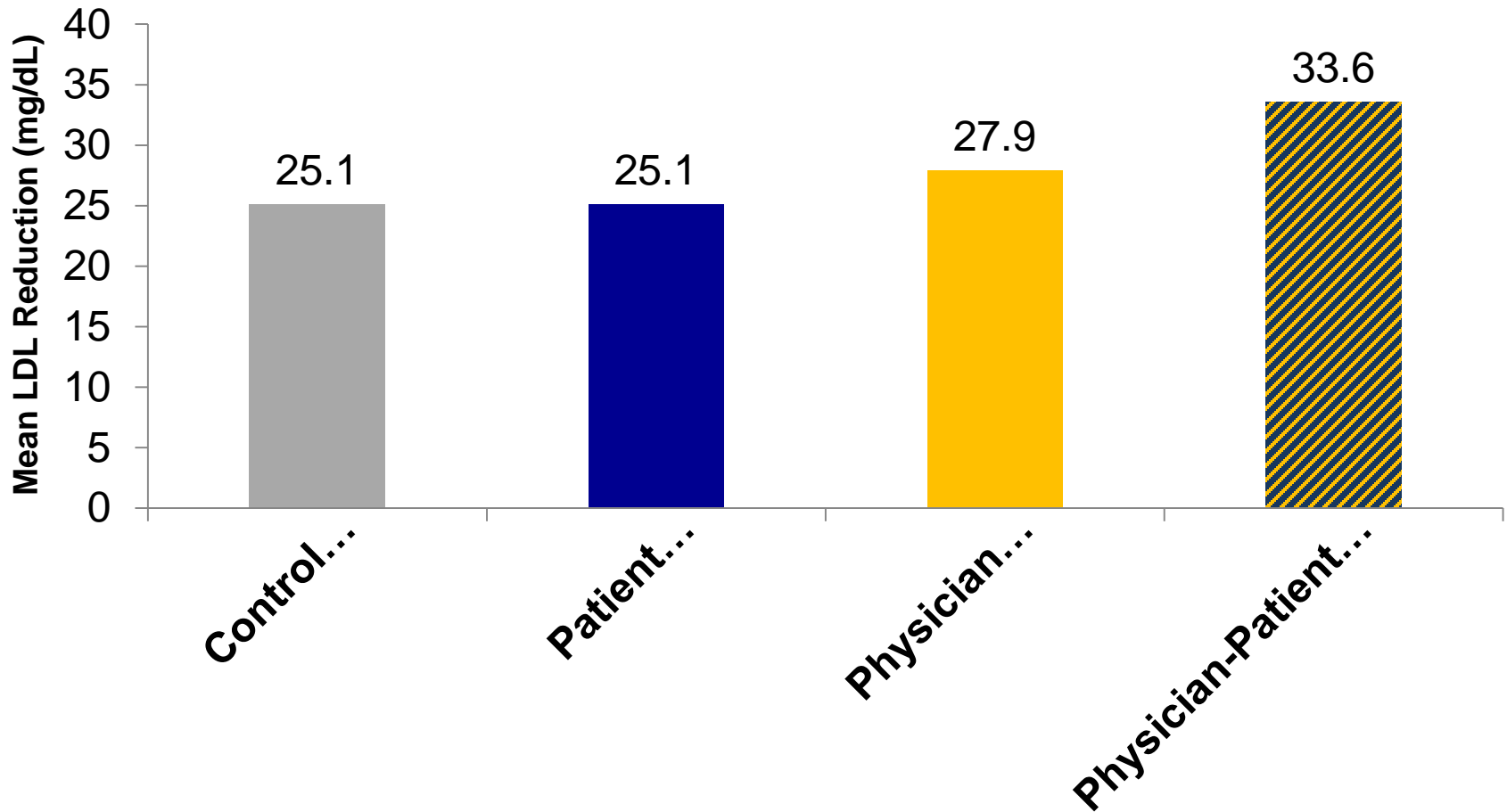


Aligning Payer and Consumer Incentives: As Easy as Peanut Butter and Jelly

Unfortunately, some “demand-side” initiatives – including consumer cost sharing - discourage consumers from pursuing the “Triple Aim”



Impact of Aligning Physicians and Patients: Financial Incentives to Lower Cholesterol



Source: *JAMA*. 2015;314(18):1926-1935



Aligning Payer and Consumer Incentives: As Easy as PB & J

The alignment of clinically nuanced, provider-facing and consumer engagement initiatives is a necessary and critical step to improve quality of care, enhance patient experience, and contain cost growth



Star Wars Science Meets Flintstones Delivery Precision Medicine Needs Precision Benefit Design



Discussion

www.vbidcenter.org



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