SCHOOL OF PUBLIC HEALTH
CENTER FOR VALUE-BASED INSURANCE DESIGN
UNIVERSITY OF MICHIGAN

Addressing Low Value Care to Improve Patient-Centered Outcomes and Reduce Medical Costs

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University of Michigan Center for Value-Based Insurance Design

www.vbidcenter.org

(slides available here)

@um_vbid

Smarter Care VIRGINIA

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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.

Health Care Costs Are a Top Issue For Purchasers, Policymakers and Voters: Solutions must protect consumers, reward providers and preserve innovation

1. Innovations to prevent and treat disease have led to impressive reductions in morbidity and mortality
2. Irrespective of remarkable clinical advances, cutting health care spending is the main focus of reform discussions
3. Underutilization of high-value persists across the entire spectrum of clinical care leading to poor health outcomes
4. Our ability to deliver high-quality health care lags behind the rapid pace of scientific innovation

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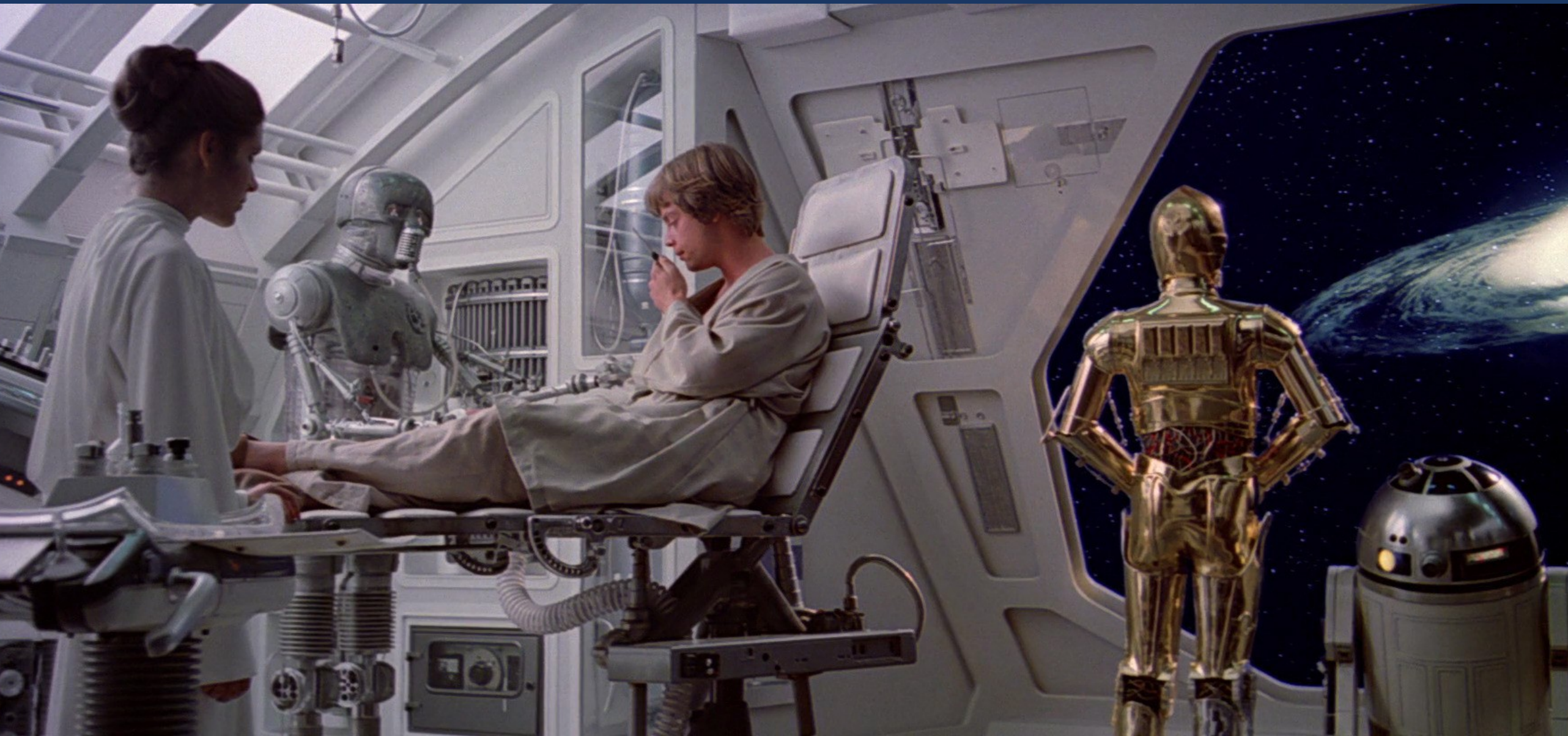
Star Wars Science



Flintstones Delivery

Outline

- Consumer Cost-sharing
- Translating Research into Policy
- Aligning Incentives
- Value-Based Insurance Design
- Low Value Care

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Moving from the Stone Age to the Space Age: Change the health care cost discussion from “How much” to “How well”

- Everyone (almost) agrees there is enough money in the US health care system; we just spend it on the wrong services
- Policy deliberations focus primarily on alternative payment and pricing models
- 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
- Consumer cost-sharing is a common policy lever

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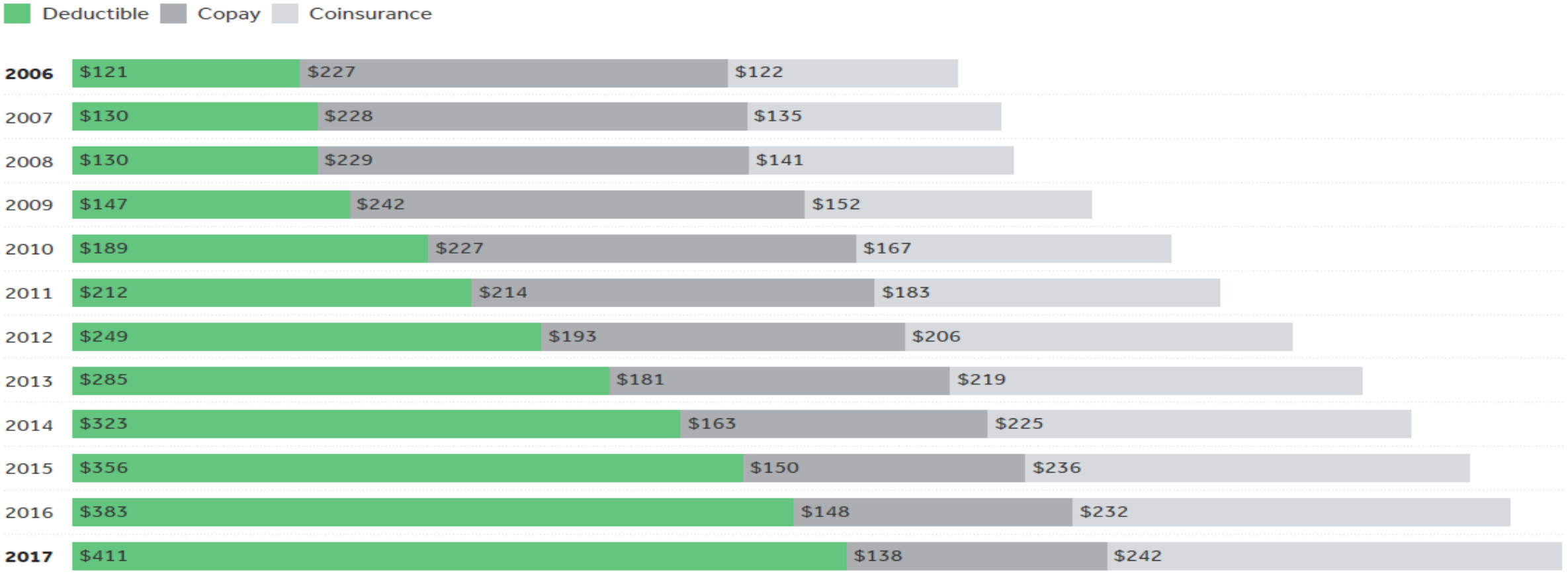
Americans Do Not Care About Health Care Costs; They Care About What It Costs Them

Patient Worry About Out-of-Pocket Healthcare Costs at All-Time High

A report from the Commonwealth Fund noted that patients are not confident they can afford high out-of-pocket healthcare costs.

Out-of-pocket spending among people with large employer coverage, Paying More for ALL Care Regardless of Value



Source: KFF analysis of data from IBM MarketScan Database and the KFF Employer Health Benefit Survey

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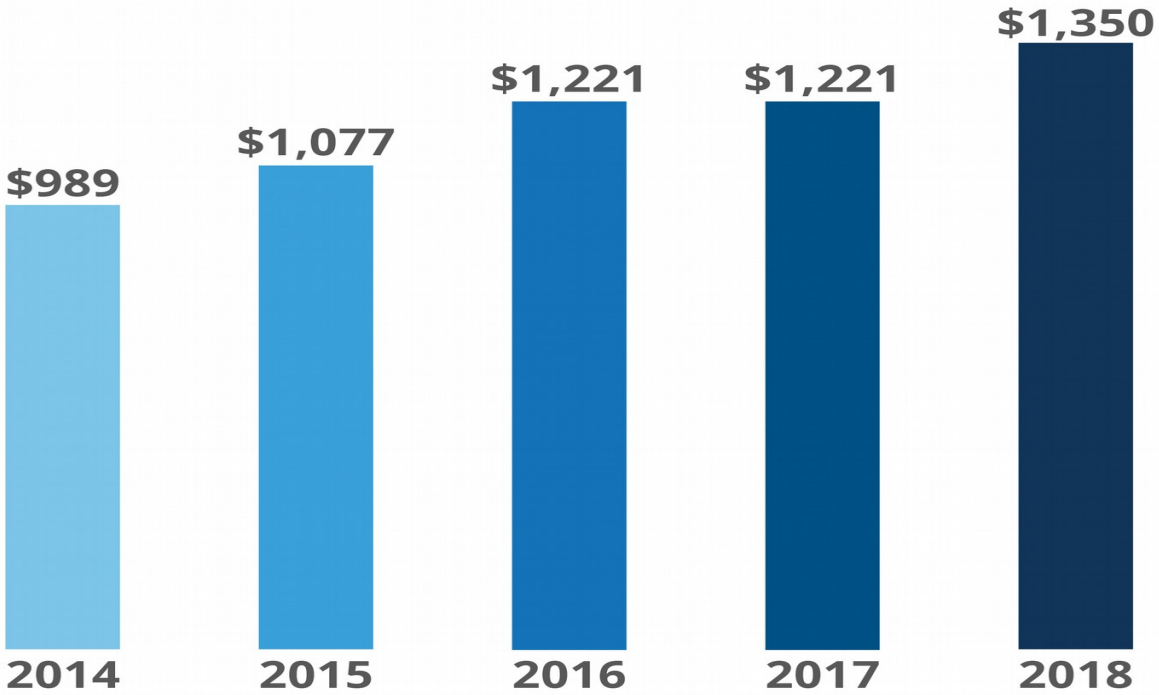
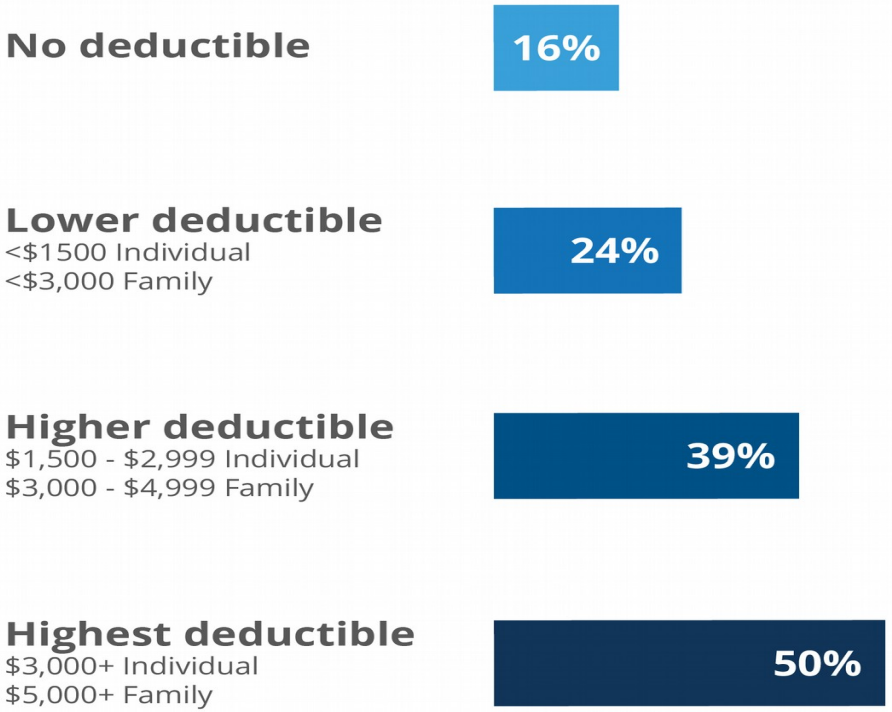
Dissatisfaction With Employer Coverage Rises As Deductibles Climb

Average deductible among large employer plans, including those with $0 deductibles



Percent who say their health insurance has gotten worse over the past 5 years



SOURCE: KFF analysis of data from KFF Employer Health Benefits Survey, 2018. KFF/LA Times Survey of Adults with Employer-Sponsored Health Insurance (Sept. 25-Oct. 9, 2018).

KFF
HENRY J KAISER FAMILY FOUNDATION

Inspiration (Still)

“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)

Six of ten people with a chronic condition and employer coverage have skipped or postponed care due to cost

Percent who say they or a family member have done the following in the past year

	NO CHRONIC CONDITION IN FAMILY	WITH CHRONIC CONDITION	
		All	Highest deductible
Postponed or put off care	23%	42%	60%
Treated at home instead of seeing doctor	28	41	58
Avoided doctor-recommended test or treatment	15	31	44
Not filled a prescription or skipped doses	12	23	35
Yes to any	40	60	75

Impact of Cost-Sharing on Health Care Disparities

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

Michael Chernew, PhD[1] Teresa B. Gibson, PhD[2] Kristina Yu-Isenberg, PhD, RPh[3]
Michael C. Sokol, MD, MS[4] Allison B. Rosen, MD, ScD[5], and A. Mark Fendrick, MD[5]

[1]Department of Health Care Policy, Harvard Medical School, Boston, MA, USA; [2]Thomson Healthcare, Ann Arbor, MI, USA; [3]Managed Markets Division, GlaxoSmithKline, Research Triangle Park, NC, USA; [4]Managed Markets Division, GlaxoSmithKline, Montvale, NJ, USA; [5]Departments 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**

Chernew M. *J Gen Intern Med* 23(8):1131–6.

An Alternative to 'Blunt' Cost-Sharing: Clinical Nuance

- A clinical service is never always high or low value
- The clinical value of a specific clinical service depends on:
  - –Who receives it
  - –When in the course of disease
  - –Who provides it
  - –Where it is provided

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Alternative to "Blunt" Consumer Cost Sharing: Value-Based Insurance Design (V-BID)

- **Sets consumer cost-sharing on clinical benefit – not price**
- **Little or no out-of-pocket cost for high value care; high cost share for low value care**
- **Successfully implemented by hundreds of public and private payers**

V-BID: Rare Bipartisan Political and Broad Multi-Stakeholder Support

- HHS
- CBO
- SEIU
- MedPAC
- Brookings Institution
- Commonwealth Fund
- NBCH
- American Fed Teachers
- Families USA
- AHIP
- AARP
- DOD
- BCBSA
- 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
- Smarter Health Care Coalition
- PhRMA
- EBRI
- AMA

Putting Innovation into Action: Translating Research into Policy

Translating Research into Policy

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 137 million Americans have received expanded coverage of preventive services

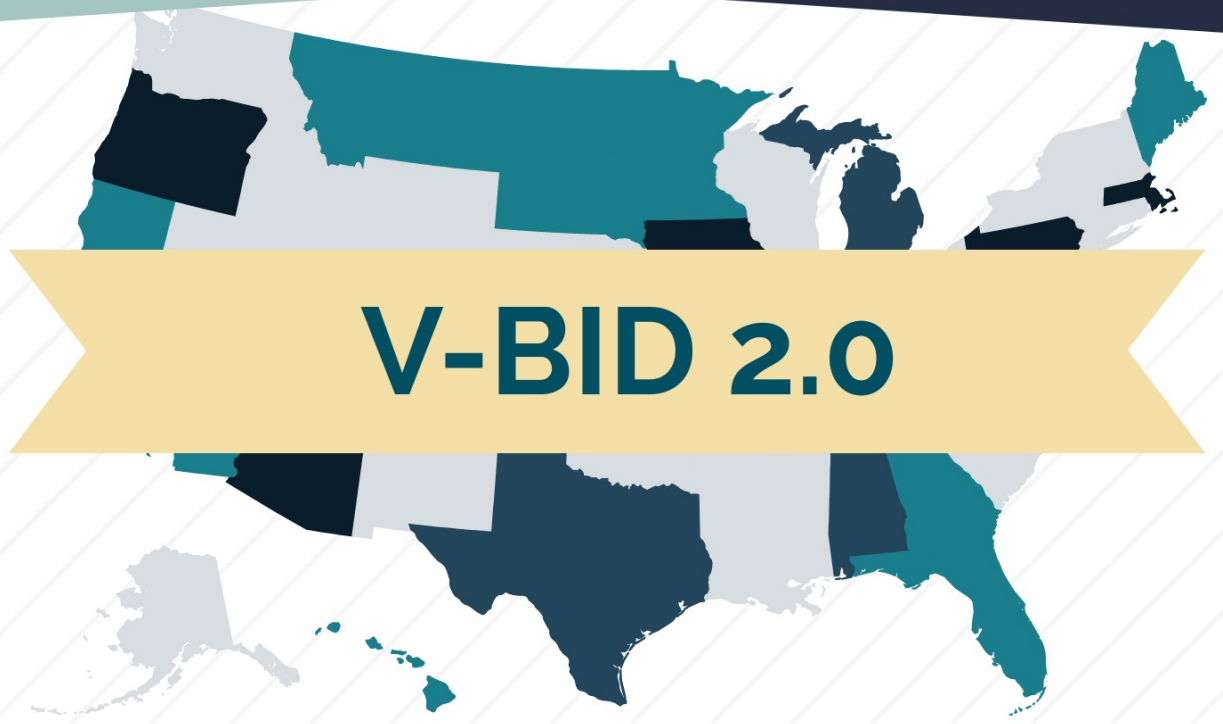
U.S. Preventive Services Task Force Recommends Expanding Use Of PrEP In High Risk People To Prevent Infection

In an effort to eliminate nearly 40,000 new HIV infections in the U.S. each year, the U.S. Preventive Services Task Force recommended Truvada, which can reduce the risk of infection by 92% when taken daily, should be offered to more patients. High cost has been a barrier, and so far fewer than 10% of high-risk people take the medication.

Putting Innovation into Action: Translating Research into Policy

Medicare

THE EXPANDED ROLE OF V-BID IN MEDICARE ADVANTAGE



CMS announced transformative updates to the **Medicare Advantage Value-Based Insurance Design model**, including its expansion to all 50 states

V-BID 2.0 allows MA plans to...

- Provide reduced cost-sharing and supplemental benefits in a more targeted fashion
- Increase access to new interventions like telehealth services, and wellness and healthcare planning
- Expand eligibility to include Dual Eligible SNPs, Institutional SNPs, and Regional PPOs
- Broaden rewards programs that improve beneficiaries' health

Putting Innovation into Action: Translating Research into Policy

TRICARE®

Value-based insurance coming to millions of people in Tricare

- 2017 NDAA: Obama Administration - reduce or eliminate co-pays and other cost sharing for certain high services and providers
- 2018 NDAA: Trump Administration – reduce cost sharing for high value drugs on the uniform formulary

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HSA-HDHP Reform

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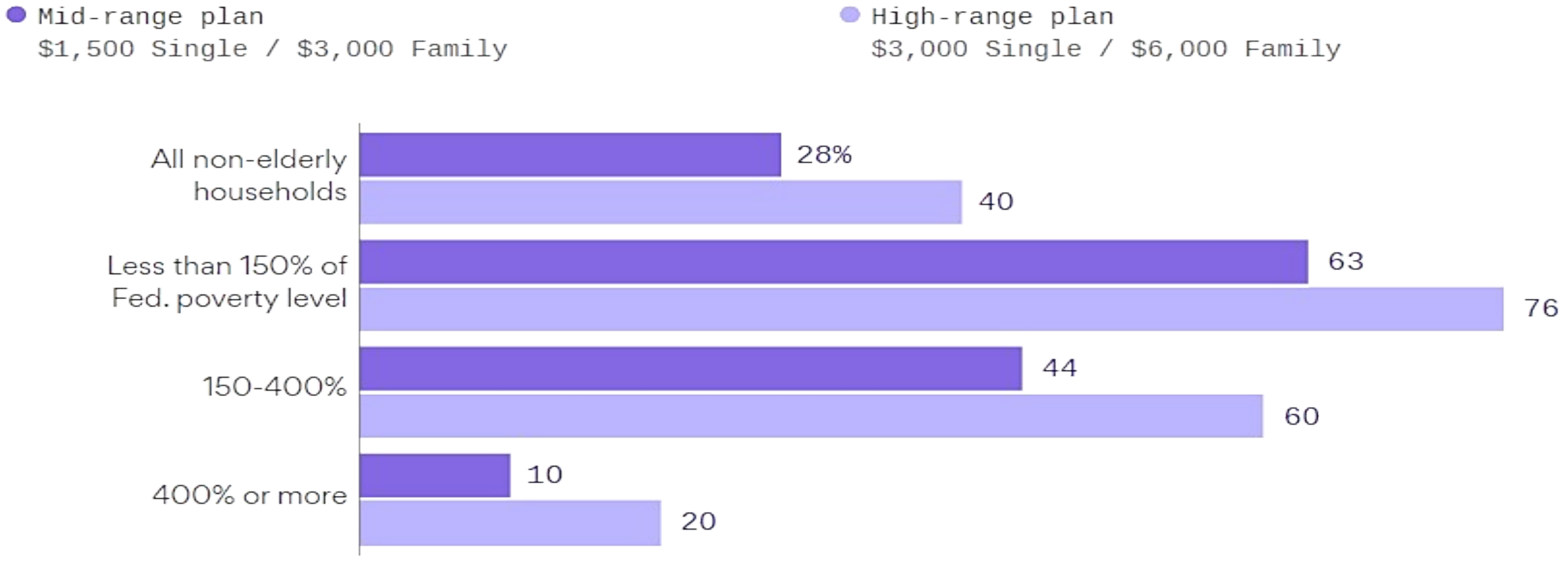
A Significant Number of Households Do NOT Have Liquid Assets to Cover Their Plan Deductible

Among people with private health insurance



Reproduced from Kaiser Family Foundation analysis of the 2016 Survey of Consumer Finance; Note: Liquid assets include the sum of checking and saving accounts, money market accounts, certificates of deposit, savings bonds, non-retirement mutual funds, stocks and bonds. Chart: Axios Visuals

IRS Rules Prohibit Coverage of Chronic Disease Care Until HSA-HDHP Deductible is Met

PREVENTIVE CARE COVERED
Dollar one

CHRONIC DISEASE CARE
NOT covered until deductible is met

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

U.S. DEPARTMENT OF THE TREASURY

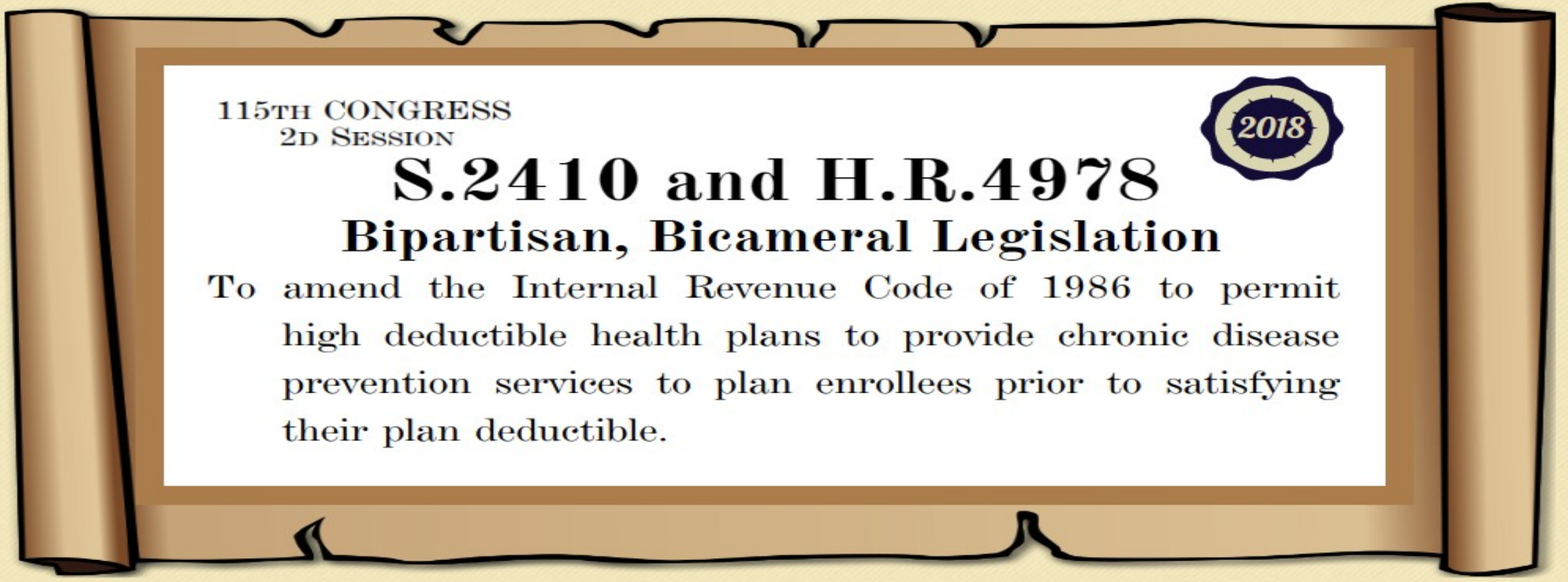
PRESS RELEASES

Treasury Expands Health Savings Account Benefits for Individuals Suffering from Chronic Conditions

List of services and drugs for certain chronic conditions that will be classified as preventive care under Notice 2019-45

Preventive Care for Specified Conditions	For Individuals Diagnosed with
Angiotensin Converting Enzyme (ACE) inhibitors	Congestive heart failure, diabetes, and/or coronary artery disease
Anti-resorptive therapy	Osteoporosis and/or osteopenia
Beta-blockers	Congestive heart failure and/or coronary artery disease
Blood pressure monitor	Hypertension
Inhaled corticosteroids	Asthma
Insulin and other glucose lowering agents	Diabetes
Retinopathy screening	Diabetes
Peak flow meter	Asthma
Glucometer	Diabetes
Hemoglobin A1c testing	Diabetes
International Normalized Ratio (INR) testing	Liver disease and/or bleeding disorders
Low-density Lipoprotein (LDL) testing	Heart disease
Selective Serotonin Reuptake Inhibitors (SSRIs)	Depression
Statins	Heart disease and/or diabetes

Chronic Disease Management Act of 2019



Where does the money come from to provide better coverage for high value care?

- **Raise Premiums**

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Where does the money come from to provide better coverage for high value care?

- ~~**Raise Premiums**~~
- **Increase Deductibles, Copayments and Coinsurance**

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Where does the money come from to provide better coverage for high value care?

- ~~Raise Premiums~~
- ~~Increase Deductibles, Copayments and Coinsurance~~
- Reduce Spending on Low Value Care

Waste in the Healthcare System Comes From Many Places

Category	Sources	Estimate of Excess Costs	% of Waste	% of Total
Unnecessary Services	• Overuse beyond evidence-established levels • Discretionary use beyond benchmarks • Unnecessary choice of higher-cost services	$210 billion	27%	9.15%
Inefficiently Delivered Services	• Mistakes, errors, preventable complications • Care fragmentation • Unnecessary use of higher-cost providers • Operational inefficiencies at care delivery sites	$130 billion	17%	5.66%
Excess Admin Costs	• Insurance paperwork costs beyond benchmarks • Insurers' administrative inefficiencies • Inefficiencies due to care documentation requirements	$190 billion	25%	8.28%
Prices that are too high	• Service prices beyond competitive benchmarks • Product prices beyond competitive benchmarks	$105 billion	14%	4.58%
Missed Prevention Opportunities	• Primary prevention • Secondary prevention • Tertiary prevention	$55 billion	7%	2.40%
Fraud	• All sources – payers, clinicians, patients	$75 billion	10%	3.27%
	Total	**$765 billion**		**33.33%**


All your labs are back. They show a serious overuse of unnecessary and inappropriate tests and procedures.
SEMELROTH ©'13

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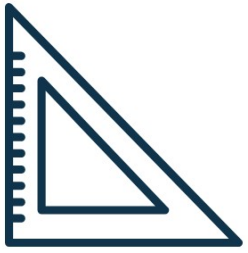
REDUCING
LOW-VALUE CARE

IDENTIFY.



MEASURE.

REDUCE.

REPORT.

Reducing Low Value Care: Identify

Choose services:

- Easily identified in administrative systems
- Mostly low value
- Reduction in their use would be barely noticed

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Multi-Stakeholder Task Force on Low Value Care Identifies 5 Commonly Overused Services Ready for Action

1. Diagnostic Testing and Imaging Prior to Low Risk Surgery

2. Vitamin D Screening

3. PSA Screening in Men 70+

4. Imaging in First 6 Weeks of Acute Low Back Pain

5. Branded Drugs When Identical Generics Are Available

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Impact of reducing Vitamin D testing in the TRICARE population

Cost 1 Vitamin D test =

Milliman MedInsight

Reducing Low Value Care: Measure

Health Waste Calculator

- Collaboration between Milliman and V-BIDHealth
- Measures potentially unnecessary services based on clinical context
- Report on and improve quality and patient safety
- Support value based initiatives by identifying services to be eliminated to facilitate better coverage of high value

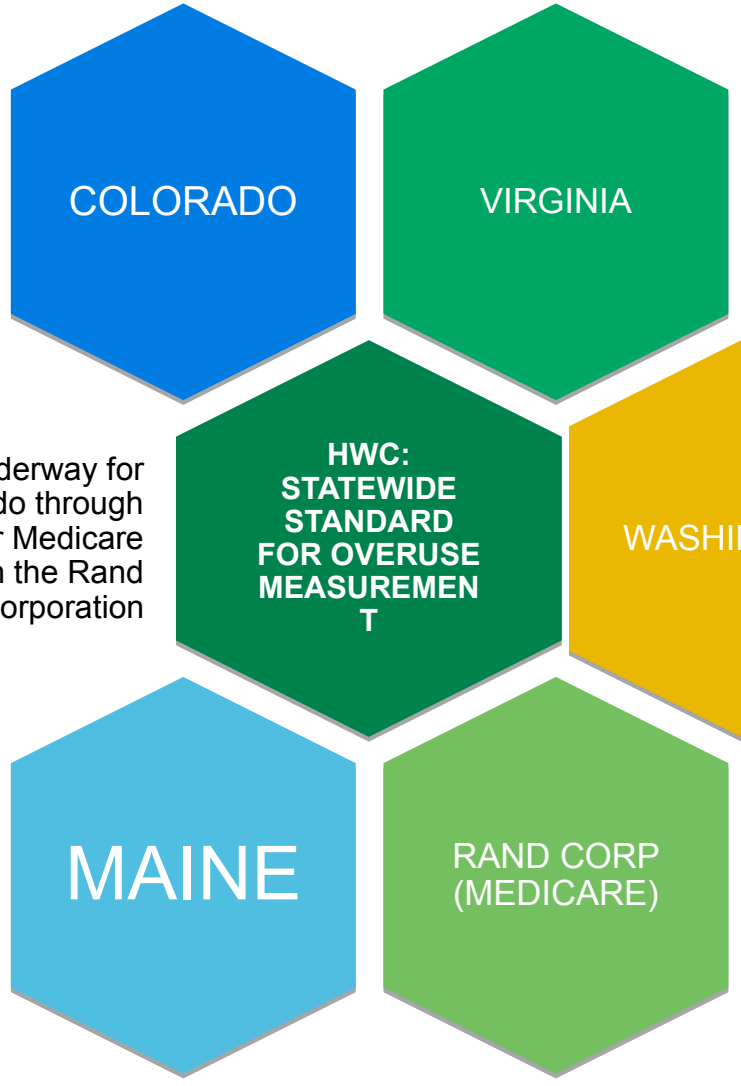
Milliman MedInsight

VBIDHEALTH

Report:
Example Measure Summary

Waste Categories (Aggregation and drill path)	Total Services Measured	Likely Wasteful		Wasteful		Quality Index	Waste Index
		Services	Total Allowed Costs	Services	Total Allowed Costs		
PSA-Based Screening	23,143	53	$10,787.09	17,855	$2,631,113	23%	77%
Sinus CT for Rhinosinusitus	865	592	$512,453	-	$0.00	32%	68%
Antibiotics for Rhinosinusitus	40,401	50	$1,826		$816,712	2%	98%
Lower Back Pain Image	6,328	521	$317,982	5,230	$4,177,463	9%	91%
Uncomplicated Headaches	2,706	1,559	$2,675,946	281	$465,378	32%	68%
Immunoglobin G/E Testing	836	406	$107,009	236	$68,527	23%	77%
Stress Cardiac Imaging or Advanced Non-Invasive Imaging	16,318	1,180	$1,255,296	3,311	$3,526,215	72%	28%
Totals	**90,597**	**4,361**	**$4,870,512**	**66,540**	**$11,685,408**	**22%**	**78%**

Health Waste Calculator: State and National Initiatives



Data runs are underway for Maine, Colorado through MedInsight and for Medicare through the Rand Corporation

Smarter Care VIRGINIA

Published two “First Do No Harm” reports.

Created “Drop the Pre-Op!” to reduce wasteful preoperative testing for low risk surgeries.

Milliman MedInsight

VBIDHEALTH

Report:
Virginia Health Value Dashboard

STATE AND REGIONAL COMPARISON 2017

● = Better than statewide rate
● = Same as statewide rate
● = Worse than statewide rate

REDUCING LOW VALUE CARE	Statewide	Northwest	Northern	Southwest	Central	Eastern
Utilization and Cost of Avoidable Emergency Room Visits						
Potentially Avoidable ED Visits - As a Percentage of Total ED Visits	12.8%	●	●	●	●	●
Potentially Avoidable ED Visits - Per 1,000 Member Months	3.5	●	●	●	●	●
Potentially Avoidable ED Visits - Per Member Per Year	0.04	●	●	●	●	●
Low Value Services as Captured by the MedInsight Health Waste Calculator						
Don't obtain baseline laboratory studies in patients without significant systemic disease (ASA I or II) undergoing low-risk surgery – specifically complete blood count, basic or comprehensive metabolic panel, coagulation studies when blood loss (or fluid shifts) is/are expected to be minimal	82%	●	●	●	●	●
Don't obtain EKG, chest X-rays or pulmonary function test in patients without significant systemic disease (ASA I or II) undergoing low-risk surgery	6%	●	●	●	●	●
Don't perform population based screening for 25-OH-Vitamin D deficiency	21%	●	●	●	●	●
Don't perform PSA-based screening for prostate cancer in all men regardless of age	75%	●	●	●	●	●
Don't do imaging for low back pain within the first six weeks, unless red flags are present	76%	●	●	●	●	●
Inappropriate Preventable Hospital Stays						
Prevention Quality Indicator #90: Prevention Quality Overall Composite Rate (per 100,000 population)	2,166	●	●	●	●	●

Smarter Care
VIRGINIA

Report:
Low Value Care in Virginia

By John N. Mafi, Kyle Russell, Beth A. Bortz, Marcos Dachary, William A. Hazel Jr., and A. Mark Fendrick

DATAWATCH

Low-Cost, High-Volume Health Services Contribute The Most To Unnecessary Health Spending

An analysis of data for 2014 about forty-four low-value health services in the Virginia All Payer Claims Database revealed more than $586 million in unnecessary costs. Among these low-value services, those that were low and very low cost ($538 or less per service) were delivered far more frequently than services that were high and very high cost ($539 or more). The combined costs of the former group were nearly twice those of the latter (65 percent versus 35 percent).

The MedInsight Health Waste Calculator identified more than $586 MM in unnecessary costs in 2014 from the Virginia All Payer Claims Database

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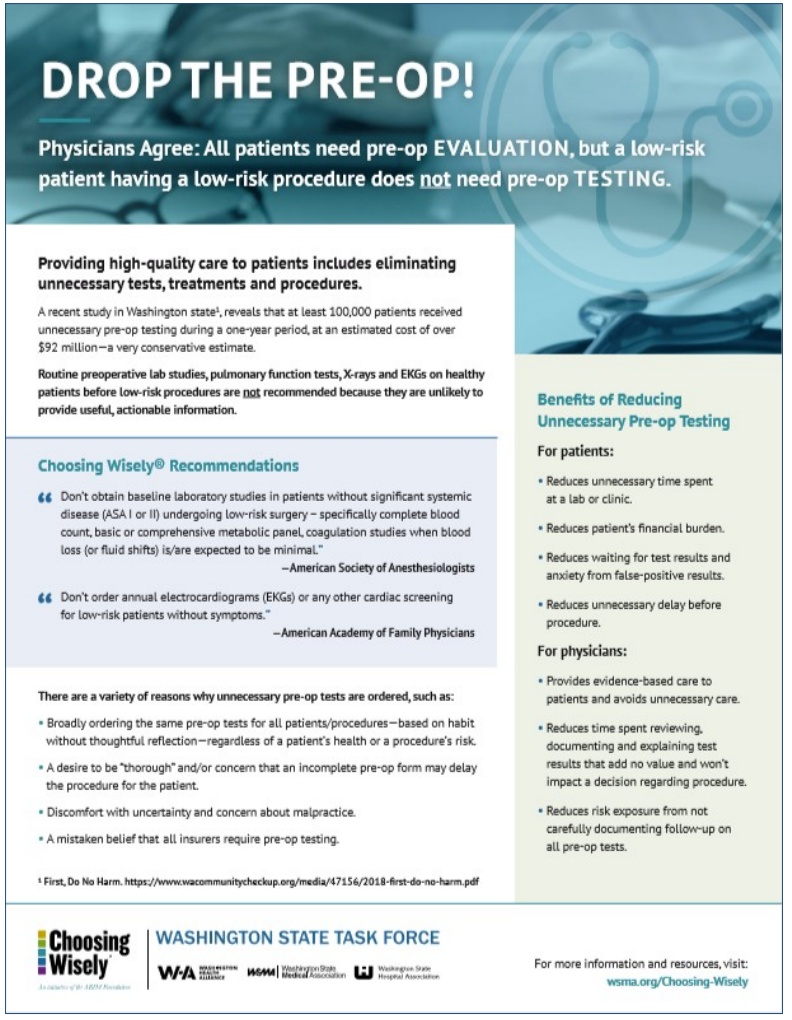
Report:
Washington Health Alliance

The Washington Health Alliance used the Health Waste Calculator to identify over $92 Million in Unnecessary Pre-Op Testing.



DROP THE PRE-OP!

Physicians Agree: All patients need pre-op EVALUATION, but a low-risk patient having a low-risk procedure does not need pre-op TESTING.

Providing high-quality care to patients includes eliminating unnecessary tests, treatments and procedures.

A recent study in Washington state[1], reveals that at least 100,000 patients received unnecessary pre-op testing during a one-year period, at an estimated cost of over $92 million—a very conservative estimate.

Routine preoperative lab studies, pulmonary function tests, X-rays and EKGs on healthy patients before low-risk procedures are not recommended because they are unlikely to provide useful, actionable information.

Choosing Wisely® Recommendations

> "Don't obtain baseline laboratory studies in patients without significant systemic disease (ASA I or II) undergoing low-risk surgery – specifically complete blood count, basic or comprehensive metabolic panel, coagulation studies when blood loss (or fluid shifts) is/are expected to be minimal."
> —American Society of Anesthesiologists

> "Don't order annual electrocardiograms (EKGs) or any other cardiac screening for low-risk patients without symptoms."
> —American Academy of Family Physicians

There are a variety of reasons why unnecessary pre-op tests are ordered, such as:

- Broadly ordering the same pre-op tests for all patients/procedures—based on habit without thoughtful reflection—regardless of a patient's health or a procedure's risk.
- A desire to be "thorough" and/or concern that an incomplete pre-op form may delay the procedure for the patient.
- Discomfort with uncertainty and concern about malpractice.
- A mistaken belief that all insurers require pre-op testing.

[1] First, Do No Harm. https://www.wacommunitycheckup.org/media/47156/2018-first-do-no-harm.pdf

Benefits of Reducing Unnecessary Pre-op Testing

For patients:

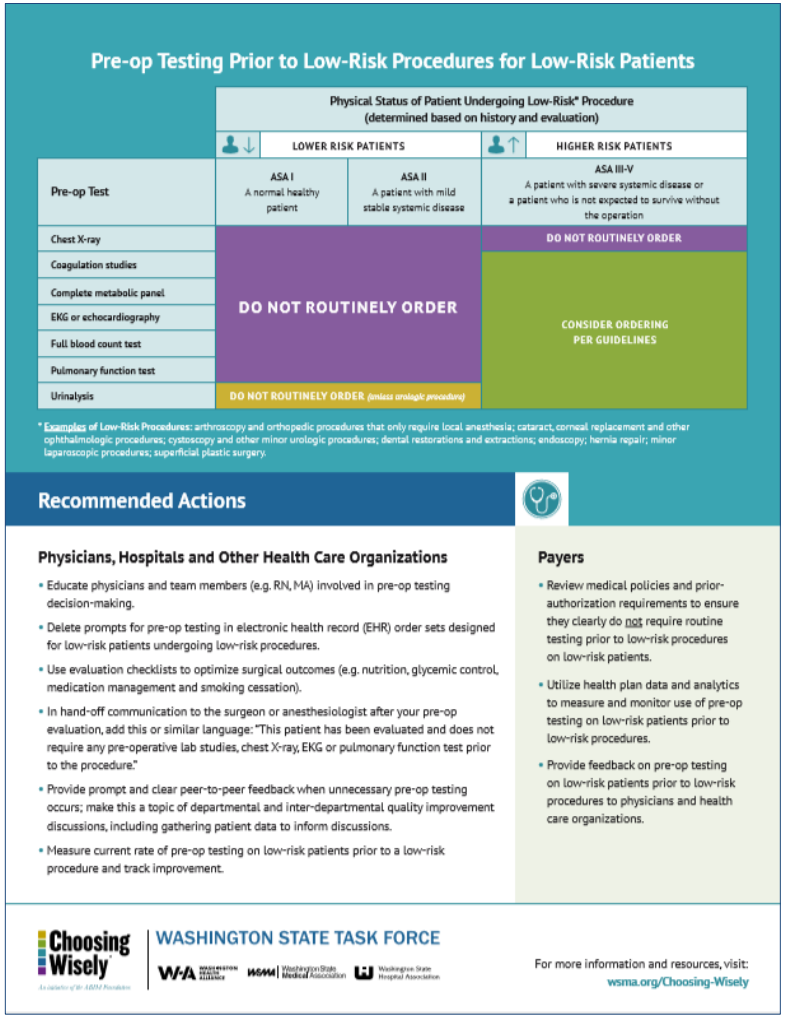
- Reduces unnecessary time spent at a lab or clinic.
- Reduces patient's financial burden.
- Reduces waiting for test results and anxiety from false-positive results.
- Reduces unnecessary delay before procedure.

For physicians:

- Provides evidence-based care to patients and avoids unnecessary care.
- Reduces time spent reviewing, documenting and explaining test results that add no value and won't impact a decision regarding procedure.
- Reduces risk exposure from not carefully documenting follow-up on all pre-op tests.

Choosing Wisely | WASHINGTON STATE TASK FORCE

For more information and resources, visit: wsma.org/Choosing-Wisely



Pre-op Testing Prior to Low-Risk Procedures for Low-Risk Patients

	Physical Status of Patient Undergoing Low-Risk* Procedure (determined based on history and evaluation)		
	LOWER RISK PATIENTS		HIGHER RISK PATIENTS
Pre-op Test	ASA I — A normal healthy patient	ASA II — A patient with mild stable systemic disease	ASA III-V — A patient with severe systemic disease or a patient who is not expected to survive without the operation
Chest X-ray	DO NOT ROUTINELY ORDER		DO NOT ROUTINELY ORDER
Coagulation studies			CONSIDER ORDERING PER GUIDELINES
Complete metabolic panel			
EKG or echocardiography			
Full blood count test			
Pulmonary function test			
Urinalysis	DO NOT ROUTINELY ORDER (unless urologic procedure)		

* Examples of Low-Risk Procedures: arthroscopy and orthopedic procedures that only require local anesthesia; cataract, corneal replacement and other ophthalmologic procedures; cystoscopy and other minor urologic procedures; dental restorations and extractions; endoscopy; hernia repair; minor laparoscopic procedures; superficial plastic surgery.

Recommended Actions

Physicians, Hospitals and Other Health Care Organizations

- Educate physicians and team members (e.g. RN, MA) involved in pre-op testing decision-making.
- Delete prompts for pre-op testing in electronic health record (EHR) order sets designed for low-risk patients undergoing low-risk procedures.
- Use evaluation checklists to optimize surgical outcomes (e.g. nutrition, glycemic control, medication management and smoking cessation).
- In hand-off communication to the surgeon or anesthesiologist after your pre-op evaluation, add this or similar language: "This patient has been evaluated and does not require any pre-operative lab studies, chest X-ray, EKG or pulmonary function test prior to the procedure."
- Provide prompt and clear peer-to-peer feedback when unnecessary pre-op testing occurs; make this a topic of departmental and inter-departmental quality improvement discussions, including gathering patient data to inform discussions.
- Measure current rate of pre-op testing on low-risk patients prior to a low-risk procedure and track improvement.

Payers

- Review medical policies and prior-authorization requirements to ensure they clearly do not require routine testing prior to low-risk procedures on low-risk patients.
- Utilize health plan data and analytics to measure and monitor use of pre-op testing on low-risk patients prior to low-risk procedures.
- Provide feedback on pre-op testing on low-risk patients prior to low-risk procedures to physicians and health care organizations.

Choosing Wisely | WASHINGTON STATE TASK FORCE

For more information and resources, visit: wsma.org/Choosing-Wisely

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Reduce:
Multiple Levers to Remove Low Value Care

Provider-Facing Levers (Supply)
Coverage policies
Payment rates
Payment models
Profiling data
Clinical decision support

Patient-Facing Levers (Demand)
Value-Based Insurance Design
Network design
Prior authorization

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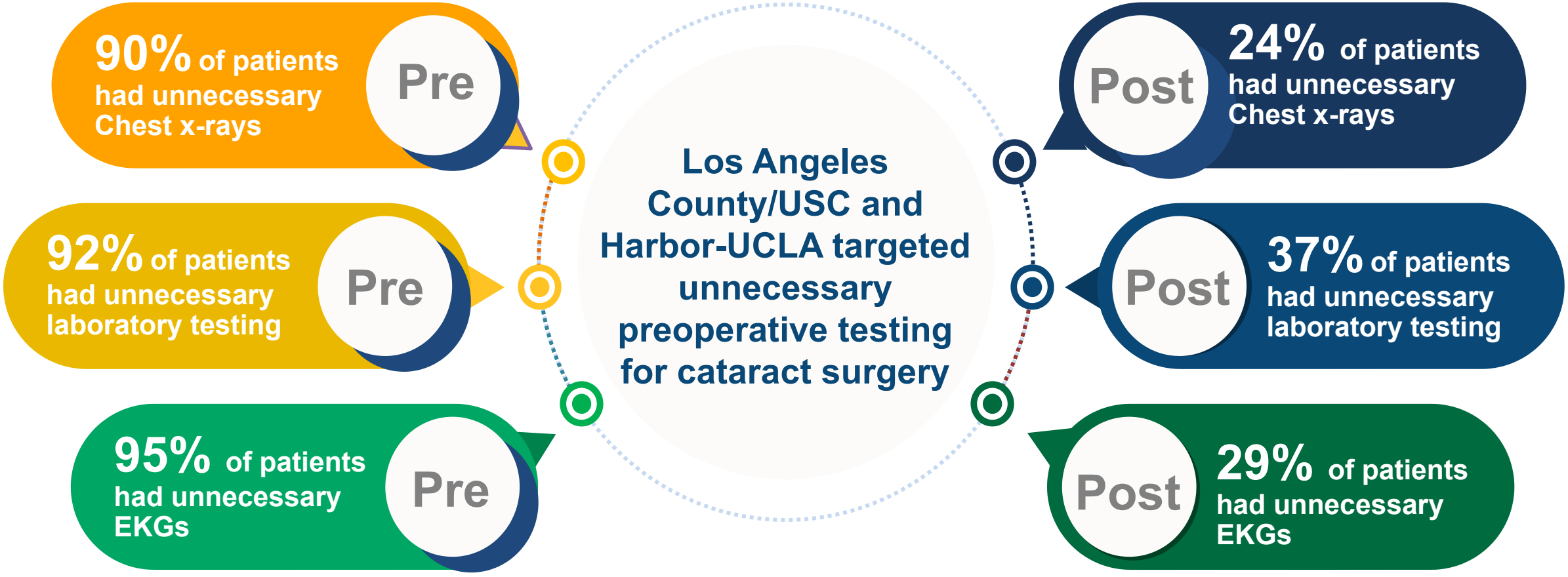
Reduce:
Eye Opening Benefits of Removing Waste



Source: Mafi JN, Godoy-Travieso P, Wei E, et al. Evaluation of an Intervention to Reduce Low-Value Preoperative Care for Patients Undergoing Cataract Surgery at a Safety-Net Health System. *JAMA Intern Med*.2019;179(5):648–657. doi:10.1001/jamainternmed.2018.8358

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Reduce:
ACA Sec 4105

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.

The ACA grants HHS the authority to eliminate coverage for USPSTF 'D' Rated Services in Medicare

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U.S. Preventive Services TASK FORCE

August 6, 2019

Final Recommendation Statement:

Pancreatic Cancer: Screening

Release Date: August 2019

Recommendation Summary

Recommendation Summary

Population	Recommendation	Grade (What's This?)
Adults	The USPSTF recommends against screening for pancreatic cancer in asymptomatic adults.	D

V-BID X:
Better Coverage, Same Premiums and Deductibles

M | V-BID

Increased cost-sharing on low-value services reduces spending...

Spinal Fusions

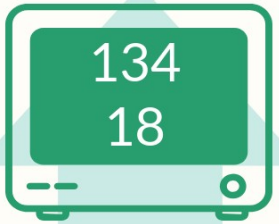
Vitamin D screening tests

Proton beam for prostate cancer

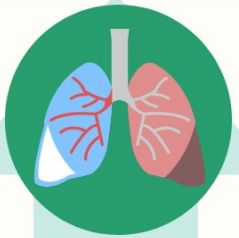
High-cost diagnostic imaging

...and allows for lower cost-sharing and increased spending on high-value services

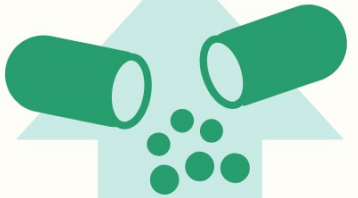
Hemoglobin A1c tests



Blood pressure monitors

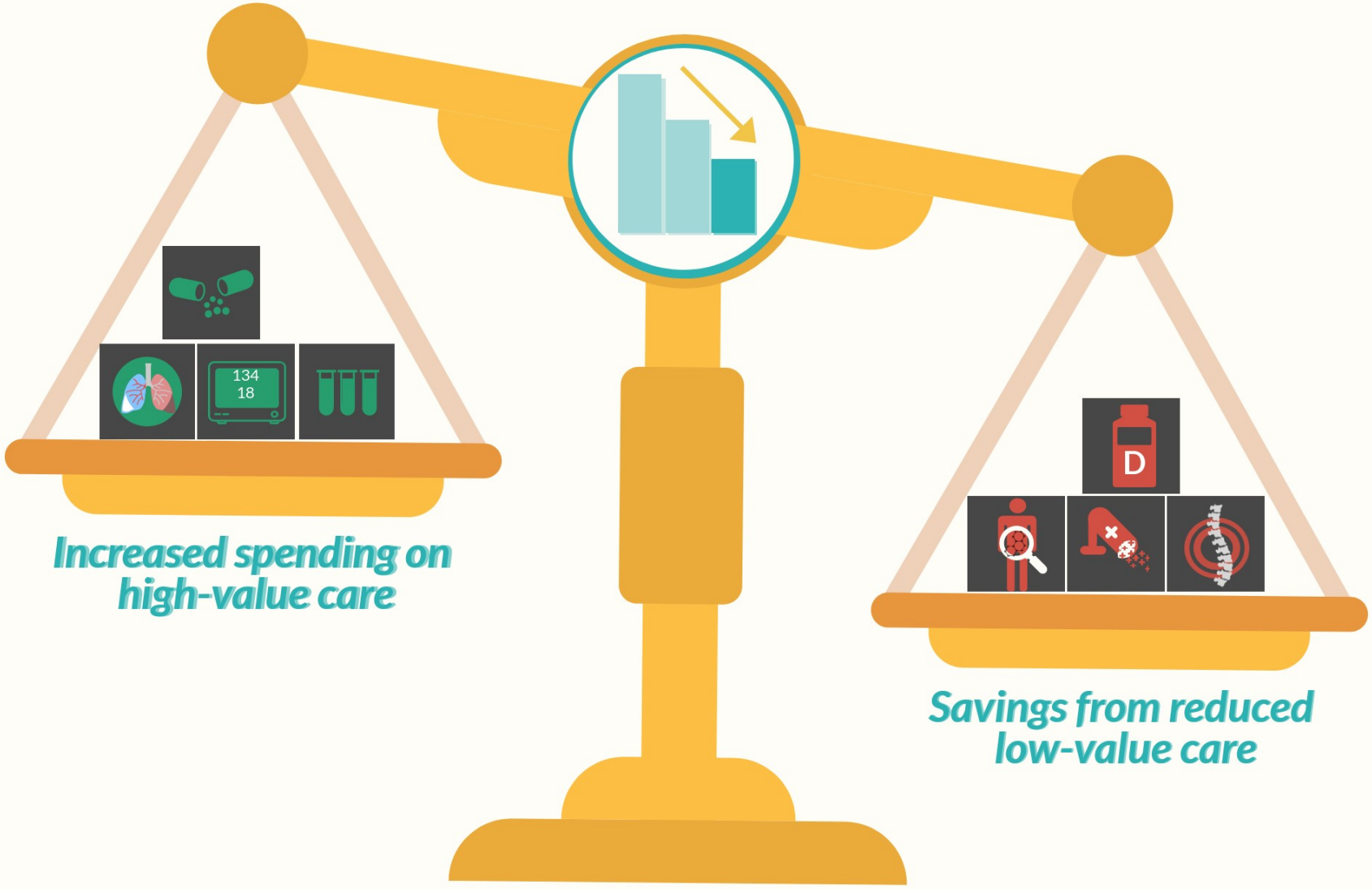


Pulmonary rehabilitation



High-value prescription drugs

When savings from reduced use of low-value care exceed extra spending on high-value services, **premiums will decrease**



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
- Electronic Medical Records
- Accountable Care Organizations
- Bundled Payments/Reference Pricing
- Global Budgets
- High Performing Networks

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”

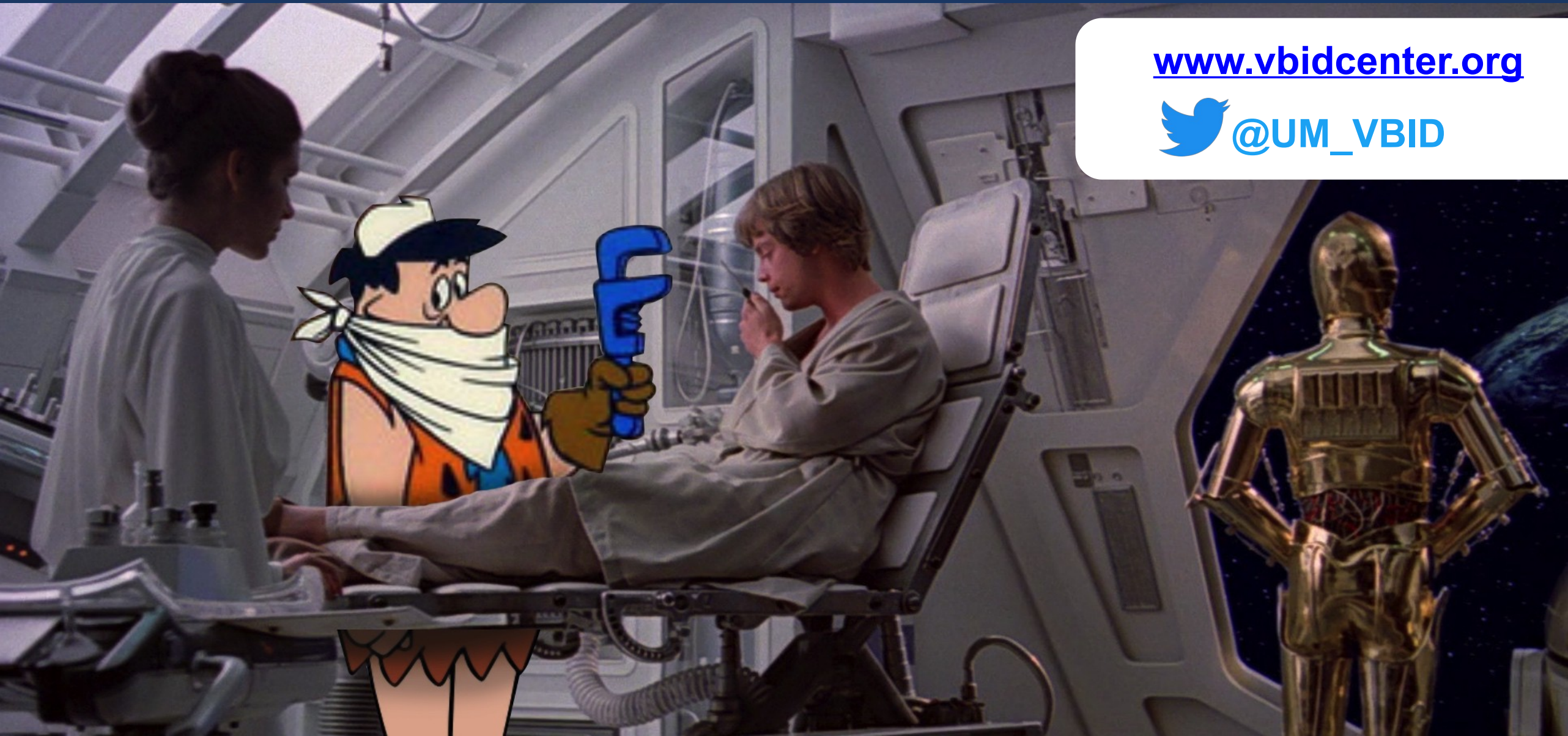
Aligning Payer and Consumer Incentives: As Easy as PB & J

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

“If we don’t succeed then we will fail.”

Dan Quayle

Questions?



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