# Co-Pay Incentives: Medicare Advantage (Part D) Can Replicate Successes of Commercial Payers

Co-pay incentives proven to drive behavior change, reduce costs, and accelerate positive outcomes

**Center for Health Value Innovation**

**March 2009**

# Co-Pay Incentives: Medicare Advantage (Part D) Can Replicate Successes of Commercial Payers

## Co-pay incentives proven to drive behavior change, reduce costs, and accelerate positive outcomes

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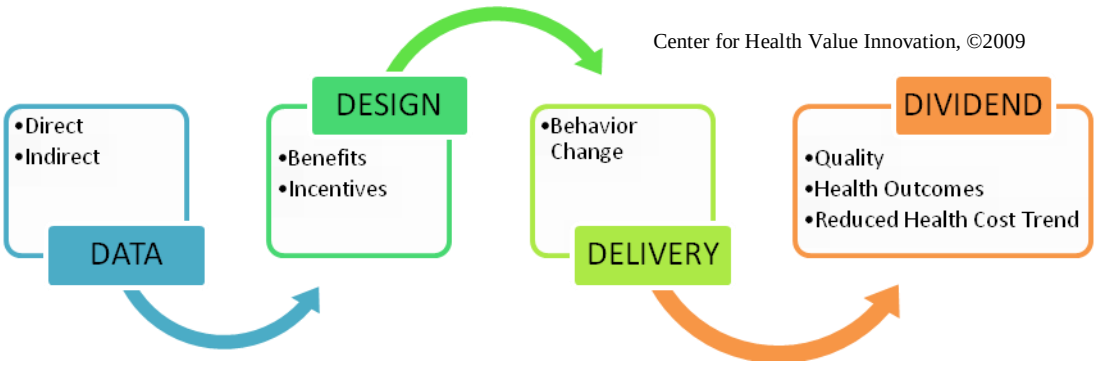
The key message for our health and economy is that we need better value for our health dollar. Various policy recommendations are being proposed, including a call for prevention, wellness, early risk detection and chronic care management in the Medicare population. The evidence for value-based designs, removing barriers to appropriate care for the most vulnerable population, is growing. Businesses are using the principles of Data, Design, Delivery and Dividend (see chart below), and they are reaping the dividends of engagement, lowered health cost trend, and improved productivity and quality of care.




The Center for Health Value Innovation, launched in 2007 (www.vbhealth.org), is accumulating the business-based evidence across stakeholders, including private sector

employers, municipalities, health systems, provider organizations, and health plans—and the evidence is replicable, scalable, and measurable: ***using incentives to change behaviors, reducing out of pocket costs, and improving the health status of populations is achievable.*** Our collective results should help to re-direct the policy discussion to the use of incentives to drive the value of health dollars and the use of value-based benefit designs to drive better financial and health outcomes.

The Kaiser Foundation, in a recent post from Drew Altman, notes: "…we need to weed out unnecessary care, get the best value we can for our health care dollar, and rein in the rate of increase in health spending… Today, it is vital that our Medicare beneficiaries have access to appropriate treatments, as our nation endeavors to reduce the total healthcare cost trend and concurrently reduce exacerbated health conditions. It is a balancing act that may be difficult – but not impossible – to achieve. The key to success may rest upon our collective abilities to implement appropriate incentives that generate better health outcomes. [1]

The Centers for Medicare and Medicaid Services (CMS) recently recommended policy changes to its Medicare Advantage (Medicare Part D) plans that could impair efforts to control healthcare costs in this country. While its authors define the concepts of prevention and wellness, promote the management of chronic disease to avoid unnecessary conditions and costs, and endorse incentives (rewards) designed to change healthcare behaviors, the policy specifically excludes incentives through co-pay or co-insurance for chronically ill beneficiaries and high-value medications that target chronic conditions. These barriers to the implementation of incentives actually reduce their impact and have the potential to reduce any measurable progress.

Incentives drive real life business-based results in commercial settings that have been actuarially defined and are documented:

| Company | # Employees | Value-Based Design | Quality Improvement | Dividend |
|---|---|---|---|---|
| **Caterpillar**[2] | 40,000 Employees, 90,000 Covered Lives | Moved all generic statins [for cholesterol mgt] to $0 copay for all employees; brand name statins are either $35/mo. or no benefit paid, depending upon dose. | Increased compliance with medication | Savings to CAT $750,000/month<br><br>Savings to Patients $175,000/mo |
| **QuadMed Quad/Graphics**[3] | 9,500 Employees | Diabetes patients receive all services and Rx treatment at waived co-pay if they participate in diabetes mgt program and are compliant with treatment regimens | Increased compliance<br><br>Reduction in HbA1C, Hypertension, Cholesterol | Reduction in health cost trend year-over-year to 4.9%; reduction in PEPY costs to $6948 v Wisconsin benchmark of $9711 |
| **City of Springfield Or**[4] | 430 Employees | Waived co-pays for diabetes Rx, labs, clinician visits; mandatory disease mgt includes pharmacy counselor for 50% of participants [to measure the effect of pharmacy counselor on outcomes] | Participants:<br><br>Reduced their HbA1C to <7 (30% drop in HbA1C)<br><br>Decreased their LDL cholesterol 5.8mg/dl | Participants who received face-to-face counseling from pharmacy counselors reduced their sick days by 21% |

These types of incentives are also reflected in a recent analysis of the current structure of the Medicare Part D program which identified several options for implementing value-based insurance design (VBID), including:[5]

Option 1: Reduce cost sharing for specific drugs or drug classes. *Targeting specific drugs or drug classes is an option that CMS can implement under current law, and has the potential to affect approximately 6 million Part D enrollees with diabetes, as an example.*

Option 2: Exempt specific drugs or drug classes from 100 percent cost sharing in the coverage gap. *While affecting fewer beneficiaries, it targets those patients with high annual drug spending who may benefit most from this type of intervention, reducing the need for rescue treatments while reducing the expansion of co-morbid conditions.*

Option 3: Reduce cost sharing for enrollees with chronic conditions. *This has the potential to reach a large number of Part D beneficiaries and could be a cost-effective approach to implementing value-based benefit design, but the potential legislative and regulatory changes required appear to be barriers to its implementation, making this a less attractive option.*

Option 4: Reduce cost sharing for enrollees participating in medication therapy management programs (MTMPs). *This is an interesting opportunity to demonstrate the value of value-based benefit design, despite potential legislative challenges in authorizing such an option.*

The Center for Health Value Innovation believes that legislative and regulatory changes at both state and federal levels should encourage the use of incentives that reduce out-of-pocket costs for those with chronic conditions, and the incentives should be linked to behaviors that drive improved compliance and persistence in the affected population, encouraging and supporting the patient's health management. Incentives that reduce co-pays are an important tool for encouraging better health choices, especially among America's most vulnerable – lower income patients, those with multiple chronic conditions, and the elderly.

Considering that 75 percent of the population over the age of 65 years takes at least one prescription medication, and that the average number of medications taken by those over 65 may be four or more, the issue of non-adherence affects a majority of elderly people,[6] many of whom do not have an established medical home and a personal physician. Out-of-pocket costs that are shifted to these vulnerable patients present a potentially harmful scenario to many Americans who rely on Medicare Advantage and Medicare as a whole. With the economic changes that have affected many retirees' pensions and savings, the treatment compliance within Medicare Advantage could be greatly reduced due to choices between active health management and other basic needs such as housing and food. Furthermore, actual enrollment into Medicare Advantage plans may decline because the "donut hole" confronting seniors poses even greater barriers.

Co-pay incentives must be tied to benefit designs that improve health, such as chronic condition and disease management, exercise/nutrition, life coaching, and use of personal health records, to name a few. They should be tailored for specific groups -- neither positioned as a permanent feature of a benefit design nor as criteria for choosing a benefit design. A strategic imperative is to focus upon attainable behaviors and goals that are satisfactory to both patient and provider. Incentives should comply with medication adherence to improve quality of life while reducing emergency room visits, hospital inpatient days, and unnecessary physician office visits as well as costly adverse events that exhaust precious resources.

Applying co-pay incentives as part of benefit design improves processes in the primary care office setting, enhances access for patients, and yields financial value -- not to mention better outcomes for patients, the system, and entire communities. Applying the incentives into the yearly benefit design avoids the costly and complicated adjudication processes of quarterly review for "eligibility." The goal should be to remove access barriers for vulnerable populations so that persistence and quality are achieved and value is secured.

**Conclusion**

Ultimately, the staggering cost of non-adherence among the chronically ill weakens the entire health care system. A co-pay incentive program is a critical tool for reducing

health cost inflation. Removing the economic barrier to treatment encourages those suffering chronic illness to maintain their prescribed regimens. Further, reducing co-pays better enables patients to continue beneficial relationships with the nurses and pharmacists who monitor changes in their weight, blood pressure, and other critical measures of chronic condition stability. In the end, improved compliance reduces more expensive treatments and improves outcomes, adding value to every health care dollar spent.

It is incumbent upon government leaders at CMS to re-frame the required criteria for Medicare Advantage. To re-emphasize the Altman quote: The key to success may rest upon our collective abilities to implement appropriate incentives that generate better health outcomes.

We agree whole-heartedly with this message, and we are ready to share our collective experiences and wisdom in driving the value of our health dollars.

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[1] Altman, Drew; *Jobs, A Reason to Fast Track Coverage; Kaiser Family Foundation,* "Pulling It Together, From Drew Altman"; March 2009; http://www.kff.org/pullingittogether/031709_altman.cfm; Accessed March 18, 2009

[2] Taylor, presentation at Employer Health and Human Capital conference, Feb 4 2009

[3] Zastrow, presentation at Employer Health and Human Capital conference, Feb 4, 2009

[4] Belknap, A. Case Study for Springfield OR. www.vbhealth.org.

[5] Murphy, Lisa; Carloss, Jenny; Brown, Ruth E.; Heaton, Erika; Carino, Tanisha; Fendrick, A. Mark; Chernew, Michael; Rosen, Allison B.; *Value-Based Insurance Design in the Medicare Prescription Drug Benefit: An Analysis of Policy Options*; March 2009

[6] Spiers, Mary V., Kutzik, David M., and Lamar, Melissa; *Variation in Medication Understanding Among the Elderly*; American Journal of Health-System Pharmacy; March 17, 2004; http://www.medscape.com/viewarticle/470832

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The Center for Health Value Innovation is a multi-stakeholder alliance focused on employers that drives the financial value of health dollars. www.vbhealth.org.

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