Changing the Health Care Cost Discussion from "How much" to "How well"

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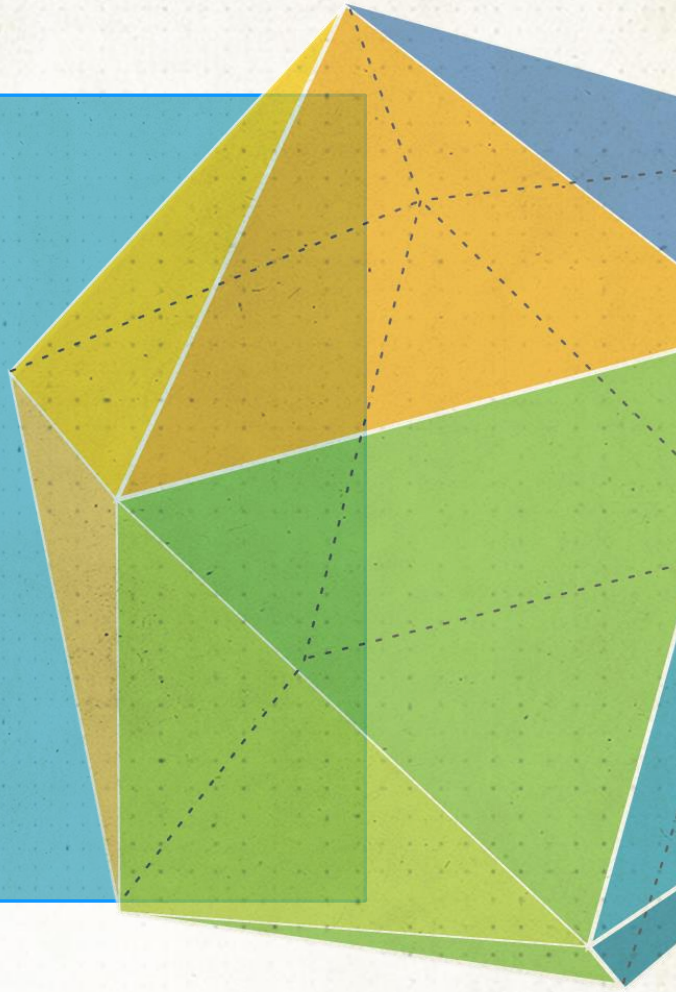
Session Outline

- Problem: ”One size fits all”
- Solution: “Clinical Nuance”
- Approach: Identify the ”Good Stuff” and the ”Bad Stuff”



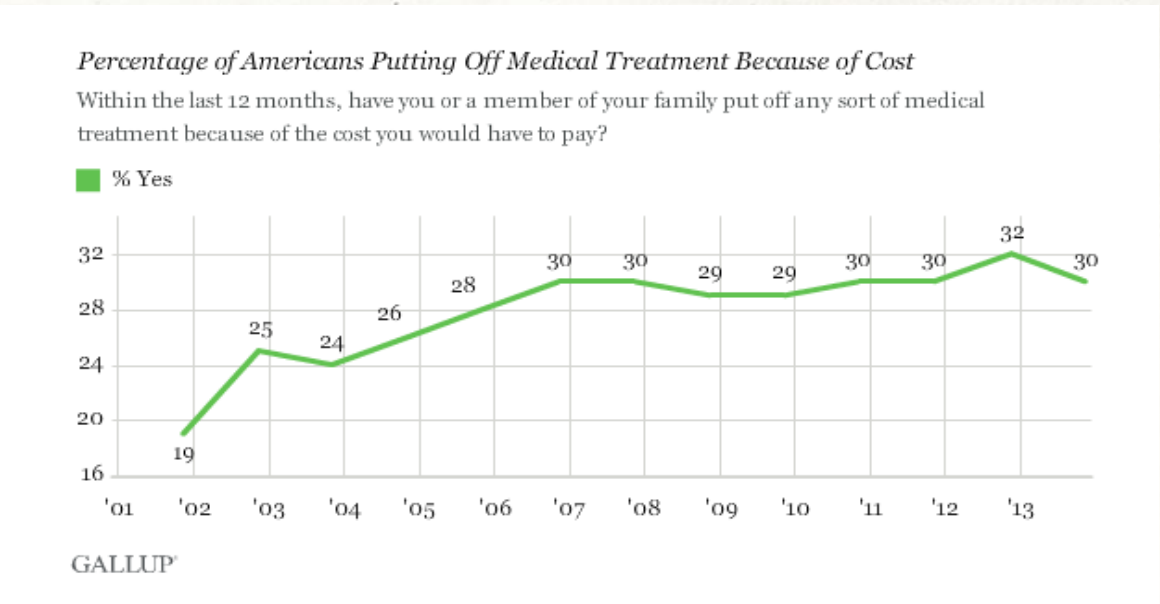
Improving Care and Bending the Cost Curve

- The past several decades have produced remarkable innovations resulting in impressive improvements in individual and population health
- Regardless of these advances, cost growth remains the principle focus of health reform discussions
- Despite clear evidence of clinical benefit, high-value services are underused across the entire spectrum of care
- Billions of dollars are spent on services that provide no clinical benefit and may cause harm
- Given systematic underuse, overuse and misuse, the cost discussion should change from *how much* to *how well* our health care dollars are spent

Problem: Misguided Financia Incentives for Clinicians and Consumers

- Ideally, reimbursement models and consumer cost-sharing would be set to encourage the clinically appropriate use of health care services
- Fee for service payment and an archaic “one-size-fits-all” approach to consumer cost sharing fails to acknowledge the differences in clinical value among medical interventions

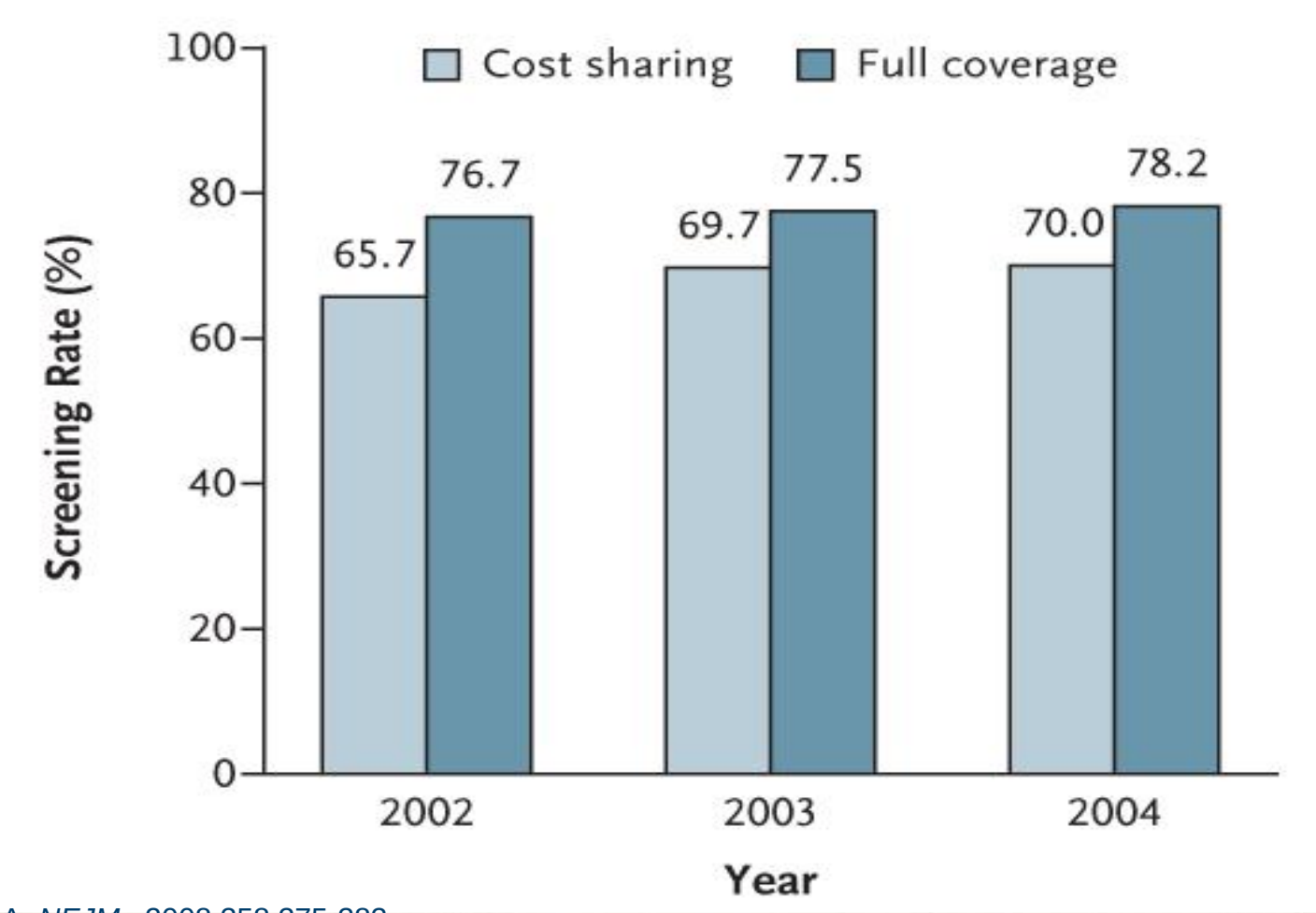
Impact of Increases in Consumer Cost-Sharing on Health Care Utilization



A growing body of evidence concludes that increases in consumer cost-sharing leads to a reduction in the use of essential care, which worsens health disparities, and in some cases leads to greater overall costs

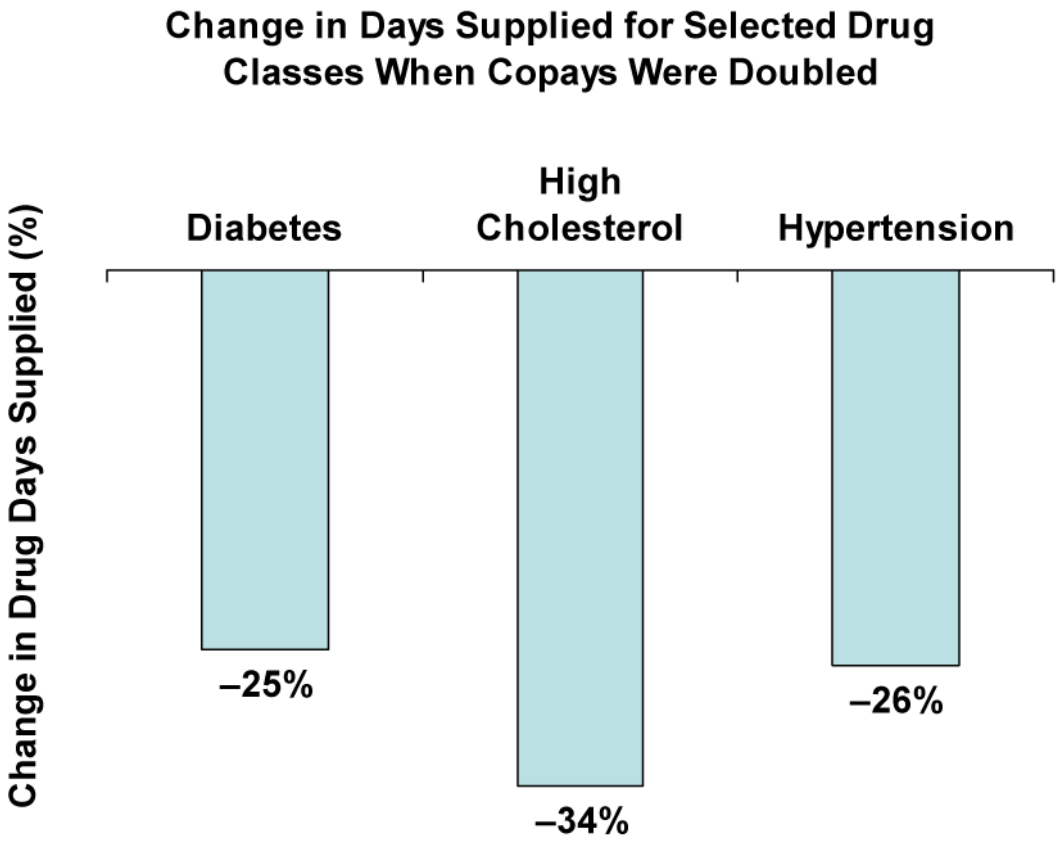
Goldman D. *JAMA*. 2007;298(1):61–9. Trivedi A. *NEJM*. 2008;358:375-383. Trivedi A. *NEJM*. 2010;362(4):320-8.. Chernew M. J Gen Intern Med 23(8):1131–6.

Cost-sharing Affects Mammography Use by Medicare Beneficiaries



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

High Copays Reduce Adherence to Appropriate Medication Use



- 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.

Goldman DP et al. *JAMA*. 2004;291:2344-2350.

Effects of Increased Copayments for Ambulatory Visits for Medicare Advantage Beneficiaries

Copays increased:

- from $7.38 to $14.38 for primary care
- from $12.66 to $22.05 for specialty care
- remained unchanged at $8.33 and $11.38 in controls

In the year after copayment increases:

- 19.8 fewer annual outpatient visits per 100 enrollees
- 2.2 additional hospital admissions per 100 enrollees
- Effects worse in low-income individuals and beneficiaries with chronic illness

Trivedi A. *NEJM*. 2010;362(4):320-8..

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]

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- Rising copayments may worsen disparities and adversely affect health, particularly among patients living in low-income areas.

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

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:

Clinical Nuance: Short Term Cost Savings Require "Carrots" and "Sticks"

- An opportunity exists for a cost-saving reallocation - within any health budget - through increasing use of high-value interventions and simultaneously reducing the use of services that offer no clinical benefit

Implementing Clinical Nuance: Value-Based Insurance Design

- Sets consumer cost-sharing level on clinical benefit – not acquisition price – of the service
- Mitigates concerns over cost-related non-adherence of high value clinical services
- Successfully implemented by hundreds of public and private payers
- Broad stakeholder support


WSJ.com 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's pay
drug should depend on how much he or she will bene
medication -- a move that would likely lower co-pay
many Americans.

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Value-Based Insurance Design
Broad Multi-Stakeholder Support

- HHS
- CBO
- SEIU
- MedPAC
- Brookings Institution
- The Commonwealth Fund
- NBCH
- PCPCC
- PhRMA
- AHIP
- National Governor's Assoc.
- Academy of Actuaries
- Bipartisan Policy Center
- Kaiser Family Foundation
- NBGH
- National Coalition on Health Care
- Urban Institute
- RWJF
- IOM
- US Chamber of Commerce

Lewin. *JAMA.* 2013;310(16):1669-1670

Evidence Supporting Value-Based Insurance Design:

- Most V-BID programs focus on removing financial barriers "carrots" to high-value prescription drugs used to treat chronic conditions (e.g., diabetes, asthma, heart disease)
- Evidence review
  - Improved adherence [1]
  - Lower consumer costs [1]
  - No increase in total spending [1]
  - Reduction in health disparities [2]

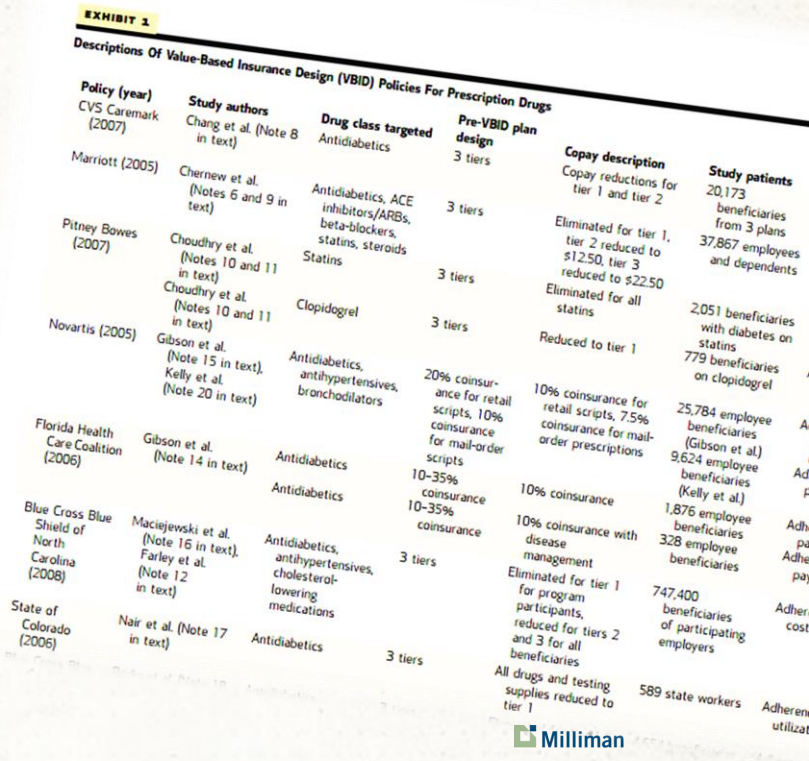

EXHIBIT 1

Descriptions Of Value-Based Insurance Design (VBID) Policies For Prescription Drugs

Policy (year)	Study authors	Drug class targeted	Pre-VBID plan design	Copay description	Study patients
CVS Caremark (2007)	Chang et al. (Note 8 in text)	Antidiabetics	3 tiers	Copay reductions for tier 1 and tier 2	20,173 beneficiaries from 3 plans
Marriott (2005)	Chernew et al. (Notes 6 and 9 in text)	Antidiabetics, ACE inhibitors/ARBs, beta-blockers, statins, steroids	3 tiers	Eliminated for tier 1, tier 2 reduced to $12.50, tier 3 reduced to $22.50	37,867 employees and dependents
Pitney Bowes (2007)	Choudhry et al. (Notes 10 and 11 in text)	Statins	3 tiers	Eliminated for all statins	2,051 beneficiaries with diabetes on statins
	Choudhry et al. (Notes 10 and 11 in text)	Clopidogrel	3 tiers	Reduced to tier 1	779 beneficiaries on clopidogrel
Novartis (2005)	Gibson et al. (Note 15 in text), Kelly et al. (Note 20 in text)	Antidiabetics, antihypertensives, bronchodilators	20% coinsurance for retail scripts, 10% coinsurance for mail-order scripts	10% coinsurance for retail scripts, 7.5% coinsurance for mail-order prescriptions	25,784 employee beneficiaries (Gibson et al.) 9,624 employee beneficiaries (Kelly et al.)
Florida Health Care Coalition (2006)	Gibson et al. (Note 14 in text)	Antidiabetics	10–35% coinsurance	10% coinsurance	1,876 employee beneficiaries
		Antidiabetics	10–35% coinsurance	10% coinsurance with disease management	328 employee beneficiaries
Blue Cross Blue Shield of North Carolina (2008)	Maciejewski et al. (Note 16 in text), Farley et al. (Note 12 in text)	Antidiabetics, antihypertensives, cholesterol-lowering medications	3 tiers	Eliminated for tier 1 for program participants, reduced for tiers 2 and 3 for all beneficiaries	747,400 beneficiaries of participating employers
State of Colorado (2006)	Nair et al. (Note 17 in text)	Antidiabetics	3 tiers	All drugs and testing supplies reduced to tier 1	589 state workers

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[1] *Health Affairs*. 2013;32(7):1251-1257 [2] *Health Affairs*.. 2014;33(5):863-70

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Emerging Best Practices in V-BID Implementation

An evaluation of 76 V-BID plans [1] identified program features that had significant impact on improvement in medication adherence:

- Magnitude of reduction in cost-sharing levels
- Targeting of high-risk individuals
- Offered with a wellness program
- Avoided disease management
- Used mail-order prescription delivery

[1] *Health Affairs*. 2014;33(3):493-501.

Evidence for Value-Based Insurance Design: MI-FREEE: Better Quality Without Higher Costs

- Assessed impact of elimination of consumer cost-sharing for preventive medications for Aetna commercial plan members with history of myocardial infarction (i.e. heart attack) [1]
- Random assignment by plan sponsor to either elimination of cost-sharing or usual cost-sharing levels
- "Enhanced prescription coverage improved medication adherence and rates of first major vascular events and decreased patient spending without increasing overall health costs." [1]

[1] *N Engl J Med*. 2011;365(22):2088–97.

Evidence for Value-Based Insurance Design: MI-FREEE: Reducing Health Care Disparities

The MI-FREEE study assessed impact of elimination of consumer cost-sharing for preventive medications for Aetna commercial plan members with history of myocardial infarction (i.e. heart attack) [1]

Among MI-FREEE subjects who self-identified as being non-white, the elimination of cost-sharing [2]

- Significantly reduced rates of a post-MI vascular event or revascularization
- Reduced total health care spending by 70 percent

[1] *N Engl J Med*.2011;365(22):2088–97. [2] *Health Affairs*. 2014;33(5):863-70

Need for Savings Drives Momentum for "Stick" V-BID Programs

- "Carrot" programs do not lead to immediate cost savings
- Programs that discourage use of low-value services are increasingly being explored
- Oregon Public Employees
  - Higher cost sharing on selected imaging and diagnostic studies led to 15% - 30% decreased use

Growing Momentum to Identify Wasteful Medical Spending

- Available evidence suggests that significant opportunities exist to save money without sacrificing high-quality care
  - The Congressional Budget Office has concluded that up to 30 percent [approximately $700 billion] of the $2.5 trillion in annual health care spending is unnecessary
- Removing waste and unnecessary care from the system will help achieve the “Triple Aim”
  - Improve health outcomes
  - Enhance the patient experience by reducing harm
  - Lower cost to consumers and third party payers

Challenge of Identifying Low-Value Services: Clinical Nuance Revisited

- Although there is urgency to bend the health care cost curve, cost containment efforts should not produce avoidable reductions in quality of care
- Many services identified as high-value in certain clinical scenarios are considered low-value when used in other patient populations or delivery settings
  - Coronary artery stenting
  - Imaging for back pain
  - Colorectal cancer screening using colonoscopy

Health Waste Calculator: Capitalizing on Momentum to Identify Waste

- VBID Health collaborated with Milliman to create a new health care analytic solution powered by Milliman's MedInsight software
- The *Health Waste Calculator* is a standalone software tool designed to help health care organizations leverage clinically nuanced principles by identifying wasteful services
- The tool identifies and quantifies the use of unnecessary or harmful clinical services, including those defined by initiatives such as the U.S. Preventive Services Task Force and *Choosing Wisely*

Barriers to V-BID in HSA-qualified HDHPs

- IRS guidance documents specifically exclude from the definition of preventive care those services or benefits meant to treat “an existing illness, injury or condition
- Confusion persists what services can and cannot be covered outside of the deductible


April 2012

V-BID Center

brief

EVIDENCE, EXAMPLES, AND INSIGHT ON VALUE-BASED INSURANCE DESIGN

Value-Based Insurance Design: Contributions to Consumer Health in Consumer-Directed Health Plans[1]

A consumer-directed health plan (CDHP) is an insurance product that offers lower premiums in exchange for higher patient deductibles than traditional plans. People who use CDHPs are responsible for paying for most of their routine care. The goal of CDHPs is to make customers more cost-conscious about the care they use, theoretically saving money on foregone services and lowering prices for consumers. In 2010, 28 million people were enrolled in a CDHP; in the same year nearly half of all employers reported that they planned to offer a CDHP to their employees within five years.[2]

CDHPs have faced criticism because the higher deductibles may cause patients to use less care. Research shows that when cost sharing is increased, consumers will forgo needed as well as unneeded care, and are likely to have poorer health as a result.[3-4,5] CDHP consumers with chronic diseases

ductibles in most CDHP plans.[6] V-BID is an innovative and widely implemented approach to providing health benefits that seeks to enhance patients' clinical outcomes and constrain health care cost growth. By reducing barriers to high-value, evidence-based services and providers (often through lower costs and other patient incentives) V-BID plans can achieve improved health outcomes at any level of health care expenditure. A V-BID waiver program would ensure that consumers are not deterred from receiving needed treatment (high-value care), while preserving disincentives to care without demonstrated effectiveness (low-value care), enhancing the quality of CDHPs while preserving the overall affordability of the plans.

The key to a V-BID program is clinical

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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

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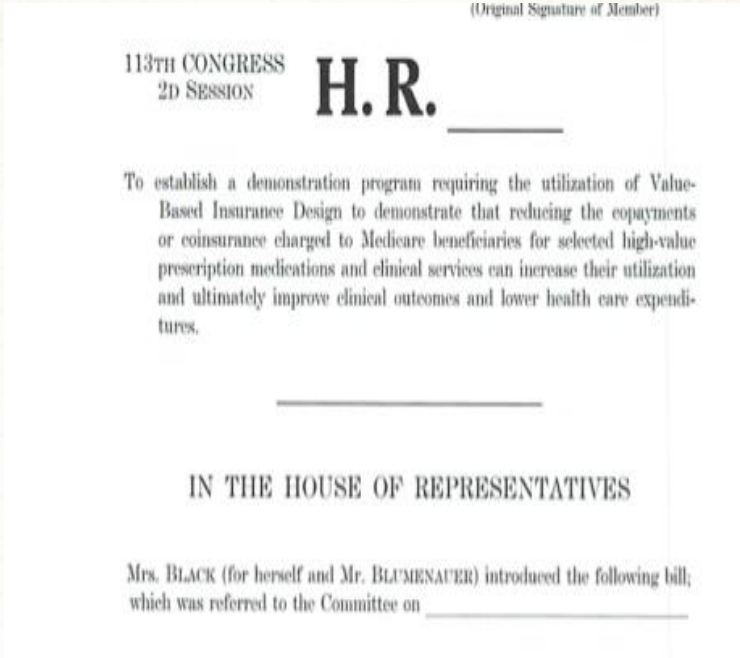
HR 5183/S.2783: Bipartisan " V-BID for Better Care Act of 2014"

- Directs HHS to establish a demonstration program to test V-BID in MA for beneficiaries with chronic conditions
- MA plans may lower cost-sharing to encourage the use of specific, evidence-based medications or services and/or specific high-performing providers

HR 5183: The Value-Based Insurance Design for Better Care Act of 2014



(Original Signature of Member)

113TH CONGRESS
2D SESSION

H. R. _____

To 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.

IN THE HOUSE OF REPRESENTATIVES

Mrs. BLACK (for herself and Mr. BLUMENAUER) introduced the following bill; which was referred to the Committee on _____

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Using Clinical Nuance to Align Payer and Consumer Incentives: As Easy as Peanut Butter and Jelly

Many “supply side” initiatives are restructuring provider incentives:

- Payment reform
  - Global budgets
  - Pay-for-performance
  - Bundled payments
  - Accountable care
- Tiered networks
- Health information technology

AJAC. 2014;2(3);10.

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Using Clinical Nuance to Align Payer and Consumer Incentives: As Easy as Peanut Butter and Jelly

Unfortunately, “supply-side” initiatives have historically paid little attention to consumer decision-making or the “demand-side” of care-seeking behavior:

- Benefit design
- Shared decision-making
- Literacy

AJAC. 2014;2(3);10.

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Using Clinical Nuance to Align Payer and Consumer Incentives: As Easy as Peanut Butter and Jelly

- The ultimate test of health reform will be whether it improves health and addresses rising costs
- Adding clinical nuance to payment reform and consumer engagement initiatives can help improve quality of care, enhance patient experience, and contain cost growth by removing waste

AJAC. 2014;2(3);10.

Questions?

For more information, please contact:

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610.247.0461

Health Waste Calculator: Capitalizing on Momentum to Identify Waste

- *Waste Calculator* algorithms process claims or electronic health record data to quantify potentially wasteful services
- For each potentially inefficient service, the *Calculator* provides a degree of appropriateness for care:
  - A ***wasteful*** score, flags a cause for concern as the service should not have been delivered
  - A ***likely to be wasteful*** score, indicates the need to question the appropriateness of service rendered
  - A ***necessary*** score, suggests appropriate services were administered by the health care provider
- Milliman benchmarks are bundled into the reporting package to improve the comparative analysis process