University of Michigan
Center for Value-Based Insurance Design

UNITED STATES HOUSE OF REPRESENTATIVES WAYS AND MEANS SUBCOMMITTEE ON HEALTH

TESTIMONY:

THE ESSENTIAL ROLE OF CLINICAL NUANCE IN MEDICARE'S BENEFIT DESIGN

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Statement of:

A. Mark Fendrick, MD

Professor of Internal Medicine and Health Management & Policy

Director, Center for Value-Based Insurance Design

University of Michigan

Good morning and thank you, Chairman Brady, Ranking Member McDermott, and Members of the Subcommittee. I am Mark Fendrick, Professor of Internal Medicine and Health Management & Policy at the University of Michigan. I am addressing you today, not as a representative of the University, but as a practicing primary care physician, a medical educator, and a public health professional. I have devoted much of the past two decades to studying the United States health care delivery system and founded the University's Center for Value-Based Insurance Design [www.vbidcenter.org] in 2005 to develop, implement and evaluate innovative payment initiatives and health insurance designs intended to ensure efficient expenditure of health care dollars and maximize benefits of care.

Mr. Chairman, I applaud you for holding this hearing on "Examining Traditional Medicare's Benefit Design," because quality improvement and health care cost containment are among the most pressing issues for our national well-being and economic security. We are well aware that the U.S. spends far more per capita on health care than any other country, yet lags behind other nations that spend substantially less on key health quality and population health measures. However, research shows that if we reallocated our health care dollars to services for which there is clear evidence for improving clinical outcomes, we could simultaneously enhance quality and reduce the amount we spend. There is consistent agreement among stakeholders that there is already enough money being spent on health care. Thus, instead of the unwavering focus on *how much* we spend – I suggest we shift our attention to *how well* we spend our increasingly scarce health care dollars in order to maximize the amount of health produced for each dollar spent.

FROM A VOLUME-DRIVEN TO VALUE-BASED SYSTEM

Moving from a volume-driven to value-based delivery system requires a change in both how we pay for care (supply side initiatives) and how we engage consumers to seek care (demand side initiatives). Other testimonies today and at earlier Committee hearings have focused on the critical importance of reforming care delivery and payment policies. These are important and worthy conversations. Prior to this hearing, little attention has been directed to how we can alter consumer behavior as a policy lever to bring about a more effective and efficient delivery system. While you have heard about the potential of Accountable Care Organizations, Patient-Centered Medical Homes, bundled payment models, and other initiatives to influence providers, today I propose that **value-driven consumer incentives - through benefit designs that promote smart decisions and enhanced personal responsibility - must be aligned with payment reform initiatives for us to really "bend the cost curve" for health care**. As noted in Mr. Hackbarth's testimony, MedPAC's 2012 Report to Congress recognized the importance of beneficiary decision-making, and I commend the Subcommittee for exploring this matter today.

DANGERS OF A BLUNT APPROACH TO BENEFICIARY COST-SHARING – THE IMPORTANCE OF "CLINICAL NUANCE"

Over the past few decades, public and private payers have implemented multiple managerial tools to constrain health care cost growth with varying levels of success. The most common approach to directly impact consumer behavior is cost shifting: requiring beneficiaries to pay more in the form of increased premiums and increased cost-sharing for clinician visits, diagnostic tests and prescription drugs. With some notable exceptions, most US health plans—including Medicare—implement cost-sharing in a "one size fits all" way, in that beneficiaries are charged the same amount for every doctor visit, diagnostic test, and prescription drug [within a specified formulary tier]. As Americans are required to pay more to visit their clinicians and fill their prescriptions, a growing body of evidence demonstrates that increases in patient cost-sharing lead to decreases in the use of both non-essential <u>and</u> essential care. Peer-reviewed studies reveal that when patients are asked to pay more for high-value cancer screenings, clinician visits and potentially life-saving drugs, they buy significantly less.

A noteworthy example is a *New England Journal of Medicine* study that examined the effects of increases in copayments for doctor visits in Medicare Advantage plans [Trivedi A. *N Engl J Med*. 2010;362(4):320-8]. As expected, individuals who were charged more to see their physician went less often; however, these patients were hospitalized more frequently, and their total medical costs increased. While this blunt approach may reduce expenditures in the short-term, higher rates of noncompliance may lead to inferior health outcomes and higher overall costs in certain clinical circumstances. This seemingly counterintuitive effect simply demonstrates that the age-old aphorism, "penny wise and pound foolish," applies to health care.

Conversely, decreases in cost-sharing applied to all services regardless of clinical benefit - which may be the case in certain Medicare supplemental insurance products - can lead to overuse or misuse of services that are potentially

harmful or provide little clinical value. **To efficiently reallocate medical spending and optimize population health, the basic tenets of clinical nuance must be considered. These tenets recognize that: 1) medical services differ in the benefit provided; and 2) the clinical benefit derived from a specific service depends on the patient using it.**

Does it make sense to you, Mr. Chairman, that my Medicare patients pay the same copayment to see a cardiologist after a heart attack as a dermatologist for mild acne, or that the patient copayment is the same for a drug that could save a life from cancer as it is to make toenail fungus go away? On the $4 generic drug tier available to most Americans, there are drugs so valuable I have often reached into my own pocket to help patients fill these prescriptions; while for the same price, there are also drugs of such dubious safety and efficacy, I honestly would not give them to my dog. Our current "one size fits all" system lacks clinical nuance, and frankly, to me, makes no sense. Chairman Brady, in your announcement for this hearing, you stated, "There is bipartisan recognition that the current structure of the Medicare benefit is outdated, confusing, and in need of reform, and taking steps to improve the current array of confusing deductibles, copayments and coinsurance is long overdue." I could not agree more. Only after we acknowledge the limitations, inefficiencies and inadequacies of Medicare's cost-sharing structure, can we identify ways to improve it. Medicare beneficiaries avail themselves of too little high-value care and too much low-value care. We need benefit designs that support consumers in obtaining evidence-based services such as diabetic retinal exams and life-saving drugs through lower cost-sharing (when clinically indicated), and discourage individuals through higher cost-sharing from using dangerous or low-value services such as those identified by professional medical societies in the Choosing Wisely initiative. Payers, purchasers, beneficiaries and taxpayers can attain more health for every dollar spent by incorporating greater clinical nuance into benefit design.

VALUE-BASED INSURANCE DESIGN [V-BID]

More than a decade ago, the private sector began to implement a concept our team developed known as Value-Based Insurance Design, or V-BID, in response to the lack of clinical nuance in available public and commercial health plans. **The basic V-BID premise calls for reducing financial barriers to evidence-based services and high-performing providers and imposing disincentives to discourage use of low value care.** A V-BID approach to benefit design recognizes that different health services have different levels of value. It's common sense—when barriers to high-value treatments are reduced and access to low-value treatments is discouraged, these plans result in better health at any level of care expenditure.

Let me be clear, Mr. Chairman, I am not asserting that using clinical nuance in benefit design is the single solution to all of Medicare's problems. But, if we are serious about "bending the health care cost curve" and improving health outcomes, we must change the incentives for consumers as well as those for providers. **Cost containment through blunt changes to Medicare benefit design must not produce avoidable reductions in quality of care,** and therefore should include clinically driven, not exclusively price driven, strategies.

Your Subcommittee is currently examining many exciting, some unproven, supply-side payment reform initiatives such as bundled payments, pay for performance, Patient-Centered Medical Homes, and ACOs. If these initiatives provide incentives to clinicians to recommend the right care, it is of equal importance that incentives for the patients are aligned with these goals as well. As a physician practicing in a medical home, **it is incomprehensible to realize that my patients' insurance coverage does not offer easy access for those exact services for which I am benchmarked**. Does it make sense that I am offered a financial bonus to get my patient's diabetes under control when the benefit design makes it prohibitively expensive to fill their insulin prescription or provide the copayment for their eye examination?

I'm pleased to tell you that the intuitiveness of a clinically nuanced design is driving momentum at a rapid pace in the private sector, and we are truly at a "tipping point" in its adoption. Hundreds of private self-insured employers, public organizations, non-profits, and insurance plans have designed and tested value-based programs. Just a few recent examples include the Connecticut State Employees' Health Enhancement Program, UnitedHealth Group's Diabetes Health Plan, Aetna, and Blue Shield of California's "Blue Groove" Plan, each of which provide incentives for individuals with chronic diseases to seek the right care at the right time from the right provider.

TRADITIONAL MEDICARE: LIMITS TO IMPLEMENTING CLINICAL NUANCE IN BENEFIT DESIGN

Medicare is a key component of our nation's commitment to take care of the elderly and disabled among us, and we all agree that the program must be sustained for future generations. Although there are some noteworthy advances implementing clinical nuance, such as the requirement that Medicare, the Federal Employee Health Benefits Programs, and private plans provide selected primary preventive services with no patient cost-sharing [Section 1001 of the Patient Protection and Affordable Care Act [PPACA] and section 2713 of the Public Health Service Act], **traditional Medicare is constrained by a set of rules and laws that allow little flexibility to implement clinically-driven, value enhancing strategies.**

Two specific features of Traditional Medicare can be viewed as potential barriers to innovation. First, Traditional Medicare beneficiaries have complete freedom regarding provider choice. Second, current benefit design generally does not allow for clinically nuanced cost-sharing. Specifically, program administrators cannot lower cost-sharing levels for a guideline recommended service such as a diabetic retinal eye exam, and they are limited in how much they can adjust coinsurance rates upward for a wasteful imaging test or harmful procedure. This lack of flexibility is highly problematic, and it fails to recognize the well-accepted notion that health care services differ in the clinical benefit achieved.

Although the "one size fits all" approach to Medicare copayments dates back to its inception in the 1960s, expert groups such as the Medicare Payment Advisory Commission (MedPAC) have repeatedly advocated for the use of V-BID as a strategy for improving quality and lowering the rate of cost growth. For example, in its 2012 Report to Congress, MedPAC references the potential benefit of implementing V-BID concepts to encourage the use of high-value services for improved health outcomes. Additionally, in 2009, Senators Hutchison and Stabenow introduced a bipartisan bill, S.1040 "Seniors' Medication Copayment Reduction Act of 2009," to allow a demonstration of V-BID within Medicare Advantage plans.

INFUSING 'CLINICAL NUANCE' INTO MEDICARE ADVANTAGE

As sweeping changes to the Traditional Medicare program are difficult to enact, an interim step could be to legislate moderate changes to the Medicare Advantage program. In contrast to the Traditional Medicare program, Medicare Advantage incorporates a system of competing private health plans. In theory, Medicare Advantage can implement innovative programs designed to improve value by applying techniques successfully implemented in the commercial health insurance market. In reality, the tools available to Medicare Advantage are limited, and include network formation, provider facing-interventions (like performance bonuses), and utilization management programs. The use of these blunt instruments often does not align economic incentives with clinical value and hinders plan ability to design benefits to promote quality and efficiency. **Additional flexibility in benefit design would allow Medicare Advantage to achieve greater efficiency and encourage personal responsibility among consumers.**

There are two major restrictions within the Medicare Advantage program that prevent clinical nuance and the promotion of high-value services and providers: (1) a lack of flexibility to steer patients to high value providers; and (2) a rigid, outdated benefit design. The standards for provider networks and non-discriminatory benefit designs were established in an effort to protect consumers from unfavorable practices such as predatory risk steering. While some of these provisions successfully improve consumer protection, they also severely limit innovation within the Medicare Advantage program and perpetuate a "one size fits all" approach to care delivery. Since these consumer protection standards prevent seniors from receiving the highest possible clinical benefits of care, they may be construed as undermining their original intent.

I. FLEXIBILITY IN IMPOSING DIFFERENTIAL COST-SHARING FOR USE OF DIFFERENT PROVIDERS OR SETTINGS

Since the value of a clinical service may depend on the specific provider or the site of care delivery, **Medicare Advantage plans should have the flexibility to vary cost-sharing for a particular outpatient service in accordance with who provides the service and /or where the service is delivered.** A recent report from The Commonwealth Fund Commission on a High Performance Health System estimated that $189 billion in savings to Medicare would accrue over 10 years if we were to "develop a value-based design that encourages beneficiaries to obtain care from high-performing care systems." This flexibility is increasingly feasible, as quality metrics and risk-adjustment tools become better able to identify high-performing health care providers and/or care settings that consistently deliver superior quality. For example, a Medicare Advantage plan might wish to impose a $50 copayment for an out of

network office visit, a $25 copayment for an in-network office visit, and a $0 copayment for an in-network office visit that takes place at a recognized patient-centered medical home (PCMH), that has demonstrated better performance on key quality measures. Existing rules prohibit this level of variance in beneficiary cost-sharing.

Currently, Medicare Advantage plans are allowed to create a provider network, but are limited in how they vary copays *within* that network. This restriction forces Medicare Advantage plans to either exclude low-performing providers completely, or permit access to them – no intermediate processes are allowed. Strict standardization in the cost sharing structures within a network severely hinders the ability of Medicare Advantage plans to promote high quality care and take steps to reduce waste and inefficiency.

The provider network requirements also create challenges for care coordination among providers. The inability to use incentives to encourage beneficiaries to access care across a specified provider group hinders the ability for practitioners to track progress, encourage proper follow-up, and prevent the need for costly services due to lack of medical adherence. This is particularly important as we seek a return from a multi-billion dollar investment in health information technology. While the long-term intent of electronic medical records is to seamlessly share data across all providers, currently the most common use is among providers in a designated group.

Improving provider choice is an essential tool that will allow plans to incorporate clinical nuance, enhance consumer engagement, and drive higher quality of care in Medicare Advantage products. **Network adequacy standards must allow issuers to create multi-tier cost sharing structures by encouraging and requiring different tiers of co-pays for services and providers that have proven high- and low-value outcomes.** Many stakeholders recognize the merit of permitting plans greater flexibility to incentivize beneficiaries to select high performing providers; the Medicare Payment Advisory Committee submitted these policy recommendations in the 2011 and 2012 Reports to Congress.

II. Flexibility in Imposing Differential Cost-Sharing for Use of Different Services

To date, most clinically nuanced designs have focused on lowering patient out-of-pocket costs (carrots) for high-value services. These are the services I beg my patients to do - for which there is no question of their clinical value - such as immunizations, preventive screenings, and critical medications and treatments for individuals with chronic disease such as asthma, diabetes and mental illness (e.g. as recommended by National Committee for Quality Assurance, National Quality Forum, professional society guidelines). Despite unequivocal evidence of clinical benefit, there is substantial underutilization of these high-value services across the spectrum of clinical care. Multiple peer-reviewed studies show that when patient barriers are reduced, compliance goes up, and, depending on the intervention or service, total costs go down.

Yet, from the payer's perspective, the cost of incentive-only "carrot" based V-BID programs depends on whether the added spending on high-value services is offset by a decrease in adverse events, such as hospitalizations and visits to the emergency department. While these high-value services are cost-effective and improve quality, many are not cost-saving – particularly in the short term. However, research suggests that non-medical economic effects—such as the improvement in productivity associated with better health—can substantially impact the financial results of V-BID programs.

While significant cost-savings are unlikely with incentive-only “carrot” programs in the short term, **a V-BID program that combines reductions in cost-sharing for high-value services and increases in cost-sharing for low-value services can both improve quality and achieve net cost savings.** Removing harmful / unnecessary care from the system is essential to reduce costs and improve quality and patient safety. Evidence suggests significant opportunities exist to save money without sacrificing high-quality care. For example, in 2011, the lowest available estimates of waste in the US health care system exceeded 20% of total health care expenditures. Though less common, some V-BID programs are designed to discourage use of low-value services and poorly performing providers. Low-value services result in either harm or no net benefit, such as services labeled with a D rating by the U.S. Preventive Services Task Force. **Many services that are identified as high quality in certain clinical scenarios are considered low-value when used in other patient populations, clinical diagnoses or delivery settings.** For example, cardiac catheterization, imaging for back pain, and colonoscopy can each be classified as a high- or low-value service depending on the clinical characteristics of the person, when in the course of the disease it is provided, and where it is delivered.

Fortunately, there is a growing movement to both identify and discourage the use of low-value services. The ABIM Foundation, in association with Consumers Union, has launched Choosing Wisely, an initiative where medical specialty societies identify commonly used tests or procedures whose necessity should be questioned and discussed. Thus far, twenty-six medical specialties have identified at least five low-value services within their respective fields while twelve additional societies are also preparing low-value services lists. Substantial cost savings are available from efforts such as Choosing Wisely. Savings of more than $5 billion were estimated if the recommendations of a recent top five overused clinical services list across three primary care specialties were implemented in practice. Thus, **programs that include both carrots and sticks may be particularly desirable in the setting of budget shortfalls.**

III. FLEXIBILITY IN IMPOSING DIFFERENTIAL COST-SHARING FOR CERTAIN SERVICES FOR SPECIFIC ENROLLEES

Since a critical aspect of clinical nuance is that the value of a medical service depends on the person receiving it, we recommend that Medicare Advantage plans be granted the flexibility to impose differential cost-sharing for specific groups of enrollees. **The flexibility to target enrollee cost-sharing based on clinical information (e.g., diagnosis, clinical risk factors, etc.) is a crucial element to the safe and efficient allocation of Medicare expenditures.** Under such a scenario, a plan may choose to exempt certain enrollees from cost-sharing for a specific service on the basis of a specific clinical indicator, while imposing cost-sharing on other enrollees for which the same service is not clinically indicated. Under such a clinically nuanced approach, plans can recognize that many outpatient services are of particularly high-value for beneficiaries with conditions such as diabetes, hypertension, asthma, and mental illness, while of low-value to others. (For example, annual retinal eye examinations are recommended in evidence-based guidelines for enrollees with diabetes, but not recommended for those without the diagnosis.) Without easy access to high-value secondary preventive services, previously diagnosed individuals may be at greater risk for poor health outcomes and avoidable, expensive, acute-care utilization. Conversely, keeping cost-sharing low for these services for all enrollees, regardless of clinical indicators, can result in overuse or misuse of services leading to wasteful spending and potential for harm.

Currently, Medicare Advantage plans are constrained by non-discrimination rules that prohibit plans from tailoring benefits to particular subgroups of patients who may receive particularly high value from a given service. If Medicare Advantage plans were to encourage use of a certain service by lowering copays, they must lower copays for everyone in the plan, even though clinical appropriateness may vary. In order to allow plans to incorporate the principles of clinical nuance in their Medicare Advantage products, the standards placed on these plans regarding targeting intervention by clinical circumstance should be updated.

Permitting "clinically nuanced" variation in copayments and coinsurance would give Medicare Advantage plans a necessary tool to incentivize beneficiaries to receive high-value services. This addition would eliminate many of the challenges and limitations of the "one size fits all" model. Medicare Advantage plans would then be able to target clinically appropriate populations for reduced cost-sharing for evidence-based high-value services and increased cost sharing for harmful services or those with unproven medical benefit.

CONCLUSION

It is my hope that as you consider changes to the Medicare benefit design, you will take the common-sense step of allowing co-payments to vary based on whether an intervention is high-value or low-value. As a practicing clinician, I believe that the goal of our health care system is to produce health, not to save money. That said, I strongly concur that health care cost containment is absolutely critical for our nation's fiscal health. Although there is urgency to bend the health care cost curve, cost containment efforts must not produce avoidable reductions in quality of care. **Applying clinical nuance in benefit design presents an enormous opportunity for the Medicare program.** If such principles encourage the utilization of high-value providers and services while discouraging only low-value services, Medicare Advantage plans can improve health, enhance consumer engagement, reduce costs, and mitigate legitimate concerns around "one size fits all" cost-sharing. Key stakeholders—including a large and growing number of medical professional clinical societies—agree that discouraging consumers from using specific low-value services and providers must be part of the strategy. As evidence-driven approaches to identify high- and low-value services and providers are coupled with carefully designed strategies for consumer education and communication, Medicare can produce more health at any level of health expenditure.

Thank you.