Changing the Health Care Cost Discussion from "How Much?" to "How Well?"

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Learning Objectives

1. Examine the relationship between cost-sharing and patient adherence.

2. Explain the concept of "clinical nuance" which recognizes 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, as well as when and where the service is provided.

3. Introduce Value-Based Insurance Design - a program where cost-sharing is based on an intervention's clinical benefit - not cost - to prioritize patients' out-of-pocket expenditures

4. Review existing evidence on Value-Based Insurance Design programs.

5. Overview of V-BID implementation in public and private payers

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.

Translating Research into Policy: 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, cost growth is the principle focus of health care 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**

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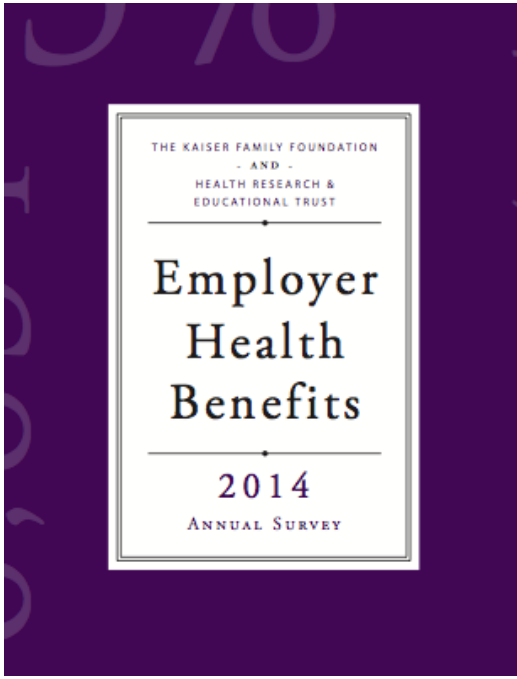
Role of Consumer Cost-Sharing in Clinical Decisions

- **For today's discussion, our focus is on costs paid by the consumer, not the employer or third party administrator**
- **Ideally consumer cost-sharing levels would be set to encourage the clinically appropriate use of health care services**
- **Instead, archaic "one-size-fits-all" cost-sharing fails to acknowledge the differences in clinical value among medical interventions**
- **Consumer cost-sharing is rising rapidly**



Health Affairs 2014. doi: 10.1377/hlthaff.2014.0792

V-BID

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 services, worsens health disparities, and in some cases leads to greater overall costs

The New York Times

Business D

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ECONOMIC VIEW

When a Co-Pay Gets in the Way of Health

By SENDHIL MULLAINATHAN
Published: August 10, 2013

ECONOMISTS specialize in pointing out unpleasant trade-offs — a skill that is on full display in the health care debate.

Enlarge This Image

Minh Uong/The New York Times

We want patients to receive the best care available. We also want consumers to pay less. And we don't want to bankrupt the government or private insurers. Something must give.

The debate centers on how to make these trade-offs, and who gets to make them. The stakes are high, and the choices are at times unseemly. No matter how necessary, putting human suffering into dollars and cents is not attractive work. It's no surprise, then, that the conversation is so heated.

What is a surprise is that amid these complex issues, one policy

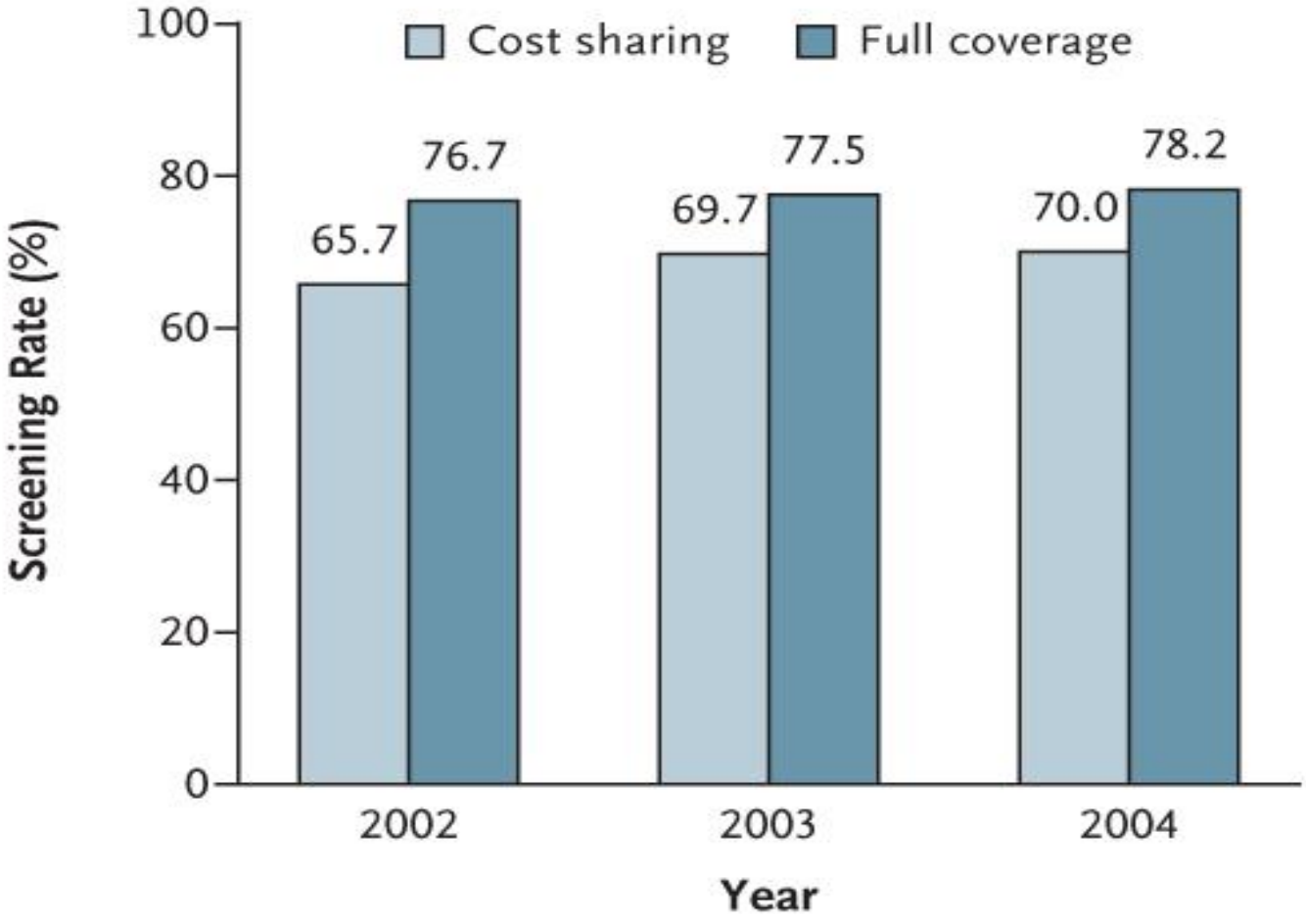
Goldman D. *JAMA*. 2007;298(1):61–9. Trivedi A. *NEJM*. 2008;358:375 2010;362(4):320-8.. Chernew M. J Gen Intern Med 23(8):1131–6.

Inspiration

"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."

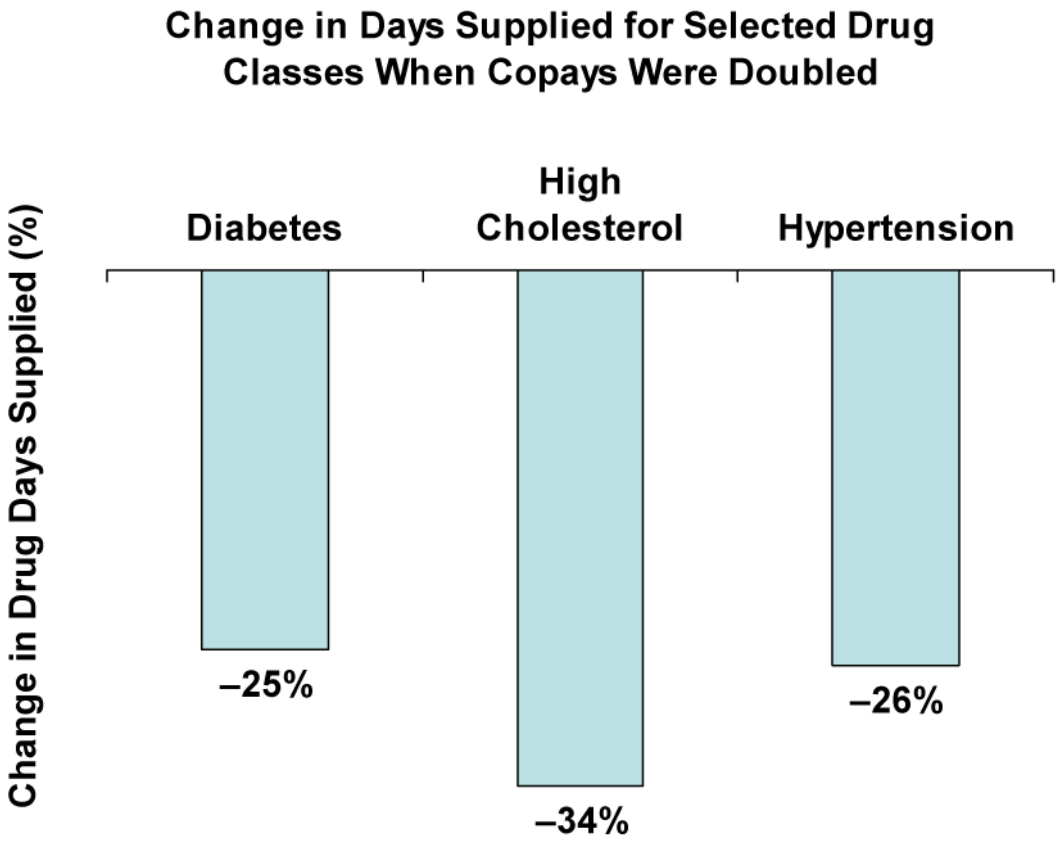
Barbara Fendrick (my mother)

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.

Medication Affordability After Medicare Part D Implementation

- **Among elderly beneficiaries with four or more chronic conditions, the prevalence of cost-related non-adherence increased from 14% in 2009 to 17% in 2011, reversing previous downward trends**
- **The prevalence among the sickest elderly of forgoing basic needs to purchase medicines decreased from 9% in 2007 to 7% in 2009 but rose to 10% in 2011**

Health Aff August 2014 vol. 33 no. 8 1435-1443

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.

Effects of Increased Copayments for Ambulatory Visits for Medicare Beneficiaries

- **Copays increased:**
  - **$7 for primary care visit**
  - **$10 for specialty care visit**
  - **remained unchanged in controls**
- **In the year after copayment increases:**
  - **20 fewer annual outpatient visits per 100 enrollees**
  - **2 additional hospital admissions per 100 enrollees**
- **Total cost higher for those with increased copayments**

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

IBM to Drop Co-Pay for Primary-Care Visits

By WILLIAM M. BULKELEY

In an unusual bid to cut health-care costs, International Business Machines Corp. plans to stop requiring $20 co-payments by employees when they visit primary-care physicians.

The company said it believed the move would save costs by encouraging people to go to primary-care doctors faster, in order to get earlier diagnoses that could save on expensive visits to specialists and emergency rooms.

IBM said that the action applies to the 80% of its workers who are enrolled in plans in which the company self-insures—that is, programs in which it pays the health-care benefits, not insurers. The new policy doesn't cover IBM employees in health-maintenance organizations.

One of the nation's largest employers with 115,000 U.S. workers, IBM spends about $1.3 billion a year on U.S. health care. Its benefit practices are closely watched in the human-resources community, and its actions are sometimes trend-setters.

Unable to Afford Surgery, Farmer Amputates His Own Feet

By AMY QIN MAY 14, 2014, 6:56 AM 1 Comments

E-MAIL
FACEBOOK
TWITTER
SAVE
MORE

BELLE
NOW PLAYING
GET TICKETS

For months, Liu Dunhe, a 44-year-old farmer in the southeastern province of Anhui, watched as what had begun as several seemingly innocuous blisters on his feet deteriorated into severe necrosis. By late April, his feet had become so rotten that he had already dug out several maggots from the dead, odorous flesh, according to a report in The Beijing News.

No longer able to withstand the torturous pain and unable to afford the out-of-pocket expenses for an operation, Mr. Liu decided that it was time for drastic measures: self-amputation.

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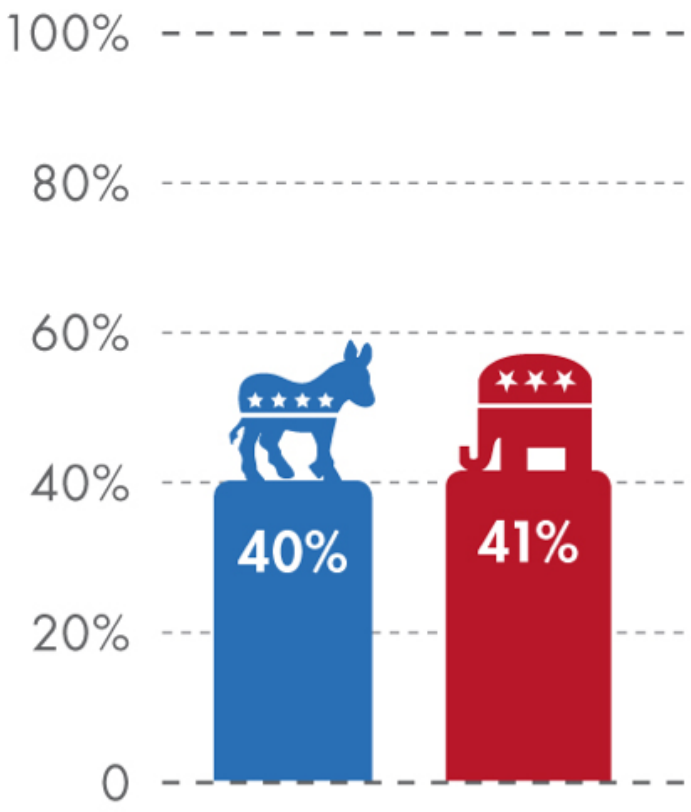
Foregoing Preventive Care Due to Cost: A Bipartisan Problem



40% of Democrats and **41%** of Republicans said cost is the number one reason they have not utilized preventive care

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A New Approach: Clinical Nuance

1. Services differ in clinical benefit produced

2. Clinical benefits from a specific service depend on:

Implementing Clinical Nuance: Value-Based Insurance Design

- **Sets consumer cost-sharing level on clinical benefit – not acquisition price – of the service**
  - **Reduce or eliminate financial barriers to high-value clinical services and providers**

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


WSJ.com THE WALL STREET JOUR
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
a move that would likely lower c

Evidence Supporting Value-Based Insurance Design: Improving Adherence Without Increasing Costs

- **Evidence review**
  - **Improved adherence**
  - **Lower consumer out-of-pocket costs**
  - **No significant increase in total spending**

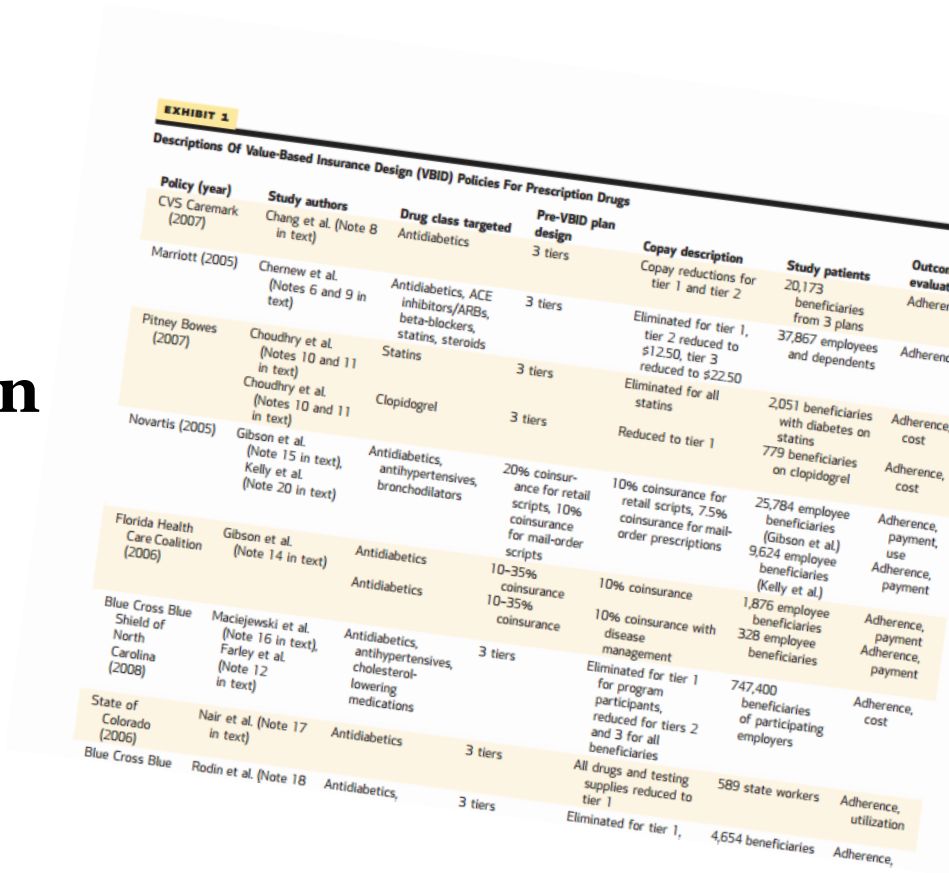

EXHIBIT 1

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	Outcomes evaluated
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	Adherence
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	Adherence
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	Adherence, cost
	Choudhry et al. (Notes 10 and 11 in text)	Clopidogrel	3 tiers	Reduced to tier 1	779 beneficiaries on clopidogrel	Adherence, cost
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.)	Adherence, payment, use
Florida Health Care Coalition (2006)	Gibson et al. (Note 14 in text)	Antidiabetics	10–35% coinsurance	10% coinsurance	1,876 employee beneficiaries	Adherence, payment
		Antidiabetics	10–35% coinsurance	10% coinsurance with disease management	328 employee beneficiaries	Adherence, payment
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	Adherence, cost
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	Adherence, utilization
Blue Cross Blue	Rodin et al. (Note 18	Antidiabetics,	3 tiers	Eliminated for tier 1,	4,654 beneficiaries	Adherence,

Lee J. *Health Affairs*. 2013;32(7):1251-1257 Health Aff (Millwood). 2014 May;33(5):863-70

MI-FREEE: Better Quality Without Higher Costs

- **Assessed impact of free access to preventive medications for Aetna members with history of MI**
- **Random assignment by plan sponsor**
- **"Enhanced prescription coverage improved medication adherence and rates of first major vascular events and decreased patient spending without increasing overall health costs."**

The NEW ENGLAND JOURNAL of MEDICI

SPECIAL ARTICLE

Full Coverage for Preventive Med
after Myocardial Infarction

Niteesh K. Choudhry, M.D., Ph.D., Jerry Avorn, M.
Robert J. Glynn, Sc.D., Ph.D., Elliott M. Antman, M.
Sebastian Schneeweiss, M.D., Sc.D., Michele Toscano,
Lonny Reisman, M.D., Joaquim Fernandes, M.S., Claire Spet
Joy L. Lee, M.S., Raisa Levin, M.S., Troyen Brennan, M.D., J.D
and William H. Shrank, M.D., M.S.H.S., for the Post-Myo
Infarction Free Rx Event and Economic Evaluation (MI FRE

ABSTRACT

BACKGROUND

Adherence to medications that are prescribed after myocardial infarction
inating out-of-pocket costs may increase adherence and improve outco

METHODS

We enrolled patients discharged after myocardial infarction and rando
their insurance-plan sponsors to full prescription coverage (1494 plan sp
2845 patients) or usual prescription coverage (1486 plan sponsors with 30
for all statins, beta-blockers, angiotensin-converting–enzyme inhibitors,
sin-receptor blockers. The primary outcome was the first major vascular eve
cularization. Secondary outcomes were rates of medication adherence,
vascular events or revascularization, the first major vascular event, and
penditures.

RESULTS

Rates of adherence ranged from 35.9 to 49.0% in the usual-coverage group
4 to 6 percentage points higher in the full-coverage group (P<0.001 for
parisons). There was no significant between-group difference in the prim
come (17.6 per 100 person-years in the full-coverage group vs. 18.8 in th
coverage group; hazard ratio, 0.93; 95% confidence interval [CI], 0.82
P=0.21). The rates of total major vascular events or revascularization were
cantly reduced in the full-coverage group (21.5 vs. 23.3; hazard ratio, 0.89;
0.90 to 0.99; P=0.03), as was the rate of the first major vascular event (11.0 v
hazard ratio, 0.86; 95% CI, 0.74 to 0.99; P=0.03). The elimination of copay
did not increase total spending ($66,008 for the full-coverage group and $71,7
the usual-coverage group; relative spending, 0.89; 95% CI, 0.50 to 1.56; P=
Patient costs were reduced for drugs and other services (relative spending,
95% CI, 0.68 to 0.80; P<0.001).

CONCLUSIONS

The elimination of copayments for drugs prescribed after myocardial infarction di
significantly reduce rates of the trial's primary outcome. Enhanced prescription c
age improved medication adherence and rates of first major vascular events and
creased patient spending without increasing overall health costs. (Funded by Ae
and the Commonwealth Fund; MI FREEE ClinicalTrials.gov number, NCT00

From the Divisions of Pharmacoepidemiology and Pharmacoeconomics (N.K.C., J.A., R.J.G., S.S., J.-L.L., R.L., W.H.S.) and Preventive Medicine (R.J.G.) and the Cardiovascular Division (E.M.A.), Department of Medicine, Brigham and Women's Hospital and Harvard Medical School, Boston; Aetna, Hartford, CT (M.T., L.R., J.F., C.S.); and CVS Caremark, Woonsocket, RI (T.B.). Address reprint requests to Dr. Choudhry at Brigham and Women's Hospital, 1620 Tremont St., Suite 3030, Boston, MA 02120, or at nchoudhry@partners.org.

This article (10.1056/NEJMsa1107913) was published on November 14, 2011, at NEJM.org.

N Engl J Med 2011;365:2088-97.
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2088

Choudhry NK, Avorn J, Glynn RJ, Antman EM, Schneeweiss S, Toscano M, et al. Full coverage for preventive medications after myocardial infarction. N Engl J Med. 2011 Dec 1;365(22):2088–97.

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

Full drug coverage:

- **Reduced rates of a post-MI vascular event or revascularization among patients who self-identified as being non-white**
- **Reduced total health care spending by 70 percent among patients who self-identified as being non-white**

DISPARITIES

By Niteesh K. Choudhry, Katsiaryna Bykov, William H. Shrank, Michele Toscano, Wayne S. Ra
Lonny Reisman, Troyen A. Brennan, and Jessica M. Franklin

Eliminating Medication Copayments Reduces Disparities In Cardiovascular Care

ABSTRACT Substantial racial and ethnic disparities in cardiovascular ca
persist in the United States. For example, African Americans and
Hispanics with cardiovascular disease are 10–40 percent less likely than
whites to receive secondary prevention therapies, such as aspirin and
beta-blockers. Lowering copayments for these therapies improves
outcomes among all patients who have had a myocardial infarction, but
the impact of lower copayments on health disparities is unknown. Using
self-reported race and ethnicity for participants in the Post-Myocardial
Infarction Free Rx Event and Economic Evaluation (MI FREEE) trial, we
found that rates of medication adherence were significantly lower and
rates of adverse clinical outcomes were significantly higher for nonwhite
patients than for white patients. Providing full drug coverage increased
medication adherence in both groups. Among nonwhite patients, it also
reduced the rates of major vascular events or revascularization by
35 percent and reduced total health care spending by 70 percent.
Providing full coverage had no effect on clinical outcomes and costs for
white patients. We conclude that lowering copayments for medications
after myocardial infarctions may reduce racial and ethnic disparities for
cardiovascular disease.

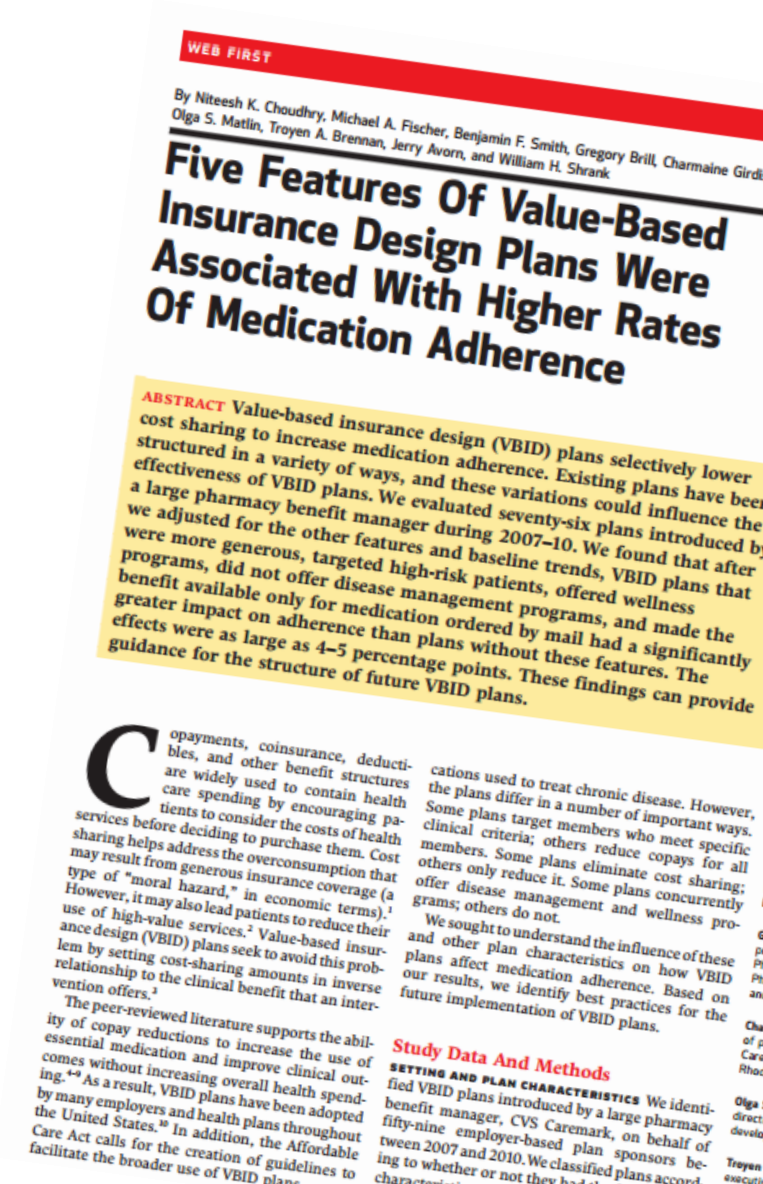
Health Aff (Millwood). 2014 May;33(5):863-70

Emerging Best Practices in V-BID Implementation

A 2014 *Health Affairs* evaluation of 76 V-BID plans reported that programs that:

- **were more generous**
- **targeted high-risk individuals**
- **offered wellness programs**

had greater impact on adherence than plans without these features



WEB FIRST

By Niteesh K. Choudhry, Michael A. Fischer, Benjamin F. Smith, Gregory Brill, Charmaine Girdi
Olga S. Matlin, Troyen A. Brennan, Jerry Avorn, and William H. Shrank

Five Features Of Value-Based Insurance Design Plans Were Associated With Higher Rates Of Medication Adherence

ABSTRACT Value-based insurance design (VBID) plans selectively lower cost sharing to increase medication adherence. Existing plans have been structured in a variety of ways, and these variations could influence the effectiveness of VBID plans. We evaluated seventy-six plans introduced by a large pharmacy benefit manager during 2007–10. We found that after we adjusted for the other features and baseline trends, VBID plans that were more generous, targeted high-risk patients, offered wellness programs, did not offer disease management programs, and made the benefit available only for medication ordered by mail had a significantly greater impact on adherence than plans without these features. The effects were as large as 4–5 percentage points. These findings can provide guidance for the structure of future VBID plans.

Copayments, coinsurance, deductibles, and other benefit structures are widely used to contain health care spending by encouraging patients to consider the costs of health services before deciding to purchase them. Cost sharing helps address the overconsumption that may result from generous insurance coverage (a type of "moral hazard," in economic terms).[1] However, it may also lead patients to reduce their use of high-value services.[2] Value-based insurance design (VBID) plans seek to avoid this problem by setting cost-sharing amounts in inverse relationship to the clinical benefit that an intervention offers.[3]

The peer-reviewed literature supports the ability of copay reductions to increase the use of essential medication and improve clinical outcomes without increasing overall health spending.[4–9] As a result, VBID plans have been adopted by many employers and health plans throughout the United States.[10] In addition, the Affordable Care Act calls for the creation of guidelines to facilitate the broader use of VBID plans

cations used to treat chronic disease. However, the plans differ in a number of important ways. Some plans target members who meet specific clinical criteria; others reduce copays for all members. Some plans eliminate cost sharing; others only reduce it. Some plans concurrently offer disease management and wellness programs; others do not.

We sought to understand the influence of these and other plan characteristics on how VBID plans affect medication adherence. Based on our results, we identify best practices for the future implementation of VBID plans.

Study Data And Methods

SETTING AND PLAN CHARACTERISTICS We identified VBID plans introduced by a large pharmacy benefit manager, CVS Caremark, on behalf of fifty-nine employer-based plan sponsors between 2007 and 2010. We classified plans according to whether or not they had

Choudhry. N. *Health Affairs*. 2014;33(3).

Value Based Insurance Design
More than High-Value Prescription Drugs

- **Prevention/Screening**
- **Diagnostic tests/Monitoring**
- **Treatments**
- **Clinician visits**
- **High performing networks**
- **PCMH**
- **Hospitals**

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HEALTH AND FITNESS
Northeast OH Healthy Living and Medical Consumer News

“Lowe's is offering employees incentives in the form of reduced out-of-pocket costs to come to the Cleveland Clinic for heart procedures.”

Harlan Spector, Health News, Insurance, Metro, Real-Time News »

Lowe's will bring its workers to Cleveland Clinic for heart surgery

By Harlan Spector, The Plain Dealer
February 17, 2010, 3:58AM

View full size Chuck Burton / Associated Press

Lowe's is offering employees nationwide incentives in the form of reduced out-

Putting Innovation into Action: Create Broad Multi-Stakeholder Support

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

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

Translating Research into Policy

V-BID

Translating Research into Policy

- **V-BID included in 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 100 million Americans have received expanded coverage of preventive services

ACA Sec. 2713c Regulation: V-BID Definition

"Value-based insurance designs include the provision of information and incentives for consumers that promote access to and use of higher value providers, treatments, and services."

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Putting Innovation into Action: Translating Research into Policy

- Patient Protection and Affordable Care Act
- **Medicare**
- State Health Reform
- HSA-qualified HDHPs

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

- **Bill directs HHS to establish a demonstration program to test V-BID for beneficiaries with chronic conditions**
- **CMS issues RFI on role of V-BID in Medicare**

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 _____

Putting Innovation into Action: Translating Research into Policy

- Patient Protection and Affordable Care Act
- Medicare
- **State Health Reform**
- HSA-qualified HDHPs

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Value-Based Insurance Design
Growing Role in State Health Reform

- **State Employees Benefit Plans**
- **State Exchanges**
- **CO-OPs**
- **Medicaid**

V-BID Center *brief*

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

V-BID in Action: A Profile of Connecticut's Health Enhancement Program

Value-Based Insurance Design (V-BID)—hailed as a "game changer" by the National Coalition on Health Care— refers to insurance designs that vary consumer cost-sharing to distinguish between high-value and low-value health care services and providers. V-BID entails (1) reducing financial barriers that deter use of evidence-based services and high-performing providers, and (2) imposing disincentives to discourage use of low-value care. Through the incorporation of greater clinical nuance in benefit design, payers, purchasers, taxpayers, and consumers can attain more health for every dollar spent. The University of Michigan Center for V-BID leads in research, development, and advocacy for innovative health benefit plans and payment reform initiatives.

Connecticut Seeks to Improve Health and Contain Costs

The State of Connecticut faced a projected budget gap of $3.8 billion in fiscal year 2012, and state employees were asked to help address the shortfall. The Governor's Office and a coalition of unions representing state employees met throughout 2011 to discuss a wide range of topics, including the health plan covering active and retired state employees. The parties focused health care discussions on possibilities for improving health as a means to control long-term costs. Discussions involving unions, the

The Key Features of HEP

Prior to 2012, Connecticut's state employee health plan did not distinguish between high-value services and low-value services in determining cost-sharing for beneficiaries. HEP is different.

Accountability. HEP rewards state employees, select retirees, and dependents who commit to a number of responsibilities. The "ask" of beneficiaries is as follows:

- Obtain specified age and gender-appropriate health risk assessments, evidence-based screenings, and physical and vision examinations;
- Undergo two dental cleanings per year;[a] and
- Participate in condition-appropriate chronic disease management services.[b]

Specified guideline-based clinical services are required of HEP enrollees with diabetes, high cholesterol, high blood pressure, heart disease, asthma, and chronic obstructive pulmonary disorder (COPD). There are provisions to exempt enrollees with unusual or special circumstances from requirements as appropriate.

Beneficiaries may be disenrolled from HEP if they do not adhere to the requirements outlined above. HEP strives to avoid this

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Value-Based Insurance Design Growing Role in State Health Reform

- **State Employees Benefit Plans**
  - **Connecticut**
  - **Oregon**
  - **Virginia**
  - **South Carolina**
  - **Minnesota**
  - **Maine**
  - **New York**
  - **North Carolina**

V-BID Center *brief*

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

V-BID in Action: A Profile of Connecticut's Health Enhancement Program

Value-Based Insurance Design (V-BID)—hailed as a "game changer" by the National Coalition on Health Care— refers to insurance designs that vary consumer cost-sharing to distinguish between high-value and low-value health care services and providers. V-BID entails (1) reducing financial barriers that deter use of evidence-based services and high-performing providers, and (2) imposing disincentives to discourage use of low-value care. Through the incorporation of greater clinical nuance in benefit design, payers, purchasers, taxpayers, and consumers can attain more health for every dollar spent. The University of Michigan Center for V-BID leads in research, development, and advocacy for innovative health benefit plans and payment reform initiatives.

Connecticut Seeks to Improve Health and Contain Costs

The State of Connecticut faced a projected budget gap of $3.8 billion in fiscal year 2012, and state employees were asked to help address the shortfall. The Governor's Office and a coalition of unions representing state employees met throughout 2011 to discuss a wide range of topics, including the health plan covering active and retired state employees. The parties focused health care discussions on possibilities for improving health as a means to control long-term costs. Discussions involving unions, the

The Key Features of HEP

Prior to 2012, Connecticut's state employee health plan did not distinguish between high-value services and low-value services in determining cost-sharing for beneficiaries. HEP is different.

Accountability. HEP rewards state employees, select retirees, and dependents who commit to a number of responsibilities. The "ask" of beneficiaries is as follows:

- Obtain specified age and gender-appropriate health risk assessments, evidence-based screenings, and physical and vision examinations;
- Undergo two dental cleanings per year;[a] and
- Participate in condition-appropriate chronic disease management services.[b]

Specified guideline-based clinical services are required of HEP enrollees with diabetes, high cholesterol, high blood pressure, heart disease, asthma, and chronic obstructive pulmonary disorder (COPD). There are provisions to exempt enrollees with unusual or special circumstances from requirements as appropriate.

Beneficiaries may be disenrolled from HEP if they do not adhere to the requirements outlined above. HEP strives to avoid this

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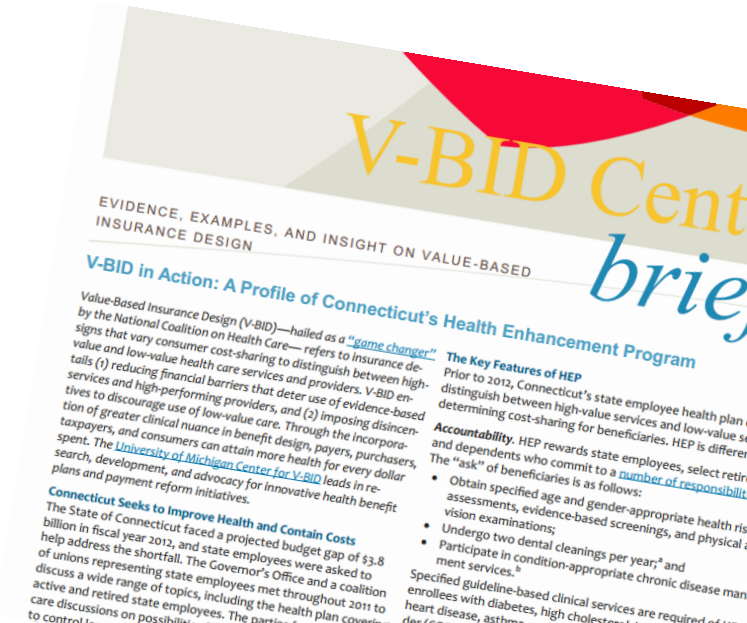
Implementing V-BID for State Employees: Connecticut State Employees Health Benefit Plan

- **Participating employees receive a reprieve from higher premiums if they commit to:**
  - **Yearly physicals, age-appropriate screenings/preventive care, two free dental cleanings**
  - **If employees have one of five chronic conditions, they must participate in disease management programs (which include free office visits and lower drug co-pays)**
- **Early results:**
  - **99% of employees enrolled and 99% compliant**
  - **Decrease in ER and specialty care**
  - **Increase in primary care visits**
  - **Increase in chronic disease medication adherence**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CMS Rules Enable V-BID in Medicaid


July 2013

V-BID Center brief

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New Regulations Permit Use of Value-Based Insurance Design in State Medicaid Programs

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New Mexico's Centennial Care: Clinical Nuance Implementation in Medicaid:

After roughly a year of negotiations, New Mexico was granted an 1115 waiver from the Centers for Medicare and Medicaid Services. In an effort to prompt individuals to accept greater accountability for their health care decisions, New Mexico Medicaid recipients will face higher co-pays for certain services. Enrollees will also be offered incentives to earn points redeemable for gifts if they take certain steps for better health such as seeing a dentist, completing a prenatal care program, or managing chronic diseases. Additionally, the program features will expand care coordination for all beneficiaries.

- **Plans may vary cost-sharing for**
  - **drugs, outpatient, inpatient, and emergency visits**
  - **specific groups of individuals based on clinical factors**
  - **an outpatient service according to where and by whom the service is provided**

V-BID was prominently featured in Healthy Michigan Plan

V-BID Prominently Featured in Healthy Michigan Plan

- **Sec 105D(1)(e), plans may waive consumer copayments, "to promote greater access to services that prevent the progression and complications related to chronic diseases."**

- **Sec 105D(1)(f), assigned to "design and implement a copay structure that encourages the use of high-value services, while discouraging low-value services."**

- **Sec 105D(5), assigned to "implement a pharmaceutical benefit that utilizes copays at appropriate levels allowable by CMS to encourage the use of high-value, low-cost prescriptions."**


February 2014

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V-BID in Action: Michigan Medicaid Expar

Introduction

Value-Based Insurance Design (V-BID) is an innovative approach that can improve clinical outcomes and contain costs. The basic premise of V-BID is to align consumer incentives with value by reducing barriers to high-value health services and providers ("carrots") and discouraging the use of low-value health services and providers ("sticks"). When "carrots" and "sticks" are used in a clinically nuanced manner, V-BID improves health care quality and controls spending growth. The concept of clinical nuance recognizes 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, as well as when and where the service is provided. By incorporating greater clinical nuance into benefit design, payers, purchasers, taxpayers, and consumers can attain more health for every dollar spent.

Federal Government Allows V-BID in Medicaid

State Medicaid programs cover some of the nation's most vulnerable citizens and account for a large and growing portion of state budgets. The Centers for Medicare and Medicaid Services (CMS) recently finalized rules (CMS-2334-F) giving state Medicaid programs greater flexibility to vary enrollee cost-sharing for prescription drugs as well as certain outpatient, emergency de-

Cost-sharing for Outpatient and Inpatien

Under the new rule, Medicaid programs cost-sharing (within certain income-base outpatient services while allowing other without cost sharing. Plans may also vary particular outpatient service in accordanc service and/or where the service is deliver rule allows state Medicaid agencies to targ sharing (within certain income-based boun groups of individuals based on clinical infor (e.g., diagnosis, clinical risk factors).

Non-emergent use of the Emergency Departm

The new rule gives Medicaid plans the option $8 copayment for non-emergency services p emergency department (ED).

Cost-sharing for Prescription Drugs

The rule provides states with the flexibility for sharing on preferred ($0-$4) and non-preferre copay). The rule also retains the states' ability preferred and non-preferred drugs within their Preferred Drug Lists.

Putting Innovation into Action: Translating Research into Policy

- Patient Protection and Affordable Care Act
- Medicare
- State Health Reform
- **High Deductible Health Plans**

HSA-qualified HDHPs: Too Much "Skin in the Game"?

- More than 25% of employers offer HDHPs
- 85% of enrollees in the individual marketplace purchased either silver or bronze HDHP plans
- Higher out-of-pocket costs hinder the use of evidence-based services (even when exempt from the deductible)
- HDHP enrollees with chronic diseases are more likely to go without care due to cost or experienced financial hardship due to medical bills

J Gen Intern Med. 2012;27(9):1105-1111. *Health Aff*. 2011; 30(2):322-331.

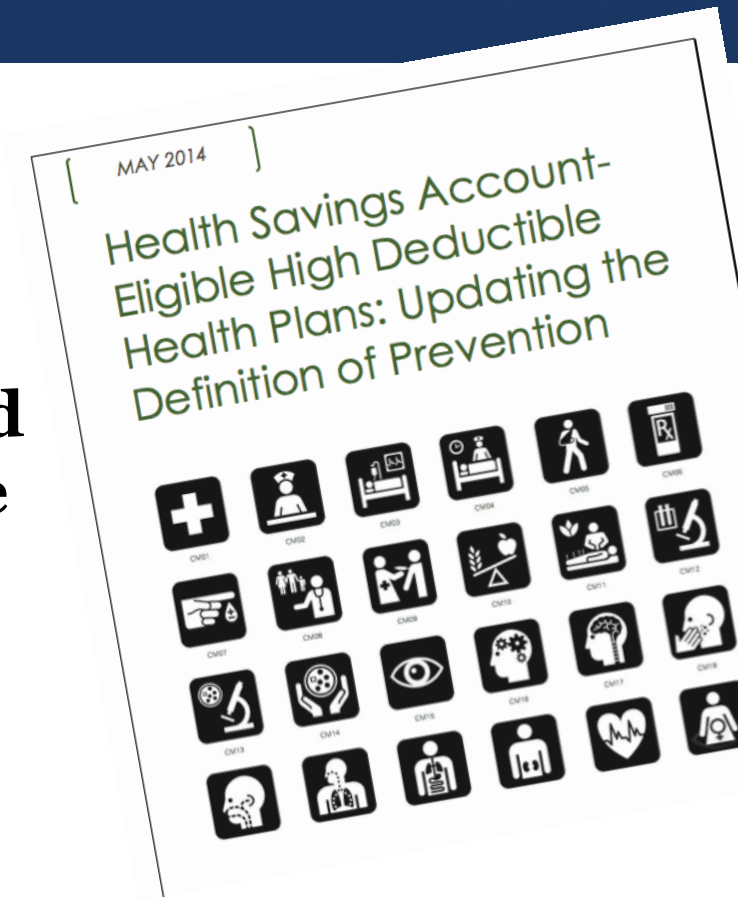
Barriers to V-BID in HSA-qualified HDHPs

- **IRS guidance specifically exclude services meant to treat "an existing illness, injury or condition" from the definition of preventive care**
- **Many well-established quality metrics require the entire deductible to be met before coverage begins**
- **90% of employers support expanding deductible-exempt definition to include chronic disease care**

V-BID HDHP Hybrid with "Smarter Deductibles": High Value Health Plan

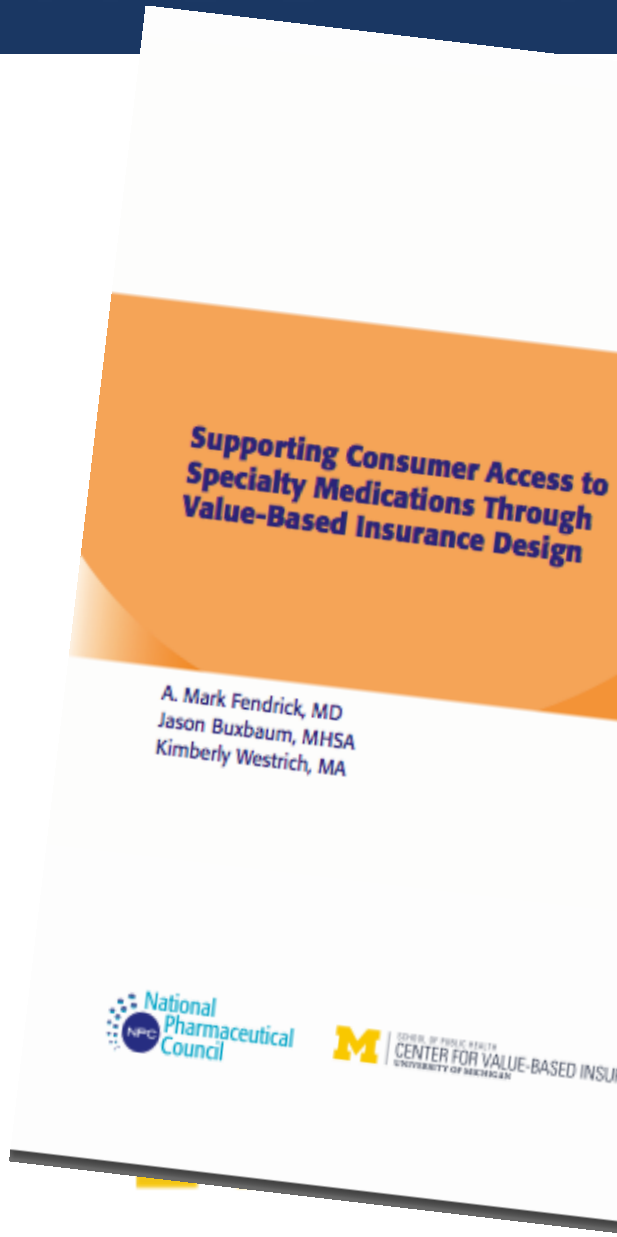
HVHP allows evidence-based, services that manage chronic disease to be deductible-exempt:

- **Lower premiums than PPOs and HMOs; slight premium increase over existing HDHPs**
- **>40 million likely enrollees**
- **Vehicle to avoid "Cadillac tax"**
- **Substantially lower aggregate healthcare expenditures on a population level**



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**



Fendrick et al. Center for Value Based Insurance Design. http://bit.ly/1kMP2cq

Using Clinical Nuance to Align Payer and Consumer Incentives

Many "supply side" initiatives are restructuring provider incentives:

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

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Using Clinical Nuance to Align Payer and Consumer Incentives

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**

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

- **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.

V-BID

Improving Care and Bending the Cost Curve

- **The ultimate test of health reform will be whether it improves health and addresses rising costs**
- **V-BID should be part of the solution to enhance the efficiency of health care spending**

The New York Times

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ECONOMIC VIEW

When a Co-Pay Gets in the Way of Health

By SENDHIL MULLAINATHAN
Published: August 10, 2013

ECONOMISTS specialize in pointing out unpleasant trade-offs — a skill that is on full display in the health care debate.

Enlarge This Image

Minh Uong/The New York Times

We want patients to receive the best care available. We also want consumers to pay less. And we don't want to bankrupt the government or private insurers. Something must give.

The debate centers on how to make these trade-offs, and who gets to make them. The stakes are high, and the choices are at times unseemly. No matter how necessary, putting human suffering into dollars and cents is not attractive work. It's no surprise, then, that the conversation is so heated.

What is a surprise is that amid th

Mullainathan S. When a Co-Pay Gets in the Way of Health. The New York Times. 2013 Aug 10.

Discussion

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