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

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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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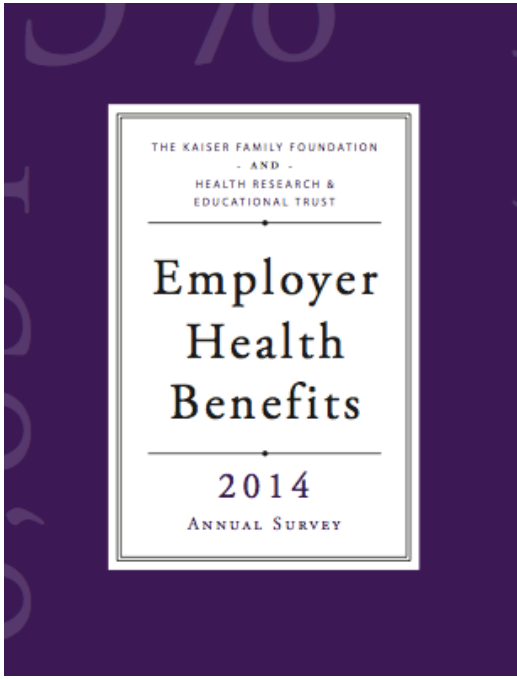
Role of Consumer Cost-Sharing in Clinical Decisions

- **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

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

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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

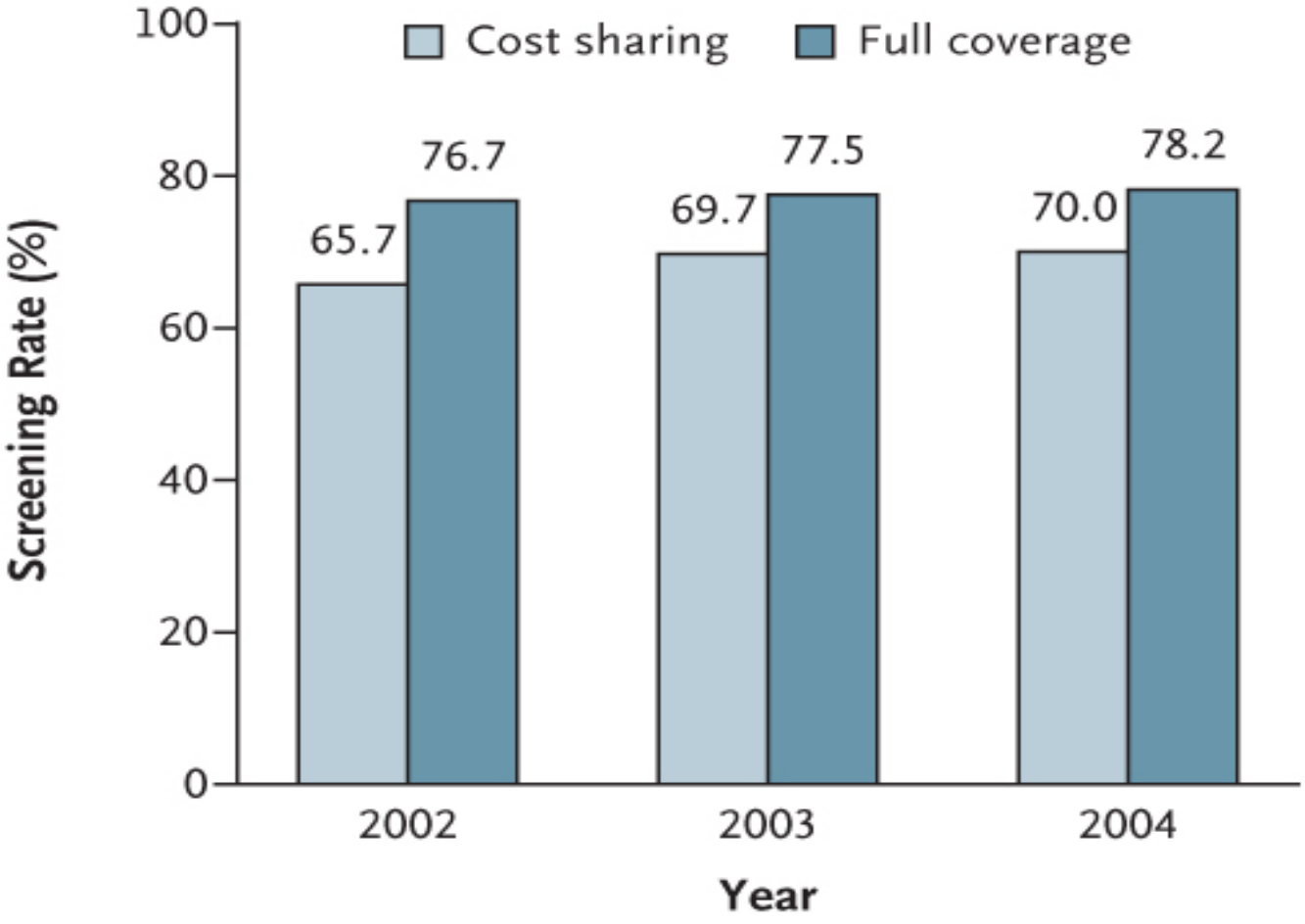
Goldman D. *JAMA*. 2007;298(1):61–9. Trivedi A. *NEJM*. 2008;358:375 2010;362(4):320-8.. Chernew M. J Gen Intern Med 23(8):1131–6.

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.”

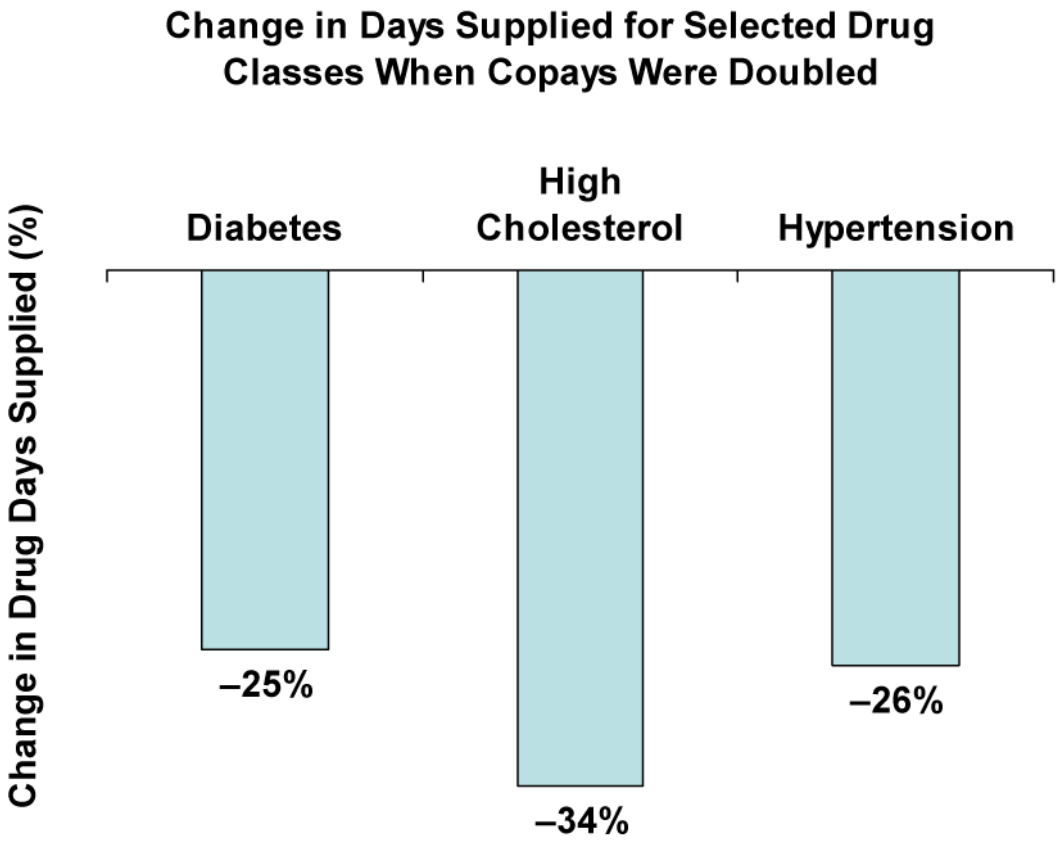
Barbara Fendrick (my mother)

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.

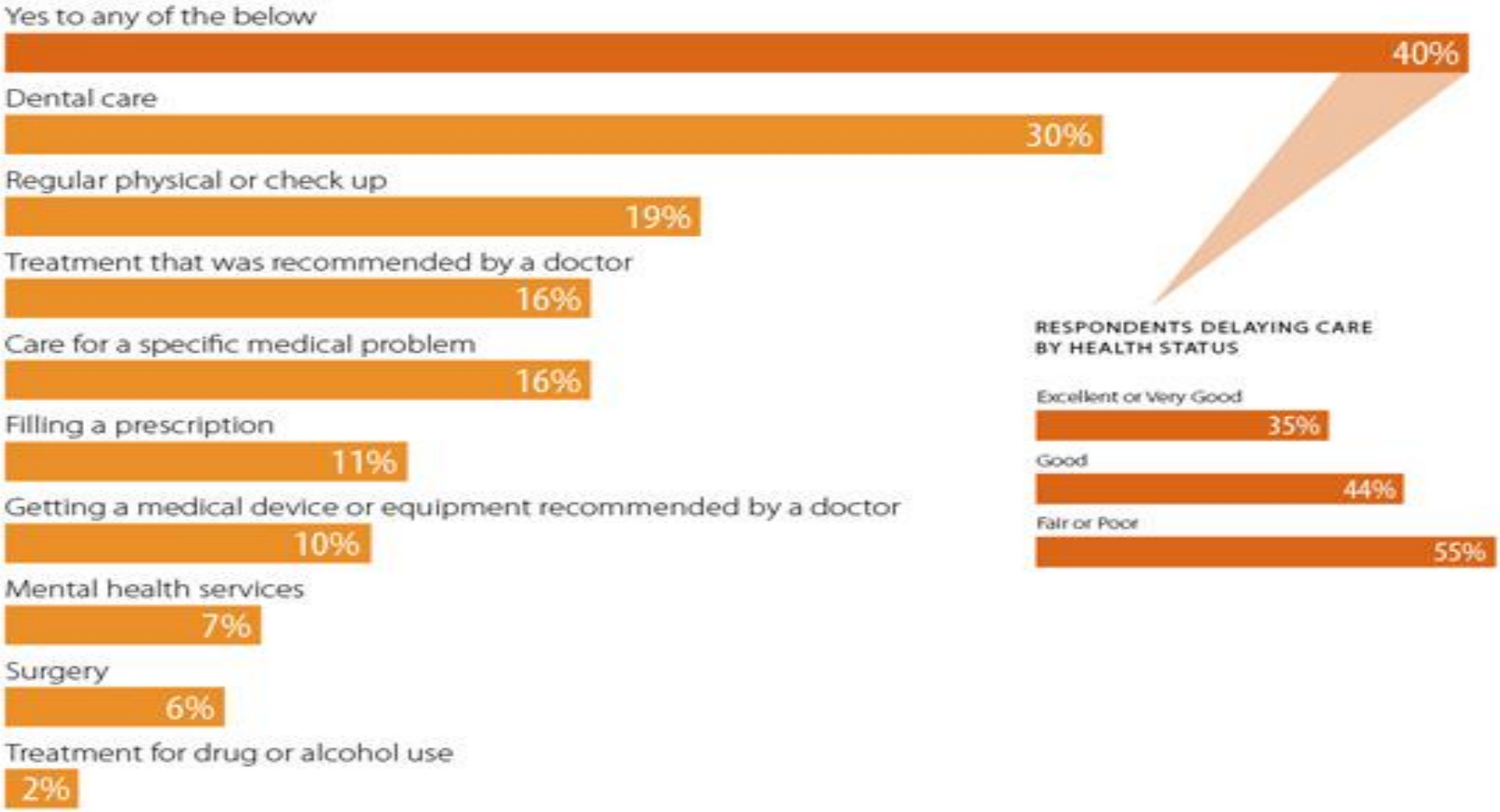
Goldman DP et al. *JAMA*. 2004;291:2344-2350.

Delayed Care Due to Costs, Overall and by Health Status

California, 2014

Have you delayed any of the following in the last 12 months because of the costs involved?

Base: All adults (n=1,548)



Source: California General Public Survey, conducted by PerryUndem Research and Communication.

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.

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:

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**
  - **Reduced health care disparities**

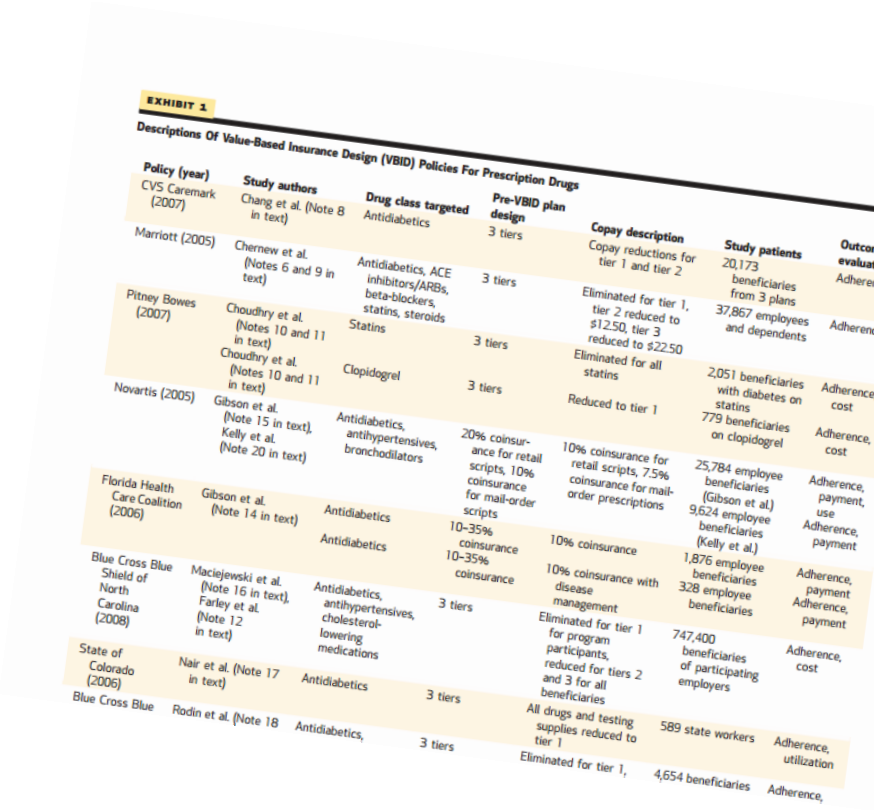


EXHIBIT 1

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	Outcome 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

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.”

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**
- **Medicare**
- **State Health Reform**
- **HSA-qualified HDHPs**

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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 130 million Americans have received expanded coverage of preventive services

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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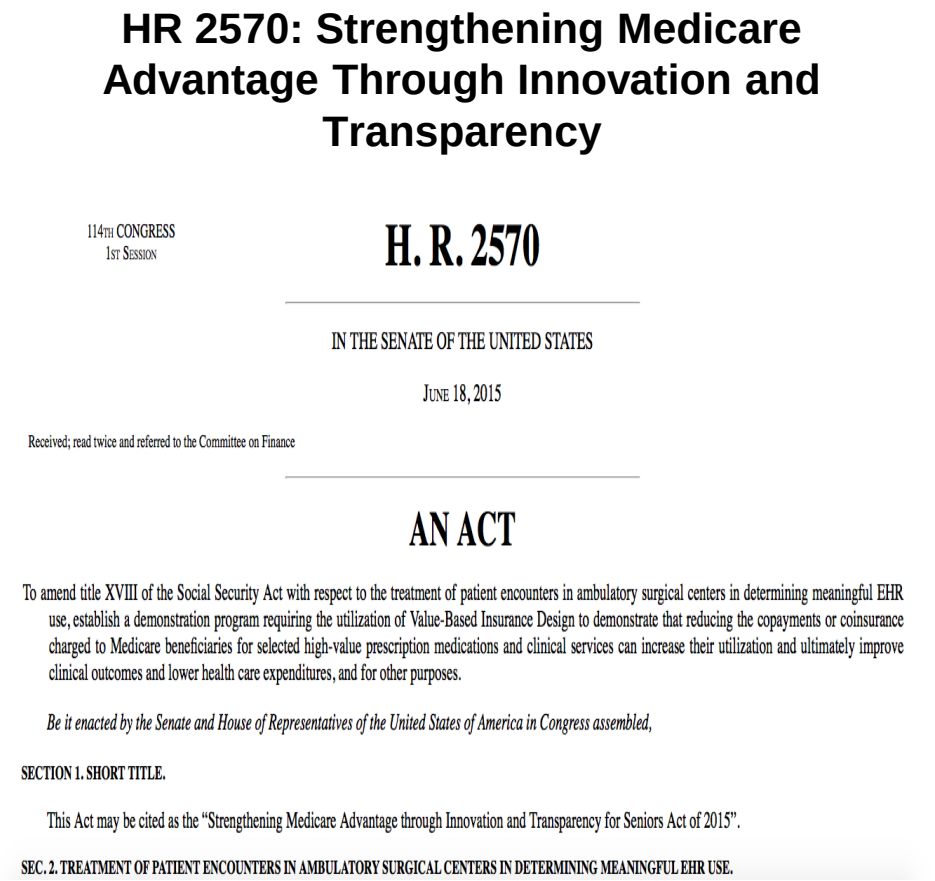
H.R.2570/S.1396: Bipartisan "Strengthening Medicare Advantage Through Innovation and Transparency"

- **Directs HHS to establish a V-BID demonstration for MA beneficiaries with chronic conditions**
- **CMS issues RFI on role of V-BID in Medicare**



HR 2570: Strengthening Medicare Advantage Through Innovation and Transparency

114TH CONGRESS
1ST SESSION

H. R. 2570

IN THE SENATE OF THE UNITED STATES

JUNE 18, 2015

Received; read twice and referred to the Committee on Finance

AN ACT

To amend title XVIII of the Social Security Act with respect to the treatment of patient encounters in ambulatory surgical centers in determining meaningful EHR use, 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, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Strengthening Medicare Advantage through Innovation and Transparency for Seniors Act of 2015".

SEC. 2. TREATMENT OF PATIENT ENCOUNTERS IN AMBULATORY SURGICAL CENTERS IN DETERMINING MEANINGFUL EHR USE.

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**
- **State Innovation Models**

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

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Putting Innovation into Action: Translating Research into Policy

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

V-BID

HSA-qualified HDHPs: Expanding the Deductible-Exempt "Safe Harbor"

- 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 may 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.

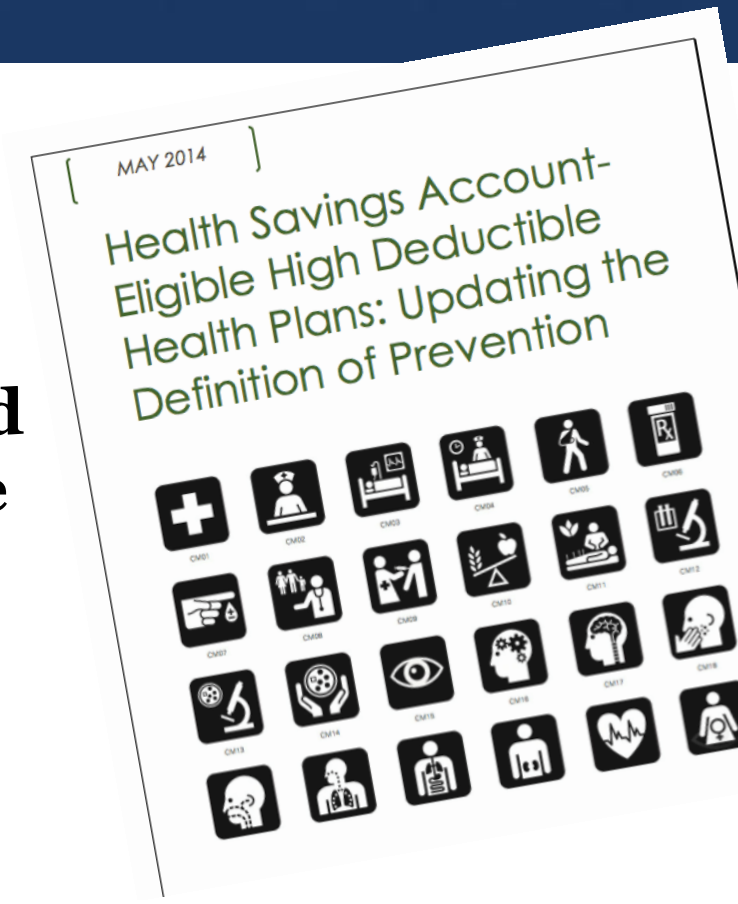
Barriers to V-BID in HSA-qualified HDHPs
Expanding the Deductible-Exempt "Safe Harbor"

- **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**



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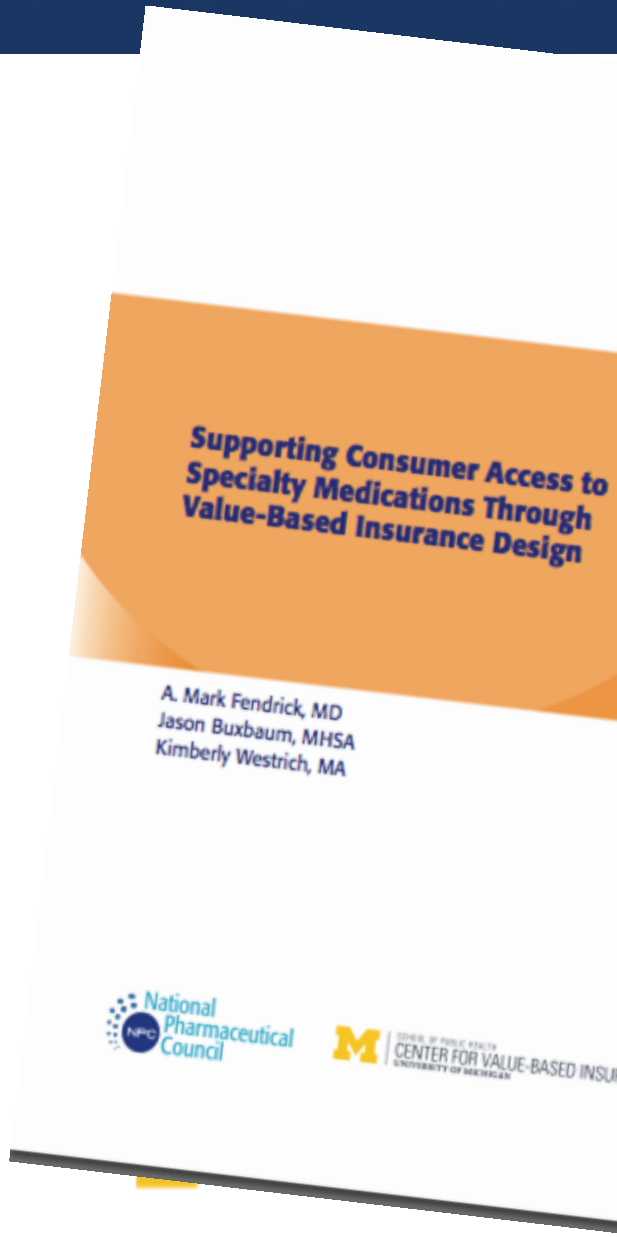
Applying V-BID to Specialty Medications

- **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**



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

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

- **Many "supply side" initiatives are restructuring provider incentives to move from volume to value**

AJAC. 2014;2(3);10.

M | V-BID

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

- **"Supply side" initiatives are restructuring provider incentives to move from volume to value**

- **Unfortunately, "demand-side" initiatives are moving consumers in the opposite direction**

AJAC. 2014;2(3);10.

M | V-BID

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

- **"Supply side" initiatives are restructuring provider incentives to move from volume to value**

- **Unfortunately, "demand-side" initiatives are moving consumers in the opposite direction**

- **Adding clinical nuance can improve quality of care, enhance employee experience, and contain cost growth**

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AJAC. 2014;2(3);10.

Improving Care and Bending the Cost Curve

- **V-BID should be part of the solution to enhance the efficiency of health care spending**
- **States can play an important role in the transition from volume to value**

The New York Times

Business D

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ECONOMIC VIEW

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

Discussion

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Coalition for Smarter Healthcare

www.smarterhc.org