SCHOOL OF PUBLIC HEALTH
CENTER FOR VALUE-BASED INSURANCE DESIGN
UNIVERSITY OF MICHIGAN

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

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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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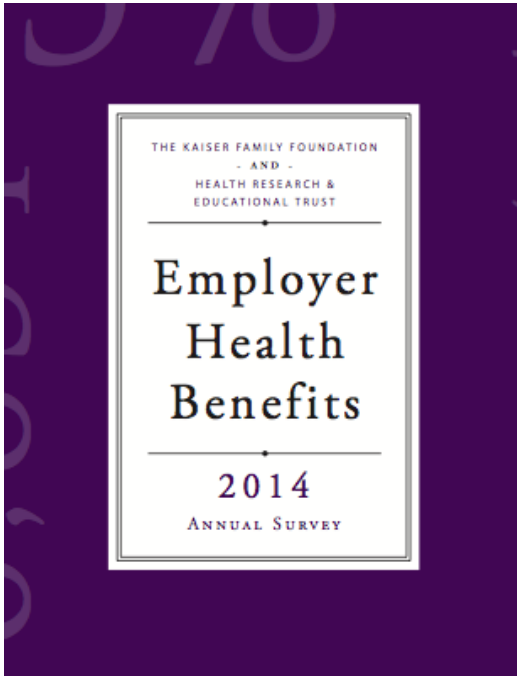
Role of Consumer Cost-Sharing in Clinical Decisions

- **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

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)

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 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.

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**
- **One in Four adults with non-group coverage report going without needed care due to cost**

The New York Times

Business Day

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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.

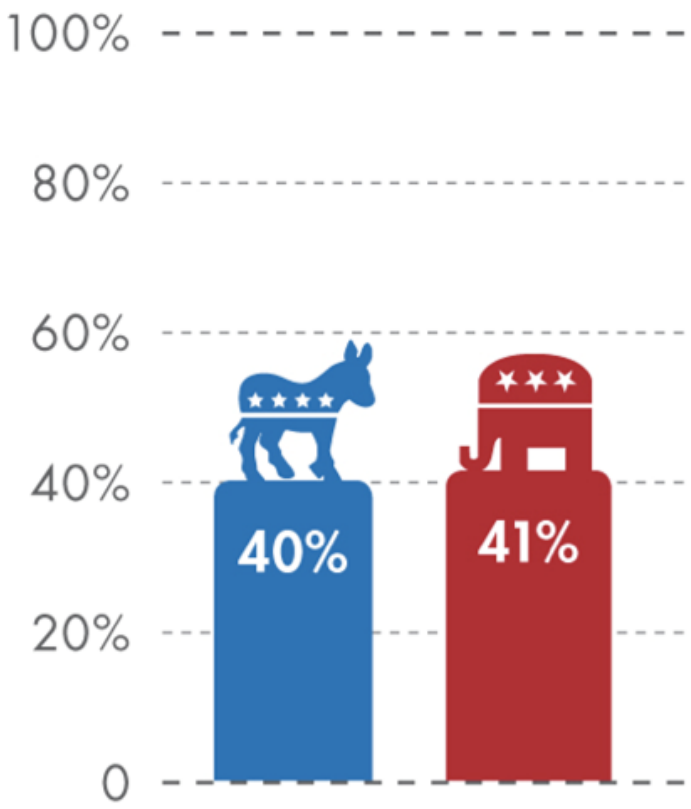
The debate centers on how to make these trade-offs, and who gets to make them. The stakes are high, and the choices are at times unseemly. No matter how necessary, putting human suffering into dollars and cents is not attractive work. It's no surprise, then, that the conversation is so heated.

What is a surprise is that amid these complex issues, one policy sidesteps these trade-offs.

FACEBOOK
TWITTER
GOOGLE+
SAVE
EMAIL
SHARE
PRINT
REPRINTS

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.

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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Innovative Solutions Needed

- **Consumers do not have the necessary information to make informed health care decisions**
- **While important, clinician incentives and providing accurate price and quality data does not ensure appropriate care delivery**
- **Consumer engagement solutions are necessary to better allocate health expenditures on the clinical benefit – not only the price or profitability – of services**

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Potential Solution to Cost-Related Non-Adherence

Clinically Nuanced Cost-Sharing

What is clinical nuance?

Services differ in clinical benefit produced

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**

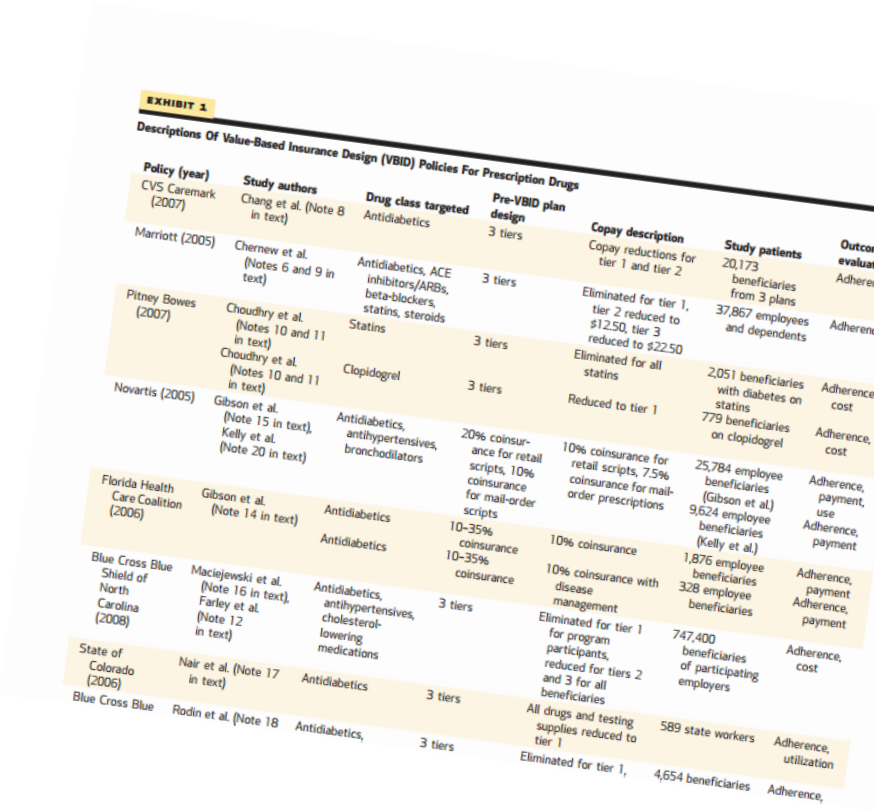

EXHIBIT 1

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

V-BID: Who Benefits and How?

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

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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

Putting Innovation into Action: Translating Research into Policy

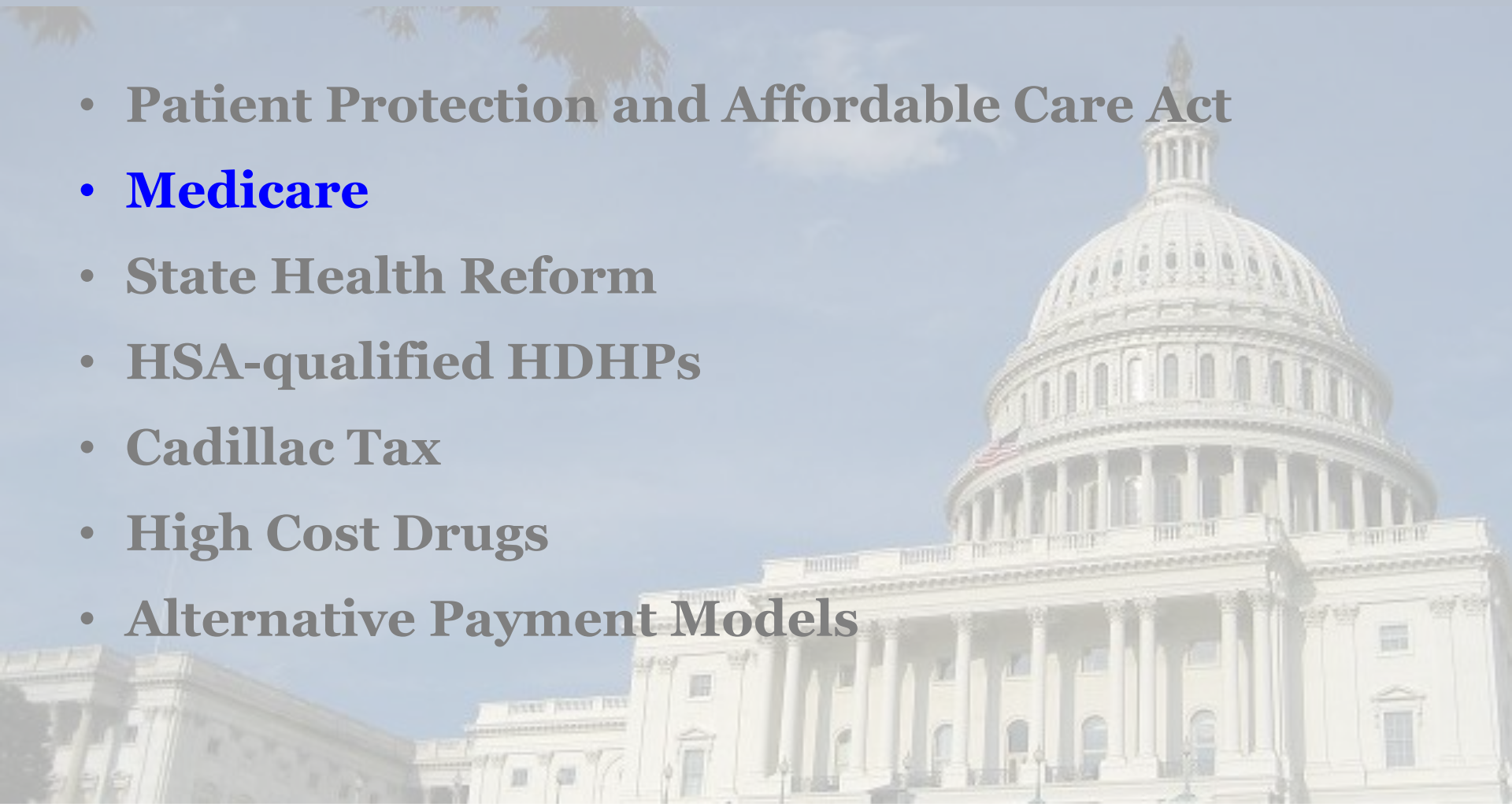
- **Patient Protection and Affordable Care Act**
- Medicare
- State Health Reform
- HSA-qualified HDHPs
- Cadillac Tax
- High Cost Drugs
- Alternative Payment Models

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 137 million Americans have received expanded coverage of preventive services

Putting Innovation into Action: Translating Research into Policy



- Patient Protection and Affordable Care Act
- **Medicare**
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Translating Research into Policy: Implementing V-BID in Medicare

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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**
- **Passed US House with strong bipartisan support in June 2015**

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.

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CMS Announces Medicare Advantage Value-Based Insurance Design Model Test

A 5-year demonstration program will test the utility of structuring consumer cost-sharing and other health plan design elements to encourage patients to use high-value clinical services and providers.

*Red denotes states included in V-BID model test

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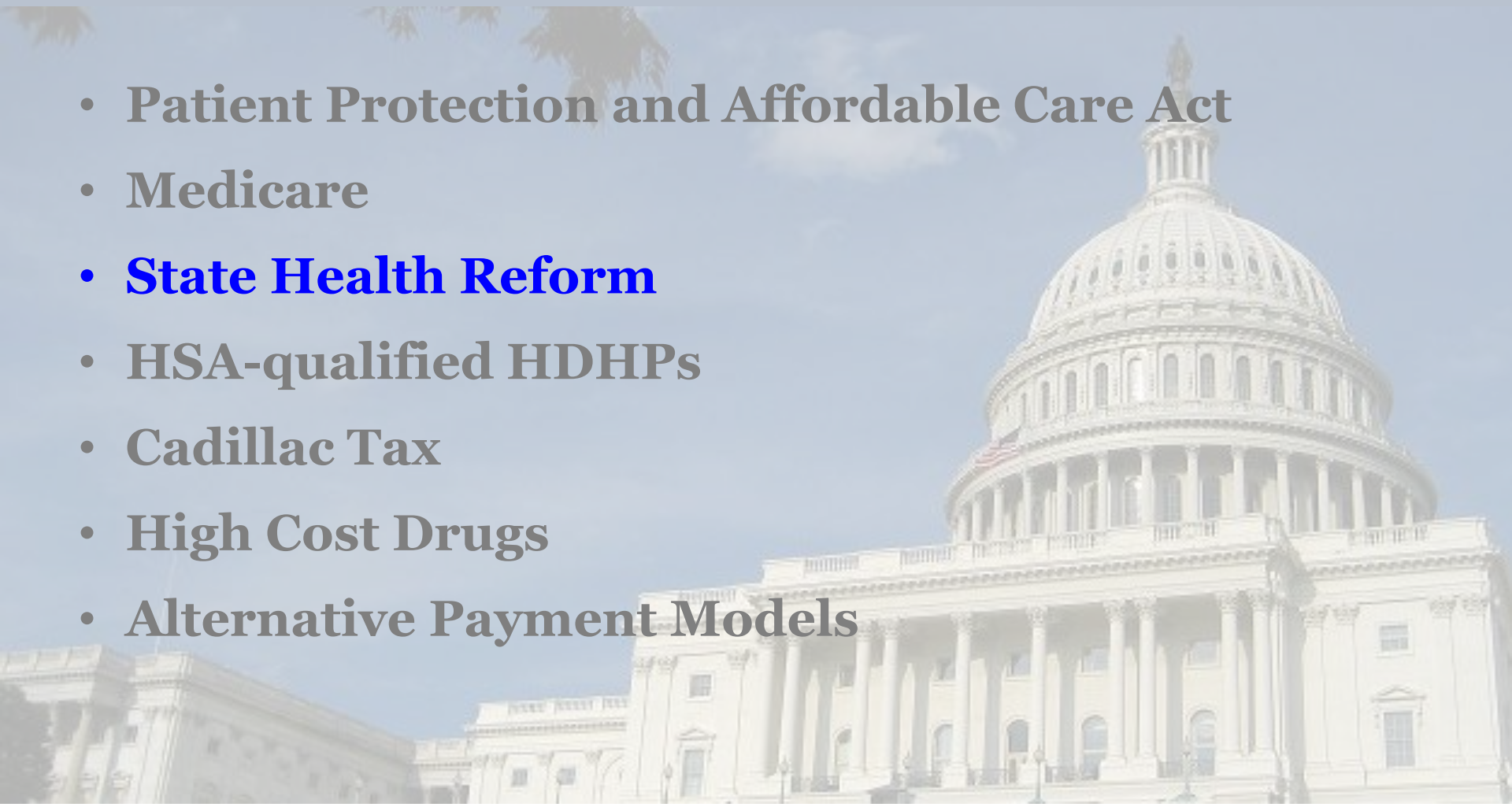
Putting Innovation into Action: Translating Research into Policy



- Patient Protection and Affordable Care Act
- Medicare
- **State Health Reform**
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Value-Based Insurance Design
Growing Role in State Health Reform

- **State Exchanges**
- **CO-OPs**
- **Medicaid**
- **State Innovation Models**
- **State Employee Benefit Plans**

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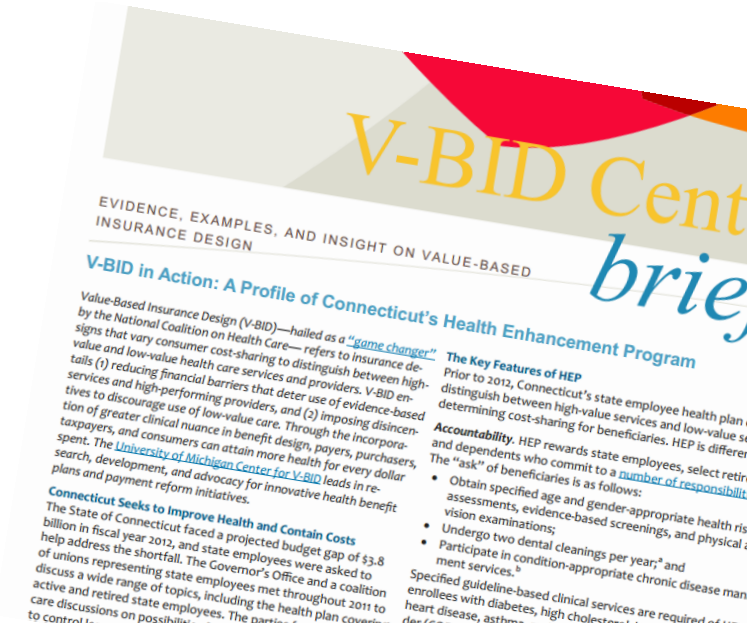
Implementing V-BID for State Employees: Connecticut State Employees Health Benefit Plan

- **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**
  - **Increase in primary care visits**
  - **Decrease in ER and specialty care**
  - **Increase in chronic disease medication adherence**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EVIDENCE, EXAMPLES, AND INSIGHT ON VALUE-BASED INSURANCE DESIGN

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Putting Innovation into Action: Translating Research into Policy

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HSA-HDHP enrollment and out-of-pocket expenses continue to grow

http://www.ahipcoverage.com/wp-content/uploads/2013/06/HSAinfographic_V9_FV.jpg

Maximum Out-of-pocket expense 2006 to 2014

individual: $5,000 to $6,350

family: $10,000 to $12,700

http://kff.org/report-section/ehbs-2014-section-eight-high-deductible-health-plans-with-savings-option/

http://www.irs.gov/pub/irs-drop/n-04-2.pdf

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IRS Safe Harbor Guidance allows zero consumer cost-sharing for specific preventive services

INCLUDING:

- ✓ periodic health evaluations/screenings
- ✓ routine prenatal and well-child care
- ✓ child and adult immunizations
- ✓ tobacco cessation programs
- ✓ obesity weight-loss programs

www.irs.gov/pub/irs-drop/n-04-23.pdf

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However, IRS guidance requires that services used to treat
"existing illness, injury or conditions"
are not covered until the minimum deductible is met

office visits

diagnostic tests

drugs

As HSA-HDHP enrollees with existing conditions are required to pay out-of-pocket for necessary services, they utilize less care, potentially resulting in poorer health outcomes and higher costs

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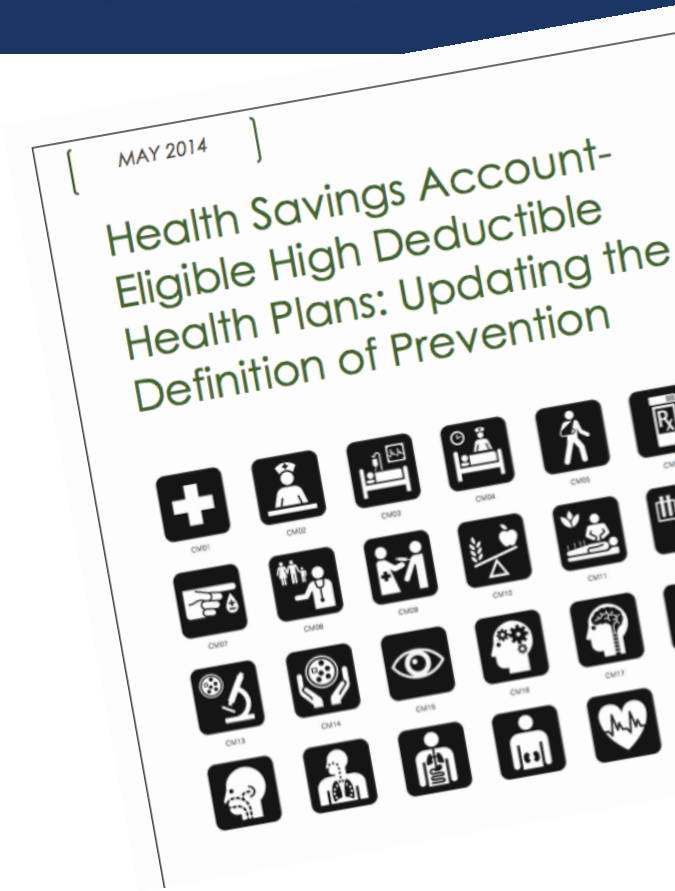
Potential Solution:

High Value Health Plan

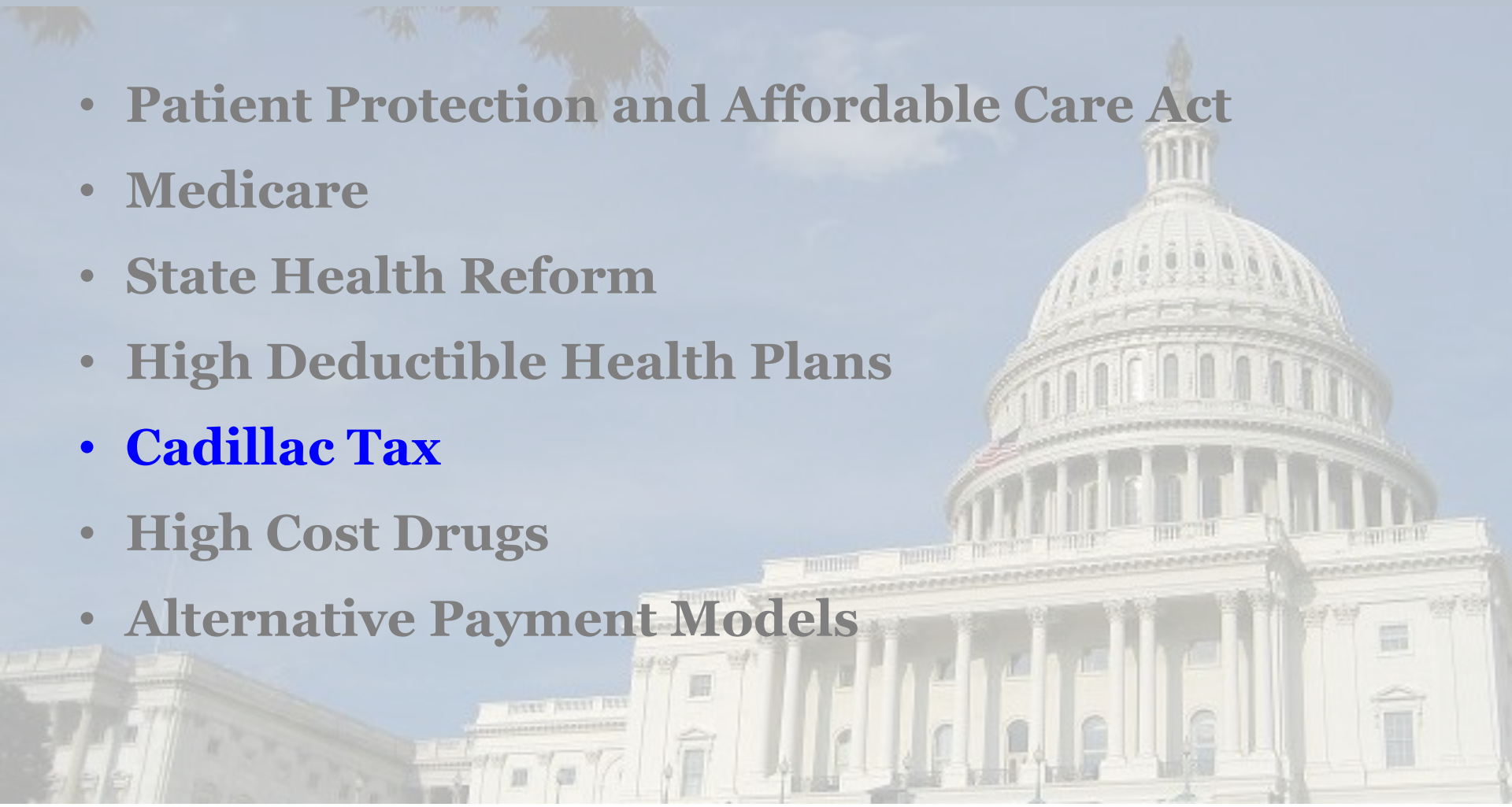
Flexibility to expand IRS "Safe Harbor" to allow coverage of additional evidence-based services prior to meeting the plan deductible

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

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



Putting Innovation into Action: Translating Research into Policy



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What is the "Cadillac Tax"?

Section 4980I of Patient Protection and Affordable Care Act mandates that if a health plan's benefits exceed...

$10,200 for 

$27,500 for 

the coverage provider must pay a **40%** excise tax on each dollar above the cap in 2018.

Common Features of "Cadillac Plans"

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Trade-In a "Cadillac Plan" for Value-Based Insurance Design

Turn in a "Cadillac Plan" loaded with unnecessary features...

- ✗ Covers low-value services
- ✗ Subject to 40% excise tax in 2018

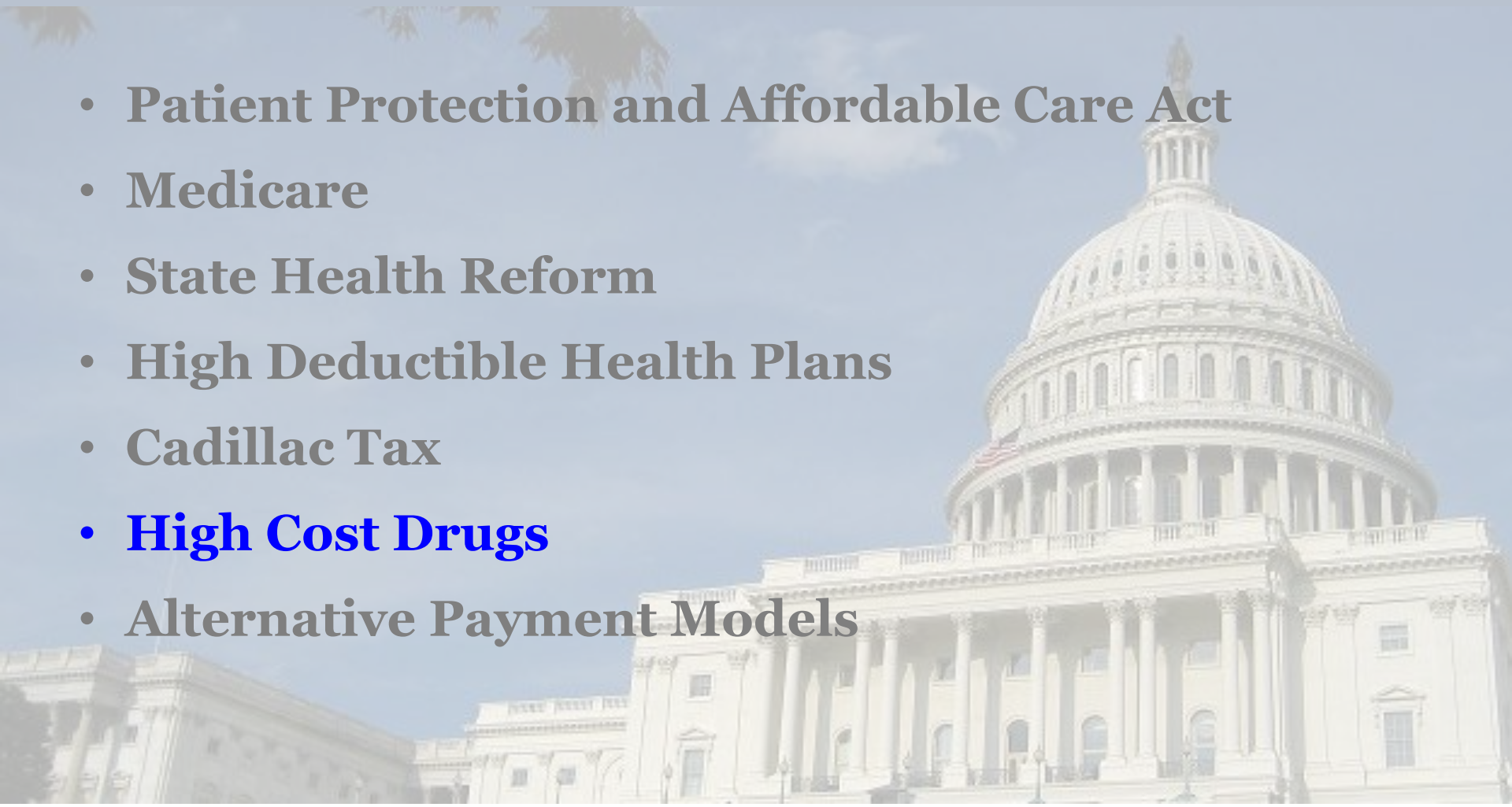
Dodge a non-nuanced High Deductible Health Plan...

- ✗ Higher out-of-pocket costs
- ✗ Increased rates of non-adherance

Choose a clinically nuanced V-BID plan that...

- ✓ Covers evidence-based services
- ✓ Enhances adherance
- ✓ Avoids the Cadillac tax

Putting Innovation into Action: Translating Research into Policy



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Motivation for "Dynamic" Benefit Design

- The natural history of chronic conditions often necessitate multiple therapies to achieve desired clinical outcomes
- Health plans frequently require certain steps be performed before access to additional therapies
- Increasing out-of-pocket costs for alternative therapies may prevent consumers from accessing recommended treatment

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"Reward the GOOD SOLDIER"™

A benefit design that lowers consumer cost-sharing for those who diligently follow the required steps for their condition, but require an alternative option

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Reward the Good Soldier™

A Dynamic Approach to Consumer Cost-sharing

- ✓ Commitment to established policies that encourage lower cost, first-line therapies
- ✓ Acknowledgment that clinical scenarios may require multiple treatment options
- ✓ Reduces cost-related non-adherence
- ✓ Enhances access to effective therapies when clinically appropriate

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Precision Medicine Requires Precision Benefit Design

Many "supply side" initiatives are restructuring provider incentives:

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

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Precision Medicine Requires Precision Benefit Design

Unfortunately, "supply-side" initiatives have pay little attention to consumer decision-making or the "demand-side" of care-seeking behavior:

- **Benefit design**
- **Literacy**
- **Shared decision-making**

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Precision Medicine Requires Precision Benefit Design

- **Using clinical nuance to align payment reform and consumer engagement initiatives can help improve quality of care, enhance patient experience, and contain cost growth**

AJAC. 2014;2(3);10.

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Discussion

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