



1 UNITED STATES SENATE ARMED SERVICES PERSONNEL SUBCOMMITTEE

2
3 THE ESSENTIAL ROLE OF CLINICAL NUANCE AND MEMBER
4 RESPONSIBILITY IN TRICARE BENEFIT REDESIGN

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14 Good morning and thank you, Chairman Graham, Ranking Member Gillibrand, and Members of the
15 Subcommittee. I am Mark Fendrick, Professor of Internal Medicine and Health Management &
16 Policy at the University of Michigan. I am addressing you today, not as a representative of the
17 University, but as a practicing primary care physician, a medical educator, and a public health
18 professional. I have devoted much of the past two decades to studying the United States health
19 care delivery system, and founded the University's Center for Value-Based Insurance Design
20 [www.vbidcenter.org] in 2005 to develop and evaluate insurance plans designed to engage
21 consumers, optimize the health of Americans and ensure efficient expenditure of our public and
22 private health care dollars.

23 Mr. Chairman, I applaud you for holding this hearing on Defense Health Care Reform,
24 because access to quality care and containing costs are among the most pressing issues for
25 our military personnel and our national well-being and economic security. We are well
26 aware that the U.S. spends far more per capita on health care than any other country, yet
27 lags behind other nations that spend substantially less, on key health quality and
28 patient-centered health measures. Since there is consistent agreement within both
29 political parties, and among key stakeholders, that there is already enough money being
30 spent on health care in this country, I would like to emphasize that if we reallocated our
31 existing dollars to clinical services for which there is clear evidence for improving health
32 and away from those that don't, we could significantly enhance quality and substantially
33 reduce the amount we spend. Thus, instead of the primary focus on *how much* we spend
34 – I suggest we shift our attention to *how well* we spend our military health care dollars.

35 **FROM A VOLUME-DRIVEN TO VALUE-BASED SYSTEM**

36 Moving from a volume-driven to value-based military health delivery system requires a
37 change in both how we pay for care (supply side initiatives) and how we engage
38 consumers to seek care (demand side initiatives). Previous discussions and earlier
39 testimonies focused on the critical importance and progress regarding reforming care
40 delivery and payment policies. Many sections of the 2016 National Defense Authorization
41 Act (NDAA) address payment issues; Sec. 726 explicitly calls for a pilot program to test
42 value-based reimbursement in TRICARE.

43 These are important and worthy conversations. Yet, less attention has been directed to
44 how we can alter consumer behavior as a policy lever to bring about a more efficient
45 delivery system. While you have heard about the potential of pay-for-performance
46 programs, patient-centered medical homes, bundled payment models, and other initiatives
47 to influence providers, today I propose that **value-driven consumer incentives -- through
48 benefit design reforms that promote smart decisions and enhanced personal
49 responsibility -- must be aligned with payment reform initiatives for us to achieve our
50 clinical and financial goals for military health care.** I commend the Subcommittee for
51 exploring this matter today.

52 **DANGERS OF A BLUNT APPROACH TO BENEFICIARY COST-SHARING – THE IMPORTANCE OF ‘CLINICAL
53 NUANCE’**

54 Over the past few decades, public and private payers -- including the TRICARE program -- have
55 implemented multiple managerial tools to constrain health care cost growth with varying levels of
56 success. The most common approach to directly impact consumer behavior is consumer cost
57 shifting: requiring beneficiaries to pay more in the form of higher premiums and increased cost-
58 sharing for clinician visits, diagnostic tests and prescription drugs. Of note, the Defense
59 Department budget proposal for 2017 calls for increasing the member out-of-pocket contributions
60 for TRICARE members, most dramatically for military retirees under 65.

61 With some notable exceptions, most U.S. health plans -- including TRICARE -- implement
62 cost-sharing in a ‘one-size-fits-all’ way, in that beneficiaries are charged the same amount
63 for every doctor visit, diagnostic test, and prescription drug [within a specified formulary
64 tier]. People frequently ask me whether the amount of cost-sharing faced by TRICARE
65 members is too high, too low, or just right. The answer, of course, is “it depends.” As
66 TRICARE members are asked to pay more for every clinician visit and for every prescription
67 -- despite clear differences in health produced -- a growing body of evidence demonstrates
68 that increases in patient cost-sharing lead to decreases in the use of both non-essential and
69 essential care. Unfortunately, research suggests that increasing ‘skin in the game’ has
70 not produced a savvier health care consumer.

71 A noteworthy example of the undesirable impact of ‘one-size-fits-all’ **increases** in
72 cost-sharing is a *New England Journal of Medicine* study that examined the effects of
73 increases in copayments for all doctor visits for Medicare Advantage beneficiaries [Trivedi
74 A. *N Engl J Med.* 2010;362(4):320-8]. As expected, individuals who were charged more to
75 see their physician(s) went less often; however, these patients were hospitalized more
76 frequently and their total medical costs increased. While this blunt approach may reduce
77 TRICARE expenditures in the short-term, lower use rates of essential care may lead to
78 inferior health outcomes and higher overall costs in certain clinical circumstances. This
79 effect simply demonstrates that the age-old aphorism ‘penny wise and pound foolish’
80 applies to health care.

81 Conversely, **decreases** in cost-sharing applied to all services regardless of clinical benefit --
82 which may have been the case in certain TRICARE plans -- can lead to overuse or misuse of
83 services that are potentially harmful or provide little clinical value. For the record, I
84 support high cost-sharing levels for those services -- but only those services -- that do not
85 make TRICARE members healthier. That said, I don’t think it makes sense to raise

86 cost-sharing on the services I beg my patients to do, such as fill their prescriptions to
87 manage their chronic conditions (e.g. diabetes, depression, HIV) and laboratory tests that
88 allow the monitoring of a specific disease (e.g., cholesterol, blood sugar).

89 Since there is evidence of both underuse of high-value services and overuse of low-value
90 services in the TRICARE program, **'smarter'** cost-sharing is a potential solution -- one that
91 encourages TRICARE members to use more of those services that make them healthier,
92 and discourages the use of services that do not. Therefore, to more efficiently reallocate
93 TRICARE medical spending and optimize health, the basic tenets of *clinical nuance* must be
94 considered. **These tenets recognize that: 1) clinical services differ in the benefit
95 provided; and 2) the clinical benefit derived from a specific service depends on the
96 patient using it, who provides it, and where it is provided.**

97 Does it make sense to you, Mr. Chairman, that my TRICARE patients pay the same
98 copayment to see a cardiologist after a heart attack as to see a dermatologist for mild
99 acne? Or that the prescription drug copayment is the same amount for a lifesaving
100 medication to treat diabetes, depression, or cancer, as it is for a drug that treats toenail
101 fungus? On the less expensive generic drug tier available to most TRICARE members
102 (current copayments are \$10 at retail pharmacies and \$0 through a mail order pharmacy),
103 certain are drugs so valuable that I often reach into my own pocket to help patients fill
104 these prescriptions; while for the same price there are also drugs of such dubious safety
105 and efficacy, I honestly would not give them to my dog. The current 'one-size-fits-all'
106 cost-sharing model lacks clinical nuance, and frankly, to me, makes no sense. As we
107 deliberate Defense Health Care benefit redesign, there is bipartisan recognition that the
108 current structure of the TRICARE benefit is outdated, confusing, and in need of reform.
109 Taking steps to improve the current array of confusing deductibles, copayments and
110 coinsurance is long overdue. I could not agree more that our military personnel deserve
111 better. Only after we acknowledge the limitations and inefficiencies of the TRICARE
112 cost-sharing structure, can we identify ways to improve it. It is my impression that
113 TRICARE members avail themselves of too little high-value care and too much low-value
114 care. Precision medicine needs precision benefit design. We need benefit designs that
115 support consumers in obtaining evidence-based services such as diabetic retinal exams and
116 discourage individuals through higher cost-sharing from using dangerous or low-value
117 services such as those identified by professional medical societies in the Choosing Wisely
118 initiative. By incorporating greater clinical nuance into benefit design, payers, purchasers,
119 beneficiaries, and taxpayers can attain more health for every dollar spent.

120 **VALUE-BASED INSURANCE DESIGN [V-BID]: IMPLEMENTING CLINICAL NUANCE**

121 Realizing the lack of clinical nuance in available public and commercial health plans, more
122 than a decade ago the private sector began to implement clinically nuanced plans based on
123 a concept our team developed known as Value-Based Insurance Design, or V-BID. **The
124 basic V-BID premise calls for reducing financial barriers to evidence-based services and
125 high-performing providers and imposing disincentives to discourage use of low-value
126 care.** A V-BID approach to benefit design recognizes that different health services have
127 different levels of value. It's common sense -- when barriers to high-value treatments are
128 reduced and access to low-value treatments is discouraged, these plans result in better
129 health with the potential to substantially lower spending levels.

130 Let me be clear, Mr. Chairman, I am not asserting that implementing V-BID into TRICARE is
131 a single solution to TRICARE’s problems. But, if we are serious about improving our
132 members’ experiences and health outcomes, while also bending the health care cost curve,
133 we must change the incentives for consumers as well as those for providers. **Blunt**
134 **changes to TRICARE benefit design -- such as those recently announced -- must not**
135 **produce avoidable reductions in quality of care.** Instead, I would recommend clinically
136 driven -- instead of a price driven -- strategies.

137 I’m pleased to tell you that the intuitiveness of the V-BID concept is driving momentum at a
138 rapid pace in both the private and public sectors, and we are truly at a ‘tipping point’ in its
139 adoption. Hundreds of private self-insured employers, public organizations, non-profits,
140 and insurance plans have designed and tested V-BID programs. The fundamental idea of
141 ‘buy more of the good stuff and less of the bad’ has made V-BID one of the very few health
142 care reform ideas with broad multi-stakeholder and bipartisan political support.

143 V-BID implementation has occurred in many of the states represented by members of this
144 subcommittee. Mr. Chairman, V-BID principles have been implemented in your State of
145 South Carolina Medicaid program to ensure that vulnerable beneficiaries have better
146 access to potentially life-saving drugs used to treat chronic diseases. Senator Gillibrand,
147 the Empire state has highlighted V-BID in Governor Cuomo’s state innovation plan and is a
148 key element of the State Innovation Model (SIM) program. Senator King, V-BID has a
149 similar high profile role in the Maine SIM program. Senator Cotton, Arkansas has been a
150 national leader in aligning consumer engagement initiatives with the episode-based
151 payment model. Senators Tillis and Blumenthal, V-BID plans are now offered to state
152 employees in North Carolina and Connecticut. Of note, the Connecticut Health
153 Enhancement Plan -- a V-BID plan for state employees -- has demonstrated high levels of
154 participation in healthy behaviors (98%), and preventive care, and has significantly reduced
155 emergency room visits in only two years. This plan has become a national model used by
156 several other states and public employers.

157 The last and most important example I would like to mention is the implementation of V-BID in the
158 Medicare program, a crucial component of our nation’s commitment to take care of the elderly
159 and disabled among us. The ‘one-size-fits-all’ approach to Medicare coverage dates back to its
160 inception in the 1960s, driven by discrimination concerns. Over the past several years, bipartisan,
161 bicameral Congressional support has grown to allow Medicare to implement clinically nuanced
162 benefit designs. In 2009, Senators Hutchison and Stabenow introduced a bipartisan bill,
163 “Seniors’ Medication Copayment Reduction Act of 2009” (S 1040), to allow a demonstration of V-
164 BID within Medicare Advantage plans. Last May, Senators Thune and Stabenow introduced the
165 “Value-Based Insurance Design Seniors’ Copayment Reduction Act of 2015” (S 1396). A
166 companion bill included in the “Strengthening Medicare Advantage through Innovation and
167 Transparency for Seniors Act of 2015” (HR 2570) passed the U.S. House of Representatives in June
168 with strong bipartisan support.

169 This strong Congressional backing led the Center for Medicare & Medicaid Innovation (CMMI) to
170 announce a program to test V-BID in Medicare Advantage (MA) plans in September 2015. The
171 5-year demonstration program will examine the utility of structuring patient cost-sharing and
172 other health plan design elements to encourage patients to use high-value clinical services and

173 providers, thereby improving quality and reducing costs. The model test will begin in January
174 2017, in Arizona, Indiana, Iowa, Massachusetts, Oregon, Pennsylvania, and Tennessee.

175 **INFUSING ‘CLINICAL NUANCE’ INTO TRICARE**

176 Flexibility in benefit design would allow TRICARE plans to achieve even greater efficiency
177 and to encourage personal responsibility among members in the following ways:

178 **I. DIFFERENTIAL COST-SHARING FOR USE OF DIFFERENT PROVIDERS OR SETTINGS**

179 Since the value of a clinical service may depend on the specific provider or the site
180 of care delivery, **TRICARE plans should have the flexibility to vary cost-sharing for a**
181 **particular outpatient service in accordance with who provides the service and /or**
182 **where the service is delivered.** This flexibility is increasingly feasible, as quality
183 metrics and risk-adjustment tools become better able to identify high-performing
184 health care providers and/or care settings that consistently deliver superior quality.

185 **II. DIFFERENTIAL COST-SHARING FOR USE OF DIFFERENT SERVICES**

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

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

205 While significant cost savings are unlikely with incentive-only ‘carrot’ programs in
206 the short term, **a V-BID program that combines reductions in cost-sharing for**
207 **high-value services and increases in cost-sharing for low-value services can both**
208 **improve quality and achieve net cost savings.** Removing harmful and/or
209 unnecessary care from the system is essential to reduce costs, and creates an
210 opportunity to improve quality and patient safety. Evidence suggests significant
211 opportunities exist to save money without sacrificing high-quality care. For
212 example, in 2014, the lowest available estimates of waste in the U.S. health care
213 system exceeded 20% of total health care expenditures. Though less common,

214 some V-BID programs are designed to discourage use of low-value services and
215 poorly performing providers. Low-value services result in either harm or no net
216 benefit, such as services labeled with a D rating by the U.S. Preventive Services Task
217 Force.

218 It is important to note that **many services that are identified as high quality in**
219 **certain clinical settings are considered low-value when used in other patient**
220 **populations, clinical diagnoses or delivery settings.** For example, cardiac
221 catheterization, imaging for back pain, and colonoscopy can each be classified as a
222 high- or low-value service depending on the clinical characteristics of the person,
223 when in the course of the disease the service is provided, and where it is delivered.

224 Fortunately, there is growing movement to both identify and discourage the use of
225 low-value services. The ABIM Foundation, in association with Consumers Union,
226 has launched Choosing Wisely, an initiative where medical specialty societies
227 identify commonly used tests or procedures whose necessity should be questioned
228 and discussed. Thus far, over 40 medical specialty societies have identified at least
229 five low-value services within their respective fields. Substantial and immediate
230 cost savings are available from waste identification and elimination. Thus, **V-BID**
231 **programs that include both ‘carrots’ and ‘sticks’ may be particularly desirable in**
232 **the setting of budget shortfalls.**

233 **III. DIFFERENTIAL COST-SHARING FOR CERTAIN SERVICES FOR SPECIFIC ENROLLEES**

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

252 Permitting ‘clinically nuanced’ variation in cost-sharing would give TRICARE plans a
253 necessary tool needed to better encourage members to receive high-value services. This
254 addition would eliminate many of the challenges and limitations of the ‘one-size-fits-all’
255 model.

256 **ALIGNMENT OF CONSUMER ENGAGEMENT WITH ALTERNATIVE PAYMENT MODELS**

257 The TRICARE program is currently examining many exciting, some unproven, value-based
258 reimbursement initiatives such as bundled payments, pay-for-performance, and patient-centered
259 medical homes, some of which are explicitly addressed in the 2016 National Defense Authorization
260 Act. As these initiatives provide incentives for clinicians to deliver specific services to particular
261 patient populations, it is of equal importance that consumer incentives are aligned. As a
262 practicing physician, **it is incomprehensible to realize that my patients' insurance coverage may**
263 **not offer easy access for those exact services for which I am benchmarked.** Does it make sense
264 to offer a financial bonus to get my patient's diabetes blood sugar under control, when her
265 benefit design makes it prohibitively expensive to fill her insulin prescription or provide the
266 copayment for her eye examination? **The alignment of clinically nuanced, provider-facing, and**
267 **consumer engagement initiatives is a necessary and critical step to improve quality of care,**
268 **enhance the member experience, and contain cost growth for the TRICARE program.**

269 **CONCLUSION**

270 As this committee considers changes to the TRICARE benefit design, it is an honor for me
271 to present one novel approach to better engage TRICARE members. As a practicing
272 clinician, I believe that the goal of the military health system is to keep its members
273 healthy, not to save money. That said, I strongly concur that health care cost
274 containment is absolutely critical for the sustainability of the TRICARE program and our
275 nation's fiscal health. While there is urgency to bend the health care cost curve, cost
276 containment efforts should not produce avoidable reductions in quality of care. As
277 cost-sharing becomes a necessity for fiscal sustainability, I encourage you to take a
278 common-sense approach of setting member co-payments on whether a clinical service
279 makes a TRICARE member healthier -- instead of the current strategy of basing member
280 contributions on the price of the service. **In other words, make it harder to buy the**
281 **services they should not be using in the first place.** If such principles encourage the
282 utilization of high-value providers and services and discourage only low-value services,
283 TRICARE plans can improve health, enhance consumer responsibility, and reduce costs.

284 Thank you.

285