University of Michigan
Center for Value-Based Insurance Design

THE ROLE OF VALUE-BASED INSURANCE DESIGN IN HEALTH CARE DELIVERY INNOVATION

Testimony
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A. Mark Fendrick, MD
Professor of Internal Medicine and Health Management & Policy
Director, Center for Value-Based Insurance Design
University of Michigan
www.vbidcenter.org

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Good afternoon and thank you, Chairman Harkin, Ranking Member Enzi, and Members of the Committee. I am Mark Fendrick, Professor of Internal Medicine and Health Management & Policy at the University of Michigan. I am addressing you today, not as a representative of the University, but as a practicing primary care physician, a medical educator, and a public health professional. I have devoted much of the past two decades to studying the clinical and economic impact of health care innovation, and founded the University's Center for Value-Based Insurance Design in 2005 to develop, implement and evaluate innovative health insurance designs to ensure efficient expenditure of health care dollars and maximize benefits of care.

Mr. Chairman, I applaud you for holding this hearing on "Improving Quality, Lowering Costs: The Role of Health Care Delivery System Reform" because quality improvement and health care cost containment are among the most pressing issues for our national well-being and economic security. We are well aware that the U.S. spends far more per capita on health care than any other country, yet lags behind other nations, that spend substantially less, on key health quality metrics. However, research shows that if we spent our health care dollars wisely on services for which there is clear evidence for improving clinical outcomes, we could simultaneously enhance quality and reduce the amount we spend. Thus,

instead of the unwavering focus on how much we spend – I suggest we shift our attention to how we spend our increasingly scarce health care dollars in order to maximize the amount of health produced for the dollar spent.

FROM A VOLUME-DRIVEN TO VALUE-BASED SYSTEM

Moving from a volume-driven to value-based system requires a change in both how we pay for care (supply side initiatives) and how we engage consumers to seek care (demand side initiatives). Other testimonies today and at earlier Committee hearings have focused on the critical importance of reforming care delivery and payment policies. Far less attention has been directed to how we can alter patient behavior to bring about a more effective and efficient delivery system. While you have heard about the potential of Accountable Care Organizations, Patient-Centered Medical Homes, bundled payments, and other initiatives to influence providers, today I propose that similarly aligned patient incentives are essential for each of these programs to accomplish their objectives and for us to really "bend the cost curve" for health care.

Over the past few decades, payers have implemented multiple managerial tools to constrain health care cost growth. The most common approach to directly impact consumer behavior is cost shifting: requiring beneficiaries to pay more in the form of increased premiums and increased cost-sharing for clinician visits, diagnostic tests and prescription drugs. In nearly every health plan across America, cost-sharing has been implemented in a "one size fits all" way, in that patients are charged the same amount for every doctor visit, diagnostic test, and prescription drug [within a specified formulary tier]. Cost-sharing increases are similarly passed on without any regard to clinical nuance. Does it make sense to you, Mr. Chairman, that my patients pay the same copayment to see a cardiologist after a heart attack as a dermatologist for mild acne, or the same copayment for a drug that could save a life from cancer or

heart disease as a drug that would make toenail fungus go away or hair grow back? In the typical $5 generic drug tier available to most Americans, there are drugs so valuable I have often reached into my own pocket to help patients fill these prescriptions; while for the same price there are also drugs of such dubious safety and efficacy, I honestly would not give them to my dog. This "one size fits all" system lacks any clinical nuance, and frankly, to me, makes no sense. Such an approach fails to acknowledge the well-documented differences in clinical value among medical interventions.

As Americans are required to pay more to visit their clinicians and fill their prescriptions, a growing body of evidence demonstrates that increases in patient cost-sharing lead to decreases in the use of both non-essential and essential care. Peer-reviewed studies reveal that when patients are asked to pay more for high-value cancer screenings, clinician visits and potentially life-saving drugs, they buy significantly less. A noteworthy example is a *New England Journal of Medicine* study that examined the effects of increases in copayments for doctor visits in Medicare Advantage plans.[i] As expected, individuals who were charged more to see their physician went less often; however, these patients were hospitalized more frequently and their total medical costs increased. This seemingly counterintuitive effect simply demonstrates that the age-old aphorism, "penny wise and pound foolish," applies to health care.

VALUE-BASED INSURANCE DESIGN [V-BID]

Realizing the lack of clinical nuance in available health plans, more than a decade ago the private sector began to implement a concept our team developed known as Value-Based Insurance Design, or V-BID, that simultaneously addresses quality improvement and cost containment – the two critical goals of health care reform. The central premise of V-BID is to reduce financial barriers to essential, high-value health services. These are the services I beg my patients to do, such as recommended immunizations,

preventive screenings, and critical medications and treatments for individuals with chronic disease such as asthma, diabetes and mental illness.

A V-BID approach to benefit plans recognizes that different health services have different levels of value. It's common sense—by reducing barriers to high-value treatments (through lower costs to patients) and discouraging low-value treatments (through higher costs to patients), these plans result in better health at any level of health care expenditure. Studies show that when patient barriers are reduced, compliance goes up, and, depending on the intervention or service, total costs go down.

To date, most V-BID programs have focused on lowering patient costs for high-value services. For example, these programs make drugs and services for chronic conditions such as diabetes, asthma and heart disease that drive the vast majority of our health care spending, less expensive and more accessible. Though less common, some V-BID programs designed to discourage use of low-value services, such as unnecessary imaging and procedures, have also been implemented. It must be stated clearly that V-BID programs never determine what is covered and what is not. Instead of having all branded drugs cost $30 out-of-pocket for the patient, a V-BID formulary would, for example, provide certain high-value drugs such as statins for high cholesterol or insulin for diabetes for $10, with other drugs for $50. This clinically nuanced reallocation of services is a necessary component in order to move from a volume-driven to value-based system.

IMPROVING QUALITY AND BENDING THE COST CURVE

Let me be clear, Mr. Chairman, I am not asserting that Value-Based Insurance Design is the solution to all of our health care system's problems. But, if we are serious about "bending the health care cost curve" and improving health outcomes, we must change the incentives for consumers as well as those for providers. Any effort to control costs should include clinically nuanced, not price driven, strategies

such as V-BID.

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

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

But, despite recent advances in the Federal Employee Health Benefits Programs, and the requirement that private plans provide selected primary preventive services with no patient cost-sharing in Section 2713 of the Patient Protection and Affordable Care Act [PPACA], federal government programs are lagging far behind. The federal government should not erect barriers to the adoption of V-BID in the private market, and it should consider ways to expand V-BID among public programs.

Provided below are some potential policy approaches:

1. **Avoid Rigid Essential Health Benefit Requirements**: As stated above, there is substantial movement in the private market towards greater adoption of V-BID. Setting uniform requirements for co-pays and deductibles can have the unintended effect of prohibiting value-based principles. The potential result of strict cost-sharing requirements without clinical nuance would be underuse of high-value services and overuse of low-value services. Additionally, as the Institute of Medicine (IOM) argued in its recent report, the essential health benefit package should evolve to promote more value over time.
2. **Maintain Flexibility and Limit Mandates in Benefit Designs with Respect to State Health Exchanges:** Value-based designs generally raise the actuarial value of a plan, even though they may reduce health spending in the long run, because they lower the up-front cost- and therefore lead to increased use of high-value services. Under PPACA, plans in each tier--platinum, gold, silver and bronze--have corresponding limits in actuarial value. Consequently, states and the federal government should take care when mandating specific benefits and services for plans. Too many prescribed benefits will exclude value-based designs, especially for the bronze and silver plans, which will be sold to the very low-income populations who have the potential to benefit most from V-BID.
3. **Expand Secondary Prevention**: While the removal of patient cost-sharing for preventive services is commendable, the V-BID premise of reduced patient cost-sharing for high-value, evidence-based care has important implications beyond preventive services as mandated in Section 2713. The definition of preventive services in PPACA is narrow, focusing on primary prevention. Evidence-based services for those with identified chronic diseases, such as eye examinations for those with diabetes, behavioral therapy for

individuals with depression, and long-acting inhalers for asthma sufferers, offer as much or more value than those preventive services identified in Section 2713. These services, often referred to as "secondary prevention," are typically the foundation of quality improvement programs, such as pay for performance, disease management and health plan accreditation. Allowing high-value secondary prevention services that would be made available without patient cost-sharing, similar to those primary prevention services selected in Section 2713, would be an important extension of the health enhancing and cost containment goals of health reform.

4. **Fixing Medicare's "One Size Fits All" Cost-Sharing**: The Medicare "one size fits all" approach to copayments dates back to its inception in the 1960s. The Medicare Payment Advisory Commission (MedPAC) has repeatedly advocated the use of V-BID as a long-run measure for improving quality and lowering spending. For example, in its 2010 Report to Congress, MedPAC wrote that V-BID could be used to tailor Part D cost-sharing requirements to individuals' clinical needs. Additionally, Senators Stabenow and Hutchison introduced a bipartisan bill, S.1040, "Seniors' Medication Copayment Reduction Act of 2009" to allow a demonstration of V-BID within Medicare Advantage plans. The federal government should remove the barriers to enable the implementation of this innovative approach.
5. **Encouraging Innovation in Medicaid**: Finally, within Medicaid we see states, under pressure to cut Medicaid spending, rai**s**ing copayments on an extremely cost-sensitive population without any regard to clinical nuance. Research demonstrates that these co-payment increases will cause some patients with chronic conditions to forgo care and end up in an emergency room or hospital, which could result in higher overall spending.

CONCLUSION

It is my hope that as you consider changes to the delivery system, you will take the common-sense step of allowing co-payments to vary based on whether an intervention is high-value or low-value. As a practicing clinician, I believe that the goal of our health care system is to produce health, not to save money. That said, I strongly concur that health care cost containment is absolutely critical for our nation's fiscal health. The goal of health reform should be to improve Americans' health *and* address rising costs by utilizing strategies that produce a more effective and efficient health system. Value-Based Insurance Design is one step toward reaching that promise. The use of clinically nuanced incentives (and disincentives) to encourage or discourage patient and provider behavior will ultimately produce more health at any level of health expenditure. This is an opportunity that we cannot miss.

Thank you.

[i] Trivedi A. *N Engl J Med*. 2010 Jan 28;362(4):320-8.