Value Based Insurance Design

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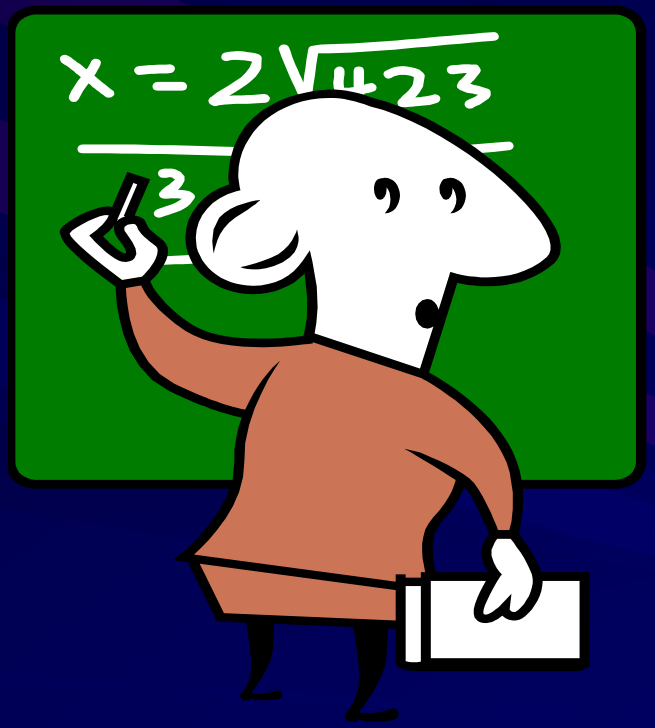
Background

- Status quo is not sustainable
- Payers have limited control over the system
- Beneficiary strategies are central
  - How should incentives be structured?
  - Cost shifting has been the norm

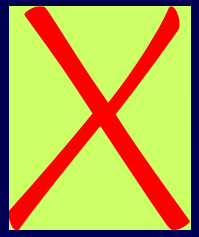
➔ We can do better

Insurance Theory

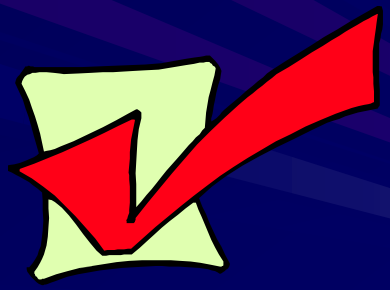


Why the cost sharing?

- To lower premiums



- To improve incentives
  - Reduce ‘excess use’
  - Encourage price shopping



Optimal insurance theory

- Balance incentives with risk aversion
- Low coinsurance if demand is unresponsive
- Efficient resource allocation reflects consumption under perfect information and appropriate pricing

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Consumers Make Suboptimal Decisions

- Reductions in appropriate use same as for inappropriate use (Sui et al. 1986)
  - Copays reduce use of preventive services
  - Copays reduce use of ‘valuable’ pharmaceuticals
- Who do we believe: patients or experts?
- Can we incent patients to improve welfare?

Value Based Insurance Design (VBID)

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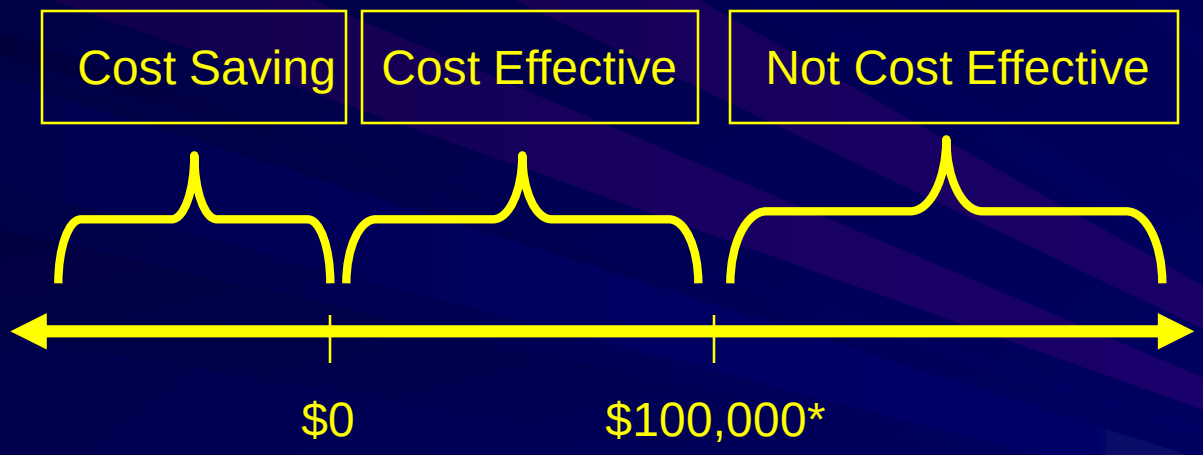
Defining Value



Cost effectiveness ratio ($/Quality adjusted life year)

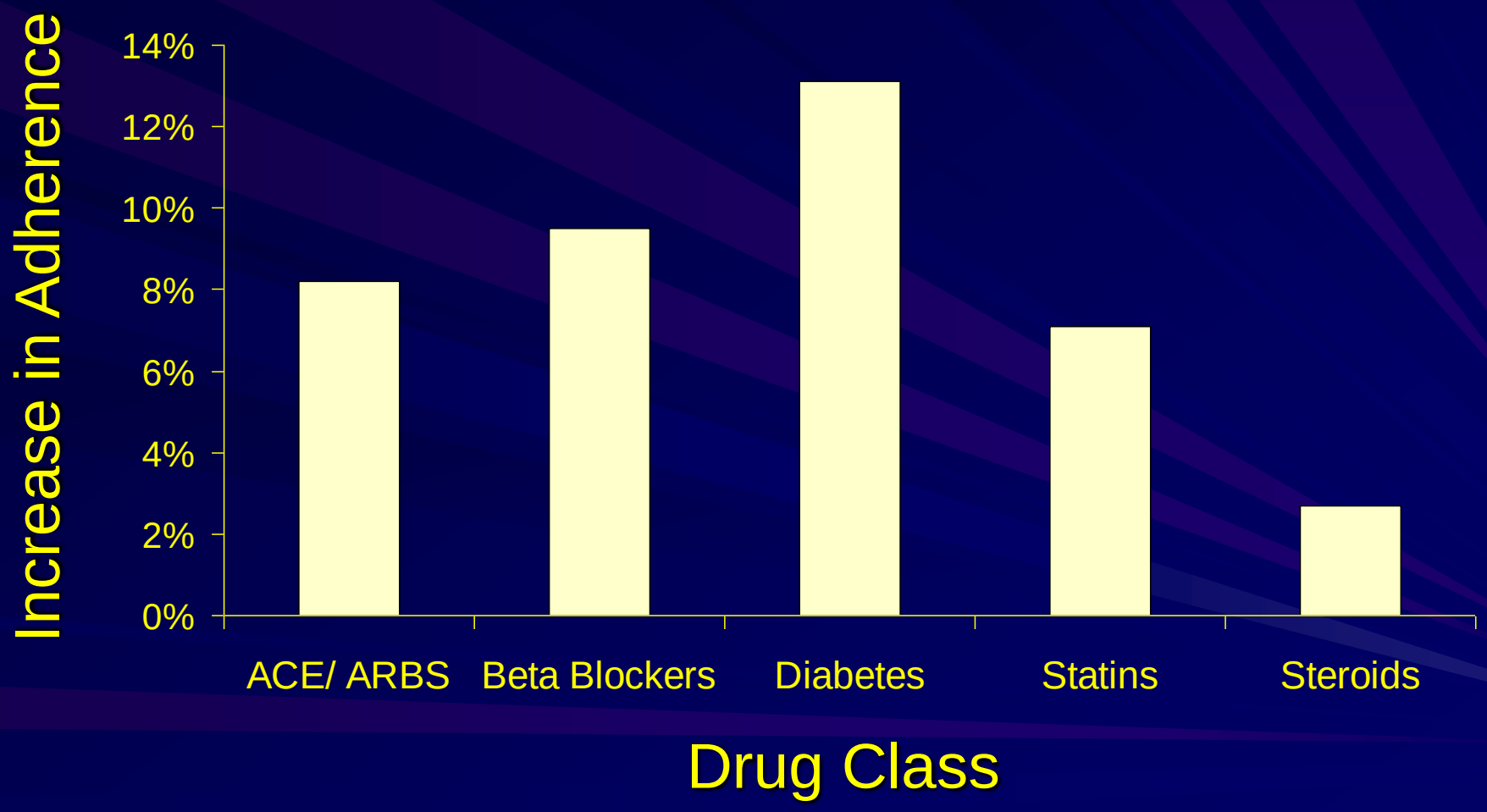
➔ Always relative to next best alternative

* This should be higher ($250,000), but decline as overall spending rises

VBID Variations

- Targeting
  - Simple VBID: Target a service
    - Blood pressure medication for everybody
  - More complex VBID: Target services only for selected patient groups
    - Blood pressure medications for patients with diabetes
- Copay lowering only or “aligning”?
  - Target increase vs across the board increase

Impact of VBID on Adherence



SOURCE: Chernew ME, *Health Affairs*. Impact of Decreasing Copayments on Medication Adherence Within a Disease Management Program. January 2008.

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Financing VBID

- Offsets
  - Lower costs due to fewer adverse events
    - Do not fully offset employer spending
    - May offset total costs
  - Productivity gains
- Increase costs for other services
  - Specifically low value services

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Goal must be to Eliminate Waste

EXHIBIT 1

Estimates of Waste in US Health Care Spending in 2011, by Category

	Cost to Medicare and Medicaid[a]			Total cost to US health care[b]		
	Low	**Midpoint**	**High**	**Low**	**Midpoint**	**High**
Failures of care delivery	$26	$36	$45	$102	$128	$154
Failures of care coordination	21	30	39	25	35	45
Overtreatment	67	77	87	158	192	226
Administrative complexity	16	36	56	107	248	389
Pricing failures	36	56	77	84	131	178
Subtotal (excluding fraud and abuse)	166	235	304	476	734	992
Percentage of total health care spending	6%	9%	11%	18%	27%	37%
Fraud and abuse	30	64	98	82	177	272
Total (including fraud and abuse)	197	300	402	558	910	1,263
Percentage of total health care spending				21%	34%	47%

SOURCE Donald M. Berwick and Andrew D. Hackbarth, "Eliminating Waste in US Health Care," *JAMA* 307, no. 14 (April 11, 2012):1513–6. Copyright © 2012 American Medical Association. All rights reserved.
NOTES Dollars in billions. Totals may not match the sum of components due to rounding. [a]Includes state portion of Medicaid. [b]Total US health care spending estimated at $2.687 trillion.

Quantifying Waste

- Choosing Wisely
  - Don’t image for suspected pulmonary embolism (PE) without moderate or high pre-test probability
  - Parathyroid hormone (PTH) measurement for patients with stage 1-3 CKD
  - Don’t order annual electrocardiograms (EKGs) or any other cardiac screening for low-risk patients without symptoms
- USPSTF
  - Don't perform PSA-based screening for prostate cancer in all men regardless of age.
- Hard to code
  - Milliman Waste Calculator

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Barriers To VBID

- Identifying high/ low value services
  - Start with those we know
- IT issues
  - Growing number of private vendors
- HR concerns
  - Education
- Financial profile
  - Combine with other strategies

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Price Transparency

- Informing vs charging
  - Charging should affect behavior
  - Informing (without charging) may have a perverse effect
- Patients respond to what they pay
  - Per episode
  - Per service

Next Generation VBID

- Expand diseases with VBID designs
  - Beyond diabetes and heart disease
  - To services other than prescription drugs
- Develop VBID implementation strategies, while considering system complexity
- Synergize VBID with other cost containment initiatives
  - Payment reform

Severe Illness Shocks

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Severe illness shocks

- Many illness have ‘minimum spending threshold’
  - Cancer
  - Heart Attack
- High deductibles are really a tax on getting the illness
  - No incentive effect

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Alternative design

- Waive cost sharing on first dollar expenditure
  - Add cost sharing for those choosing the high cost (low value?) alternative
- Share savings for patients choosing low cost service

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General Conclusions

- VBID is a paradigm, not a specific program
  - Assumes willingness to use patient incentives
- Co-pays will never be set perfectly
- Improvements can be made
  - Set co-pays differentially based on likely clinical benefit (net of cost)
  - Remove first dollar co-pays for consumers with serious illness shocks

END

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