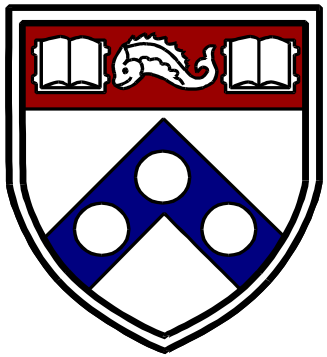
Some thoughts about value-based insurance design



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Disclosures

I am a partner at VAL Health, a behavioral economics consulting firm

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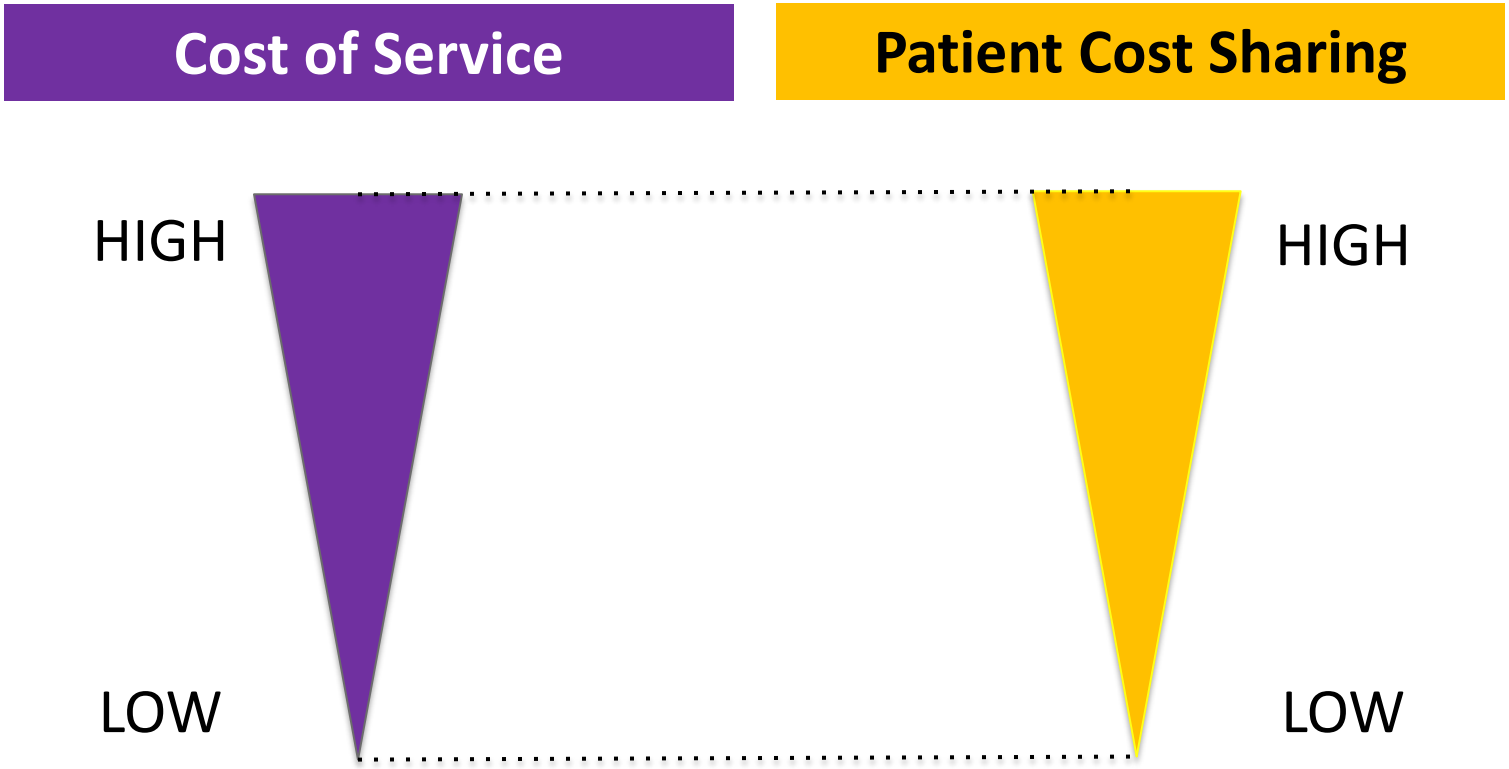
Other disclosures

- I am an above-average dancer
- I sometimes sing show tunes when I am in the shower

Typical cost sharing

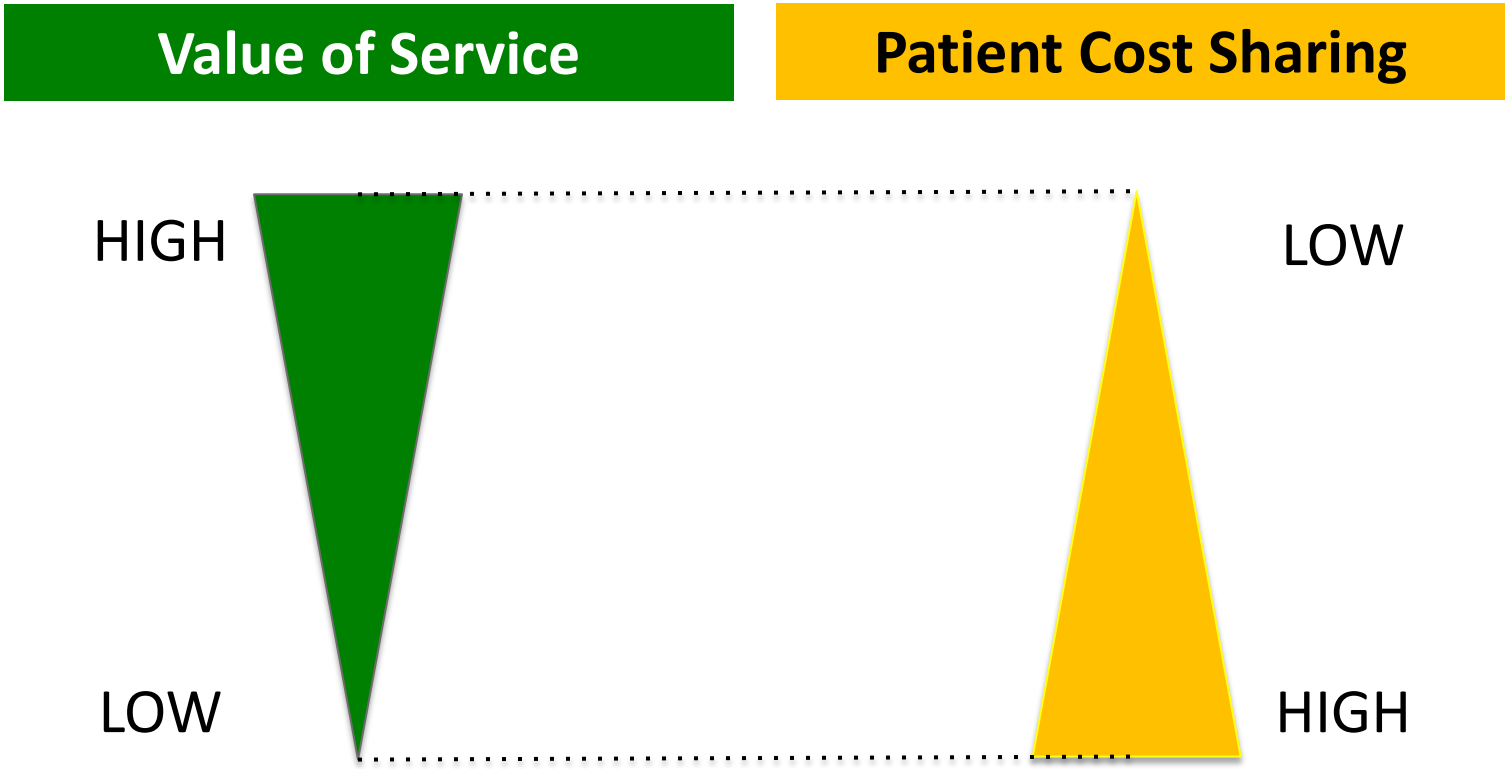
When the cost is high, patient cost-sharing is high



Fendrick AM, et al. Am J Manag Care 2001;7:861-867

Value-based insurance design

When the value is high, patient cost-sharing is low



Fendrick AM, et al. Am J Manag Care 2001;7:861-867

An extremely appealing idea

- Increase costs for low value services
- Decrease costs for high value services

But only half of this formula actually works

Increased cost-sharing: ↓adherence, ↑mortality, no savings

Annual drug benefits cap of $1,000 among some Medicare Advantage beneficiaries.

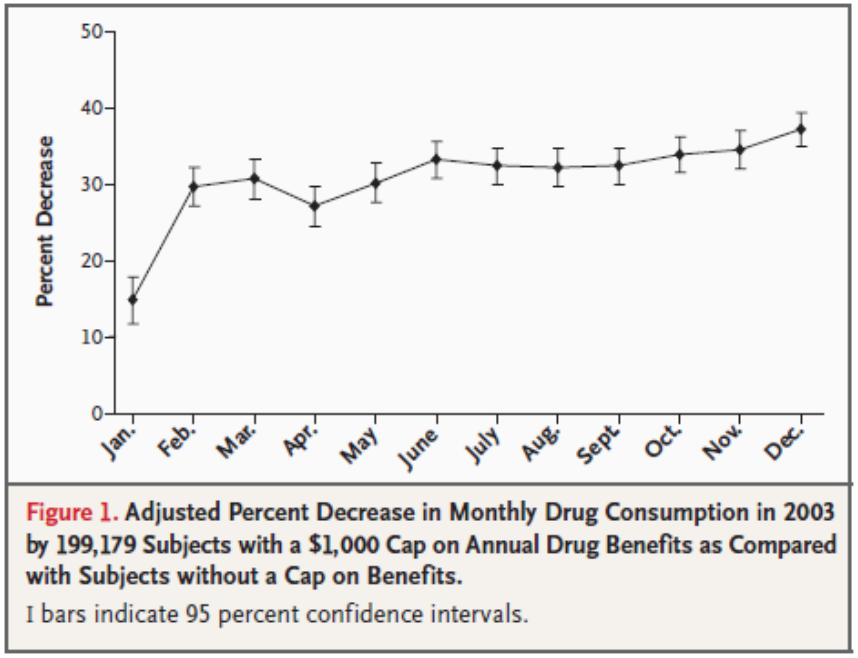
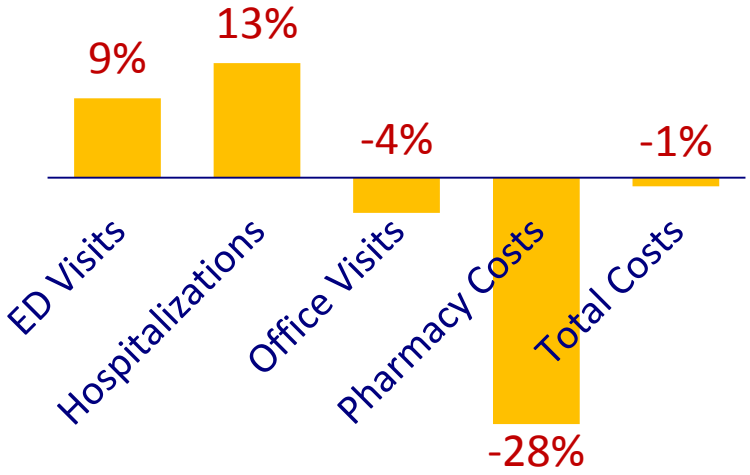


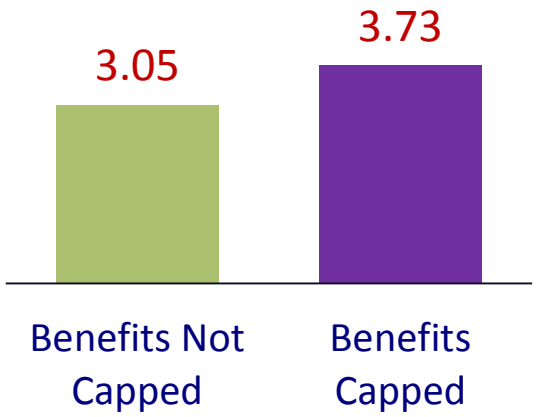
Figure 1. Adjusted Percent Decrease in Monthly Drug Consumption in 2003 by 199,179 Subjects with a $1,000 Cap on Annual Drug Benefits as Compared with Subjects without a Cap on Benefits.

I bars indicate 95 percent confidence intervals.

Differences in Use of Services and Costs



Mortality Per 100 Person Years



Hsu J, et al. NEJM 2006;354:2349-59.

The mirror-image argument

- Copayment increases seem to decrease adherence and increase mortality
- So, maybe copayment decreases will increase adherence and decrease mortality

Copay reductions for patients with diabetes

- $5 → $0 generics
- $25 → $12.50 preferred drugs
- $45 → 22.50 non-preferred drugs

→ Minimal increase in adherence

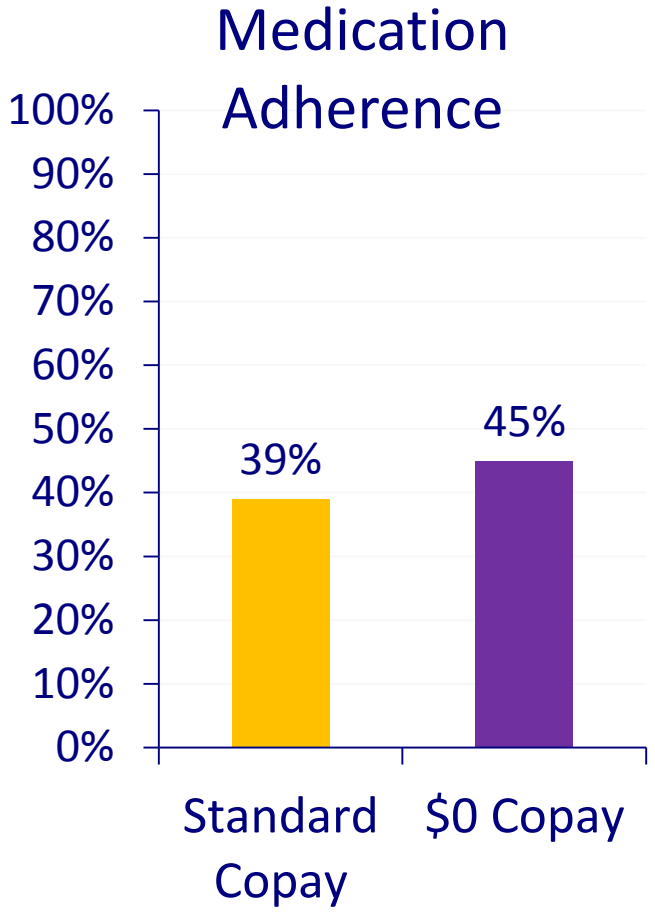
Drug Class	Baseline MPR (%)	% Increase
ACEi/ARB	68.4	3.8
β-blocker	68.3	4.4
Diabetes drug	69.5	5.8
Statin	53.0	6.3
Steroids	31.6	5.9

Chernew ME, et al. Health Affairs 2008;27(1):103-12.

Making medications free doesn't increase adherence much—Even after a heart attack

- Government and private employees in several different Aetna health plans discharged after myocardial infarction. Randomized to:
  - **A. Standard Co-payment**
  - **B. $0 Co-payments**

- Did not reduce rate of first major vascular event or revascularization



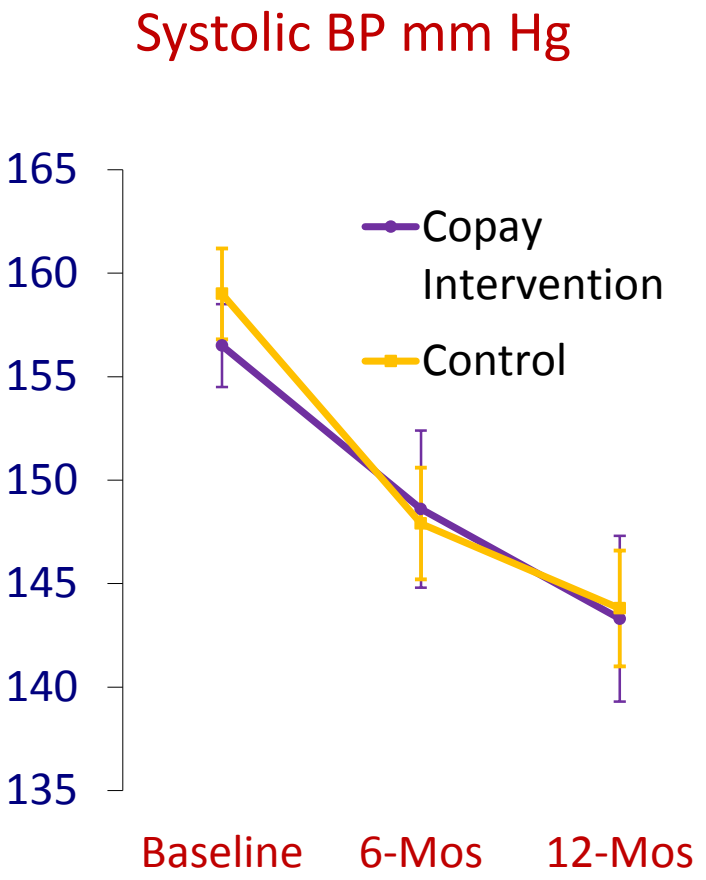
Choudhry N, et al. NEJM 2011; 365:2088-2097

No effect of copay reductions on BP

- 2 RCTs among veterans with poorly controlled BP
- Average SBP at entry: 160

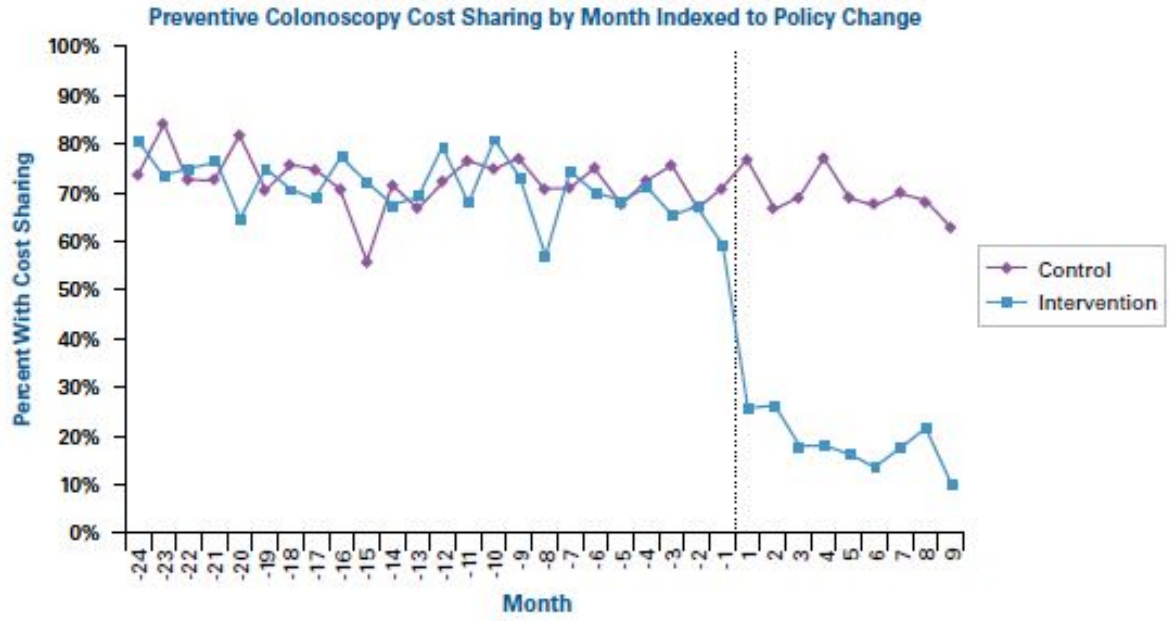
1. Copayments reduced from $8 per month to $0
2. Copayments reduced from $0 per month to -$8

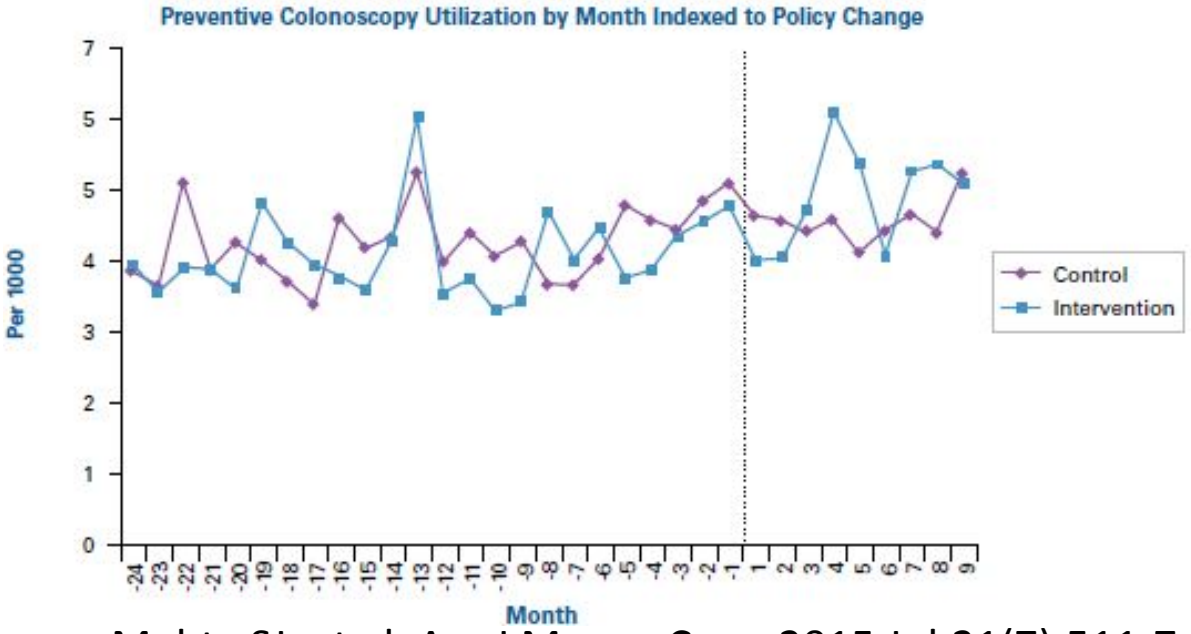
- No significant effect on blood pressure or medication adherence in either study



Volpp KG, et al. Am J Managed Care. 2015 Aug;21(8):e455-64.

- ACA eliminated cost sharing for colonoscopy except for grandfathered plans
- We would <u>expect</u> to see increases in colonoscopy in plans that had to change
- In this study of 63,246 men and women 50-64 we see <u>no change</u>





Mehta SJ, et al. Am J Manag Care. 2015 Jul;21(7):511-7.

If increased copayments decrease use, why don't decreased copayments increase use?

- Copayment increases and decreases affect fundamentally different populations.
- Non-adherent patients may have a smaller change in quantity demand for given change in price
- Copayment reductions are like "the dog that didn't bark"
- Reductions may be processed as gains
- Change in amounts is typically small
- ✪ Feedback is too infrequent for a behavior that is required at least daily

Value Based Insurance Design isn't a bad idea, but these results indicate it will provide less benefit than expected

Volpp KG, Loewenstein G, Asch DA. JAMA. 2012;308:1635-6.

Losses and gains are not mirror images

- Losses are more potent motivators than gains
- Increasing high value care is not the same as decreasing low value care driven in reverse

But, why should we create ANY barriers to high value care?

Contact

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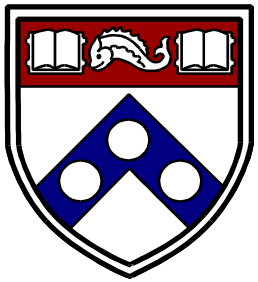

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