



buyers health care action group
BHCAG

Community
Dialogue
on Value-Based
Benefit Design

March 3, 2009



BHCAG Community Dialogues

Several times a year, BHCAG hosts a Community Dialogue on health care topics relevant to providers, purchasers, health care plans and patients. Most often, these topics relate to the MN Bridges to Excellence pay-for-performance program administered by BHCAG. The aim of these meetings is to foster communication among stakeholders and to gain a better understanding of different stakeholder perspectives. In March, BHCAG invited Dr. Mark Fendrick from the University of Michigan to discuss value-based benefit design. A panel of speakers, each representing a different stakeholder point of view, was then asked to respond to Dr. Fendrick's comments and address value-based benefit design from the perspective of their organizations. The discussion illuminated the advantages of value-based benefit design as well as the challenges stakeholders face in transforming their systems to promote value.

Value-Based Design for Sustainable Health Improvement

A. Mark Fendrick, M.D., University of Michigan

Dr. Fendrick is a Professor of both Internal Medicine and Health Management and Policy at the University of Michigan. He is also Co-Director of the Center for Value-Based Insurance Design. Fendrick opened his remarks by stating that the health care debate is too often about cost when it should be about quality, health and wellness. While cost is an important factor for plans and purchasers, health and wellness are the ultimate goals of the health care system, and there must be a bridge between these priorities.

Fendrick argued that the nation needs to invest more money in high value services such as chronic care, cancer screening and disease management programs in order to improve the health care system and ultimately bring down the costs of health care. Health plans and purchasers must also rely heavily on accurate data to drive their benefit design. This, he believes, will lead them to choose value-based benefit design over cost-based benefit design.

A major flaw Fendrick identified in current benefit design is that strategies are not aligned to meet the

overall goals of health and wellness. For instance, plans and purchasers put in place disease management programs but do not offer co-pay relief for services recommended by the programs. In one case, employees were paid by their company to quit smoking but the plan then doubled the co-payment for smoking cessation drugs. In order to influence people's behavior and encourage them to use the services that will improve their health, plans and purchasers must decrease the cost of these higher value services to the patient. According to Fendrick, over 90% of Americans with private health insurance pay equal amounts for essential and non-essential services. Within a value-based design, a patient's out-of-pocket costs would reflect the clinical benefit achieved by the care, with services that deliver greater clinical benefits leading to lower costs for the patient.

Another example Dr. Fendrick used is in benefits for pharmaceutical care. Plans and employers often set the co-pay for drugs based on cost tiers rather than value provided by specific medications. Generics have the lowest co-pays, preferred brands have mid-level co-pays and non-preferred brands have the highest co-pay. This cost-shifting strategy for pharmaceutical benefit design does not take into account the fact that certain brand-name drugs do not have generic equivalents, and yet are essential to patients' health, or the fact that all drugs within a cost tier do not have the same proven value. A value-based approach would take these facts into consideration and place pharmaceuticals in cost tiers based on the clinical value to the patient. Fendrick argues that while charging consumers high out-of-pocket fees will likely reduce costs in the short run, it can lead to worse clinical outcomes.

Value-based benefit design has been implemented by several companies including UnitedHealthcare, Cargill and Carlson Companies. Wellness programs, disease management and pay-for-performance programs are being adopted by plans and purchasers. These programs work best when at-risk patients are clearly targeted for participation. Fendrick challenged audience members to choose one area of care and apply value-based benefit design. In his experience, companies that do so inevitably see positive results and increase the scope of their programs. For more information on value-based benefit design, see Fendrick's presentation to Congress by clicking [here](#).

Panel Discussion

Nathan Moracco, State of Minnesota

The State of Minnesota covers 120,000 lives, spends \$1.5 billion on insurance and works with 1200 clinics statewide. Nathan Moracco, Director of Benefits for the State of Minnesota, admits that the answer to whether the State uses value-based benefit design depends on whom you ask. The State's program includes many elements of value-based benefit design. It provides incentives to members who seek low cost, high quality providers. Its Health Risk Assessment program helps members become aware of their health status and provides coaching services and a \$5 office co-pay reduction. In 2007, the State initiated a Medication Therapy Management pilot program for diabetic patients that resulted in 39% fewer ER visits and 24% fewer hospital admissions.

The State has a tiered benefits system for pharmaceuticals – if no generic exists for a certain drug, the State keeps the cost of the brand-name drug low to encourage compliance. In addition, the State has established certain providers as Centers of Excellence, though it has yet to design incentives that promote them to members. Along with the Joint Labor Committee on Health Plans, the State of Minnesota initiated Advantage Health Advisors, a phone-based system that helps members make decisions about important medical procedures. These steps have moved the State of Minnesota closer to a benefits system based on value, and it has pledged to continue to purchase health care based on both cost and outcomes. To view Moracco's presentation, click [here](#).

Marcus Thygeson, M.D., HealthPartners

Dr. Marcus Thygeson is Vice President of Consumer Health Solutions and Associate Medical Director at HealthPartners. In his remarks, Thygeson challenged some of Fendrick's ideas about value-based benefit design. Thygeson recently completed a cost/benefit analysis of incentives designed to promote wellness. He studied the price elasticity for blood pressure and asthma drugs. Thygeson found that cost-related non-adherence for blood pressure drugs was 5%; only 2% did not have their blood pressure in control. For asthma, cost-related non-adherence was 30%. According to Thygeson's results, 200 people would need to receive free blood pressure medication in order for an

additional one person to get their blood pressure under control. Thygeson's data also suggests that less than 1% of patients fail to take their medication because it is too expensive. To access Thygeson's presentation, click [here](#).

Teresa Pearson, RN, Fairview Health Services

Teresa Pearson is Director of Diabetes Care for Fairview Health Services. She emphasized the importance of providing benefit coverage to educate diabetes patients, or patients with other types of chronic disease, on how to self-manage their care as part of a value-based benefit design. Diabetes is a progressive disease, and despite it being the last resort for treatment, most patients will eventually end up on insulin. Diabetes patients are tempted to deviate from their physician's advice every 15 minutes throughout the day. Because they spend most of their lives outside the observation of their physician, people with diabetes must learn problem-solving skills that will help them manage their disease in every day life. They must learn how the clinical numbers they are striving to reach correlate to better health. Pearson reminded the audience that any strategy for improving health care should maintain a balanced approach that includes coaching patients to do the right thing for the sake of their health. To view Pearson's presentation, click [here](#).

Tim Hernandez, M.D., Family Health Services Minnesota

Dr. Hernandez, Medical Director of Family Health Services Minnesota, spoke about the DIAMOND depression program that they initiated in several of their clinics. While the program has been more successful in treating patients with depression than the usual way of delivering depression care, Hernandez noted that barriers to treatment include the cost of office visit co-pays and deductibles, as well as the clinic's ability to engage patients in the program. He suggested that providers need financial support from plans in order to implement effective programs, and from employers through value-based benefit design to remove the barriers to obtaining care that delivers improved health outcomes.