The Role of Employers in Promoting Value-Based Health Care

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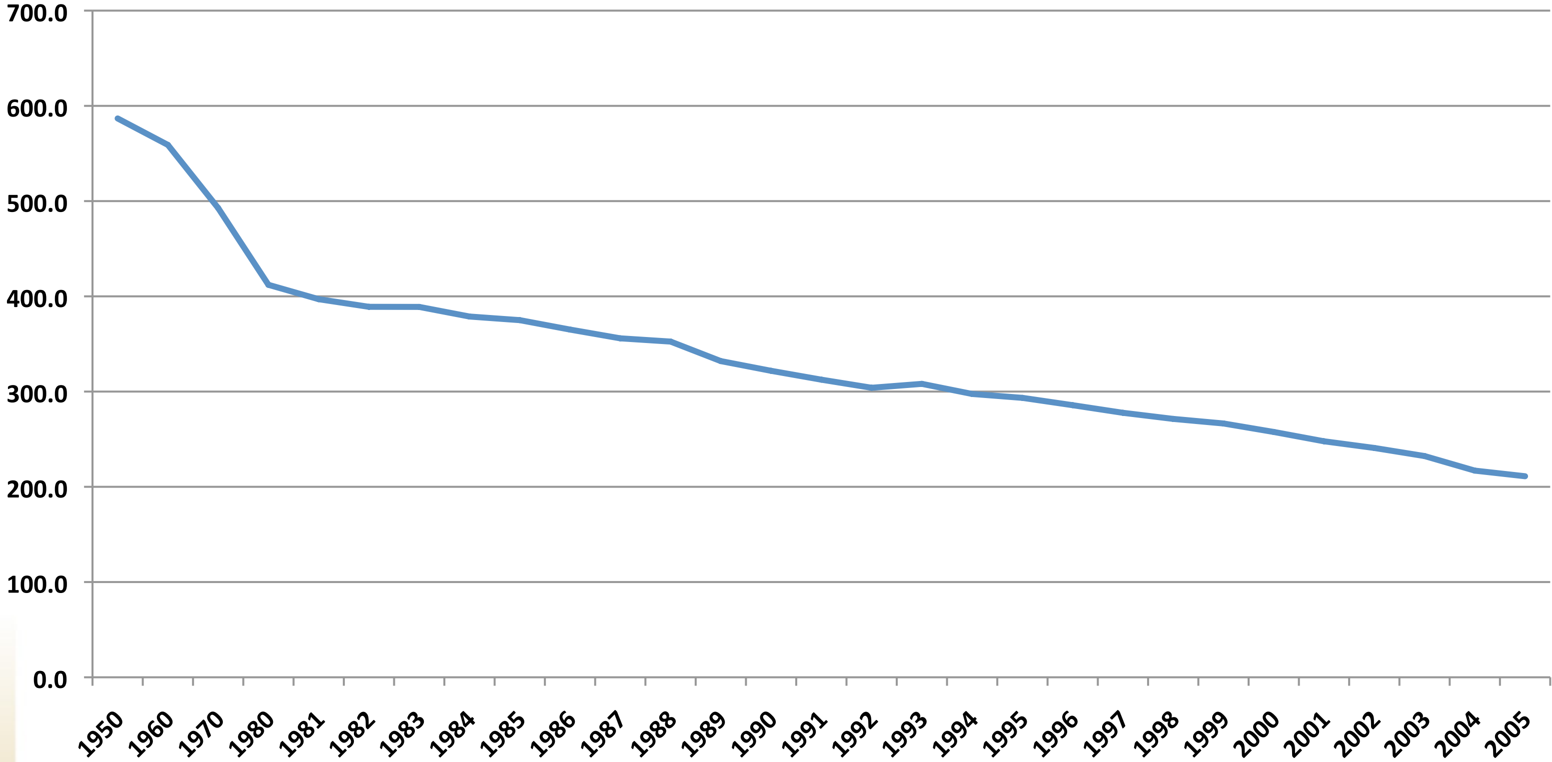
OVERVIEW

- Clinical evidence and economic incentives
- Mechanisms for promoting value
- The role of employers
- Value-based coverage, benefits, networks, prices
- Wisdom about value

The jargon of "value"

- It's all value, all the time, in health policy
  - Value-based purchasing
  - Value-based pricing
  - Value-based insurance design
  - Value networks
- This has something to do with V=Q/P, but what?
- How can employers increase value?

The record on value: improvements in health



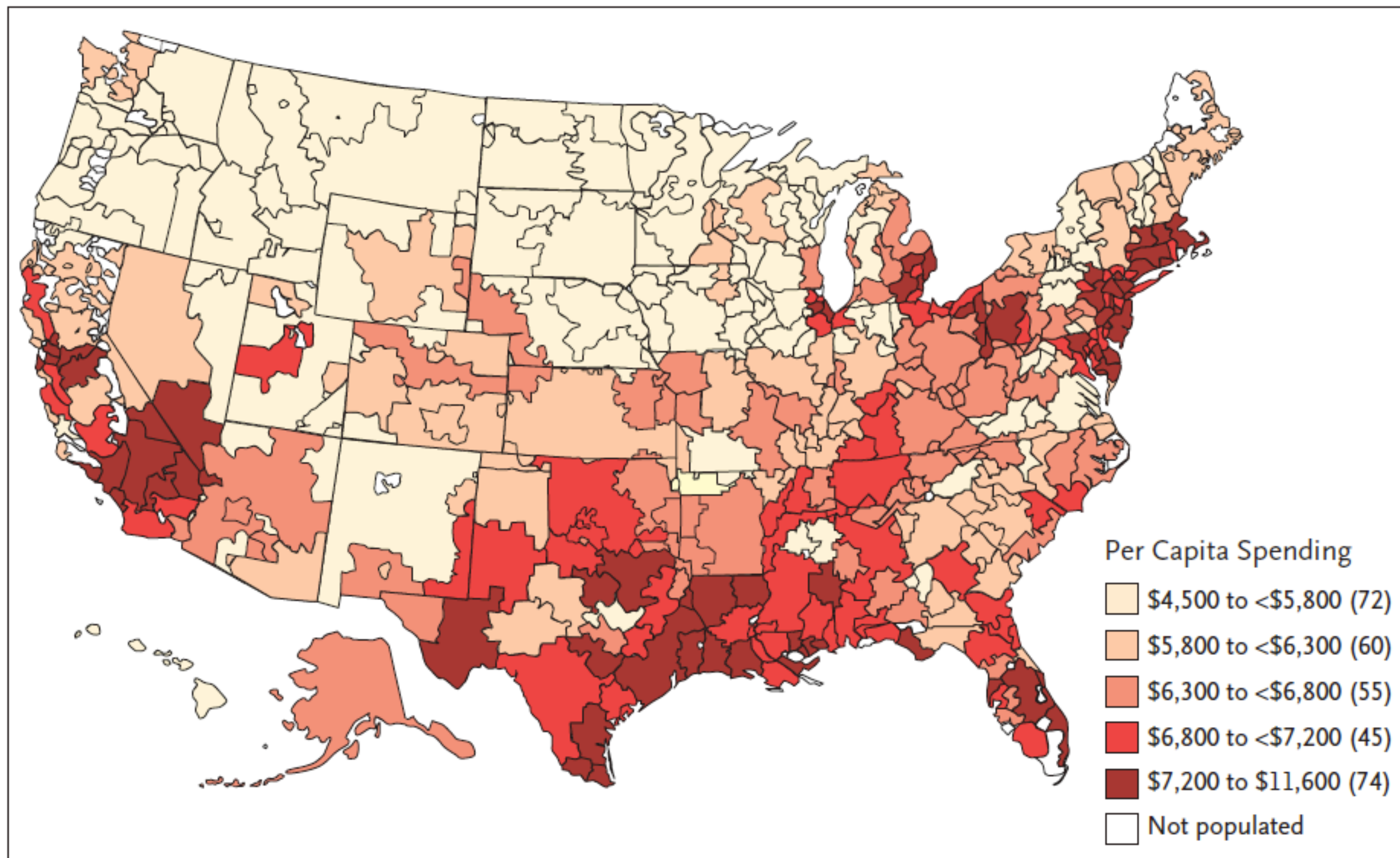
Source: CDC Report: Health, United States, 2007

The record on value: costs

National Health Expenditures Per Capita

Source: Centers for Medicare and Medicaid Services

The record on value: unjustified variation



Source: Dartmouth Atlas of Health Care

Variation in value across products, providers

- V=Q/P but Q and P vary in multiple ways
- For any one product there are often alternative uses (e.g., indications)
  - This is a focus of FDA oversight
- For any one condition, there are alternative treatments, providers, sites of care
  - This is a focus of comparative effectiveness research
- For any one product or procedure, there are often alternative prices (e.g., brand v. generic; provider contracted rates)
  - This is a focus of rate negotiations

Variation in value across time: innovation

- Q often improves and P often declines over time
  - Learning by doing, economies of scale
  - But costs often increase as product mix changes
- But Q declines and P increases in relative terms as new treatments or providers emerge with better quality and/or lower price
- Innovation: what we care most about is improvements over time in quality relative to cost ($\Delta V = \Delta Q / \Delta P$)

The fundamental imperative

- **We need more data on Q and P but, realistically, we have more data than at any time in the past**
- **More importantly, we need improved incentives** that encourage appropriateness and promote value
- **Four principal mechanisms**
  1. Coverage policy (e.g., prior authorization)
  2. Benefit design and consumer cost sharing
  3. Provider payment and product distribution
  4. Product pricing (e.g., drugs, devices)
- **Let's examine each of these**

1. Coverage policy

- Valuable therapies should be covered without limits
- Therapies that are ineffective or where risks outweigh benefits should not be covered at all
- But many therapies are effective in some contexts and not in others, hence gets conditional coverage
  - Prior authorization
    - By clinical indication, severity, provider (e.g., specialty)
  - Step therapy
    - Patient first needs to try and fail on high value treatment before moving to lower value
  - Coverage with evidence development (CED)
    - Product/procedure covered if part of registry, RCT, or other mechanism to improve evidence

2. Benefit design

- Cost sharing provisions should be, but often are not, linked to value
- Examples of not linking benefits to value
  - Four tier formulary with coinsurance rather than copays
  - HDHP with full coverage above deductible
- Examples of linking benefits to value (VBID)
  - Reduced copay for preventive tests (e.g., mammography)
  - Reduced copay for chronic illness drugs (e.g., diabetes)
- Experiments with VBID to date have focused on low cost services and ones where appropriateness is uncontroversial
- There is a lot more to be done

3. Provider network and product distribution

- Network contracting seeks to:
  - Channel patients towards higher value providers
  - Increase value by inducing price reductions by providers
- Novel payment mechanisms can promote value without limiting provider choice
- For high-cost clinical services, it is often the technical component and cost of clinical inputs, rather than professional fees, that determine value

  - Value-based network contracting needs to focus on product distribution and site of care as well as use and fees

4. Product pricing

- Prices for drugs and other products are not linked to the value of their use
  - Appropriate indication (diagnosis, severity)
  - Patient characteristics (genetic profile, severity)
  - Characteristics of setting (patient care management and education, follow-up)
- Prices on today's drugs give signals for R&D
  - We over-pay for inappropriate, low-value uses
  - We under-pay for appropriate, high-value uses
  - This is not the right set of signals

The Role for Employers in Promoting Value

- What has been the track record?
  - Value promoting activities by employers
  - Value reducing activities
- The achievements
- If we wanted to get real on value …
- Value-based incentives

What has been the track record?

- Value promoting activities by employers
  - Pooling of risk and limits on underwriting
  - Network design innovations: managed care
  - Benefit design innovations: consumer directed plans
- Value reducing activities by employers
  - Non-transparency: convincing employees that health care benefits are paid by employer rather than employee
  - Exploiting tax exclusion for gold plated benefits
  - Paternalism: encouraging attitude that health is a right (someone else should pay for it) rather than a valuable social resource (we all pay for it)

Wisdom on children, college students, health care

You can no, and then yes.

You cannot say yes, and then no.

Saying no, then saying yes

- Let's do a thought experiment:
- For each incentive mechanism (coverage, benefit design, network design, pricing):
  - Imagine a strategy that would get real
  - Then imagine a strategy that would enhance value

(1) If we wanted to get real: coverage policy

- A new drug, device, diagnostic, or other intervention is not covered by insurance unless it is superior in value (Q/P) than the existing intervention
- Burden of proof is on new intervention to prove superiority, not on payer to prove inferiority
- If a new intervention does not meet criteria, it can:
  - Improve its clinical performance, or
  - Reduce its price

(1) Value based coverage policy

- Follow NICE: A new intervention is covered if it is cost-effective, e.g., offers equal or better value than other uses for health care dollars
- CEA threshold at $50K-100K/QALY
- If a new intervention does not meet criteria, it can:
  - Seek ‘coverage with evidence development’, or
  - Restrict its use to cost-effective indications, or
  - Improve its clinical performance, or
  - Reduce its price

(2) If we wanted to get real: benefit design

- Model health benefits on dental benefits
  - Preventive and primary care services are fully covered
  - All other services are subject to 50% coinsurance
- Tiered formulary for drugs
  1. No copay for very cost-effective, under-used drugs
  2. 50% coinsurance elsewhere

(2) Value based benefit design

- Full coverage for preventive and primary care
- Good coverage for chronic illness care if (and only if) patient enrolls in DM program and cooperates
- 50% coinsurance otherwise
- Reference pricing for major acute interventions
  - Insurer pays rate equal to cost of efficient provider
- Tiered formulary for drugs
  1. No copay for very cost-effective drugs
  2. Low copay for other drugs used on-label or compendium
  3. 50% coinsurance elsewhere

(3) If we wanted to get real: network design

- Narrow physician network based on efficiency
- No coverage for non-network physicians
  - Consumer pays 100% out of pocket
- Narrow pharmacy and specialty pharmacy network
  - No coverage for non-network distributors

(3) Value based network design

- Narrow physician network based on efficiency
  - No consumer cost sharing for in-network providers
  - High provider fees for in-network providers
  - Reference pricing for non-network providers: insurer pays 50% of in-network fee schedule (not UCR) and consumer pays remainder
- For major acute interventions, create national Center of Excellence networks with episode pricing and no consumer cost sharing
  - 50% coinsurance and reference pricing outside COE

(4) If we wanted to get real: product pricing

The EU model: reference pricing

- Drugs and devices grouped by therapeutic category; insurer pays rate equal to lowest price within category
- Prices also referenced to lowest rates paid by other nations and other health plans
- It manufacturer refuses these prices, its product is excluded from formulary

(4) Value-based pricing

- VBP=R+D+E
  - R: reference price of lowest cost therapeutic equivalent, using comparative effectiveness studies to determine equivalence
  - D: clinical difference between new and reference drug, updated with new evidence on efficacy, safety, patient experience
  - E: efficiencies offered by drug manufacturer: adherence to criteria for appropriate use, patient care management, efficient distribution, physician practice support, data capture and analysis
- Higher prices for targeted therapies
  - Molecular diagnostics
  - Biomarker evidence of patient response

Conclusion and summary

- Promotion of value requires better evidence and better incentives
- Changing incentives to reflect value is the hard part
  - Coverage and prior authorization
  - Benefit design and cost sharing
  - Provider network and payment methods
  - Product prices
- It is particularly important to align incentives with value for new medical technologies, where effectiveness and cost are uncertain and changing

Wisdom about value

- It’s hard to change incentives to promote high-value care when we have created entitlement for all care
- When everyone has a right to everything, it’s hard to:
    - Deny coverage or impose prior authorization
    - Impose or raise consumer cost sharing
    - Reduce provider fees or mark-up profit opportunities
    - Negotiate lower prices for drugs and devices
- You cannot say yes, then no.

More wisdom about value

- We need to change the default position because health care is a valuable but scarce social resource
- Default: coverage is tight, cost sharing is high, provider networks are tight, product prices are low
- Then we implement incentives to favor high-value services, products, and providers
  - Remove or reduce prior authorization and cost sharing
  - Raise provider payments and drug prices

- You can no, then yes.