SCHOOL OF PUBLIC HEALTH
CENTER FOR VALUE-BASED INSURANCE DESIGN
UNIVERSITY OF MICHIGAN

Value-Based Insurance Design:
Changing the Health Care Cost Discussion from How Much to How Well

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Improving Care and Bending the Cost Curve

- **The past several decades have produced remarkable medical innovations resulting in impressive reductions in morbidity and mortality**
- **Regardless of these advances, cost growth remains the principle focus of health reform discussions**
- **Despite unequivocal evidence of clinical benefit, Americans systematically underuse high-value services across the care spectrum**
- **Attention should turn from *how much* to *how well* we spend our health care dollars**

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Role of Consumer Cost-Sharing in Medical Spending

- **For today's discussion, our focus is on costs paid by the consumer, not the employer or insurance company**

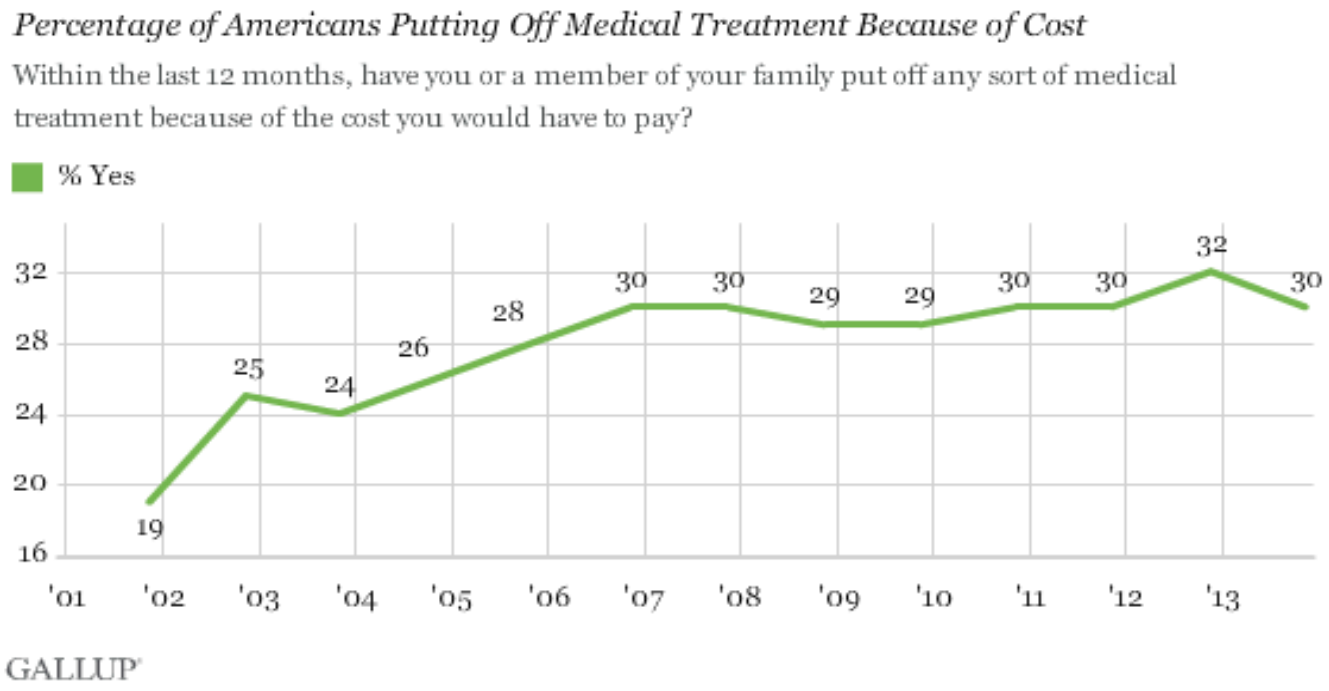
V-BID

Impact of Cost-Sharing on Health Care Utilization

- **Ideally, consumer cost-sharing levels would be set to encourage the clinically appropriate use of health care services**
- **The archaic "one-size-fits-all" approach to consumer cost-sharing fails to acknowledge the differences in clinical value among medical interventions**

Goldman D. *JAMA*. 2007;298(1):61–9.

Impact of Cost-Sharing on Health Care Utilization



A growing body of evidence concludes that increases in cost-sharing leads consumers to reduce the use of essential care, which in some cases, leads to greater overall costs

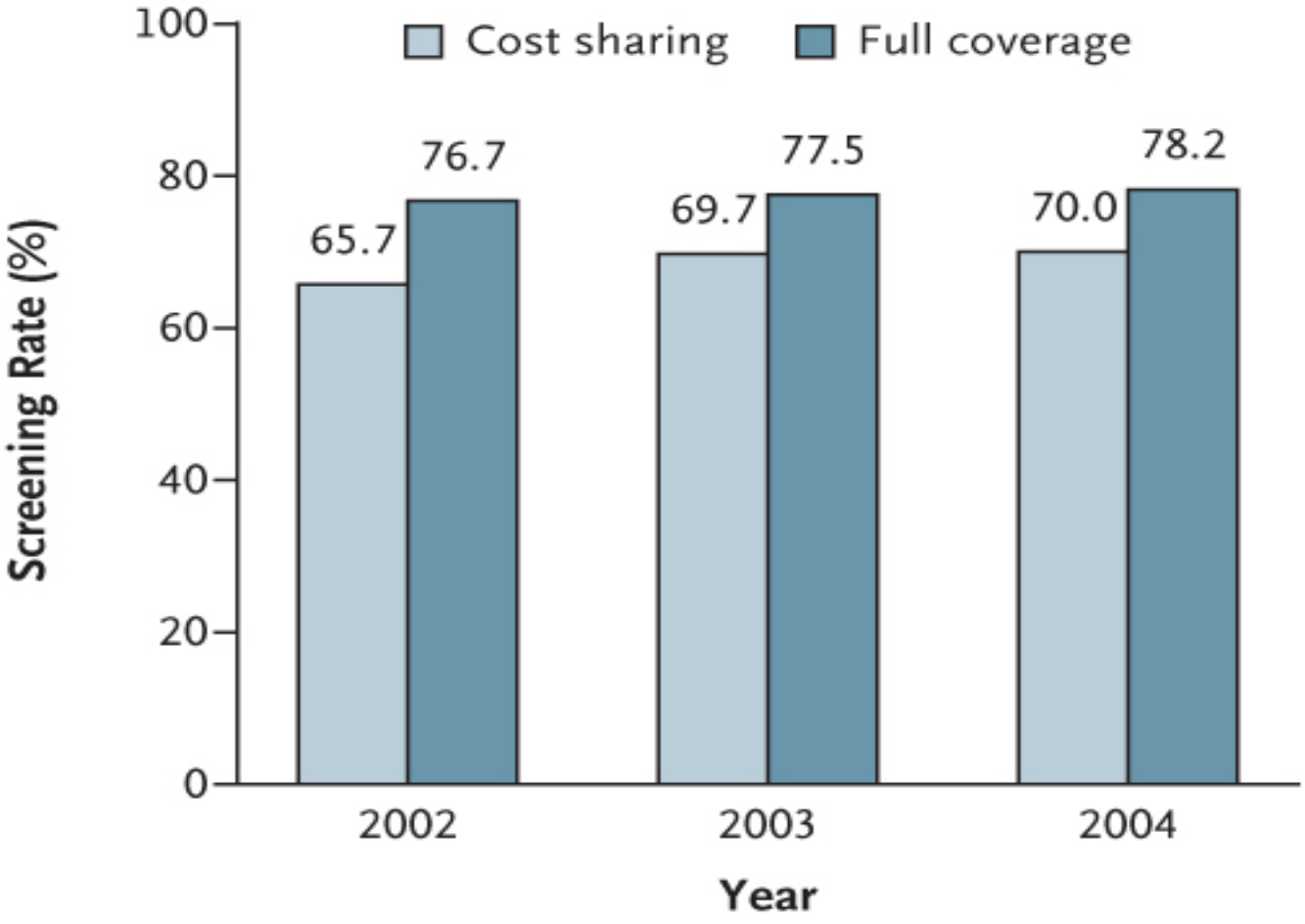
Goldman D. *JAMA*. 2007;298(1):61–9.

Inspiration

“I can’t believe you had to spend a million dollars to show that if you make people pay more for something, they will buy less of it.”

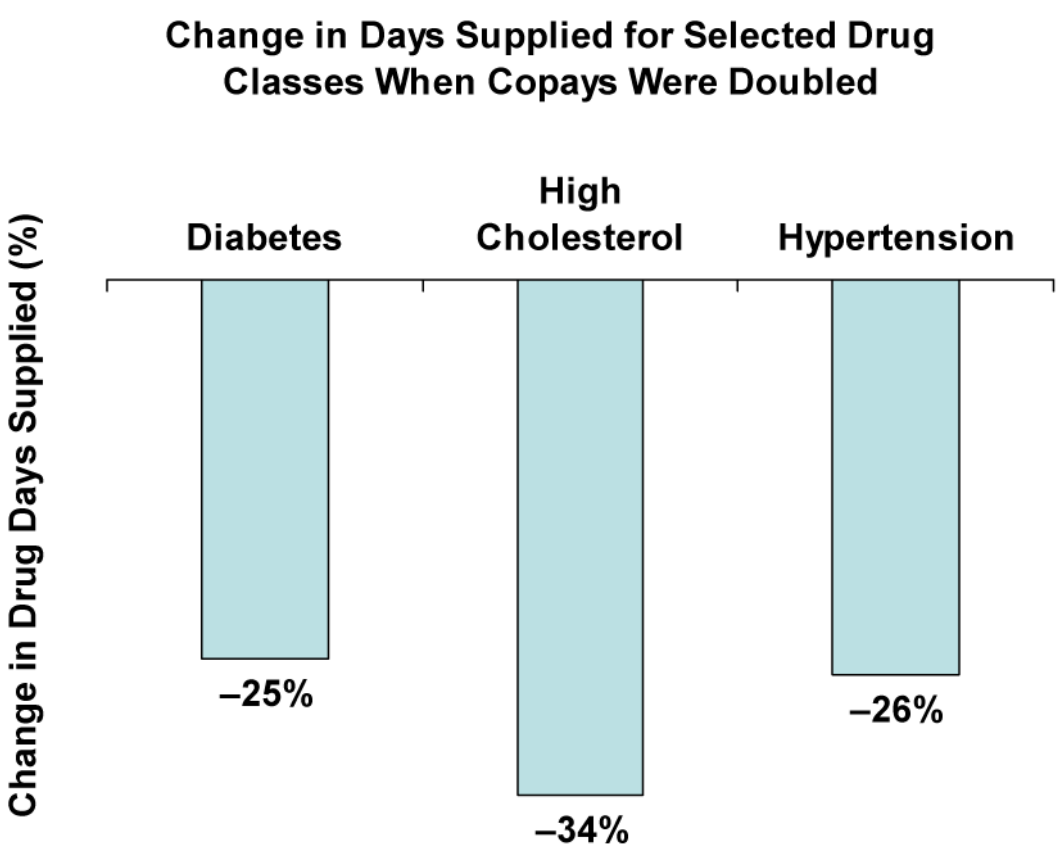
Barbara Fendrick (my mother)

Cost-sharing Affects Mammography Use by Medicare Beneficiaries



Trivedi A. *NEJM.* 2008;358:375-383

High Copays Reduce Adherence to Appropriate Medication Use



- When copays were doubled, patients took less medication in important classes. These reductions in medication levels were profound
- Reductions in medications supplied were also noted for:
  - NSAIDs 45%
  - Antihistamines 44%
  - Antiulcerants 33%
  - Antiasthmatics 32%
  - Antidepressants 26%
- For patients taking medications for asthma, diabetes, and gastric disorders, there was a 17% increase in annual ER visits and a 10% increase in hospital stays

ER = emergency room.

Goldman DP et al. *JAMA*. 2004;291:2344-2350.

Effects of Increased Copayments for Ambulatory Visits for Medicare Advantage Beneficiaries

Copays increased:

- **from $7.38 to $14.38 for primary care**
- **from $12.66 to $22.05 for specialty care**
- **remained unchanged at $8.33 and $11.38 in controls**

In the year after copayment increases:

- **19.8 fewer annual outpatient visits per 100 enrollees**
- **2.2 additional hospital admissions per 100 enrollees**
- **Effects worse in low-income individuals and beneficiaries with chronic illness**

Trivedi A. *NEJM*. 2010;362(4):320-8..

BUSINESS | OCTOBER 29, 2009

IBM to Drop Co-Pay for Primary-Care Visits

By WILLIAM M. BULKELEY

In an unusual bid to cut health-care costs, International Business Machines Corp. plans to stop requiring $20 co-payments by employees when they visit primary-care physicians.

The company said it believed the move would save costs by encouraging people to go to primary-care doctors faster, in order to get earlier diagnoses that could save on expensive visits to specialists and emergency rooms.

IBM said that the action applies to the 80% of its workers who are enrolled in plans in which the company self-insures—that is, programs in which it pays the health-care benefits, not insurers. The new policy doesn't cover IBM employees in health-maintenance organizations.

One of the nation's largest employers with 115,000 U.S. workers, IBM spends about $1.3 billion a year on U.S. health care. Its benefit practices are closely watched in the human-resources community, and its actions are sometimes trend-setters.

Impact of Cost-Sharing on Health Care Disparities

Effects of Increased Patient Cost Sharing on Socioeconomic Disparities in Health Care

Michael Chernew, PhD[1] Teresa B. Gibson, PhD[2] Kristina Yu-Isenberg, PhD, RPh[3]
Michael C. Sokol, MD, MS[4] Allison B. Rosen, MD, ScD[5], and A. Mark Fendrick, MD[5]

[1]Department of Health Care Policy, Harvard Medical School, Boston, MA, USA; [2]Thomson Healthcare, Ann Arbor, MI, USA; [3]Managed Markets Division, GlaxoSmithKline, Research Triangle Park, NC, USA; [4]Managed Markets Division, GlaxoSmithKline, Montvale, NJ, USA; [5]Departments of Internal Medicine and Health Management and Policy, Schools of Medicine and Public Health, University of Michigan, Ann Arbor, MI, USA.

- **Rising copayments may worsen disparities and adversely affect health, particularly among patients living in low-income areas.**

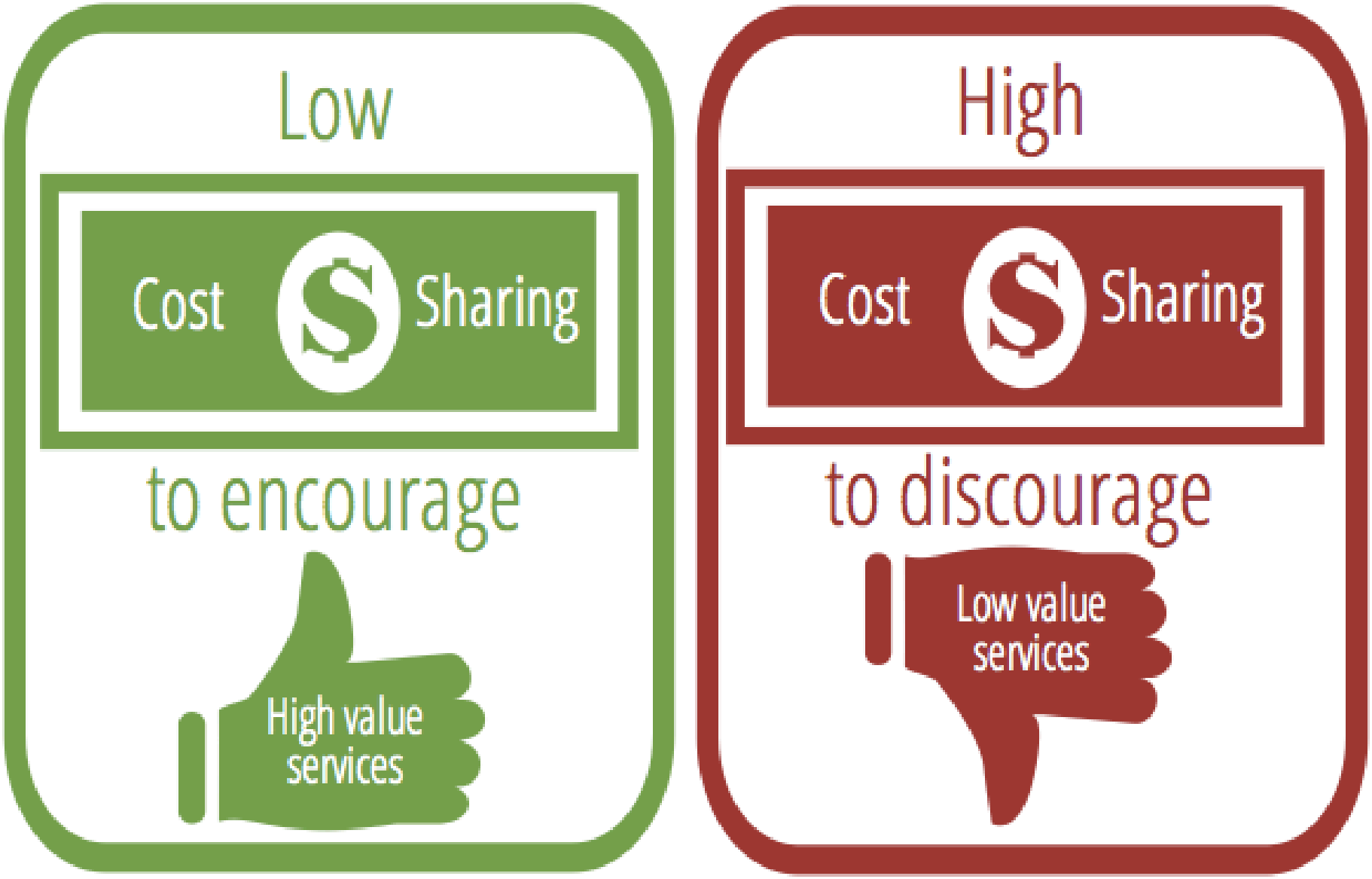
Chernew M. J Gen Intern Med 23(8):1131–6.

A New Approach: Clinical Nuance

1. Services differ in clinical benefit produced

2. Clinical benefits from a specific service depend on:

The Solution: Clinically-Nuanced Cost Sharing



Value-Based Insurance Design

- **Sets consumer cost-sharing level on clinical benefit – not acquisition price – of the service**
  - **Reduce or eliminate financial barriers to high-value clinical services**
- **Successfully implemented by hundreds of public and private payers**


WSJ.com THE WALL STREET JOURNAL ONLINE

June 16, 2004

FOLLOW THE MONEY

From 'One Size Fits All' To Tailored Co-Payments

June 16, 2004

University of Michigan researchers say a patient's drug should depend on how much he or she will medication -- a move that would likely lower co

MI-FREEE: Better Quality Without Higher Costs

- **Assessed impact of free access to preventive medications for Aetna members with history of MI**
- **Random assignment by plan sponsor**
- **"Enhanced prescription coverage improved medication adherence and rates of first major vascular events and decreased patient spending without increasing overall health costs."**

The NEW ENGLAND JOURNAL of MEDICI

SPECIAL ARTICLE

Full Coverage for Preventive Med
after Myocardial Infarction

Niteesh K. Choudhry, M.D., Ph.D., Jerry Avorn, M.
Robert J. Glynn, Sc.D., Ph.D., Elliott M. Antman, M.
Sebastian Schneeweiss, M.D., Sc.D., Michele Toscano,
Lonny Reisman, M.D., Joaquim Fernandes, M.S., Claire Spe
Joy L. Lee, M.S., Raisa Levin, M.S., Troyen Brennan, M.D., J.
and William H. Shrank, M.D., M.S.H.S., for the Post-Myo
Infarction Free Rx Event and Economic Evaluation (MI FRE

ABSTRACT

BACKGROUND

Adherence to medications that are prescribed after myocardial infarction
inating out-of-pocket costs may increase adherence and improve outc

METHODS

We enrolled patients discharged after myocardial infarction and rando
their insurance-plan sponsors to full prescription coverage (1494 plan s
2845 patients) or usual prescription coverage (1486 plan sponsors with 3
for all statins, beta-blockers, angiotensin-converting–enzyme inhibitors,
sin-receptor blockers. The primary outcome was the first major vascular ev
cularization. Secondary outcomes were rates of medication adherence,
vascular events or revascularization, the first major vascular event, and
penditures.

RESULTS

Rates of adherence ranged from 35.9 to 49.0% in the usual-coverage group
4 to 6 percentage points higher in the full-coverage group (P<0.001 for
parisons). There was no significant between-group difference in the prin
come (17.6 per 100 person-years in the full-coverage group vs. 18.8 in th
coverage group; hazard ratio, 0.93; 95% confidence interval [CI], 0.82
P=0.21). The rates of total major vascular events or revascularization were
cantly reduced in the full-coverage group (21.5 vs. 23.3; hazard ratio, 0.89;
0.90 to 0.99; P=0.03), as was the rate of the first major vascular event (11.0 v
hazard ratio, 0.86; 95% CI, 0.74 to 0.99; P=0.03). The elimination of copa
did not increase total spending ($66,008 for the full-coverage group and $71,
the usual-coverage group; relative spending, 0.89; 95% CI, 0.50 to 1.56; P=
Patient costs were reduced for drugs and other services (relative spending,
95% CI, 0.68 to 0.80; P<0.001).

CONCLUSIONS

The elimination of copayments for drugs prescribed after myocardial infarction di
significantly reduce rates of the trial's primary outcome. Enhanced prescription c
age improved medication adherence and rates of first major vascular events and
creased patient spending without increasing overall health costs. (Funded by Ae
and the Commonwealth Fund; MI FREEE ClinicalTrials.gov number, NCT00

From the Divisions of Pharmacoepidemiology and Pharmacoeconomics (N.K.C., J.A., R.J.G., S.S., J.L.L., R.L., W.H.S.) and Preventive Medicine (R.J.G.) and the Cardiovascular Division (E.M.A.), Department of Medicine, Brigham and Women's Hospital and Harvard Medical School, Boston; Aetna, Hartford, CT (M.T., L.R., J.F., C.S.); and CVS Caremark, Woonsocket, RI (T.B.). Address reprint requests to Dr. Choudhry at Brigham and Women's Hospital, 1620 Tremont St., Suite 3030, Boston, MA 02120, or at nchoudhry@partners.org.

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N Engl J Med 2011;365:2088-97.
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2088

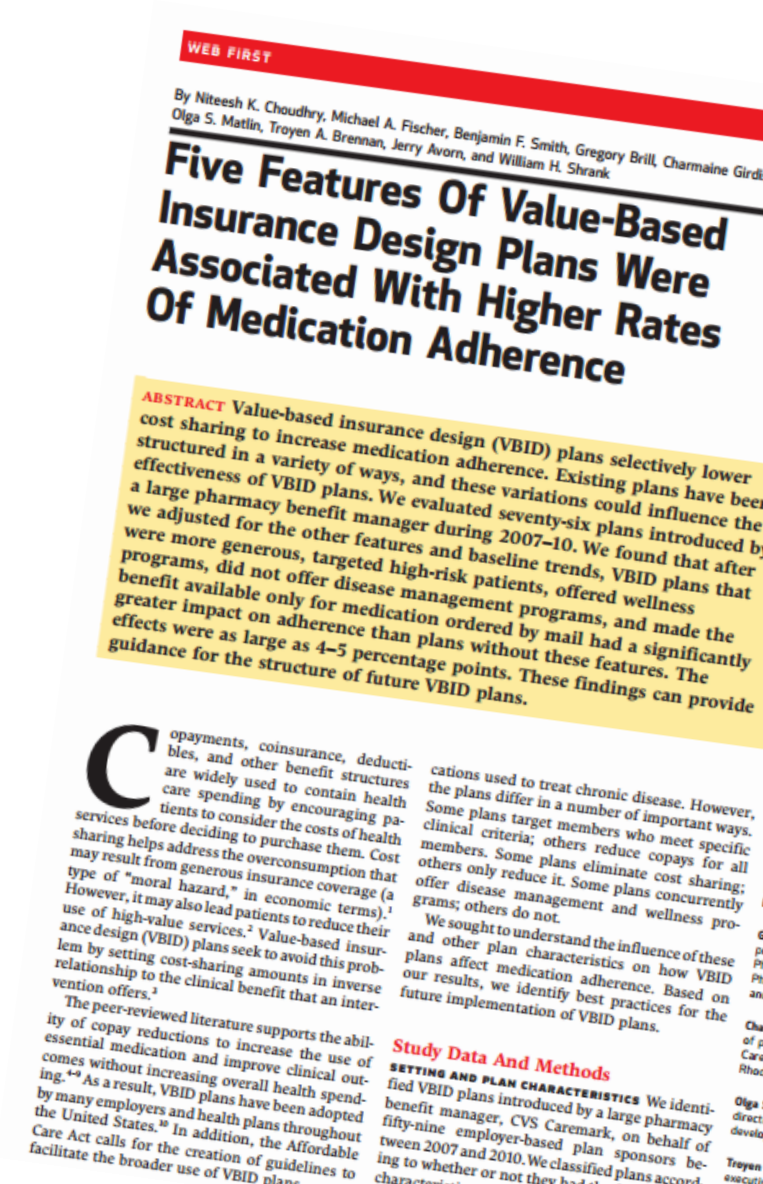
Choudhry NK, Avorn J, Glynn RJ, Antman EM, Schneeweiss S, Toscano M, et al. Full coverage for preventive medications after myocardial infarction. N Engl J Med. 2011 Dec 1;365(22):2088–97.

Emerging Best Practices in V-BID Implementation

A 2014 *Health Affairs* evaluation of 76 V-BID plans reported that programs that:

- **were more generous**
- **targeted high-risk individuals**
- **offered wellness programs**
- **avoided disease management**
- **used mail-order prescriptions**

had greater impact on adherence than plans without these features



WEB FIRST

By Niteesh K. Choudhry, Michael A. Fischer, Benjamin F. Smith, Gregory Brill, Charmaine Girdi
Olga S. Matlin, Troyen A. Brennan, Jerry Avorn, and William H. Shrank

Five Features Of Value-Based Insurance Design Plans Were Associated With Higher Rates Of Medication Adherence

ABSTRACT Value-based insurance design (VBID) plans selectively lower cost sharing to increase medication adherence. Existing plans have been structured in a variety of ways, and these variations could influence the effectiveness of VBID plans. We evaluated seventy-six plans introduced by a large pharmacy benefit manager during 2007–10. We found that after we adjusted for the other features and baseline trends, VBID plans that were more generous, targeted high-risk patients, offered wellness programs, did not offer disease management programs, and made the benefit available only for medication ordered by mail had a significantly greater impact on adherence than plans without these features. The effects were as large as 4–5 percentage points. These findings can provide guidance for the structure of future VBID plans.

Copayments, coinsurance, deductibles, and other benefit structures are widely used to contain health care spending by encouraging patients to consider the costs of health services before deciding to purchase them. Cost sharing helps address the overconsumption that may result from generous insurance coverage (a type of "moral hazard," in economic terms).[1] However, it may also lead patients to reduce their use of high-value services.[2] Value-based insurance design (VBID) plans seek to avoid this problem by setting cost-sharing amounts in inverse relationship to the clinical benefit that an intervention offers.[3]

The peer-reviewed literature supports the ability of copay reductions to increase the use of essential medication and improve clinical outcomes without increasing overall health spending.[4–9] As a result, VBID plans have been adopted by many employers and health plans throughout the United States.[10] In addition, the Affordable Care Act calls for the creation of guidelines to facilitate the broader use of VBID plans. cations used to treat chronic disease. However, the plans differ in a number of important ways. Some plans target members who meet specific clinical criteria; others reduce copays for all members. Some plans eliminate cost sharing; others only reduce it. Some plans concurrently offer disease management and wellness programs; others do not.

We sought to understand the influence of these and other plan characteristics on how VBID plans affect medication adherence. Based on our results, we identify best practices for the future implementation of VBID plans.

Study Data And Methods

SETTING AND PLAN CHARACTERISTICS We identified VBID plans introduced by a large pharmacy benefit manager, CVS Caremark, on behalf of fifty-nine employer-based plan sponsors between 2007 and 2010. We classified plans according to whether or not they had

Choudhry. N. *Health Affairs*. 2014;33(3).

Evidence Supporting Value-Based Insurance Design: Improving Adherence Without Increasing Costs

- **Improved adherence**
- **Lower consumer out-of-pocket costs**
- **No significant increase in total spending**
- **Reduction in health care disparities**

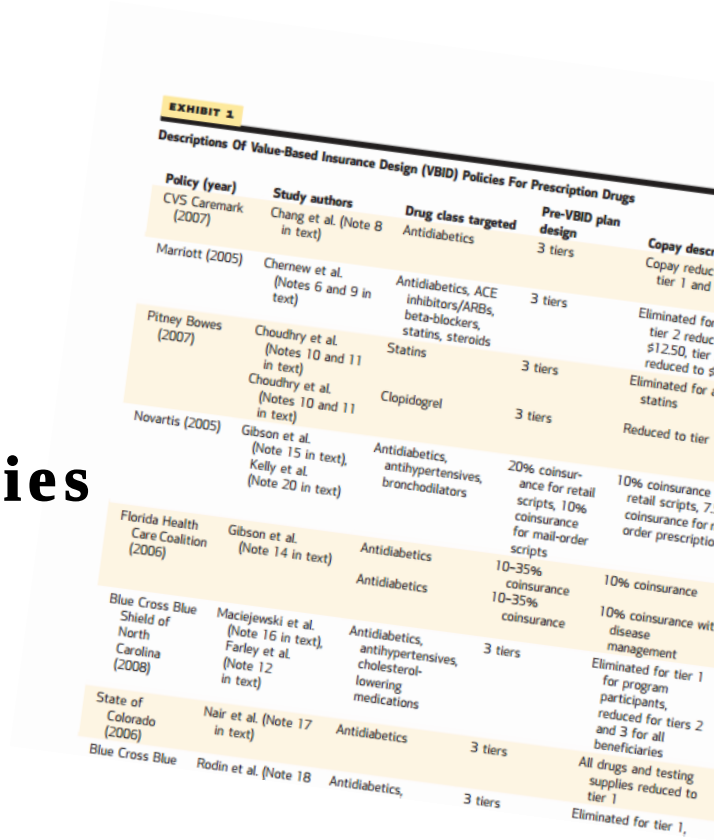


EXHIBIT 1

Descriptions Of Value-Based Insurance Design (VBID) Policies For Prescription Drugs

Policy (year)	Study authors	Drug class targeted	Pre-VBID plan design	Copay desc
CVS Caremark (2007)	Chang et al. (Note 8 in text)	Antidiabetics	3 tiers	Copay reduc tier 1 and
Marriott (2005)	Chernew et al. (Notes 6 and 9 in text)	Antidiabetics, ACE inhibitors/ARBs, beta-blockers, statins, steroids	3 tiers	Eliminated fo tier 2 reduc $12.50, tier reduced to $
Pitney Bowes (2007)	Choudhry et al. (Notes 10 and 11 in text)	Statins	3 tiers	Eliminated for statins
	Choudhry et al. (Notes 10 and 11 in text)	Clopidogrel	3 tiers	Reduced to tier
Novartis (2005)	Gibson et al. (Note 15 in text), Kelly et al. (Note 20 in text)	Antidiabetics, antihypertensives, bronchodilators	20% coinsur-ance for retail scripts, 10% coinsurance for mail-order scripts	10% coinsurance retail scripts, 7 coinsurance for order prescriptio
Florida Health Care Coalition (2006)	Gibson et al. (Note 14 in text)	Antidiabetics	10–35% coinsurance	10% coinsurance
		Antidiabetics	10–35% coinsurance	10% coinsurance wit disease management
Blue Cross Blue Shield of North Carolina (2008)	Maciejewski et al. (Note 16 in text), Farley et al. (Note 12 in text)	Antidiabetics, antihypertensives, cholesterol-lowering medications	3 tiers	Eliminated for tier 1 for program participants, reduced for tiers 2 and 3 for all beneficiaries
State of Colorado (2006)	Nair et al. (Note 17 in text)	Antidiabetics	3 tiers	All drugs and testing supplies reduced to tier 1
Blue Cross Blue	Rodin et al. (Note 18	Antidiabetics,	3 tiers	Eliminated for tier 1,

Lee J. *Health Affairs.*. 2013;32(7):1251-1257

Evidence for Value-Based Insurance Design: Reducing Health Care Disparities

Full drug coverage:

- **Reduced rates of a post-MI vascular event or revascularization among patients who self-identified as being non-white**
- **Reduced total health care spending by 70 percent among patients who self-identified as being non-white**

DISPARITIES

By Niteesh K. Choudhry, Katsiaryna Bykov, William H. Shrank, Michele Toscano, Wayne S. Ra
Lonny Reisman, Troyen A. Brennan, and Jessica M. Franklin

Eliminating Medication Copayments Reduces Disparities In Cardiovascular Care

ABSTRACT Substantial racial and ethnic disparities in cardiovascular ca
persist in the United States. For example, African Americans and
Hispanics with cardiovascular disease are 10–40 percent less likely than
whites to receive secondary prevention therapies, such as aspirin and
beta-blockers. Lowering copayments for these therapies improves
outcomes among all patients who have had a myocardial infarction, but
the impact of lower copayments on health disparities is unknown. Using
self-reported race and ethnicity for participants in the Post-Myocardial
Infarction Free Rx Event and Economic Evaluation (MI FREEE) trial, we
found that rates of medication adherence were significantly lower and
rates of adverse clinical outcomes were significantly higher for nonwhite
patients than for white patients. Providing full drug coverage increased
medication adherence in both groups. Among nonwhite patients, it also
reduced the rates of major vascular events or revascularization by
35 percent and reduced total health care spending by 70 percent.
Providing full coverage had no effect on clinical outcomes and costs for
white patients. We conclude that lowering copayments for medications
after myocardial infarctions may reduce racial and ethnic disparities for
cardiovascular disease.

Health Aff (Millwood). 2014 May;33(5):863-70

Value-Based Insurance Design
"Clinically Nuanced, Fiscally Responsible"

- To date, most V-BID programs have focused on removing barriers to high-value services
- V-BID programs that encourage conversations about the use of low-value services are being implemented
  - Choosing Wisely
  - MedInsight Health Waste Calculator

Value Based Insurance Design
More than High-Value Prescription Drugs

- Prevention/Screening
- Diagnostic tests/Monitoring
- Treatments
- Clinician visits
- Physician networks
- Hospitals

Value-Based Insurance Design
Broad Multi-Stakeholder Support

- HHS
- CBO
- SEIU
- MedPAC
- Brookings Institution
- The Commonwealth Fund
- NBCH
- PCPCC
- PhRMA
- AHIP
- NBCH
- National Governor's Assoc.
- Academy of Actuaries
- Bipartisan Policy Center
- Kaiser Family Foundation
- NBGH
- National Coalition on Health Care
- Urban Institute
- RWJF
- IOM
- US Chamber of Commerce

Lewin. *JAMA.* 2013;310(16):1669-1670

Sec 2713: Selected Preventive Services be Provided without Cost-Sharing

- **Receiving an A or B rating from the United States Preventive Services Taskforce (USPSTF)**
- **Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP)**
- **Preventive care and screenings supported by the Health Resources and Services Administration (HRSA)**

Over 100 million Americans have received expanded coverage of preventive services

Value-Based Insurance Design
Growing Role in State Health Reform

- **State Employees Benefit Plans**
  - **Connecticut**
  - **Oregon**
  - **Virginia**
  - **Minnesota**
  - **Maine**
- **State Exchanges**
  - **Maryland**
  - **California**
- **CO-OPs**
- **Medicaid**

V-BID Center brief

EVIDENCE, EXAMPLES, AND INSIGHT ON VALUE-BASED INSURANCE DESIGN

V-BID in Action: A Profile of Connecticut's Health Enhancement Program

Value-Based Insurance Design (V-BID)—hailed as a "game changer" by the National Coalition on Health Care— refers to insurance designs that vary consumer cost-sharing to distinguish between high-value and low-value health care services and providers. V-BID entails (1) reducing financial barriers that deter use of evidence-based services and high-performing providers, and (2) imposing disincentives to discourage use of low-value care. Through the incorporation of greater clinical nuance in benefit design, payers, purchasers, taxpayers, and consumers can attain more health for every dollar spent. The University of Michigan Center for V-BID leads in research, development, and advocacy for innovative health benefit plans and payment reform initiatives.

Connecticut Seeks to Improve Health and Contain Costs

The State of Connecticut faced a projected budget gap of $3.8 billion in fiscal year 2012, and state employees were asked to help address the shortfall. The Governor's Office and a coalition of unions representing state employees met throughout 2011 to discuss a wide range of topics, including the health plan covering active and retired state employees. The parties focused health care discussions on possibilities for improving health as a means to control long-term costs. Discussions involving unions, the

The Key Features of HEP

Prior to 2012, Connecticut's state employee health plan did not distinguish between high-value services and low-value services in determining cost-sharing for beneficiaries. HEP is different.

Accountability. HEP rewards state employees, select retirees, and dependents who commit to a number of responsibilities. The "ask" of beneficiaries is as follows:

- Obtain specified age and gender-appropriate health risk assessments, evidence-based screenings, and physical and vision examinations;
- Undergo two dental cleanings per year;[a] and
- Participate in condition-appropriate chronic disease management services.[b]

Specified guideline-based clinical services are required of HEP enrollees with diabetes, high cholesterol, high blood pressure, heart disease, asthma, and chronic obstructive pulmonary disorder (COPD). There are provisions to exempt enrollees with unusual or special circumstances from requirements as appropriate.

Beneficiaries may be disenrolled from HEP if they do not adhere to the requirements outlined above. HEP strives to avoid this

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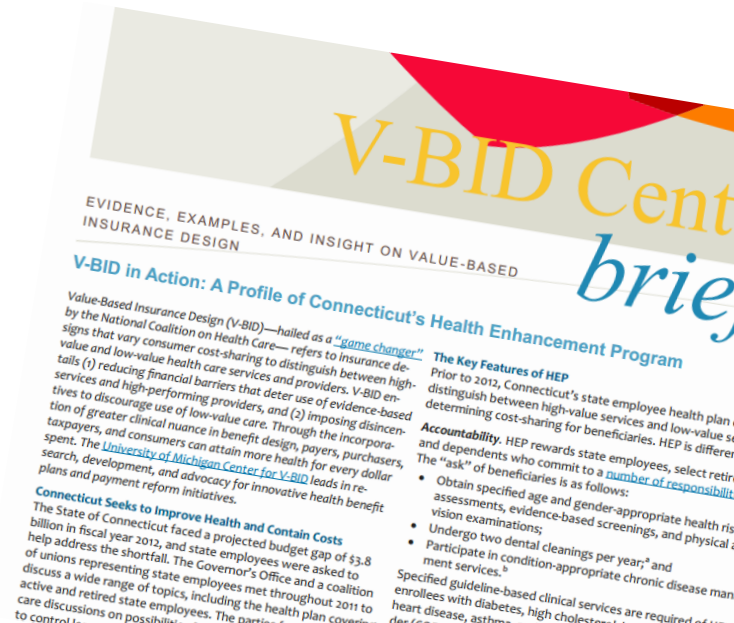
Implementing V-BID for State Employees: Connecticut State Employees Health Benefit Plan

- **Participating employees receive a reprieve from higher premiums if they commit to:**
  - **Yearly physicals, age-appropriate screenings/preventive care, two free dental cleanings**
  - **If employees have one of five chronic conditions, they must participate in disease management programs (which include free office visits and lower drug co-pays)**
- **Early results:**
  - **99% of employees enrolled and 99% compliant**
  - **Decrease in ER and specialty care**
  - **Increase in primary care visits**
  - **Increase in chronic disease medication adherence**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EVIDENCE, EXAMPLES, AND INSIGHT ON VALUE-BASED INSURANCE DESIGN

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Specified guideline-based clinical services are required of enrollees with diabetes, high cholesterol heart disease, asthma

V-BID for State Employees: Oregon Educators and Public Employees

- Prioritized list of services based on evidence
- No cost-sharing for participating members: Living Well with Chronic Disease, Diabetes Prevention Program
  - Complete a health assessment & take two actions
- Expand self management programs
- Promoted evidence based programs & wellness programs through grants and pilots
  - Participation 70% first year, 77% second year

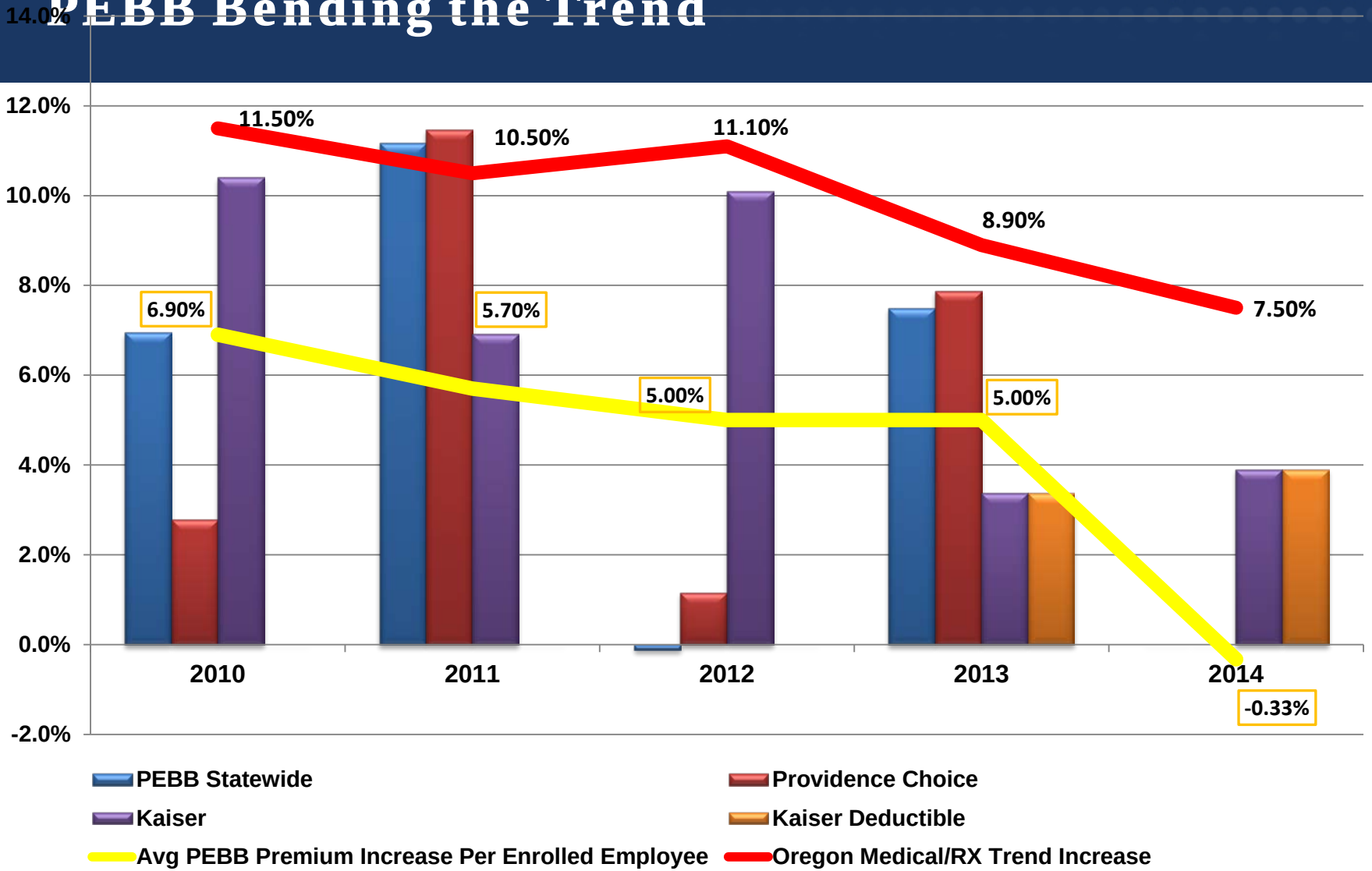
Oregon Health Authority

Oregon Educators and Public Employees
Strategies With Financial Impact

- Quality based pay for performance
- Lower cost sharing and increase payments for certified primary care homes
- Higher cost sharing on certain imaging and sleep studies led to 15% - 30% decreased use; other procedures 5% -17%
- Data-driven 45% reduction in cardiac interventions
- Weight Watchers ROI in the first year

Oregon Health Authority

Oregon Educators and Public Employees PEBB Bending the Trend



Oregon Health Authority

NC State Health Plan Option: Enhanced 80/20

(For Active Employees and Non-Medicare Primary Retirees)

Plan Design Features	In-Network	Out-of-Network
Annual Deductible	$700 Individual $2,100 Family	$1,400 Individual $4,200 Family
Coinsurance	20% of eligible expenses after deductible	40% of eligible expenses after deductible and the difference between the allowed amount and the charge
Coinsurance Maximum (excludes deductible)	$3,210 Individual $9,630 Family	$6,420 Individual $19,260 Family
Out-of-Pocket Maximum (includes deductible)	Not Applicable	Not Applicable
Pharmacy Out-of-Pocket Maximum	$2500	$2500
Preventive Care	$0 (covered at 100%)	Not Applicable
Office Visits	$30 for primary doctor, $15 if you use PCP on ID card; $70 for specialist, $60 for Blue Options Designated Specialist	40% after deductible
Inpatient Hospital	$233 copay, then 20% after deductible; copay not applied if you use Blue Options Designated hospital	$233 copay, then 40% after deductible
Prescription Drugs		
Tier 1	$12 copay per 30-day supply	Applicable copay and the difference between the allowed amount and the charge
Tier 2	$40 copay per 30-day supply	
Tier 3	$64 copay per 30-day supply	
Tier 4	25% up to $100 per 30-day supply	
Tier 5	25% up to $125 per 30-day supply	
ACA Preventive Medications	$0 (covered at 100%)	$0 (covered at 100%)

NC State Health Plan Option: Traditional 70/30

(For Active Employees and Non-Medicare Primary Retirees)

Plan Design Features	In-Network	Out-of-Network
Annual Deductible	$933 Individual $2,799 Family	$1,866 Individual $5,598 Family
Coinsurance	30% of eligible expenses after deductible	50% of eligible expenses after deductible and the difference between the allowed amount and the charge
Coinsurance Maximum (excludes deductible)	$3,793 Individual $11,379 Family	$7,586 Individual $22,758 Family
Out-of-Pocket Maximum (includes deductible)	Not Applicable	Not Applicable
Pharmacy Out-of-Pocket Maximum	$2500	$2500
Preventive Care	$35 for primary doctor; $81 for specialist	Only certain services are covered
Office Visits	$35 for primary doctor; $81 for specialist	50% after deductible
Inpatient Hospital	$291 copay, then 30% after deductible	$291 copay, then 50% after deductible
Prescription Drugs		
Tier 1	$12 copay per 30-day supply	Applicable copay and the difference between the allowed amount and the charge
Tier 2	$40 copay per 30-day supply	
Tier 3	$64 copay per 30-day supply	
Tier 4	25% up to $100 per 30-day supply	
Tier 5	25% up to $125 per 30-day supply	
ACA Preventive Medications	Not applicable	Not applicable

NC State Health Plan Option: CDHP

(For Active Employees and Non-Medicare Primary Retirees)

Plan Design Features	In-Network	Out-of-Network
HRA Starting Balance	$500 Employee/Retiree $1000 Employee/Retiree + 1 $1,500 Employee/Retiree + 2 or more	
Annual Deductible	$1.500 Individual $4,500 Family	$3,000 Individual $9,000 Family
Coinsurance	15% of eligible expenses after deductible	35% of eligible expenses after deductible and the difference between the allowed amount and the charge
Coinsurance Maximum	Not Applicable	Not Applicable
Out-of-Pocket Maximum (includes deductible)	$3,000 Individual $9,000 Family	$6,000 Individual $18,000 Family
Pharmacy Out-of-Pocket Maximum	Included in total out-of-pocket maximum	Included in total out-of-pocket maximum
Preventive Care	$0 (covered at 100%)	Not Applicable
Office Visits	15% after deductible; $15 added to HRA if you use PCP on ID; $10 added to HRA if you use Blue Options Designated specialist	35% after deductible
Inpatient Hospital	15% after deductible; $50 added to HRA if you use Blue Options hospital	35% after deductible
Prescription Drugs		
Tier 1	15% after deductible	35% after deductible
Tier 2		
Tier 3		
Tier 4		
Tier 5		
ACA Preventive Medications	$0 (covered at 100%)	$0 (covered at 100%)
CDHP Preventive Medications	15%, no deductible	15%, no deductible

NC State Health Plan Wellness Premium Credits

Enhanced 80/20 Plan	Consumer-Directed Health Plan (CDHP) with HRA	Traditional 70/30 Plan
1) Health Assessment ($15) • Members will need to complete or update a Health Assessment through the Personal Health Portal. **2) Primary Care Provider ($15)** • Members will need to select a Primary Care Provider for themselves and any covered dependents. **3) Smoking Attestation ($20)** • Members and if applicable their spouse will need to attest to being a non-smoker or commit to a smoking cessation program by Jan. 1, 2015.	**1) Health Assessment ($10)** • Members will need to complete or update a Health Assessment through the Personal Health Portal. **2) Primary Care Provider ($10)** • Members will need to select a Primary Care Provider for themselves and any covered dependents. **3) Smoking Attestation ($20)** • Members and if applicable their spouse will need to attest to being a non-smoker or commit to a smoking cessation program by Jan. 1, 2015.	Premium Credits Are Not Available

V-BID in Medicare: Bipartisan Political Support

The Value-Based Insurance Design for Better Care Act of 2014

(Original Signature of Member)

113TH CONGRESS
2D SESSION

H. R. _____

To establish a demonstration program requiring the utilization of Value-Based Insurance Design to demonstrate that reducing the copayments or coinsurance charged to Medicare beneficiaries for selected high-value prescription medications and clinical services can increase their utilization and ultimately improve clinical outcomes and lower health care expenditures.

IN THE HOUSE OF REPRESENTATIVES

Mrs. BLACK (for herself and Mr. BLUMENAUER) introduced the following bill; which was referred to the Committee on _____

The Better Care, Lower Cost Act of 2014

Sponsored by:

U.S. Sen. Ron Wyden, D-Ore.

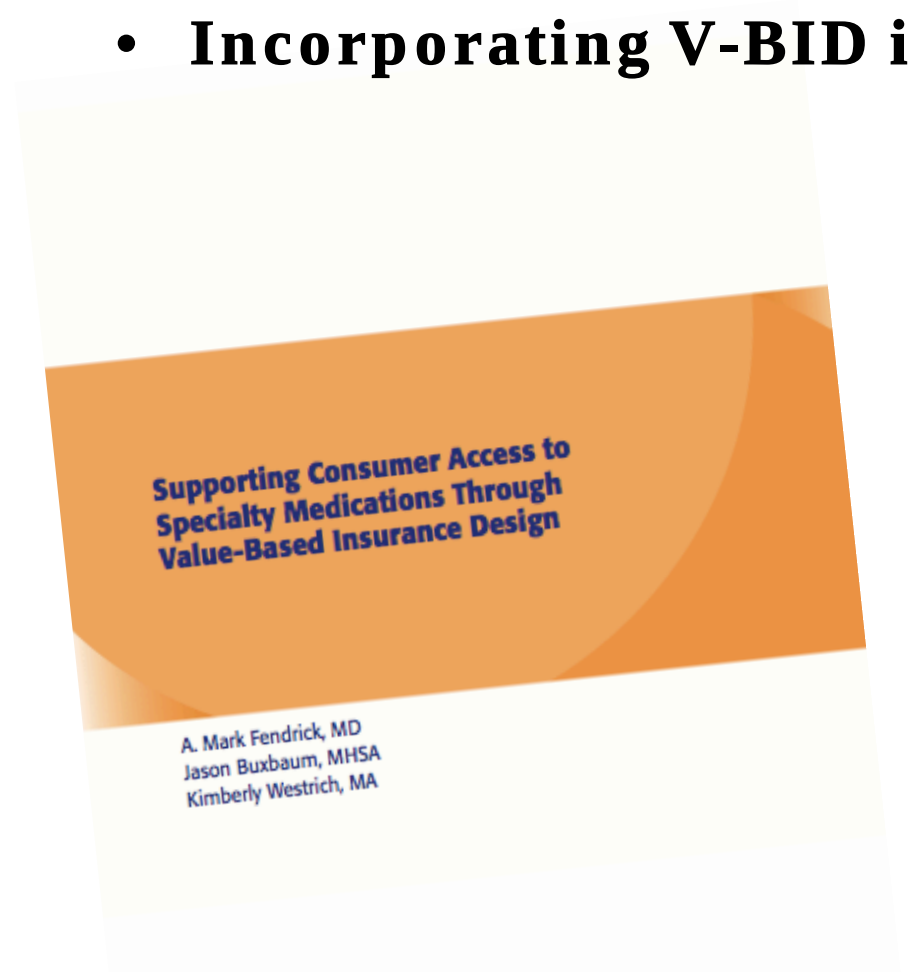
U.S. Sen. Johnny Isakson, R-Ga.

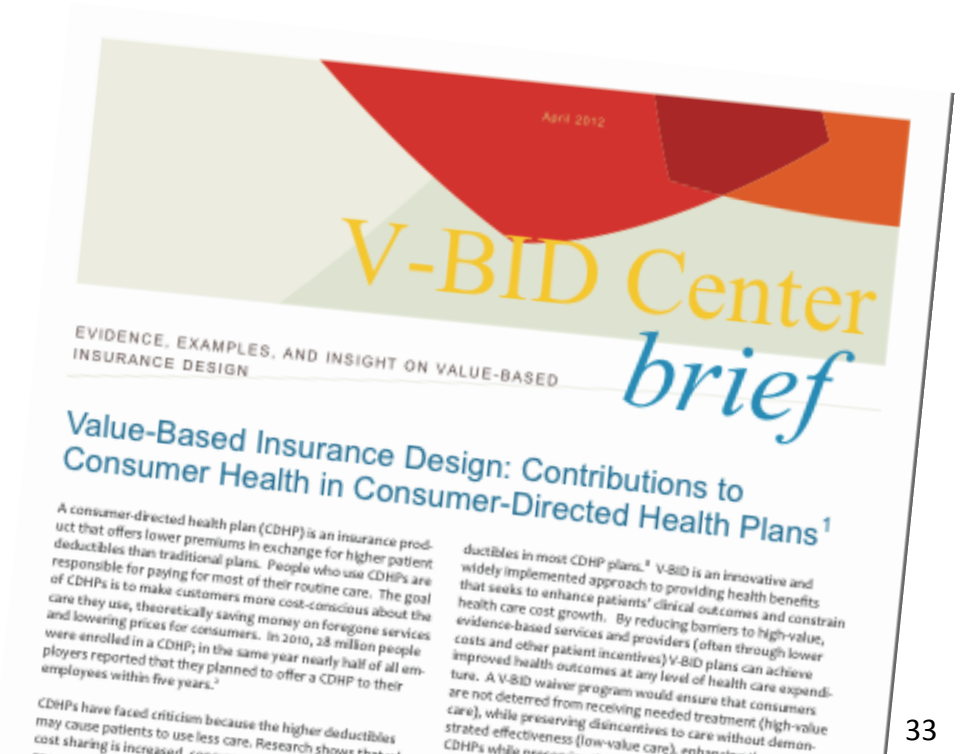
U.S. Rep. Erik Paulsen, R-Minn.

U.S. Rep. Peter Welch, D-Vt.

Value-Based Insurance Design: Key Initiatives

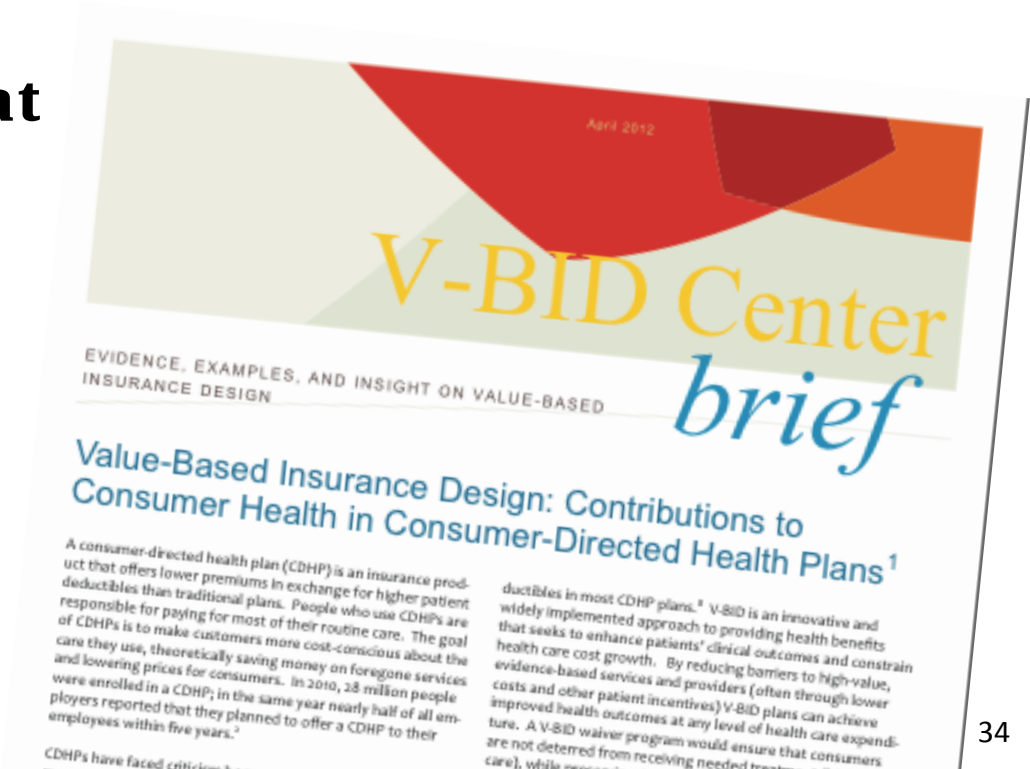
- **Applying V-BID to Specialty Medications**
- **Incorporating V-BID in HSA-qualified HDHPs**





Barriers to V-BID in HSA-qualified HDHPs

- **IRS guidance documents specifically exclude from the definition of preventive care those services or benefits meant to treat "an existing illness, injury or condition**
- **Confusion persists what services can and cannot be covered outside of the deductible**


April 2012

V-BID Center

brief

EVIDENCE, EXAMPLES, AND INSIGHT ON VALUE-BASED INSURANCE DESIGN

Value-Based Insurance Design: Contributions to Consumer Health in Consumer-Directed Health Plans[1]

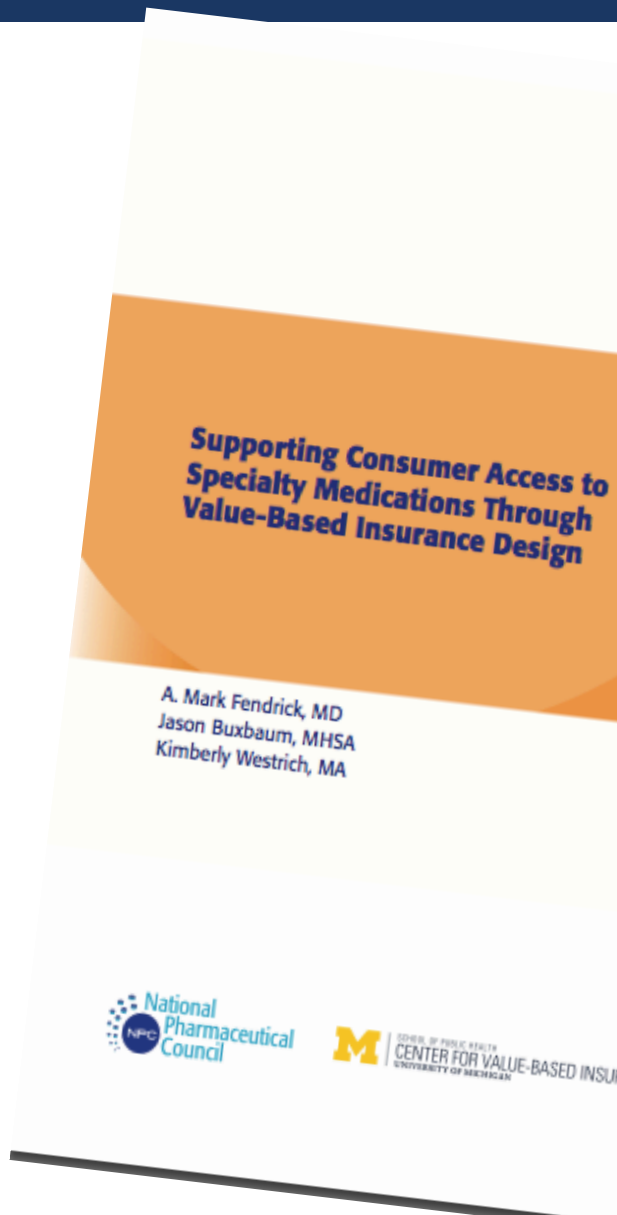
A consumer-directed health plan (CDHP) is an insurance product that offers lower premiums in exchange for higher patient deductibles than traditional plans. People who use CDHPs are responsible for paying for most of their routine care. The goal of CDHPs is to make customers more cost-conscious about the care they use, theoretically saving money on foregone services and lowering prices for consumers. In 2010, 28 million people were enrolled in a CDHP; in the same year nearly half of all employers reported that they planned to offer a CDHP to their employees within five years.[2]

CDHPs have faced criticism [illegible]

ductibles in most CDHP plans.[3] V-BID is an innovative and widely implemented approach to providing health benefits that seeks to enhance patients' clinical outcomes and constrain health care cost growth. By reducing barriers to high-value, evidence-based services and providers (often through lower costs and other patient incentives) V-BID plans can achieve improved health outcomes at any level of health care expenditure. A V-BID waiver program would ensure that consumers are not deterred from receiving needed [illegible] care), while

Applying V-BID to Specialty Medications

- Impose no more than modest cost-sharing on high-value services
- Reduce cost-sharing in accordance with patient- or disease-specific characteristics
- Relieve patients from high cost-sharing after failure on a different medication
- Use cost-sharing to encourage patients to select high-performing providers and settings



Using Clinical Nuance to Align Payer and Consumer Incentives

Many "supply side" initiatives are restructuring provider incentives:

- **Payment reform**
  - **Global budgets**
  - **Pay-for-performance**
  - **Bundled payments**
  - **Accountable care**
- **Tiered networks**
- **Health information technology**

V-BID

Using Clinical Nuance to Align Payer and Consumer Incentives

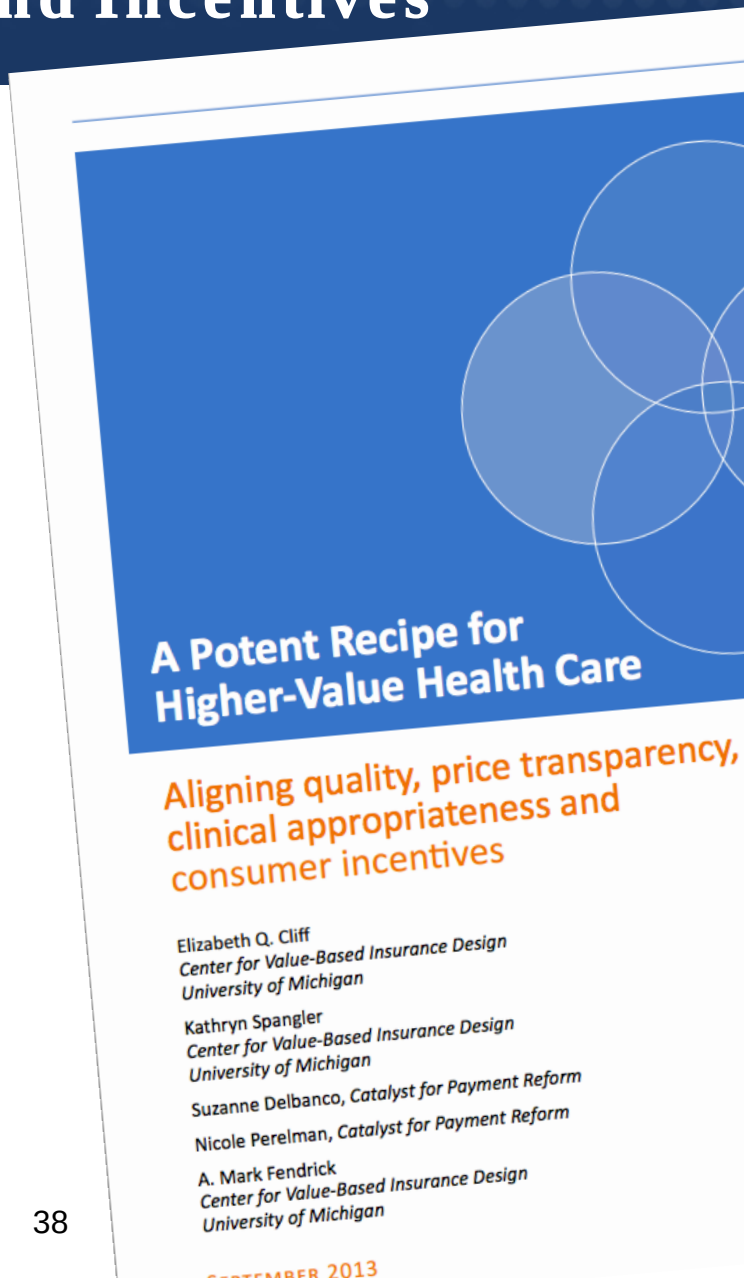
Unfortunately, "supply-side" initiatives have historically paid little attention to consumer decision-making or the "demand-side" of care-seeking behavior:

- **Benefit design**
- **Shared decision-making**
- **Literacy**

V-BID

Recipe for Value: Aligning Quality, Transparency, Appropriateness and Incentives

- Lack of quality and price transparency
- Significant price variation with no connection to quality
- Price transparency and anti-competitive behavior
- Lack of information about clinical necessity



Role of V-BID in Multi-Payer Reform: Using Clinical Nuance to Align Payer and Consumer Incentives

- **Adding clinical nuance into payment reform and consumer engagement initiatives can help states improve quality of care, enhance patient experience, and contain cost growth**
- **The alignment of supply- and demand-side incentives can improve quality and achieve savings more efficiently than either one alone**

M | V-BID

Improving Care and Bending the Cost Curve

- **The ultimate test of health reform will be whether it improves health and addresses rising costs**
- **V-BID should be part of the solution to enhance the efficiency of health care spending**

The New York Times

Business D

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ECONOMIC VIEW

When a Co-Pay Gets in the Way of Health

By SENDHIL MULLAINATHAN
Published: August 10, 2013

ECONOMISTS specialize in pointing out unpleasant trade-offs — a skill that is on full display in the health care debate.

Enlarge This Image

Minh Uong/The New York Times

We want patients to receive the best care available. We also want consumers to pay less. And we don't want to bankrupt the government or private insurers. Something must give.

The debate centers on how to make these trade-offs, and who gets to make them. The stakes are high, and the choices are at times unseemly. No matter how necessary, putting human suffering into dollars and cents is not attractive work. It's no surprise, then, that the conversation is so heated.

What is a surprise is that amid th

Mullainathan S. When a Co-Pay Gets in the Way of Health. The New York Times. 2013 Aug 10.

Discussion