Value Based Insurance Design-Opportunities for Clinicians to Engage

March 24, 2011

Dr. Jeff Rideout - SVP and Chief Medical Officer, TriZetto

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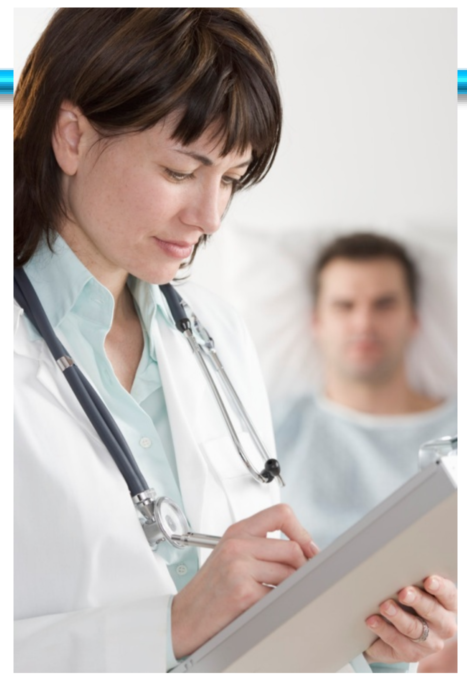
Value-Based Insurance Design

VBID emerged from the observation that short-term cost savings resulting from increased cost sharing may decrease patient health and in certain circumstances increase aggregate health care cost



The system should provide incentives to patients and clinicians to encourage the use of high value services

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Key Takeaways From This Talk

Value Purchasing is More Critical Than Ever

Consumer Health and Demand Can Managed Using Value Based Insurance Design ("Smart Benefits")

Physician Engagement is Critical to Value Based Strategies But Is Only In Its Infancy

Recent MLR Definitions Regarding Qualifying Medical Expenses Are Very Favorable for Value Based Solutions

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Agenda

The Urgency of Value

Consumer Incentives– The “Demand” Side

Clinician Incentives – The “Supply” Side

Value-based strategies and health reform

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Returning Value to the Health Care Debate

Healthcare cost growth isn't going away with the passage of reform

Health Care share of GDP made its biggest one-year jump ever in 2009, going from 16.2 to 17.3%

…and substantial underutilization of high value health care services persists

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Spending and Health Are Not Correlated

Life Expectancy in the G7 Countries vs. Predicted Life Expectancy based on Standard of Living and Expenditures on Health Care

82
81
80
79
78
77
76
75
74

Japan Italy Canada France UK Germany US

Actual Predicted

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"Do No Harm" - Cost Containment Efforts Should NOT Produce Reductions in Quality of Care

Up to 60% of chronically ill patients have poor adherence to evidence-based treatment

Responsible for up to one-quarter of all hospital and nursing-home admissions

Costs from poor medication adherence estimated to exceed $100 billion annually

Non-Adherence to Evidence-Based Services: already a cost and quality problem

Dunbar-Jacob, *Journal of Clinical Epidemiology* 54 (2001) S57-S60.

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Blunt Cost Control Can Make Things Worse

► 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 increases:

- 19.8 fewer annual outpatient visits per 100 enrollees
- 2.2 additional hospital admissions per 100 enrollees
- Effects worse in low income and patients with chronic illness
- 5 year study of almost 900,000 Medicare enrollees in 36 states

1. Trivedi A. N Engl J Med. 2010 Jan 28;362(4):320-8..

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High Copays Also Reduce Adherence to Appropriate Medication Use

Change in Days Supplied for Selected Drug Classes When Copays Were Doubled

Change in Drug Days Supplied (%)	Diabetes	High Cholesterol	Hypertension
	-25%	-34%	-26%

- **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

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What to Do? Focus on Appropriateness of Care

$600-800 billion is spent on care that does nothing to improve our health*

Demand-Side

Personal choices and behaviors drive excessive demand

Supply-Side

Existing model encourages excessive volume

Administrative

Inefficiencies in administrative transactions, communication, and information sharing

*Source: Dartmouth Atlas

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Example of a Value-Based Insurance Design

Person is a newly diagnosed diabetic

- Offered an incentive to either complete an online course on managing diabetes or to speak with a health coach

- When completed, receives reduced co-pays on diabetes drugs, supplies and diabetes-related office visits, labs
- Incented and enrolled in a diabetes DM program if indicated
- Ideally patient's physician is incented to provide EBM based care, appropriate referrals (e.g. DTC), education (informed decision making) and ongoing management support between office visits

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Consumers Understand The Value of VBID

Reasons for Enrolling In a Value Based Benefit Plan

	Consumers (867)
The financial benefits	87%
The health benefits	59%
It was the only type of plan offered by employer	1%
Some other reason	3%

2010 TriZetto survey research

Q10a Why would you be likely to enroll in this type of plan?

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… and VBID Availability Will Likely Impact Consumer Choice

Consumers:
Will VBID encourage switching to a different insurance company?

Response	Percent
High impact	36%
Moderate impact	42%
Low impact	16%
No impact	6%

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QuadMed VBID Results

Average Healthcare Cost per Employee

$ Thousands

Year	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007

Y-axis: 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11

Legend: Midwest, Quad/Graphics

Overall Trend 2000-2007: **4.9%**

Quad/Med Program:

- **No patient costs for chronic care treatment for diabetes, asthma, hypertension**
- **Incorporated fitness and better health management**
- **Up to $400 per employee for goal achievement**

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City of Asheville VBID Results

Annual percentage of participants requiring ER visits or hospitalizations

% ER Visits

	% ER Visits
Baseline	9.9
Follow-up	1.3

% Hospitalizations

	% Hospitalizations
Baseline	4
Follow-up	1.9

Major Improvements in quality of life and work productivity

City of Asheville Asthma Program:

- No patient costs for asthma medications
- Asthma education provided to participants

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CDHP vs. VBID- Better Together

CDHP

- 8 million and growing at a rate of 34%/year
- Savings average $900-1000/member per year vs. "low" CDHP employers
- Lower rate increases (3.5% vs. 6.1%)

but……

- Poorer care and medication compliance for the chronically ill

VBID

- Higher care and drug compliance
- Lower hospitalization and ER rates for chronically ill
- Cost savings demonstrated in specific settings

but…..

- Higher initial utilization of services, so impact on premiums & ROI unclear

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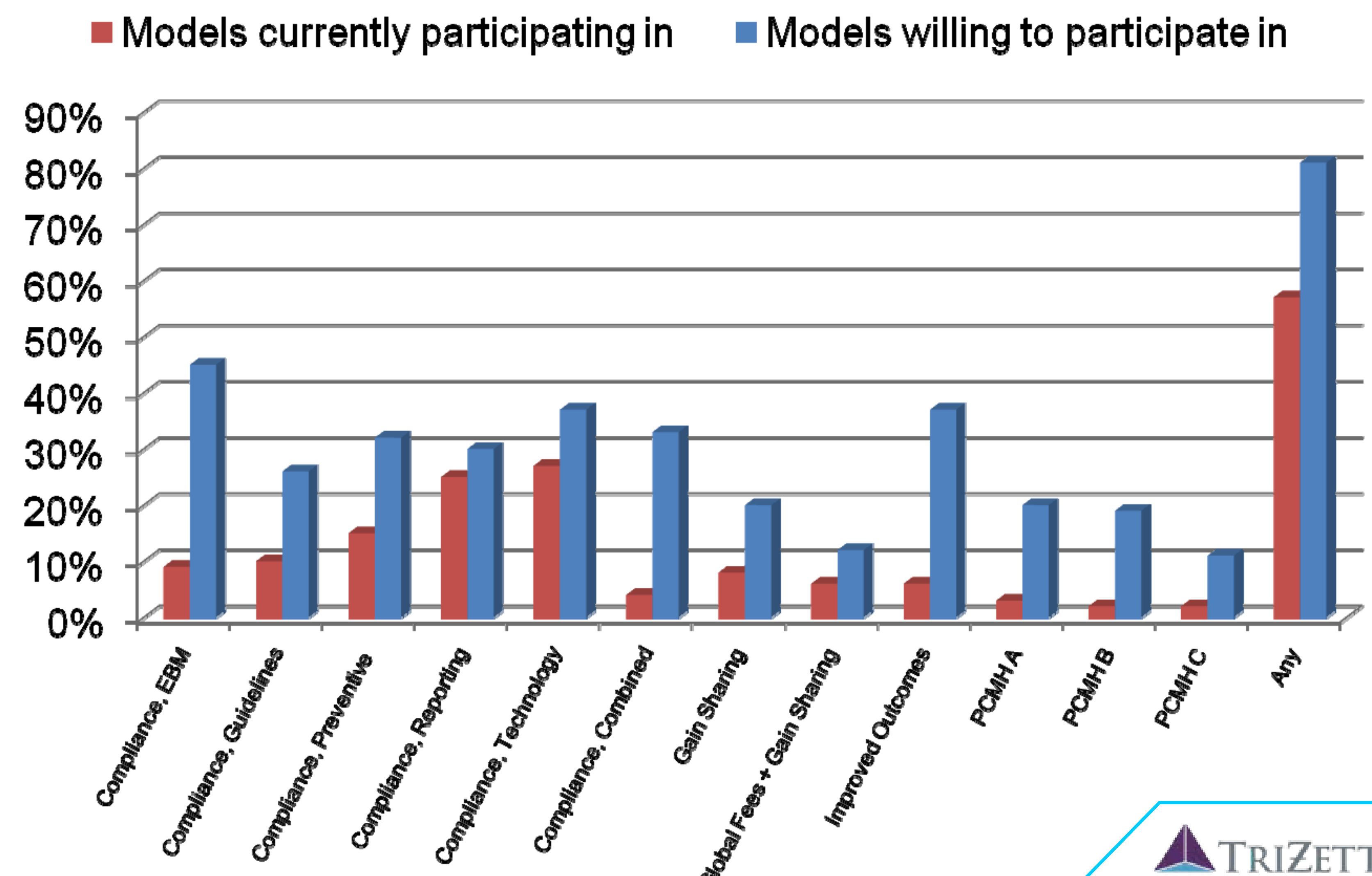
Plenty of Physician Engagement in Value Based Payment Schemes



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The Promise of PCMH & Lots of Expectations

Classic PCMH Definition

- Take personal responsibility and accountability for the ongoing care of patients;
- Be accessible to their patients on short notice for expanded hours and open scheduling;
- Be able to conduct consultations through email and telephone;
- Utilize the latest health information technology and evidence-based medical approaches, as well as maintain updated electronic personal health records;
- Conduct regular check-ups with patients to identify looming health crises, and initiate treatment/prevention measures before costly, last-minute emergency procedures are required;
- Advise patients on preventative care based on environmental and genetic risk factors they face;
- Help patients make healthy lifestyle decisions; and
- Coordinate care, when needed, making sure procedures are relevant, necessary and performed efficiently.

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And Lots of Government Support- PCMH in the Patient Protection and Affordable Care Act (PPACA)

- Medical Home is in 9 different sections of the PPACA
- Not new: Introduced in 1967 by American Academy of Pediatrics
- Puts Primary Care Physicians in central role of managing patients health
- Many other physician-based organizations have endorsed
- 'Cause Célèbre' on Capitol Hill

H. R. 3590

One Hundred Eleventh Congress
of the
United States of America

AT THE SECOND SESSION

Begun and held at the City of Washington on Tuesday, the fifth day of January, two thousand and ten

An Act

Entitled The Patient Protection and Affordable Care Act.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Patient Protection and Affordable Care Act".

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS

Subtitle A—Immediate Improvements in Health Care Coverage for All Americans

Sec. 1001. Amendments to the Public Health Service Act.

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Some Fair Questions from Physicians

> **"Everybody is in favor of progress. It's the change they don't like."**
>
> ***Anonymous***

- **Demonstrate the benefits to me and my patients specifically**
- **How will this affect my workflow and revenue?**
- **What will it cost me to participate?**
- **Data and analytics – whose data and can I trust it?**

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Current PCMH State of the Art-Deloitte Brief

- **100 planned or established programs**
  - Average number of physicians involve less than a few hundred
  - Largest over 8,000, but many less than 30
  - Few formal studies of effectiveness
- **Program designs are highly variable-** 2010 Harvard study (Bitton, et al)
  - Study id'ed 26 programs encompassing 15,000 physicians in 4700 practices
  - Highly variable structural, financial and operational features
  - Models typically use a collaborative chronic care model or an external consultant-facilitated model
- **Four key success themes-** 2010 Harvard study (Fields, et al)
  - Dedicated care managers, expanded access, data driven analytic tools, new incentives; HIT is the essential front end investment
  - Savings typically several hundred dollars per patient
- **National Demonstration Project from 2006-2008 concluded PCMH model is potentially effective but requires significant investment and operating competencies**
- **Health plans lead several of the most successful efforts**

Source: Deloitte Center for Health Solutions. **Issue Brief:** Medical Home 2.0, *The Present, the Future*

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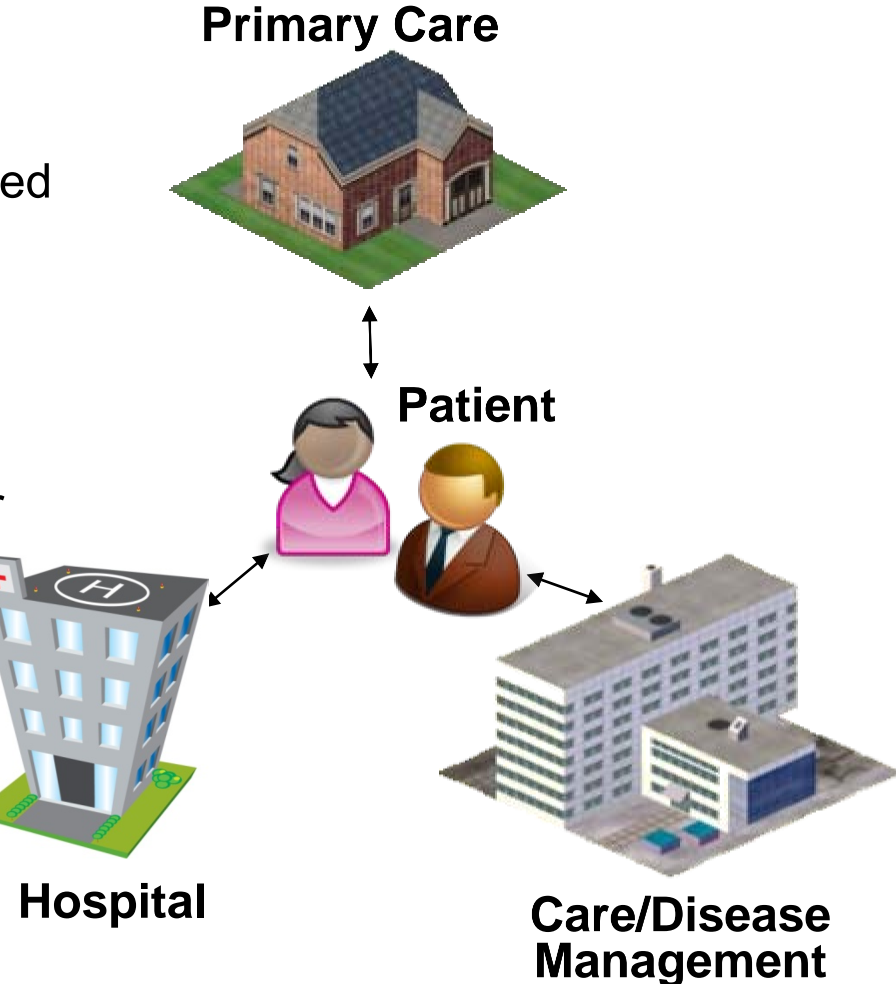
Keys to Success: The Single Patient View

▶ What everyone should know:

- Which patients are high risk?
- Are patients compliant to evidence based guidelines?
- Are they motivated to maintain their health status?
- What interventions are most effective?
- Who is most likely to have a hospital or ER visit?
- Medication & Care History
- What is the patients evidence-based care plan?



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Value of Superior Analytics

Example 1: Using Acute & Chronic Impact Index

Disease Focus: Diabetes

Total Population: 925,407 members
Diabetic Population: 50,847 members
Savings Potential: $62,643,504

High-Risk Population Risk Levels 4 & 5	High Acute & Chronic Impact Population
14,250 Members Forecasted Cost: $14,634 Prior Year Cost: $14,527	13,872 Members Forecasted Cost: $8,698 Prior Year Cost: $5,089
Savings Potential: $1,524,750	**Savings Potential: $50,064,048**

Example 2: Using Movers

Focus: High-Risk Members Forecasted with Upward Risk Movement

Total Population: 216,842 members

Top 2% High-Risk Members	Movers with Forecasted Cost Increase >= 50%
4,362 Members Forecasted Cost: $25,741 Prior Year Cost: $45,006	498 Members Forecasted Cost: $20,084 Prior Year Cost: $8,832
Savings Potential: -$84,033,930	**Savings Potential: $5,603,496**

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Example: Physician Portal Home Page

Risk Navigator Provider

Risk Navigator Home | Help | Logout

MEDai Demonstration Data - DMO 04/01/2005 - 03/31/2006

Home My Patient List Disease Registry Diagnosis Profile Utilization Profile

Physician Guideline Reporting Module

Choose a new Startup Page: Home Page

Select a Patient
Last Name:

My Patient List
Patient Summaries and Guideline Compliance

Disease Registry
Physician Guideline Compliance

Diagnosis Profile
Physician Diagnosis Summary

Utilization Profile
Physician and Population Utilization Comparison

Detailed Physician Profile
Detailed Physician Profile with links to Pharmacy Reports

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Example: My Patient List

Risk Navigator Provider

Risk Navigator Home | Help | Logout | Change Password

DMO Hospital System -

04/01/2005 - 03/31/2006

Home | My Patient List | Disease Registry | Diagnosis Profile | Utilization Profile

My Patient List

Disease Registry | Diagnosis Profile | Utilization Profile

Physician Demographics (based on all patients for the current physician)			
Physician Name	UHXM-THLX, SNME	# Patients	496
Physician ID	030774	Avg Total Cost	$2,995
		Avg Forecasted Cost	$3,623

First | < Prev | Next > | Last | Page 1 of 10 Pages | Go

Patient List						Guideline Compliance Information														
Patient Name	DOB	Primary Disease	Total Cost	Forecasted Cost	Risk Index	Asth...	CAD	COPD	CVA...	Depr...	Diab...	Drug Mgmt	Heart Failu...	Hep... C	HIV	Hyp...	Lower Back Pain	Migr...	Multi... Scle...	Oste...
LNMSXF, GNQT...	02/2...	Cardiovascular ...	$ 35,483	$ 17,437	5.05						67 %					50 %				
QNUXQSR IQ, V...	08/1...	AIDS	$ 14,195	$ 17,056	4.94											100 %				
LNRXKXE, CHK...	08/0...	Conduction disor...	$ 64,593	$ 16,754	4.85	67 %							83 %							
CHKKHTLR-LNS...	11/1...	CNS Neoplasm	$ 3,094	$ 16,008	4.63															
LAQQXKK, ITHLX	10/3...	AIDS	$ 13,231	$ 15,311	4.43															
RSXOGXMR, QN...	05/1...	Conduction disor...	$ 10,462	$ 15,106	4.37						60 %					25 %				
RXQQXS, ITVP...	04/0...	CNS Neoplasm	$ 1,152	$ 14,322	4.14	0 %														
KXBHRNM, ZHR...	10/2...	AIDS	$ 12,004	$ 14,256	4.13															
WTBHR-QTHYN...	08/1...	Breast neoplasm	$ 7,497	$ 13,746	3.98	100 %														
RLHSG, UTQUTQT	08/2...	Epilepsy	$ 12,307	$ 13,557	3.92					100 %	100 %									
TLHKVTQ, OHX...	03/1...	Degenerative Or...	$ 13,989	$ 13,162	3.81															
TKXDTMWXQ, K...	03/2...	Prostate neoplasm	$ 14,545	$ 12,264	3.55						100 %					100 %				
JHQJKTMW, XK...	01/0...	Pneumonia	$ 11,080	$ 11,802	3.41	100 %										0 %				
SQNE, TMSGNME	07/1...	Congestive Hear...	$ 1,961	$ 11,721	3.39								0 %							
IXQNLX, GTQQ...	12/0...	Cerebrovascular ...	$ 7,812	$ 10,375	3				67 %		60 %					100 %				
UEQW, RGHQK...	01/2...	Diabetes	$ 6,969	$ 9,057	2.62						67 %					100 %				
ZNMFTKXF, MH...	03/2...	Arthritis, tendoni...	$ 4,774	$ 8,615	2.49															
RSTMKXE, JHLU...	03/0...	Hypertension	$ 963	$ 8,497	2.46											25 %				

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Example: Patient Profile

Risk Navigator Provider

Risk Navigator Home | Help | Logout | Change Password

DMO Hospital System - 04/01/2005 - 03/31/2006

Home My Patient List Disease Registry Diagnosis Profile Utilization Profile

Patient Profile

Lab Profile | Chronological Care History

Patient Demographics

Patient Name	RTMWXQR, IATMHST	**Total Cost**	$165,762
Address	123 MAIN STREET ANYTOWN, ST 12345- 6789	**Forecasted Cost**	$109,784
		Risk Index	31.77
Age	59	**RX Detail?**	Yes
Gender	F		

Top Patient Diagnosis Care History Maintenance Drugs Lab Opportunities Guideline Compliance

Patient Diagnosis

Primary Condition	Cl frac or disloc of lower extremity, with surgery - foot and ankle
Co-Morbidities	Chronic renal failure, with ESRD Major inflammation of skin & subcutaneous tissue Late effects and late complications Minor inflammation of skin & subcutaneous tissue Benign hypertension with comorbidity

Top Patient Diagnosis Care History Maintenance Drugs Lab Opportunities Guideline Compliance

Care History

Visit Type	Date of Service	Primary Diagnosis	Procedure Description	Provider Name
ER Visit	10/25/2005	STUTTERING		OTQJCTE QXZHNMTK LXWHVTK V...
Inpatient Stay	10/25/2005	STUTTERING		OTQJCTE QXZHNMTK LXWHVTK V...
Outpatient	08/03/2005	FX DISTAL RADIUS NEC-CL		OTQJCTE QXZHNMTK LXWHVTK V...
Professional	03/16/2006	GANGRENE	OFFICE CONSULTATION, PROBLEMS OF MO...	INGQ, UXQMTQWN L

Top Patient Diagnosis Care History Maintenance Drugs Lab Opportunities Guideline Compliance

Maintenance Drug Compliance

Drug Name	Last Fill Date	% Compliance	Next Fill Date
METOPROLOL TARTRATE	01/23/2006	66.4%	04/24/2006
CLONIDINE HCL	01/23/2006	66.4%	04/24/2006

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Example: Patient Profile (Continued)

Risk Navigator Provider

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DMO Hospital System -

04/01/2005 - 03/31/2006

Home My Patient List Disease Registry Diagnosis Profile Utilization Profile

Maintenance Drug Compliance

Drug Name	Last Fill Date	% Compliance	Next Fill Date
METOPROLOL TARTRATE	01/23/2006	66.4%	04/24/2006
CLONIDINE HCL	01/23/2006	66.4%	04/24/2006
FUROSEMIDE	01/23/2006	66.4%	04/24/2006
CALCIUM ACETATE	01/23/2006	66.4%	04/24/2006

Top Patient Diagnosis Care History Maintenance Drugs Lab Opportunities Guideline Compliance

Laboratory Clinical Opportunities

Lab Test Name	First Test - Abnormal?	First Test - Date	First Test - Result	Last Test - Abnormal?	Last Test - Date	Last Test - Result

Top Patient Diagnosis Care History Maintenance Drugs Lab Opportunities Guideline Compliance

Guideline Compliance

Guideline Group	Description	Compliant
Preventive Care-Women	Breast cancer screening: Women 40-69 years	Yes
Preventive Care	Colon cancer screening: Age 50 and older	NO
	Tobacco avoidance	Yes
	Influenza immunization: Individuals age 5-64 with chronic conditions	NO
	Influenza immunization: Individuals age 50 to 64	NO
	Pneumonia immunization: Age >=65 or 2-64 with chronic condition	NO
Heart Failure	Plus Hypertension: ACE-I, ARB, beta-blocker, diuretic or digoxin; Age >=18	Yes
	Plus Hypertension: echocardiogram, age >= 18	Yes
	ACE-I, ARB or beta-blocker; Age >= 18	Yes
	ACE-I, ARB, diuretic, beta-blocker or digoxin; Age >=18	Yes
	Plus Hypertension: ACE-I, ARB or beta blocker; Age >=18	Yes
	Diuretic plus serum chemistry panel or potassium; Age >=18	Yes
Diabetes	Eye exam (retinal) performed	Yes
	Hemoglobin A1c (HbA1c) testing	NO
	With nephropathy: ACE-I or ARB	NO
	LDL-C screening performed	Yes
	Plus Hypertension: ACE-I, ARB, beta-blocker, diuretic, calcium channel blocker	Yes

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Example: Disease Registry

Risk Navigator Profiling - Windows Internet Explorer

https://app.medai.com/RNC_DEMO/Default_RNPro.aspx?clientcode=DMX

Risk Navigator Provider

Home | Help | Logout | Change Password

Demo - Commercial - DMO 02/01/2007 - 01/31/2008

Home Physician List My Patient List Disease Registry Diagnosis Profile Utilization Profile Batch Filters Batch Reports

Disease Registry

Patient List | Diagnosis Profile | Utilization Profile | Export Page

Physician Demographics (based on all patients for the current physician)

Physician Name	ZKEMM, LTQSHM A	# Patients	1831
Physician ID	0071012	Avg Risk Index	0.91

Disease Registry

Guideline Condition	# Members w/Condition	# Members w/any Gap	Average % Compliance	% Members w/Chronic Impact >= 95	% Members w/Acute Impact >= 95
Asthma	6	1	83.3%	16.7%	0%
CAD	25	10	71.4%	40%	8%
COPD	13	12	20.8%	53.9%	15.4%
CVA	2	1	66.7%	100%	50%
Depression	10	5	50%	30%	10%
Diabetes	33	32	35.2%	27.3%	3%
Drug Management	66	22	67%	28.8%	3%
HIV	2	2	0%	100%	0%
Heart Failure	1	0	100%	100%	100%
Hyperlipidemia	90	57	36.7%	27.8%	2.2%
Hypertension	42	25	52.5%	21.4%	0%
Immunizations - Children	20	18	18.3%	0%	0%
Low Back Pain	192	45	88.7%	21.9%	1%
Migraine Headache	46	6	93.7%	69.6%	4.4%

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Example: Diagnosis Profile

Risk Navigator Profiling - Windows Internet Explorer

https://app.medai.com/RNC_DEMO/Default_RNPro.aspx?clientcode=DMX

Risk Navigator Provider

Home | Help | Logout | Change Password

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Diagnosis Profile

Patient List | Disease Registry | Utilization Profile | Export Page

Physician Demographics (based on all patients for the current physician)

Physician Name	ZKEMM, LTQSHM A	**# Patients**	1831
Physician ID	O071012	**Avg Risk Index**	0.91

Diagnosis Profile

Diagnosis	# Members	% Prevalence	Avg Forecasted Index	Avg Forecasted Cost	Population % Prevalence	Population Avg Forecasted Index	Population Avg Forecasted Cost
AIDS	2	0.1 %	1.13	$ 3,195	0.1 %	5.22	$ 14,840
Adrenal dysfunction, neoplasm	1	0.1 %	8.24	$ 23,431	0.1 %	4.36	$ 12,416
Arthritis, tendonitis	230	12.6 %	1.41	$ 4,013	10.4 %	1.92	$ 5,454
Asthma	54	3 %	1.77	$ 5,051	2.8 %	2.03	$ 5,775
Bone & Connective Tissue Neoplasm	4	0.2 %	3.01	$ 8,567	0.2 %	3.47	$ 9,886
Breast neoplasm	23	1.3 %	3	$ 8,548	1.8 %	2.71	$ 7,717
Bronchitis	283	15.5 %	1.20	$ 3,419	5.9 %	1.68	$ 4,767
Burns, Skin Trauma	9	0.5 %	0.95	$ 2,704	0.2 %	1.52	$ 4,322
CNS Neoplasm	1	0.1 %	2.37	$ 6,735	0.1 %	6.90	$ 19,626
Cardiovascular Medical	96	5.2 %	2.07	$ 5,892	7.3 %	2.60	$ 7,391
Cardiovascular Surgery	3	0.2 %	1.61	$ 4,572	0.1 %	5.13	$ 14,597
Cataracts	9	0.5 %	1.86	$ 5,289	1.3 %	2.85	$ 8,112
Central Nervous System	115	6.3 %	2.07	$ 5,885	5 %	2.62	$ 7,444
Cerebrovascular Accident	2	0.1 %	5.42	$ 15,419	0.4 %	4.45	$ 12,670
Cholelithiasis	10	0.6 %	2.27	$ 6,457	0.5 %	2.84	$ 8,090

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Example: Utilization Profile

Risk Navigator Profiling - Windows Internet Explorer

https://app.medai.com/RNC_DEMO/Default_RNPro.aspx?clientcode=DMX

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Physician Demographics (based on all patients for the current physician)			
Physician Name	ZKEMM, LTQSHM A	# Patients	1831
Physician ID	0071012	Avg Risk Index	0.91

Group Utilization Profile		Population Utilization Profile	
Admits/1000	33.5	Admits/1000	61.1
Days/1000	106.7	Days/1000	234.7
OP ER Visits/1000	179.4	OP ER Visits/1000	178.6
Rx Cost PMPM	$31	Rx Cost PMPM	$47
Inpatient Cost PMPM	$24	Inpatient Cost PMPM	$42
Professional Cost PMPM	$89	Professional Cost PMPM	$96
Total Cost PMPM	$184	Total Cost PMPM	$241
Forecasted Cost PMPM	$215	Forecasted Cost PMPM	$230

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Reminder- There Are Lots of New Payment Options to Consider

- **Patient Centered Medical Home**

and…

- **Payment Bundling/episode of care payments (ACE)**
- **Traditional capitation/ "new" CMS global payment programs**
- **Accountable Care Organizations**
- **Next generation Pay for Performance**
- **Hospital performance scores**
- **Medicare re-admission, never event and avoidable condition payment rules**
- **New NAIC medical loss ratio (MLR) qualifying expenses**

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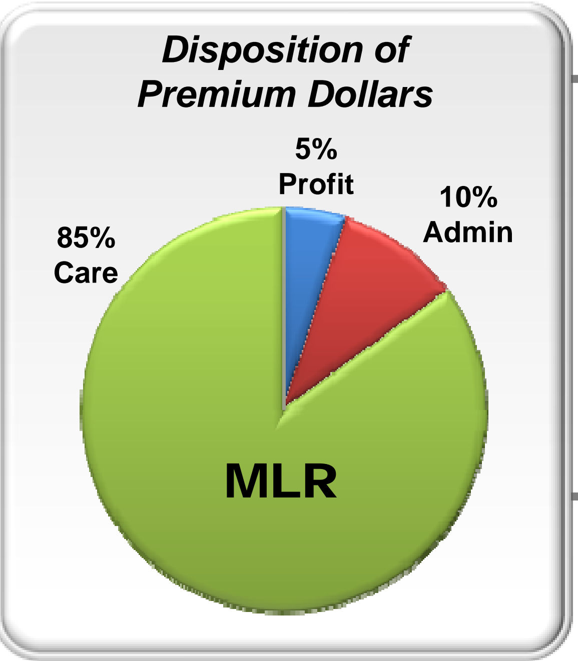
Healthcare Reform Affects Finances in 3 Waves

First Wave: 2010

- Integrate new costs into their economic models (Rescissions, dependent coverage, lifetime and annual limits)

Second Wave: 2011-2013

- Meet Medical Loss Ratio (MLR) requirements
- Begin transitioning to new exchange distribution model
- Massive shifts in business line profitability and enrollment



Third Wave: 2014

- Integrate $8B in federal fees
- Required competency in consumer marketing

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The MLR Qualifying Funnel

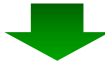
Recommendations from the NAIC to HHS Pursuant to the PPACA

Quality Improvement IN

- Improved Health Outcomes
- Reducing Health Disparities
- Hospital Readmission Prevention
- Improved Patient Safety & Medical Error Reduction
- Increase Wellness
- Enhanced Use of Healthcare Data

Objectively measured showing verifiable results and achievement - not designed primarily to contain costs

Expense directed toward individual members or specific segments of enrollees



Grounded in EBM, widely held clinical practice, government bodies, national quality organizations and/or accreditation bodies

- Network Management
- UM
- Claims processing
- ICD 10

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Qualifying QI Activities- A Deeper Look

- **Improve Health Outcomes- Care and Disease Management, Coaching, Compliance support, PCMH, Reporting, Data Analytics**
- **Prevent Hospital Re-admission- Discharge planning, post discharge care, analytics, information sharing post discharge**
- **Improve Patient Safety and Reduce Medical Errors- error identification and prevention, infection control, analytics, data sharing**
- **Wellness and Health Promotion- wellness assessment, coaching and education, prevention, HIT associated with these activities**
- **HIT for Healthcare Quality Improvement**

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"Column 1"- Improve Health Outcomes

- **Effective Case management, Care coordination, and Chronic Disease Management, including:**
  - Patient centered intervention such as:
    - Making/verifying appointments,
    - Medication and care compliance initiatives,
    - Arranging and managing transitions from one setting to another (such as hospital discharge to home or to a rehabilitation center), and
    - Reminding insured of physician appointment, lab tests or other appropriate contact with specific providers;

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“Column 1”- Improve Health Outcomes (cont)

- **Effective Case management, Care coordination, and Chronic Disease Management, including:**
  - Incorporating feedback from the insured to effectively monitor compliance;
  - Providing coaching to encourage compliance with evidence based medicine;
  - Activities to identify and encourage evidence based medicine;
  - Use of the medical homes model as defined for purposes of section 3602 of PPACA); and
  - Medication and care compliance initiatives, such as checking that the insured is following a medically effective prescribed regimen for dealing with the specific disease/condition and incorporating feedback from the insured in the management program to effectively monitor compliance;

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"Column 4"- Wellness and Health Promotion

Expenses for programs that provide wellness and health promotion activity (e.g., face-to-face, telephonic or web-based interactions or other forms of communication), including:

- **Wellness assessment;**
- **Wellness/lifestyle coaching programs designed to achieve specific and measurable improvements;**
- **Coaching programs designed to educate individuals on clinically effective methods for dealing with a specific chronic disease or condition; and**
- **Coaching or education programs and health promotion activities designed to change member behavior (e.g., smoking, obesity); or**
- **Health information technology expenses to support these activities**

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Key Takeaways From This Talk

Value Purchasing is More Critical Than Ever

Consumer Health and Demand Can Managed Using Value Based Insurance Design ("Smart Benefits")

Physician Engagement is Critical to Value Based Strategies But Is Only In Its Infancy

Recent MLR Definitions Regarding Qualifying Medical Expenses Are Very Favorable for Value Based Solutions

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Case Studies of VBID

- **Prescription drug / supply co-pays that incentivize high-value care**
  - For asthma, diabetes, and heart disease drug classes: Pitney Bowes; Marriott Inc.; SEIU
  - Moving lower-value drugs to more costly tiers: Health Alliance Medical Plans, Inc.
  - Chronic conditions: Blue Cross Blue Shield North Carolina (3:1 returns)

- **Drug and care service co-pays that incentivize high-value care**
  - For diabetics: City of Asheville Project; University of Michigan “Focus on Diabetes” program; many others
  - Reduced co-pays and behavior rewards: Quad/Graphics
  - Zero co-pay for well-women, well-baby, diabetes drugs, colon cancer high-risk: Caterpillar

- **Comparative effectiveness in consumer decision-making**
  - Provider choice (tiers of providers based on comparative quality): Aetna Aexcel
  - Treatment choice (surgery): Colorado Springs School District 11; Hannaford Brothers

- **Incentivizing health & wellness activities**
  - Lower deductible for health and wellness activity participation: United Health Vital Measures Plan

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Recommended Reading on VBID

- **Value-based Insurance Design Landscape Digest.** Fendrick July 2009. Available at: http://ww.sph.umich.edu/vbidcenter
- **Value-Based Benefit Design: A Purchaser Guide**. National Business Coalition on Health. Jan 2009. www.nbch.org
- **Health Plan Capabilities to Support Value-Based Benefit Design**. National Business Coalition on Health October 2009. Available at: www.npcnow.org
- **Aligning Incentives and Systems: Promoting Synergy Between Value-Based Insurance Design and the Patient Centered Medical Home.** Fendrick, Sherman, Patient-Centered Primary Care Collaborative 2010. www.pcpcc.net.
- **Adding Value to PPO Services – A White Paper on Value-Based Benefit Design**. American Association of Preferred Provider Organizations 2009. Available at www.aappo.org
- **eValue8** National Business Coalition on Health's initiative for review of health plans. Available at: www.evalue8.com
- **Pitney Bowes' VBID pilot results**: Berger J. "Economic and clinical impact of innovative pharmacy benefit designs in the management of diabetes pharmacotherapy." Am J Manag Care 2007
- **Value-based Insurance Design: Aligning Incentives to Bridge the Divide Between Quality Improvement and Cost Containment**. Fendrick, Chernew Am J Manag Care 2006
- **Value-based Insurance Design: A Clinically Sensitive Approach to Preserve Quality of Care and Contain Costs.** Fendrick, Chernew.. Am J Manag Care 2006
- **A Strategy for Health Care Reform – Toward a Value-based System.** Porter. NEJM 2009
- **Value in Health Care: Preliminary Discussion Brief.** IOM March 2009. Available at: ww.iom.edu
- **vbidcenter.org** – research and additional case studies

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Thank you

Additional Resources:

- www.TriZetto.com
    - **TriZetto Value-Based Benefits Solution –** a technology solution for health plans to design and administer value-based benefits and incentive programs
- www.TriZetto.com/vbidwp
    - **Value-Based Insurance Design: A proactive approach to a healthier membership.** New TriZetto research shows that payers, employers, providers, brokers and consumers are in agreement about the potential benefits of VBID and that demand is significant.

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TriZetto Constituent Survey Overview

Methodology

Opinion Research conducted 1,761 interviews

Constituent Group	Number of Interviews	Sampling Error
Payers	157	8%
Brokers	200	7%
Employers	200	7%
Clinicians	203	7%
Consumers	1,001	3%

Reliability – 95% confidence level

60-day online survey, Oct. – Dec. 2009.

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