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.
**Key Takeaways From This Talk**

1. **Value Purchasing is More Critical Than Ever**
2. **Consumer Health and Demand Can Managed Using Value Based Insurance Design (“Smart Benefits”)**
3. **Physician Engagement is Critical to Value Based Strategies But Is Only In Its Infancy**
4. **Recent MLR Definitions Regarding Qualifying Medical Expenses Are Very Favorable for Value Based Solutions**
Agenda

The Urgency of Value

Consumer Incentives– The “Demand” Side

Clinician Incentives – The “Supply” Side

Value-based strategies and health reform
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
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
Non-Adherence to Evidence-Based Services: already a cost and quality problem

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

High Copays Also 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.

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

- Diabetes: -25%
- High Cholesterol: -34%
- Hypertension: -26%

ER = Emergency room
Goldman DP et al. JAMA, 2004; 291:2344-2350
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
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
Agenda

The Urgency of Value

Consumer Incentives – The “Demand” Side

Clinician Incentives – The “Supply” Side

Value-based strategies and health reform
### Reasons for Enrolling In a Value Based Benefit Plan

<table>
<thead>
<tr>
<th>Reason</th>
<th>Consumers (867)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The financial benefits</td>
<td>87%</td>
</tr>
<tr>
<td>The health benefits</td>
<td>59%</td>
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<tr>
<td>It was the only type of plan offered by employer</td>
<td>1%</td>
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<tr>
<td>Some other reason</td>
<td>3%</td>
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</table>

2010 TriZetto survey research

Q10a Why would you be likely to enroll in this type of plan?
... and VBID Availability Will Likely Impact Consumer Choice

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

Average Healthcare Cost per Employee

- **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
City of Asheville VBID Results

Annual percentage of participants requiring ER visits or hospitalizations

City of Asheville Asthma Program:
- No patient costs for asthma medications
- Asthma education provided to participants

Major Improvements in quality of life and work productivity
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
Agenda

The Urgency of Value

Consumer Incentives – The “Demand” Side

Clinician Incentives – The “Supply” Side

Value-based strategies and health reform
Plenty of Physician Engagement in Value Based Payment Schemes

- Models currently participating in
- Models willing to participate in

Chart illustrating the percentage of models participating and willing to participate in various payment schemes.
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.
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
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?
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
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?
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**
  - **14,250 Members**
    - **Forecasted Cost:** $14,634
    - **Prior Year Cost:** $14,527

- **High Acute & Chronic Impact Population**
  - **13,872 Members**
    - **Forecasted Cost:** $8,698
    - **Prior Year Cost:** $5,089

- **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**

- **4,362 Members**
  - **Forecasted Cost:** $25,741
  - **Prior Year Cost:** $25,741

- **Savings Potential:** $50,064,048

**Movers with Forecasted Cost Increase >= 50%**

- **498 Members**
  - **Forecasted Cost:** $20,084
  - **Prior Year Cost:** $8,832

- **Savings Potential:** $5,603,496
**Example: Physician Portal Home Page**

**Physician Guideline Reporting Module**

- **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
## Example: My Patient List

### My Patient List

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

### Patient List

<table>
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<tr>
<th>Patient Name</th>
<th>DOB</th>
<th>Primary Disease</th>
<th>Total Cost</th>
<th>Forecasted Cost</th>
<th>Risk Index</th>
<th>Asth...</th>
<th>CAD</th>
<th>COPD</th>
<th>CVA...</th>
<th>Depr...</th>
<th>Diab...</th>
<th>Drug Mgmt</th>
<th>Heart Failu...</th>
<th>Rep...</th>
<th>HIV</th>
<th>Hyp...</th>
<th>Lower Back Pain</th>
<th>Migr...</th>
<th>Multi...</th>
<th>Scle...</th>
<th>Oste...</th>
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<td>Arthritis, tendoni...</td>
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<td>67 %</td>
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<td>Hypertension</td>
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</table>
Example: Patient Profile

Patient Profile

<table>
<thead>
<tr>
<th>Lab Profile</th>
<th>Chronological Care History</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Demographics</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Patient Name</strong></td>
<td>R7MXXQR, IAMHST</td>
</tr>
</tbody>
</table>
| **Address** | 123 MAIN STREET
ANYTOWN, ST 12345-6789 | **Forecasted Cost** | $109,784 |
| **Age** | 50 | **Risk Index** | 31.77 |
| **Gender** | F | **RX Detail?** | Yes |

**Top Patient Diagnosis**
- **Primary Condition**: 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

**Care History**

<table>
<thead>
<tr>
<th>Visit Type</th>
<th>Date of Service</th>
<th>Primary Diagnosis</th>
<th>Procedure Description</th>
<th>Provider Name</th>
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<tr>
<td>ER Visit</td>
<td>10/25/2005</td>
<td>STUTTERING</td>
<td>OTQJCXQYXNZMTCXNWXQXV...</td>
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<td>Inpatient Stay</td>
<td>10/25/2005</td>
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<td>OTQJCXQYXNZMTCXNWXQXV...</td>
<td></td>
</tr>
<tr>
<td>Outpatient</td>
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<td>FX DISTAL RADIUS NEC-CL</td>
<td>OTQJCXQYXNZMTCXNWXQXV...</td>
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<tr>
<td>Professional</td>
<td>03/16/2006</td>
<td>GANGRENE</td>
<td>OFFICE CONSULTATION, PROBLEMS OF MO... INQJ, UXQMTQWN L</td>
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**Maintenance Drug Compliance**

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<thead>
<tr>
<th>Drug Name</th>
<th>Last Fill Date</th>
<th>% Compliance</th>
<th>Next Fill Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>METOPROLOL TARTRATE</td>
<td>01/23/2006</td>
<td>65.4%</td>
<td>04/24/2006</td>
</tr>
<tr>
<td>CLONIDINE HCL</td>
<td>01/23/2006</td>
<td>65.4%</td>
<td>04/24/2006</td>
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</table>
Example: Patient Profile (Continued)
Example: Disease Registry
Example: Diagnosis Profile

### Diagnosis Profile

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

<table>
<thead>
<tr>
<th>Physician Name</th>
<th>Physician ID</th>
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</thead>
<tbody>
<tr>
<td>ZC8MM, LTQSHM A</td>
<td>O071012</td>
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</table>

<table>
<thead>
<tr>
<th># Patients</th>
<th>Avg Risk Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>1831</td>
<td>0.91</td>
</tr>
</tbody>
</table>

#### Diagnosis Profile

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th># Members</th>
<th>% Prevalence</th>
<th>Avg Forecasted Index</th>
<th>Avg Forecasted Cost</th>
<th>Population % Prevalence</th>
<th>Population Avg Forecasted Index</th>
<th>Population Avg Forecasted Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>2</td>
<td>0.1 %</td>
<td>1.13</td>
<td>$3,195</td>
<td>0.1 %</td>
<td>5.22</td>
<td>$14,840</td>
</tr>
<tr>
<td>Adrenal dysfunction, neoplasm</td>
<td>1</td>
<td>0.1 %</td>
<td>8.24</td>
<td>$23,431</td>
<td>0.1 %</td>
<td>4.36</td>
<td>$12,416</td>
</tr>
<tr>
<td>Arthritis, tendinitis</td>
<td>230</td>
<td>12.6 %</td>
<td>1.41</td>
<td>$4,013</td>
<td>10.4 %</td>
<td>1.92</td>
<td>$5,454</td>
</tr>
<tr>
<td>Asthma</td>
<td>54</td>
<td>3 %</td>
<td>1.77</td>
<td>$5,051</td>
<td>2.8 %</td>
<td>2.03</td>
<td>$5,775</td>
</tr>
<tr>
<td>Bone &amp; Connective Tissue Neoplasm</td>
<td>4</td>
<td>0.2 %</td>
<td>3.01</td>
<td>$8,567</td>
<td>0.2 %</td>
<td>3.47</td>
<td>$9,886</td>
</tr>
<tr>
<td>Breast neoplasm</td>
<td>23</td>
<td>1.3 %</td>
<td>3</td>
<td>$8,548</td>
<td>1.8 %</td>
<td>2.71</td>
<td>$7,717</td>
</tr>
<tr>
<td>Bronchitis</td>
<td>283</td>
<td>15.5 %</td>
<td>1.20</td>
<td>$3,419</td>
<td>5.9 %</td>
<td>1.56</td>
<td>$4,767</td>
</tr>
<tr>
<td>Burns, Skin Trauma</td>
<td>9</td>
<td>0.5 %</td>
<td>0.95</td>
<td>$2,704</td>
<td>0.2 %</td>
<td>1.52</td>
<td>$4,322</td>
</tr>
<tr>
<td>CNS Neoplasm</td>
<td>1</td>
<td>0.1 %</td>
<td>2.37</td>
<td>$6,735</td>
<td>0.1 %</td>
<td>6.90</td>
<td>$19,626</td>
</tr>
<tr>
<td>Cardiovascular Medical</td>
<td>96</td>
<td>5.2 %</td>
<td>2.07</td>
<td>$5,892</td>
<td>7.3 %</td>
<td>2.56</td>
<td>$7,391</td>
</tr>
<tr>
<td>Cardiovascular Surgery</td>
<td>3</td>
<td>0.2 %</td>
<td>1.61</td>
<td>$4,572</td>
<td>0.1 %</td>
<td>5.13</td>
<td>$14,597</td>
</tr>
<tr>
<td>Cataracts</td>
<td>9</td>
<td>0.5 %</td>
<td>1.88</td>
<td>$5,289</td>
<td>1.3 %</td>
<td>2.85</td>
<td>$8,112</td>
</tr>
<tr>
<td>Central Nervous System</td>
<td>115</td>
<td>6.3 %</td>
<td>2.07</td>
<td>$5,885</td>
<td>5 %</td>
<td>2.62</td>
<td>$7,444</td>
</tr>
<tr>
<td>Cerebrovascular Accident</td>
<td>2</td>
<td>0.1 %</td>
<td>5.42</td>
<td>$15,419</td>
<td>0.4 %</td>
<td>4.45</td>
<td>$12,670</td>
</tr>
<tr>
<td>Cholelithiasis</td>
<td>10</td>
<td>0.6 %</td>
<td>2.27</td>
<td>$6,457</td>
<td>0.5 %</td>
<td>2.84</td>
<td>$8,090</td>
</tr>
</tbody>
</table>
**Example: Utilization Profile**

![Utilization Profile](image)

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

<table>
<thead>
<tr>
<th>Physician Name</th>
<th>2K2MN, LYQSHMA</th>
<th># Patients</th>
<th>1631</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician ID</td>
<td>0071012</td>
<td>Avg Risk Index</td>
<td>0.01</td>
</tr>
</tbody>
</table>

**Group Utilization Profile**

<table>
<thead>
<tr>
<th>Category</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admits/1000</td>
<td>32.5</td>
</tr>
<tr>
<td>Days/1000</td>
<td>106.7</td>
</tr>
<tr>
<td>OP ER Visits/1000</td>
<td>179.4</td>
</tr>
<tr>
<td>Rx Cost PMPM</td>
<td>$21</td>
</tr>
<tr>
<td>Inpatient Cost PMPM</td>
<td>$24</td>
</tr>
<tr>
<td>Professional Cost PMPM</td>
<td>$89</td>
</tr>
<tr>
<td>Total Cost PMPM</td>
<td>$104</td>
</tr>
<tr>
<td>Forecasted Cost PMPM</td>
<td>$215</td>
</tr>
</tbody>
</table>

**Population Utilization Profile**

<table>
<thead>
<tr>
<th>Category</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admits/1000</td>
<td>61.1</td>
</tr>
<tr>
<td>Days/1000</td>
<td>234.7</td>
</tr>
<tr>
<td>OP ER Visits/1000</td>
<td>178.6</td>
</tr>
<tr>
<td>Rx Cost PMPM</td>
<td>$47</td>
</tr>
<tr>
<td>Inpatient Cost PMPM</td>
<td>$42</td>
</tr>
<tr>
<td>Professional Cost PMPM</td>
<td>$96</td>
</tr>
<tr>
<td>Total Cost PMPM</td>
<td>$241</td>
</tr>
<tr>
<td>Forecasted Cost PMPM</td>
<td>$230</td>
</tr>
</tbody>
</table>
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
Agenda

The Urgency of Value

Consumer Incentives – The “Demand” Side

Clinician Incentives – The “Supply” Side

Value-based strategies and health reform
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
The MLR Qualifying Funnel

Recommendations from the NAIC to HHS Pursuant to the PPACA

- 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
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
“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;
“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;
“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.
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
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
Recommended Reading on VBID

- **Value-based Insurance Design Landscape Digest.** Fendrick July 2009. Available at: [http://www.sph.umich.edu/vbidcenter](http://www.sph.umich.edu/vbidcenter)
- **Health Plan Capabilities to Support Value-Based Benefit Design.** National Business Coalition on Health October 2009. Available at: [www.npcnow.org](http://www.npcnow.org)
- **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](http://www.aappo.org)
- **eValue8** National Business Coalition on Health’s initiative for review of health plans. Available at: [www.evaluate8.com](http://www.evaluate8.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](http://ww.iom.edu)
- **vbidcenter.org** – research and additional case studies
Thank you

Additional Resources:

- [www.TriZetto.com](http://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](http://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.
TriZetto Constituent Survey Overview

Methodology
Opinion Research conducted 1,761 interviews

<table>
<thead>
<tr>
<th>Constituent Group</th>
<th>Number of Interviews</th>
<th>Sampling Error</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payers</td>
<td>157</td>
<td>8%</td>
</tr>
<tr>
<td>Brokers</td>
<td>200</td>
<td>7%</td>
</tr>
<tr>
<td>Employers</td>
<td>200</td>
<td>7%</td>
</tr>
<tr>
<td>Clinicians</td>
<td>203</td>
<td>7%</td>
</tr>
<tr>
<td>Consumers</td>
<td>1,001</td>
<td>3%</td>
</tr>
</tbody>
</table>

Reliability – 95% confidence level