UNITED STATES SENATE ARMED SERVICES PERSONNEL SUBCOMMITTEE

THE ESSENTIAL ROLE OF CLINICAL NUANCE AND MEMBER RESPONSIBILITY IN TRICARE BENEFIT REDESIGN

TESTIMONY OF: A. Mark Fendrick, MD
Professor of Internal Medicine and Health Management & Policy
Director, Center for Value-Based Insurance Design
University of Michigan
www.vbidcenter.org
February 23, 2016

Good morning and thank you, Chairman Graham, Ranking Member Gillibrand, and Members of the Subcommittee. I am Mark Fendrick, Professor of Internal Medicine and Health Management & Policy at the University of Michigan. I am addressing you today, not as a representative of the University, but as a practicing primary care physician, a medical educator, and a public health professional. I have devoted much of the past two decades to studying the United States health care delivery system, and founded the University's Center for Value-Based Insurance Design [www.vbidcenter.org] in 2005 to develop and evaluate insurance plans designed to engage consumers, optimize the health of Americans and ensure efficient expenditure of our public and private health care dollars.

Mr. Chairman, I applaud you for holding this hearing on Defense Health Care Reform, because access to quality care and containing costs are among the most pressing issues for our military personnel and our national well-being and economic security. We are well aware that the U.S. spends far more per capita on health care than any other country, yet lags behind other nations that spend substantially less, on key health quality and patient-centered health measures. Since there is consistent agreement within both political parties, and among key stakeholders, that there is already enough money being spent on health care in this country, I would like to emphasize that if we reallocated our existing dollars to clinical services for which there is clear evidence for improving health and away from those that don't, we could significantly enhance quality and substantially reduce the amount we spend. Thus, instead of the primary focus on *how much* we spend – I suggest we shift our attention to *how well* we spend our military health care dollars.

FROM A VOLUME-DRIVEN TO VALUE-BASED SYSTEM

Moving from a volume-driven to value-based military health delivery system requires a change in both how we pay for care (supply side initiatives) and how we engage consumers to seek care (demand side initiatives). Previous discussions and earlier testimonies focused on the critical importance and progress regarding reforming care delivery and payment policies. Many sections of the 2016 National Defense Authorization Act (NDAA) address payment issues; Sec. 726 explicitly calls for a pilot program to test value-based reimbursement in TRICARE.

These are important and worthy conversations. Yet, less attention has been directed to how we can alter consumer behavior as a policy lever to bring about a more efficient delivery system. While you have heard about the potential of pay-for-performance programs, patient-centered medical homes, bundled payment models, and other initiatives to influence providers, today I propose that **value-driven consumer incentives -- through benefit design reforms that promote smart decisions and enhanced personal responsibility -- must be aligned with payment reform initiatives for us to achieve our clinical and financial goals for military health care**. I commend the Subcommittee for exploring this matter today.

DANGERS OF A BLUNT APPROACH TO BENEFICIARY COST-SHARING – THE IMPORTANCE OF 'CLINICAL NUANCE'

Over the past few decades, public and private payers -- including the TRICARE program -- have implemented multiple managerial tools to constrain health care cost growth with varying levels of success. The most common approach to directly impact consumer behavior is consumer cost shifting: requiring beneficiaries to pay more in the form of higher premiums and increased cost-sharing for clinician visits, diagnostic tests and prescription drugs. Of note, the Defense Department budget proposal for 2017 calls for increasing the member out-of-pocket contributions for TRICARE members, most dramatically for military retirees under 65.

With some notable exceptions, most U.S. health plans -- including TRICARE -- implement cost-sharing in a 'one-size-fits-all' way, in that beneficiaries are charged the same amount for every doctor visit, diagnostic test, and prescription drug [within a specified formulary tier]. People frequently ask me whether the amount of cost-sharing faced by TRICARE members is too high, too low, or just right. The answer, of course, is "it depends." As TRICARE members are asked to pay more for *every* clinician visit and for *every* prescription -- despite clear differences in health produced -- a growing body of evidence demonstrates that increases in patient cost-sharing lead to decreases in the use of both non-essential and essential care. Unfortunately, research suggests that increasing 'skin in the game' has not produced a savvier health care consumer.

A noteworthy example of the undesirable impact of 'one-size-fits-all' ***increases*** in cost-sharing is a *New England Journal of Medicine* study that examined the effects of increases in copayments for all doctor visits for Medicare Advantage beneficiaries [Trivedi A. *N Engl J Med*. 2010;362(4):320-8]. As expected, individuals who were charged more to see their physician(s) went less often; however, these patients were hospitalized more frequently and their total medical costs increased. While this blunt approach may reduce TRICARE expenditures in the short-term, lower use rates of essential care may lead to inferior health outcomes and higher overall costs in certain clinical circumstances. This effect simply demonstrates that the age-old aphorism 'penny wise and pound foolish' applies to health care.

Conversely, ***decreases*** in cost-sharing applied to all services regardless of clinical benefit -- which may have been the case in certain TRICARE plans -- can lead to overuse or misuse of services that are potentially harmful or provide little clinical value. For the record, I support high cost-sharing levels for those services -- but only those services -- that do not make TRICARE members healthier. That said, I don't think it makes sense to raise

cost-sharing on the services I beg my patients to do, such as fill their prescriptions to manage their chronic conditions (e.g. diabetes, depression, HIV) and laboratory tests that allow the monitoring of a specific disease (e.g., cholesterol, blood sugar).

Since there is evidence of both underuse of high-value services and overuse of low-value services in the TRICARE program, **'smarter'** cost-sharing is a potential solution -- one that encourages TRICARE members to use more of those services that make them healthier, and discourages the use of services that do not. Therefore, to more efficiently reallocate TRICARE medical spending and optimize health, the basic tenets of *clinical nuance* must be considered. **These tenets recognize that: 1) clinical services differ in the benefit provided; and 2) the clinical benefit derived from a specific service depends on the patient using it, who provides it, and where it is provided.**

Does it make sense to you, Mr. Chairman, that my TRICARE patients pay the same copayment to see a cardiologist after a heart attack as to see a dermatologist for mild acne? Or that the prescription drug copayment is the same amount for a lifesaving medication to treat diabetes, depression, or cancer, as it is for a drug that treats toenail fungus? On the less expensive generic drug tier available to most TRICARE members (current copayments are $10 at retail pharmacies and $0 through a mail order pharmacy), certain are drugs so valuable that I often reach into my own pocket to help patients fill these prescriptions; while for the same price there are also drugs of such dubious safety and efficacy, I honestly would not give them to my dog. The current 'one-size-fits-all' cost-sharing model lacks clinical nuance, and frankly, to me, makes no sense. As we deliberate Defense Health Care benefit redesign, there is bipartisan recognition that the current structure of the TRICARE benefit is outdated, confusing, and in need of reform. Taking steps to improve the current array of confusing deductibles, copayments and coinsurance is long overdue. I could not agree more that our military personnel deserve better. Only after we acknowledge the limitations and inefficiencies of the TRICARE cost-sharing structure, can we identify ways to improve it. It is my impression that TRICARE members avail themselves of too little high-value care and too much low-value care. Precision medicine needs precision benefit design. We need benefit designs that support consumers in obtaining evidence-based services such as diabetic retinal exams and discourage individuals through higher cost-sharing from using dangerous or low-value services such as those identified by professional medical societies in the Choosing Wisely initiative. By incorporating greater clinical nuance into benefit design, payers, purchasers, beneficiaries, and taxpayers can attain more health for every dollar spent.

VALUE-BASED INSURANCE DESIGN [V-BID]: IMPLEMENTING CLINICAL NUANCE

Realizing the lack of clinical nuance in available public and commercial health plans, more than a decade ago the private sector began to implement clinically nuanced plans based on a concept our team developed known as Value-Based Insurance Design, or V-BID. **The basic V-BID premise calls for reducing financial barriers to evidence-based services and high-performing providers and imposing disincentives to discourage use of low-value care.** A V-BID approach to benefit design recognizes that different health services have different levels of value. It's common sense -- when barriers to high-value treatments are reduced and access to low-value treatments is discouraged, these plans result in better health with the potential to substantially lower spending levels.

Let me be clear, Mr. Chairman, I am not asserting that implementing V-BID into TRICARE is a single solution to TRICARE's problems. But, if we are serious about improving our members' experiences and health outcomes, while also bending the health care cost curve, we must change the incentives for consumers as well as those for providers. **Blunt changes to TRICARE benefit design -- such as those recently announced -- must not produce avoidable reductions in quality of care.** Instead, I would recommend clinically driven -- instead of a price driven -- strategies.

I'm pleased to tell you that the intuitiveness of the V-BID concept is driving momentum at a rapid pace in both the private and public sectors, and we are truly at a 'tipping point' in its adoption. Hundreds of private self-insured employers, public organizations, non-profits, and insurance plans have designed and tested V-BID programs. The fundamental idea of 'buy more of the good stuff and less of the bad' has made V-BID one of the very few health care reform ideas with broad multi-stakeholder and bipartisan political support.

V-BID implementation has occurred in many of the states represented by members of this subcommittee. Mr. Chairman, V-BID principles have been implemented in your State of South Carolina Medicaid program to ensure that vulnerable beneficiaries have better access to potentially life-saving drugs used to treat chronic diseases. Senator Gillibrand, the Empire state has highlighted V-BID in Governor Cuomo's state innovation plan and is a key element of the State Innovation Model (SIM) program. Senator King, V-BID has a similar high profile role in the Maine SIM program. Senator Cotton, Arkansas has been a national leader in aligning consumer engagement initiatives with the episode-based payment model. Senators Tillis and Blumenthal, V-BID plans are now offered to state employees in North Carolina and Connecticut. Of note, the Connecticut Health Enhancement Plan -- a V-BID plan for state employees -- has demonstrated high levels of participation in healthy behaviors (98%), and preventive care, and has significantly reduced emergency room visits in only two years. This plan has become a national model used by several other states and public employers.

The last and most important example I would like to mention is the implementation of V-BID in the Medicare program, a crucial component of our nation's commitment to take care of the elderly and disabled among us. The 'one-size-fits-all' approach to Medicare coverage dates back to its inception in the 1960s**,** driven by discrimination concerns. Over the past several years, bipartisan, bicameral Congressional support has grown to allow Medicare to implement clinically nuanced benefit designs. In 2009, Senators Hutchison and Stabenow introduced a bipartisan bill, "Seniors' Medication Copayment Reduction Act of 2009" (S 1040), to allow a demonstration of V-BID within Medicare Advantage plans. Last May, Senators Thune and Stabenow introduced the "Value-Based Insurance Design Seniors' Copayment Reduction Act of 2015" (S 1396). A companion bill included in the "Strengthening Medicare Advantage through Innovation and Transparency for Seniors Act of 2015" (HR 2570) passed the U.S. House of Representatives in June with strong bipartisan support.

This strong Congressional backing led the Center for Medicare & Medicaid Innovation (CMMI) to announce a program to test V-BID in Medicare Advantage (MA) plans in September 2015. The 5-year demonstration program will examine the utility of structuring patient cost-sharing and other health plan design elements to encourage patients to use high-value clinical services and

providers, thereby improving quality and reducing costs. The model test will begin in January 2017, in Arizona, Indiana, Iowa, Massachusetts, Oregon, Pennsylvania, and Tennessee.

INFUSING 'CLINICAL NUANCE' INTO TRICARE

Flexibility in benefit design would allow TRICARE plans to achieve even greater efficiency and to encourage personal responsibility among members in the following ways:

I. Differential Cost-Sharing for Use of Different Providers or Settings

Since the value of a clinical service may depend on the specific provider or the site of care delivery, **TRICARE plans should have the flexibility to vary cost-sharing for a particular outpatient service in accordance with who provides the service and /or where the service is delivered.** This flexibility is increasingly feasible, as quality metrics and risk-adjustment tools become better able to identify high-performing health care providers and/or care settings that consistently deliver superior quality.

II. Differential Cost-Sharing for Use of Different Services

To date, most clinically nuanced designs have focused on lowering patient out-of-pocket costs for high-value services (carrots). These are the services I beg my patients to do -- for which there is no question of their clinical value -- such as immunizations, preventive screenings, and critical medications and treatments for individuals with chronic disease such as asthma, diabetes, and mental illness (e.g. as recommended by National Committee for Quality Assurance, National Quality Forum, professional society guidelines). Despite unequivocal evidence of clinical benefit, there is substantial underutilization of these high-value services by TRICARE members. Multiple peer-reviewed studies show that when patient barriers are reduced, compliance goes up, and, depending on the intervention or service, total costs go down.

Yet, from the TRICARE program's perspective, the cost of incentive-only 'carrot-based' V-BID programs depends on whether the added spending on high-value services is offset by a decrease in adverse events, such as hospitalizations and visits to the emergency department. While these high-value services are cost-effective and improve quality, many are not cost saving -- particularly in the short term. However, research suggests that non-medical economic effects -- such as the improvement in productivity associated with better health -- can substantially impact the financial results of V-BID programs.

While significant cost savings are unlikely with incentive-only 'carrot' programs in the short term, **a V-BID program that combines reductions in cost-sharing for high-value services and increases in cost-sharing for low-value services can both improve quality and achieve net cost savings.** Removing harmful and/or unnecessary care from the system is essential to reduce costs, and creates an opportunity to improve quality and patient safety. Evidence suggests significant opportunities exist to save money without sacrificing high-quality care. For example, in 2014, the lowest available estimates of waste in the U.S. health care system exceeded 20% of total health care expenditures. Though less common,

some V-BID programs are designed to discourage use of low-value services and poorly performing providers. Low-value services result in either harm or no net benefit, such as services labeled with a D rating by the U.S. Preventive Services Task Force.

It is important to note that **many services that are identified as high quality in certain clinical settings are considered low-value when used in other patient populations, clinical diagnoses or delivery settings.** For example, cardiac catheterization, imaging for back pain, and colonoscopy can each be classified as a high- or low-value service depending on the clinical characteristics of the person, when in the course of the disease the service is provided, and where it is delivered.

Fortunately, there is growing movement to both identify and discourage the use of low-value services. The ABIM Foundation, in association with Consumers Union, has launched Choosing Wisely, an initiative where medical specialty societies identify commonly used tests or procedures whose necessity should be questioned and discussed. Thus far, over 40 medical specialty societies have identified at least five low-value services within their respective fields. Substantial and immediate cost savings are available from waste identification and elimination. Thus, **V-BID programs that include both 'carrots' and 'sticks' may be particularly desirable in the setting of budget shortfalls.**

III. Differential Cost-Sharing for Certain Services For Specific Enrollees

Since a critical aspect of clinical nuance is that the value of a medical service depends on the person receiving it, we recommend that TRICARE plans encourage differential cost-sharing for specific groups of enrollees. **The flexibility to target enrollee cost-sharing based on clinical information (e.g., diagnosis, clinical risk factors, etc.) is a crucial element to the safe and efficient allocation of expenditures.** Under such a scenario, a plan may choose to exempt certain enrollees from cost-sharing for a specific service on the basis of a specific clinical indicator, while imposing cost-sharing on other enrollees for which the same service is not clinically indicated. Under such an approach, plans can recognize that many services are of particularly high-value for beneficiaries with conditions such as diabetes, hypertension, asthma, and mental illness, while of low-value to others. (For example, annual retinal eye examinations are recommended in evidence-based guidelines for enrollees with diabetes, but not recommended for those without the diagnosis.) Without easy access to high-value secondary preventive services, previously diagnosed individuals may be at greater risk for poor health outcomes and avoidable, expensive, acute-care utilization. Conversely, keeping cost-sharing low for all enrollees for these services, regardless of clinical indicators, can result in overuse or misuse of services leading to wasteful spending and potential for harm.

Permitting 'clinically nuanced' variation in cost-sharing would give TRICARE plans a necessary tool needed to better encourage members to receive high-value services. This addition would eliminate many of the challenges and limitations of the 'one-size-fits-all' model.

ALIGNMENT OF CONSUMER ENGAGEMENT WITH ALTERNATIVE PAYMENT MODELS

The TRICARE program is currently examining many exciting, some unproven, value-based reimbursement initiatives such as bundled payments, pay-for-performance, and patient-centered medical homes, some of which are explicitly addressed in the 2016 National Defense Authorization Act. As these initiatives provide incentives for clinicians to deliver specific services to particular patient populations, it is of equal importance that consumer incentives are aligned. As a practicing physician, **it is incomprehensible to realize that my patients' insurance coverage may not offer easy access for those exact services for which I am benchmarked**. Does it make sense to offer a financial bonus to get my patient's diabetes blood sugar under control, when her benefit design makes it prohibitively expensive to fill her insulin prescription or provide the copayment for her eye examination? **The alignment of clinically nuanced, provider-facing, and consumer engagement initiatives is a necessary and critical step to improve quality of care, enhance the member experience, and contain cost growth for the TRICARE program.**

CONCLUSION

As this committee considers changes to the TRICARE benefit design, it is an honor for me to present one novel approach to better engage TRICARE members. As a practicing clinician, I believe that the goal of the military health system is to keep its members healthy, not to save money. That said, I strongly concur that health care cost containment is absolutely critical for the sustainability of the TRICARE program and our nation's fiscal health. While there is urgency to bend the health care cost curve, cost containment efforts should not produce avoidable reductions in quality of care. As cost-sharing becomes a necessity for fiscal sustainability, I encourage you to take a common-sense approach of setting member co-payments on whether a clinical service makes a TRICARE member healthier -- instead of the current strategy of basing member contributions on the price of the service. **In other words, make it harder to buy the services they should not be using in the first place.** If such principles encourage the utilization of high-value providers and services and discourage only low-value services, TRICARE plans can improve health, enhance consumer responsibility, and reduce costs.

Thank you.