University of Michigan
Center for Value-Based Insurance Design

Testimony Regarding H.B. 5345
Michigan House of Representatives
Committee on Public Employee Health Care Reform

A. Mark Fendrick, M.D.
Professor of Internal Medicine and Health Management & Policy
Co-director, Center for Value-Based Insurance Design
University of Michigan

October 22, 2009

Thank you, Madame Chair. Members of the Committee, good afternoon, 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 primary care clinician and public health professional. I have devoted much of the past 2 decades studying the clinical and economic impact of health care innovation, and specifically, founded the University's Center for Value-Based Insurance design in 2005 to develop and evaluate value-based insurance design initiatives, an idea that I was happy to see explicitly included in H.B. 5345.

My main point today is that **cost savings should not be the exclusive goal of health care reform efforts; we must not forget that the goal of the health care system is to improve health, not save money.** In order to achieve this goal we propose that appropriate incentives be provided for individuals and clinicians to enhance the use of those medical services that we know will improve the quality and length of life of Michiganders. While containing costs is one essential objective, our health care budgetary target should not be how little to spend, but be a value-driven, goal-oriented, approach similar to that used for education and transportation spending. As an alternative to simply cutting costs, consider a different question, analogous to other crucial budget decisions: "How do we best invest our increasingly scarce resources to improve the health of the people of Michigan? In other words, **let's support programs that produce the most amount of health for the dollars spent.**

Madame Chair, it's no secret to you and this committee that all purchasers of health care – whether in the private or public sector – are struggling to contain rising costs. In my view, our dire economic situation has distracted

us from why we purchase health care benefits in the first place. I, along with the thousands of dedicated and compassionate clinicians in this state did not go to pharmacy, nursing, and medical schools to learn how to save people money. **Our aim is simple, to make the people of Michigan healthier.** As I watch the debate to reform our nation's health care system, in Washington and here in Lansing, I can't help but be struck by the near exclusive attention on cost – with little to no mention of health. Given this irony, **I strongly request that you and the committee place more emphasis on "health" in your deliberations.**

Let's be honest. As the health care cost crisis escalates, payers of all kinds are shifting the growing costs to their beneficiaries – in the form of higher premiums and co-payments when we see a clinician, or fill a prescription. It is now well established that increasing patient cost sharing produces harmful consequences on our health. It is no surprise to anyone in this room to learn that when patients are asked to pay more, they buy less. **Reduced utilization – without considering the health effects – is not a desirable goal.**

There are those around the country and within this chamber that believe that people should and can spend their own money wisely on health care, and that "skin in the game" would encourage individuals to shop around and ultimately do the right thing. Remember, the reason why cost sharing exists is to motivate individuals to carefully consider their discretionary purchases. **Ideally, higher patient co-payments would discourage only the use of low-value care.** Yet, in almost every health plan in Michigan, out of pocket costs have increased in an "across the board" way, such that every doctor visit, diagnostic test, and prescription drug within a formulary tier costs the individual the same, with no consideration of the amount of health those services produce.

Does it make sense that my patients pay the same co-payment for a drug that would save their life as a drug that would make their hair grow back? The same to see a cardiologist for a heart attack as to see a dermatologist for mild acne? This "one size fits all" system lacks any clinical nuance and to me, frankly makes no sense. As a result, as patients are required to pay more – they do buy less of the non-essential services, BUT they also buy less of those potentially life saving services that I "beg" my patients to do, such as immunizations, cancer screenings, and essential therapies for the treatment of chronic diseases. **Efforts to control spending through cost sharing should not produce preventable reductions in quality of care**.

Please do not prematurely conclude that I do not clearly support the use of patient cost sharing as a critical lever in health care cost containment – that could not be further from the truth. I strongly endorse the use of cost-sharing, but feel that it should be implemented in a "clinically sensitive" way. **Patients need a system that removes financial barriers for those clinical services where there is clear evidence of value, and likely underutilization if left to individual spending patterns.** In other words, any plan to increase the consumers' role in health spending must also include incentives to seek essential, proven preventive care for little or no money of their own. **This concept – one with Michigan origins – is referred to as "value-based insurance design" [VBID]; the basic premise is that patient out-of-pocket cost and clinician payment are tied to value - not just the cost - of health services.** The more clinically beneficial the service is to the patient, the lower the cost-sharing.

VBID plans have been implemented in Michigan [the City of Battle Creek, Whirlpool and my own employer the University of Michigan have been national leaders] and by numerous private and public payers around the country. Research published by our Center and other investigators concluded that VBID plans significantly increase the use of recommended services and therefore lead to improvements in population health.

Madame Chair, in anticipation of a frequently asked question: "Does the VBID approach save money?" The answer is – it depends. **The financial impact of VBID plans depends on the level of clinical targeting and the extent of the changes in co-payments**. "Value-based" does not necessarily mean less expensive, particularly in the short term. The savings associated with improved health are usually measured by reductions in future adverse events – such as keeping people out of the ER or the hospital – which may offset the added costs of collecting lower co-payments and the increased use of high-value services. For example, the increased costs of lower patient cost-sharing for asthma control medications would be at least partially offset by savings from fewer emergency room visits for acute asthma attacks. Our own research would suggest that when carefully targeted, the return on investment for VBID programs far exceed many commonly employed cost containment strategies.

In addition to the direct financial benefits of improved health on medical spending, it is very important to note that additional return on investment [ROI] to the payer accrues when the "non-medical" benefits, such as

reduced disability and absenteeism, and enhanced productivity are included. It is my opinion, that when both medical and non-medical benefits of enhanced health are combined, that a positive ROI will likely result from VBID programs in many disease conditions.

Finally, I think it's important to note that the VBID concept is gaining substantial momentum among policymakers. Governor Granholm included VBID principles in her Michigan First Healthcare Plan and several states have incorporated VBID standards into the benefit design for their employees. On the federal level, this May, Senators Stabenow and Hutchison introduced legislation to implement VBID demonstration projects in the Medicare population. The U.S. House of Representatives health reform legislation includes VBID as a means to allow for modifications in cost sharing and payment rates. Most noteworthy, is that legislation introduced by the Senate Finance Committee this past Monday explicitly codified VBID as "a methodology under which clinically beneficial preventive screenings, lifestyle interventions, medications, immunizations, diagnostic tests and procedures, and treatments are identified and cost-sharing is reduced or eliminated to reflect the high value and effectiveness of the items and services." The idea is catching on.

Madame Chair, I am delighted to see that you are considering a role for expertise in value-based insurance design in your deliberations on H.B. 5345. Cost savings should not be the exclusive goal of health care reform efforts. **It is critical to develop strategies that simultaneously address spending growth and aim to improve population health**. Compared to the archaic "one size fits all" benefit design that does not acknowledge that clinician visits, diagnostic tests, and prescriptions differ, the VBID approach can contain costs while mitigating the adverse health effects associated with patient cost sharing. The alignment of incentives would encourage the use of high-value care, and **ultimately produce more health at any level of health expenditure.** By adopting a "clinically sensitive" approach, we can ensure that two critical goals of health reform – containing costs and improving quality – are met.

For more information please visit www.vbidcenter.org