

CDHC and VBID

Clash of the Titans or a Powerful New Hybrid for Improved Health Care?

From February to December 1916, one of the fiercest battles of World War I was fought at Verdun-sur-Meuse in northeast France. Marshal Petain was in command of the Allied troops; Crown Prince Frederick William commanded the Germans. At the beginning of the battle a determined Petain said of the German troops, "They shall not pass." Good to his word, Petain and the Allies triumphed in this yearlong battle, but only after 1 million lives had been lost.

What shall be the loss from the war of words between proponents of consumer-driven health care (CDHC) and value-based insurance design (VBID), a clash of titans in the U.S. health care industry? What great opportunity might these two great movements miss as they tussle and trade barbs?

And the barbs, without naming names, have been cutting.

VBID programs use personalized benefit designs and targeted incentives to promote individual health and good management of chronic conditions by removing barriers to appropriate care and rewarding members for making healthy choices. VBID advocates charge that consumer-driven health plans (CDHP) discourage necessary care.

In truth, this charge has some basis. One retrospective cohort study found that patients in a CDHP grew less adherent to certain drug classes for chronic conditions than patients who remained continuously enrolled in a traditional managed care plan.¹ A second study found that individuals in CDHPs were much more likely than those with other coverage to discontinue use of anti-hypertensives, which lower blood pressure, and statins, which lower cholesterol.² A third concluded that CDHP members were less likely than their non-CDHP counterparts to have received any health care services since enrolling in their current plan or, specifically, to have had a medical checkup.³ And a fourth study reported that 38% of those with consumer-directed coverage said they had delayed or avoided necessary health care because of cost.⁴

CDHC proponents fire back, arguing that few VBID experiences have saved money—that, to the contrary, VBID increases health care utilization and hence claim costs in the short run and that such plan designs typically carry higher premiums than do high-deductible health plans (HDHP). This, they say, is why payer organizations have been comparatively slow to adopt VBID. Questionable ROI is a concern, say critics, especially at a time of intense pressure on health plans, both from employers and Washington, to rein in the double-digit cost increases that come with each passing year. In particular, small and mid-size employers, which change insurers often, have had little incentive to invest in VBID, knowing that a positive financial ROI could take more than a year.

Truth is, the criticism from both sides requires context. While each has an Achilles heel, CDHC and VBID in fact are the titans of health care. They are here to stay; they hold tremendous promise; and each brings many more strengths than weaknesses.

The strengths of CDHC are apparent at first glance. Companies this year with at least 50% of workers in CDHPs report annual costs per employee of nearly \$900 less than companies

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with low CDHP enrollment and almost \$1,000 less than non-CDHP companies.⁵ Another survey found that CDHPs cost employers 20% less than other health plans and that the year-to-year rate of increase in these costs was lower, averaging just 3.5%, compared to 6.1% for other plans.⁶ (Of course, employers pay less for CDHPs because such plans shift more of the cost to employees. Therefore, the total health care spend of CDHPs may equal or even exceed the spend of traditional managed care plans.)

Not only has CDHC saved employers money, it has grown quickly and become ubiquitous. Enrollment in HSA-linked CDHPs grew to 8 million lives at the beginning of 2009, compared with 6.1 million in 2008, 4.5 million in 2007, and 3.2 million in 2006.⁷ And these counts don't include HRA-linked plans. CDHPs grew at a rate of 33.9% last year and now cover more workers than do HMO plans. They've become the second most popular plan design with employees.⁸ Today, 54% of companies have a CDHP in place.⁹

The strengths of VBID are every bit as impressive. More than a decade of case studies

shows that by lowering copays or co-insurance for necessary, effective medical services and drugs that treat chronic conditions, VBID improves patient health and reduces more expensive, acute care.

A Pitney Bowes program increased adherence to asthma controller drugs from 49% to 66% among its workforce—correlating with a 22% decline in emergency room use and 62% decline in hospital admissions during the same time period.¹⁰ At the start of a three-month pilot VBID program for diabetics in the city of Springfield, OR, mean HbA1c levels were 7.25% and 7.32% for those in control and intervention groups, respectively. After waiving copayments for both groups and providing additional counseling for the intervention patients, HbA1c levels decreased 30% and 50% for the control and intervention groups, respectively.¹¹ The provider-sponsored Health Alliance Medical Plans in Illinois developed a low out-of-pocket copayment tier of medications for members with diabetes, hypertension, and asthma. As a result, members and dependents demonstrated increased compliance, better blood sugar control, a move from rescue to control drugs for asthma, and fewer heart attacks, strokes, and kidney failures.¹²

Further, VBID can bend the cost curve. Pitney Bowes reported substantial savings after lowering copayments for prescription drugs that treat high-cost chronic illnesses.¹³ Health care payer Wellpoint Inc. said that members who participated in its VBID diabetes program for State of Maine employees had an adjusted average cost of \$1,300 less over 12 months of follow-up than those in a control group.¹⁴ Stories in the New York Times, Wall Street Journal, and Chicago Tribune pointed to cost savings by other employers that launched VBID programs.¹⁵ And people are ready and willing to adopt VBID programs. On this, all constituents of the U.S. health care system find themselves in rare agreement. A recent study commissioned by The TriZetto Group found that:

- Eight in 10 doctors (83%) believed VBID would have a moderate to high impact on selecting care alternatives that are proven effective and cost less.
- Seventy-four percent of health care payer executives said VBID would reduce overall health care costs; 75% believed it would help win more new business.
- Nine in 10 employer executives (88%) reported that they would be encouraged to switch to an insurance company that offered VBID.

- Eighty-six percent of consumers and 88% of the brokers who sell health insurance policies said VBID would encourage people to be healthier and more productive.¹⁶

The conclusion is clear. Rather than combat, CDHC and VBID should combine. This new hybrid would reduce the cost and improve the quality of U.S. health care, producing more value from every health care dollar spent.

What might a hybrid look like? Think not of an HDHP, but of a VBHP—a variable-benefit health plan. Like an HDHP, it would have a high annual deductible and include first-dollar coverage for preventive care. Individuals with chronic conditions such as asthma and diabetes—60% of whom have poor adherence to evidence-based treatment and hence drive more than \$100 billion in additional costs annually¹⁷—would get high-value, proven medications and medical services at low or no out-of-pocket cost. The copays and co-insurance would vary based on both patient profile and treatment efficacy. The more clinically beneficial the therapy for a particular patient, the lower that patient's cost share; the less clinically beneficial, the higher the patient's share. A. Mark Fendrick, MD, an acknowledged founder of the health care value movement and co-director of the Center for Value-Based Insurance Design at the University of Michigan, said it best: "Fifty-year-olds should get a colonoscopy for free, but a healthy 29-year-old who wants a colonoscopy should pay 100% of the cost and be fined \$500 for taking his or her mother's slot."¹⁸

Until recently, a CHDC-VBID hybrid would have required a heavily manual, labor-intensive effort. But technology available to health care payers today automatically adjusts copays or co-insurance or waives a deductible on specific claims in real time during the plan year. The software bases low or no out-of-pocket adjustments on effective dates of qualifying events, such as a diabetic health plan member completing a course to better understand his or her condition, helping improve member health and productivity and avert medical cost increases. Further, this technology for health plans combines fully automated value-based adjudication with proven best clinical protocols—templated algorithms—for treating these chronic conditions. The likely advantages to payers and the employers they serve are the accessibility of the technology, an accelerated time-to-benefit and hence ROI, and an increase in the percentage of effective member care, and commensurate decrease in unwarranted

member care.

The Chinese Taoist philosopher Chuang Tzu criticized the wrangling of Confucians and Mohists, proponents of two prominent schools of thought at the time. "Each denies what the other affirms and affirms what the other denies. What use is this struggle to set up 'no' against 'yes' and 'yes' against 'no'? ... Opposites produce each other, depend on each other and complement each other." Today, more than 2,300 years later, technology makes it possible for two opposites—CDHC and VBID—to complement one another and, as a powerful new hybrid, to dramatically improve U.S. health care. **CDHC**

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