Medical Xpress

One size should not fit all when it comes to our out-of-pocket health care costs, experts say

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If you've tried to see a doctor, fill a prescription or get a diagnostic test lately, you've probably had to pay more out of your own pocket than you would have even a few years ago. Most insurance plans have increased their co-pays and deductibles, to keep monthly premiums from rising even faster.

But a pair of experts who have studied this trend see a lost opportunity to give you – and all health care consumers—the right incentives to use the services that are most likely to improve your health.

Rather than charging all patients the same amount for every doctor visit, diagnostic test, and prescription drug, out-of-pocket costs should be based on how much a specific clinical service improves health, say Mark Fendrick, M.D. of the University of Michigan and Michael Chernew, Ph.D. of Harvard University.

In a new *JAMA* article, they lay out key steps that public and private insurance providers could take to alter consumer cost-sharing from 'one-size-fits-all' to a more 'clinically nuanced' model, based on individual patient and provider factors.

Their piece, commissioned by the National Academy of Medicine as part of its Vital Directions effort to lay out a framework for future health care reforms, appears alongside 18 others by other top-tier health

care experts from around the country.

Fendrick, a professor in U-M's Medical School and School of Public Health, and Chernew, a professor at Harvard Medical School, have worked for more than a decade to advance a concept they developed, known as value-based insurance design, or V-BID.

They've documented that when people are asked to pay more for medical care, they often skip or skimp on the clinician visits, diagnostic tests and treatments they need to stay healthy. And that skipping of recommended care can adversely affect health, worsen health disparities, and in some cases, increase total spending.

Their JAMA piece points to specific changes to encourage value-based cost-sharing. They propose:

- Changing Internal Revenue Service rules so that people enrolled in high-deductible health plans (HDHPs) with chronic conditions won't have to meet the deductible before their plan covers essential care, such as insulin and eye exams for people with diabetes, or counseling and medication for those with depression. Under current Internal Revenue Service rules, HDHPs may provide select preventive care benefits prior to satisfaction of the deductible. However, services meant to treat "an existing illness, injury or condition" are excluded from coverage until deductibles are met. A bipartisan bill was recently introduced to the U.S. House of Representatives to change IRS rules to allow high-deductible plans the flexibility to better cover clinical services for chronic medical conditions.
- Changing the standard coverage requirements for insurance plans that companies sell on Healthcare.gov and other exchanges, so that they promote value-based cost-sharing.
- Reforming Medicare's benefit package so that beneficiaries pay

less out-of-pocket for high-value clinical service and providers. One step in that direction is already in the works: This January, the Centers for Medicare & Medicaid Services (CMS) will launch the Medicare Advantage (MA) Value-Based Insurance Design Model. It's an opportunity for MA plans run by private insurance companies in seven states to reduce cost-sharing on visits and services that are of highest clinical value to enrollees with specified chronic conditions.
- Encouraging efficient employee insurance packages that focus on the value of services to the individual. This could be done by implementing V-BID principles on high-cost plans to avoid the "Cadillac" tax, or capping the tax on plans at a certain level. This would yield federal dollars that could be used to provide better health care for people with lower incomes.

"Increasing health care spending has created serious challenges for purchasers in the U.S. health care system. Solutions will require both payment reform and greater patient engagement," the authors write. "Patient-facing tools should not create barriers to access, but instead encourage people to use high-value services from high-value health professionals and health care organizations."

More information: Michael E. Chernew et al. Improving Benefit Design to Promote Effective, Efficient, and Affordable Care, *JAMA* (2016). DOI: 10.1001/jama.2016.13637

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