Value-Based Insurance Design:

A Fiscally Responsible, Clinically Driven Approach to Help Employers Disrupt the Healthcare System

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Table 1: Risk factors for nodding off at lectures

Factor	Odds ratio (and 95% CI)
Environmental	
Dim lighting	1.6 (0.8–2.5)
Warm room temperature	1.4 (0.9–1.6)
Comfortable seating	1.0 (0.7–1.3)
Audiovisual	
Poor slides	1.8 (1.3–2.0)
Failure to speak into microphone	1.7 (1.3–2.1)
Circadian	
Early morning	1.3 (0.9–1.8)
Post prandial	1.7 (0.9–2.3)
Speaker-related	
Monotonous tone	6.8 (5.4–8.0)
Tweed jacket	2.1 (1.7–3.0)
Losing place in lecture	2.0 (1.5–2.6)

Note: CI = confidence interval.

Health Care Costs Are a Top Issue For Employers (and Voters): Policy solutions must protect consumers and preserve innovation

1. Innovations to prevent and treat disease have led to impressive reductions in morbidity and mortality
2. Irrespective of remarkable clinical advances, cutting health care spending is the main focus of reform discussions
3. Underutilization of high-value persists across the entire spectrum of clinical care leading to poor health outcomes
4. Our ability to deliver high-quality health care lags behind the rapid pace of scientific innovation

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Star Wars Science

Flintstones Delivery

Outline

- Consumer Cost-sharing
- Translating Research into Policy
- Aligning Incentives
- Value-Based Insurance Design
- Low Value Care

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Changing the discussion from “How much” to “How well” we spend our health care dollars

- Everyone (almost) agrees there is enough money in the US health care system; we just spend it on the wrong services
- Policy deliberations focus primarily on alternative payment and pricing models
- Moving from a volume-driven to value-based system requires a change in both how we pay for care and how we engage consumers to seek care
- “One size fits all” consumer cost-sharing is a ‘blunt’ instrument that reduces the use of high value care and adversely affects health, particularly among economically vulnerable individuals and those with chronic conditions

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Inspiration (Still)

“I can’t believe you had to spend a million dollars to show that if you make people pay more for something, they will buy less of it.”

- Barbara Fendrick (my mother)

Six of ten people with a chronic condition and employer coverage have skipped or postponed care due to cost

Percent who say they or a family member have done the following in the past year

	NO CHRONIC CONDITION IN FAMILY	WITH CHRONIC CONDITION	
		All	Highest deductible
Postponed or put off care	23%	42%	60%
Treated at home instead of seeing doctor	28	41	58
Avoided doctor-recommended test or treatment	15	31	44
Not filled a prescription or skipped doses	12	23	35
Yes to any	40	60	75

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Moving from the Stone Age to the Space Age: Change the discussion from “How much” to “How well”

- Three-quarters of Americans say that our country doesn’t get good value for what it spends on healthcare
- Moving from a volume-driven to value-based system requires a change in both how we pay for care and how we engage consumers to seek care
- Policy deliberations focus primarily on alternative payment and pricing models
- Consumer engagement is an essential and important lever to enhance efficiency
- Consumer cost-sharing is a common policy lever

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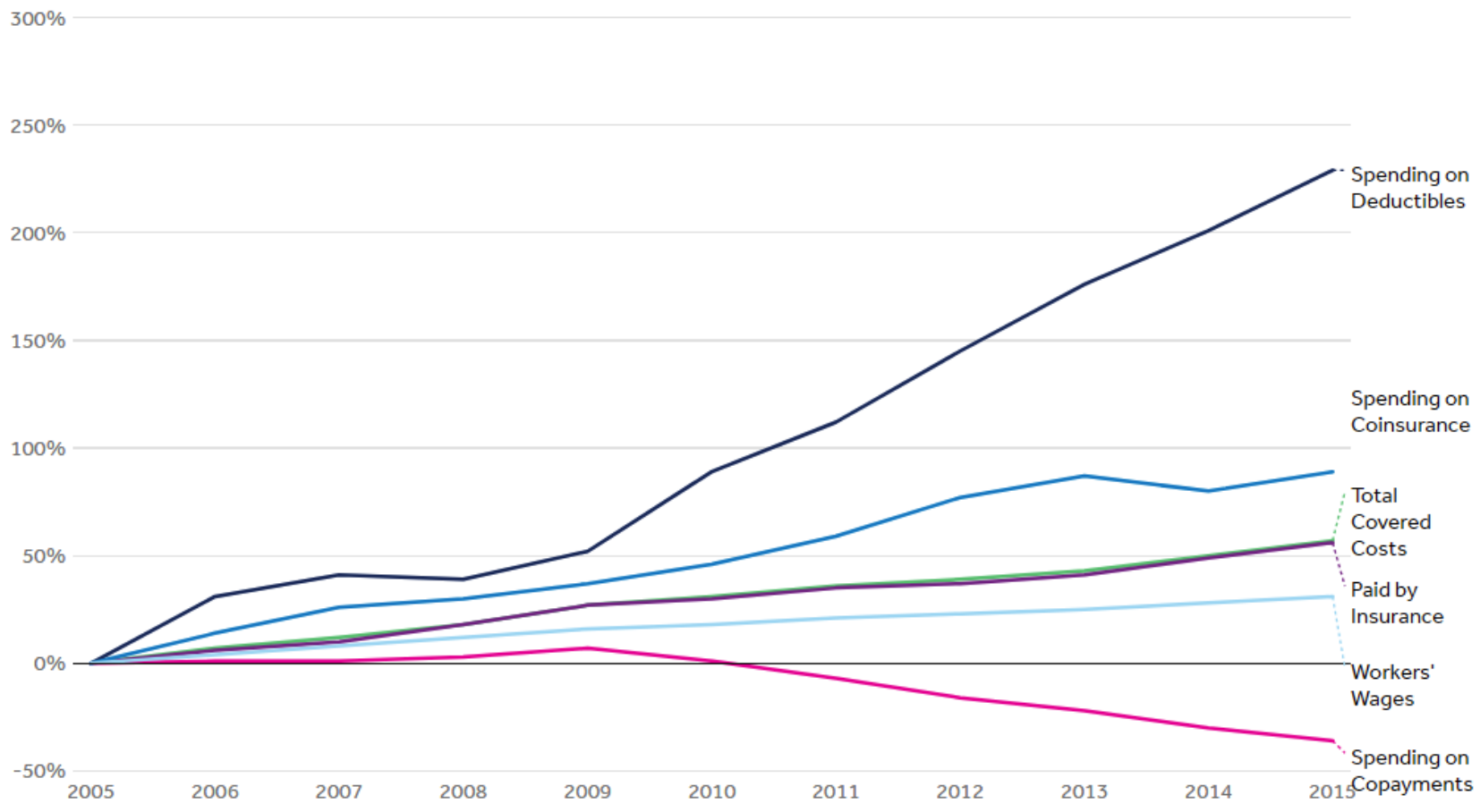
Employer Tactics to Control Health Expenditures
Consumer cost-sharing is a common policy lever

Source: NBGH

Consumer Cost-Sharing: Paying More for ALL Care Regardless of Value

Impact of Consumer Cost-sharing

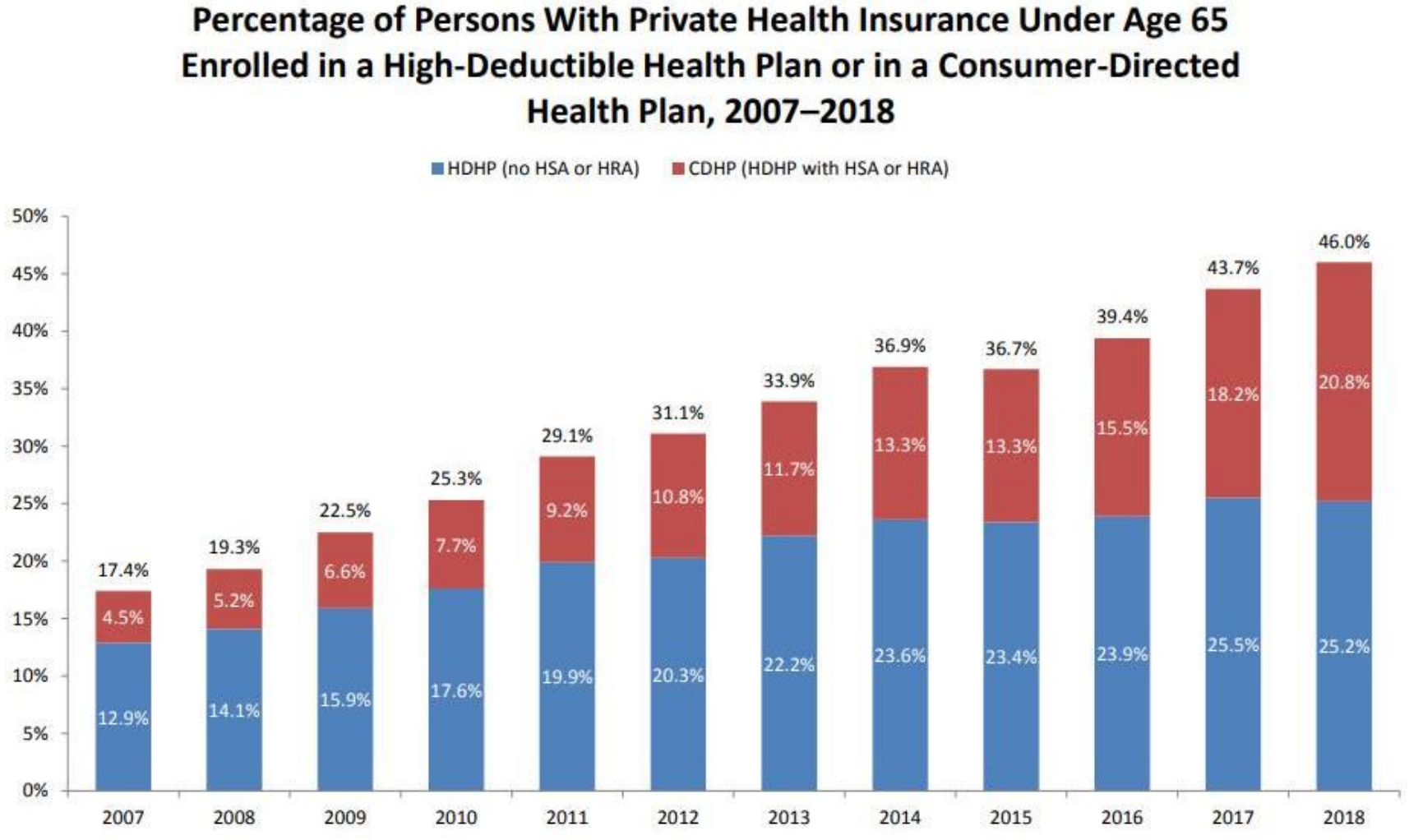


Deductibles

Co-insurance

Co-payments

Since 2007, the share of individuals enrolled in high-deductible health plans has substantially increased



Source: National Center for Health Statistics

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“I can’t believe you had to spend a million dollars to show that if you make people pay more for something, they will buy less of it.”

- Barbara Fendrick (my mother)

Impact of Cost-Sharing on Health Care Disparities

Effects of Increased Patient Cost Sharing on Socioeconomic Disparities in Health Care

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Michael C. Sokol, MD, MS[4] Allison B. Rosen, MD, ScD[5], and A. Mark Fendrick, MD[5]

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- **Rising copayments worsen disparities and adversely affect health, particularly among economically vulnerable individuals and those with chronic conditions**

Chernew M. *J Gen Intern Med* 23(8):1131–6.

Americans Do Not Care About Health Care Costs; They Care About What It Costs Them

Patient Worry About Out-of-Pocket Healthcare Costs at All-Time High

A report from the Commonwealth Fund noted that patients are not confident they can afford high out-of-pocket healthcare costs.

Alternative to "Blunt" Consumer Cost Sharing: Value-Based Insurance Design (V-BID)

- **Sets consumer cost-sharing on clinical benefit – not price**
- **Little or no out-of-pocket cost for high value care; high cost share for low value care**
- **Successfully implemented by hundreds of public and private payers**

The Upshot

Health Plans That Nudge Patients to Do the Right Thing

Austin Frakt
THE NEW HEALTH CARE JULY 10, 2017

RELATED COVERAGE

V-BID: Rare Bipartisan Political and Broad Multi-Stakeholder Support

- HHS
- CBO
- SEIU
- MedPAC
- Brookings Institution
- Commonwealth Fund
- NBCH
- American Fed Teachers
- Families USA
- AHIP
- AARP
- DOD
- BCBSA
- National Governor's Assoc.
- US Chamber of Commerce
- Bipartisan Policy Center
- Kaiser Family Foundation
- American Benefits Council
- National Coalition on Health Care
- Urban Institute
- RWJF
- IOM
- Smarter Health Care Coalition
- PhRMA
- EBRI
- AMA

Putting Innovation into Action: Translating Research into Policy

Translating Research into Policy

THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

ACA Sec 2713: Selected Preventive Services be Provided without Cost-Sharing

- Receiving an A or B rating from the United States Preventive Services Taskforce (USPSTF)
- Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP)
- Preventive care and screenings supported by the Health Resources and Services Administration (HRSA)

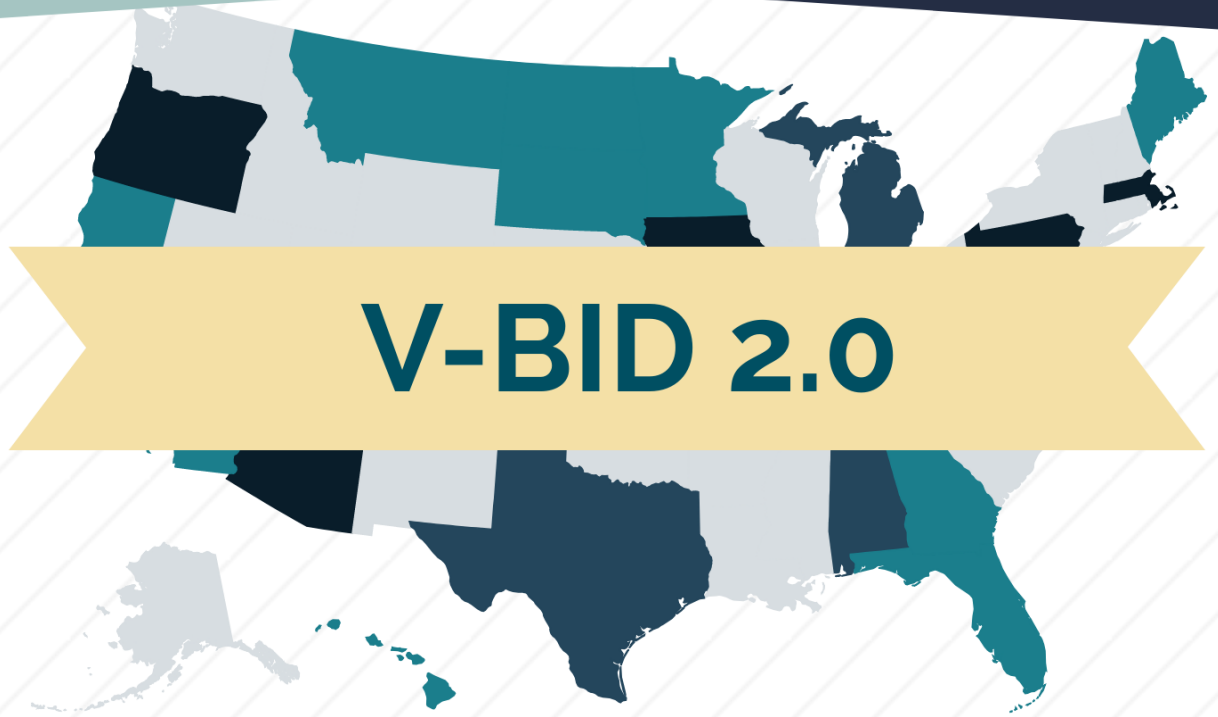
Over 137 million Americans have received expanded coverage of preventive services

Putting Innovation into Action: Translating Research into Policy

Translating Research into Policy

Medicare

THE EXPANDED ROLE OF V-BID IN MEDICARE ADVANTAGE



CMS announced transformative updates to the **Medicare Advantage Value-Based Insurance Design model**, including its expansion to all 50 states

V-BID 2.0 allows MA plans to...

- Provide reduced cost-sharing and supplemental benefits in a more targeted fashion
- Increase access to new interventions like telehealth services, and wellness and healthcare planning
- Expand eligibility to include Dual Eligible SNPs, Institutional SNPs, and Regional PPOs
- Broaden rewards programs that improve beneficiaries' health

Putting Innovation into Action: Translating Research into Policy

Translating Research into Policy

TRICARE®

Value-based insurance coming to millions of people in Tricare

- **2017 NDAA: Obama Administration - reduce or eliminate co-pays and other cost sharing for certain high services and providers**

- **2018 NDAA: Trump Administration – reduce cost sharing for high value drugs on the uniform formulary**

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HSA-HDHP Reform

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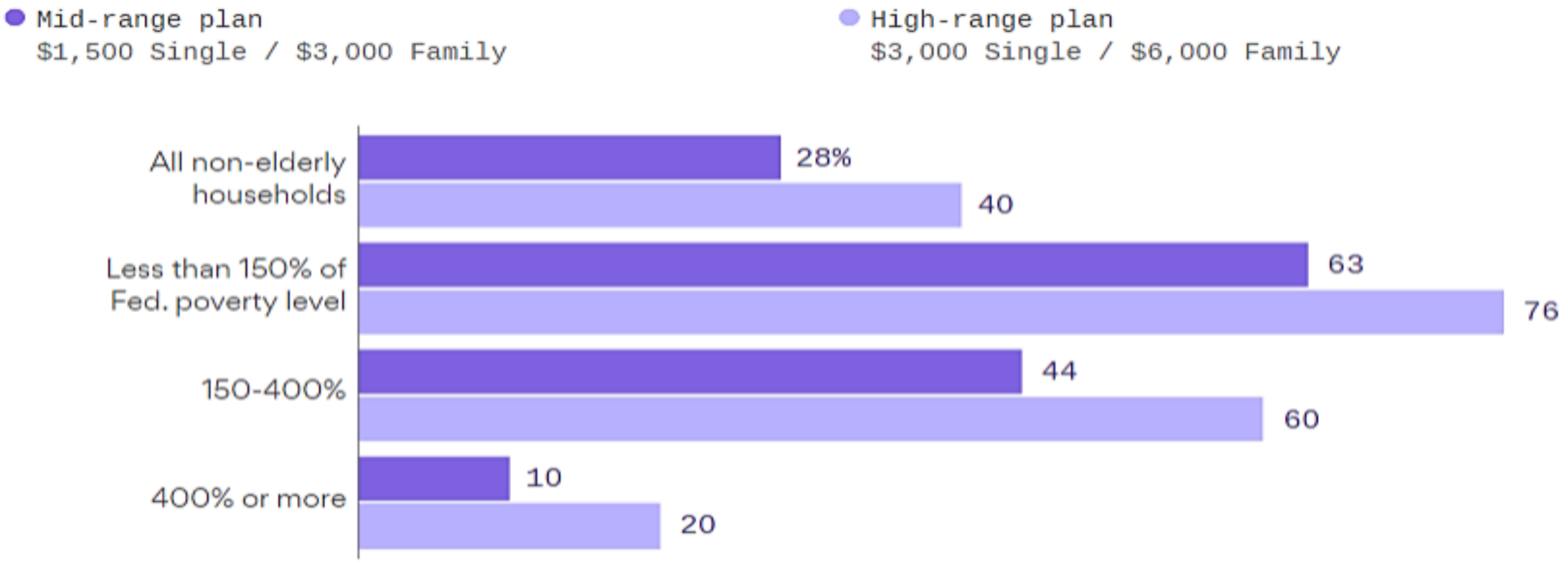
A Significant Number of Households Do NOT Have Liquid Assets to Cover Their Plan Deductible

Among people with private health insurance



Reproduced from Kaiser Family Foundation analysis of the 2016 Survey of Consumer Finance; Note: Liquid assets include the sum of checking and saving accounts, money market accounts, certificates of deposit, savings bonds, non-retirement mutual funds, stocks and bonds. Chart: Axios Visuals

IRS Rules Prohibit Coverage of Chronic Disease Care Until HSA-HDHP Deductible is Met

PREVENTIVE CARE COVERED
Dollar one

CHRONIC DISEASE CARE
NOT covered until deductible is met

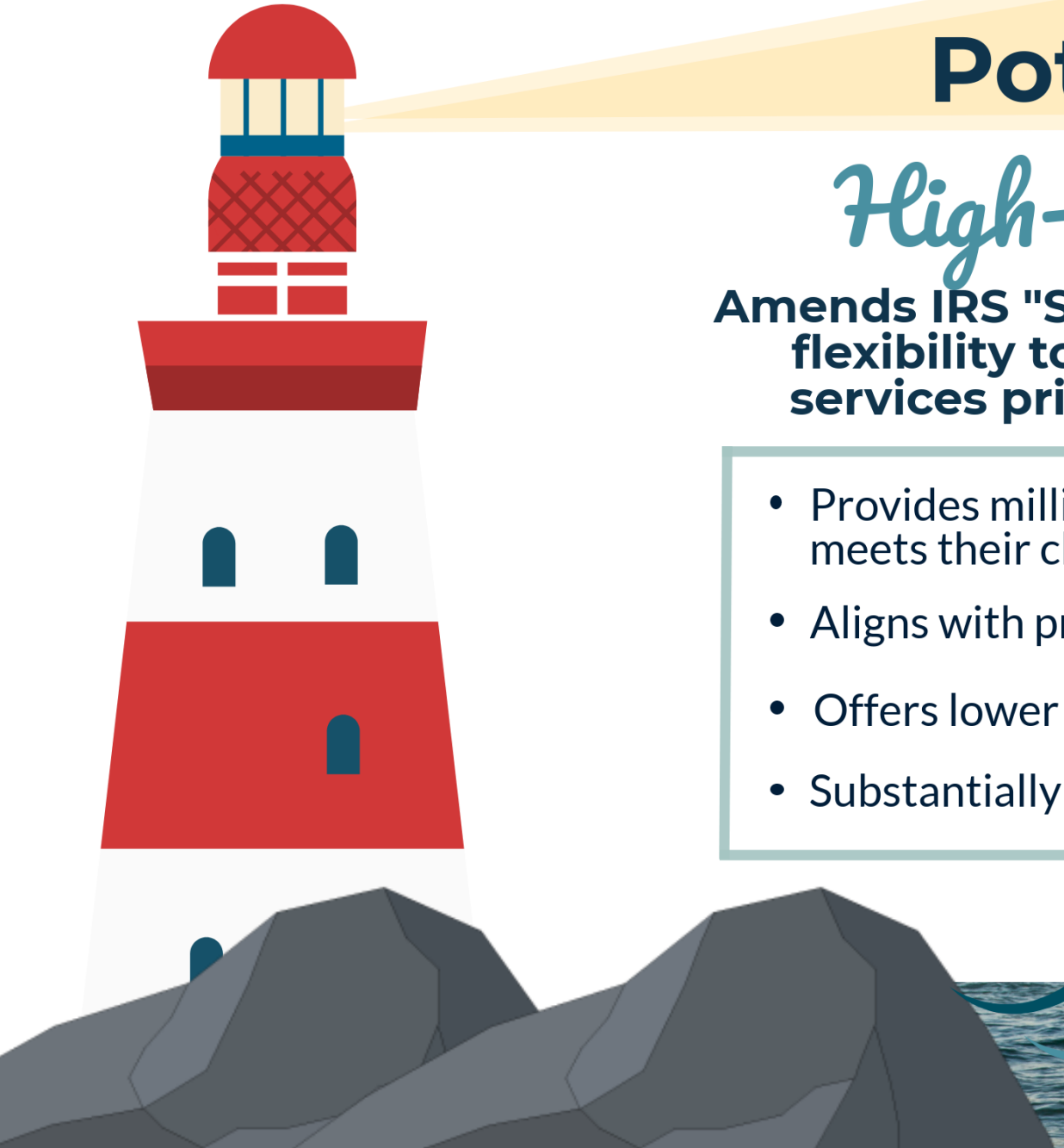
However, IRS guidance requires that services used to treat **"existing illness, injury or conditions"** are not covered until the minimum deductible is met

office visits

diagnostic tests

drugs

As HSA-HDHP enrollees with existing conditions are required to pay out-of-pocket for necessary services, they utilize less care, potentially resulting in poorer health outcomes and higher costs



Potential Solution:

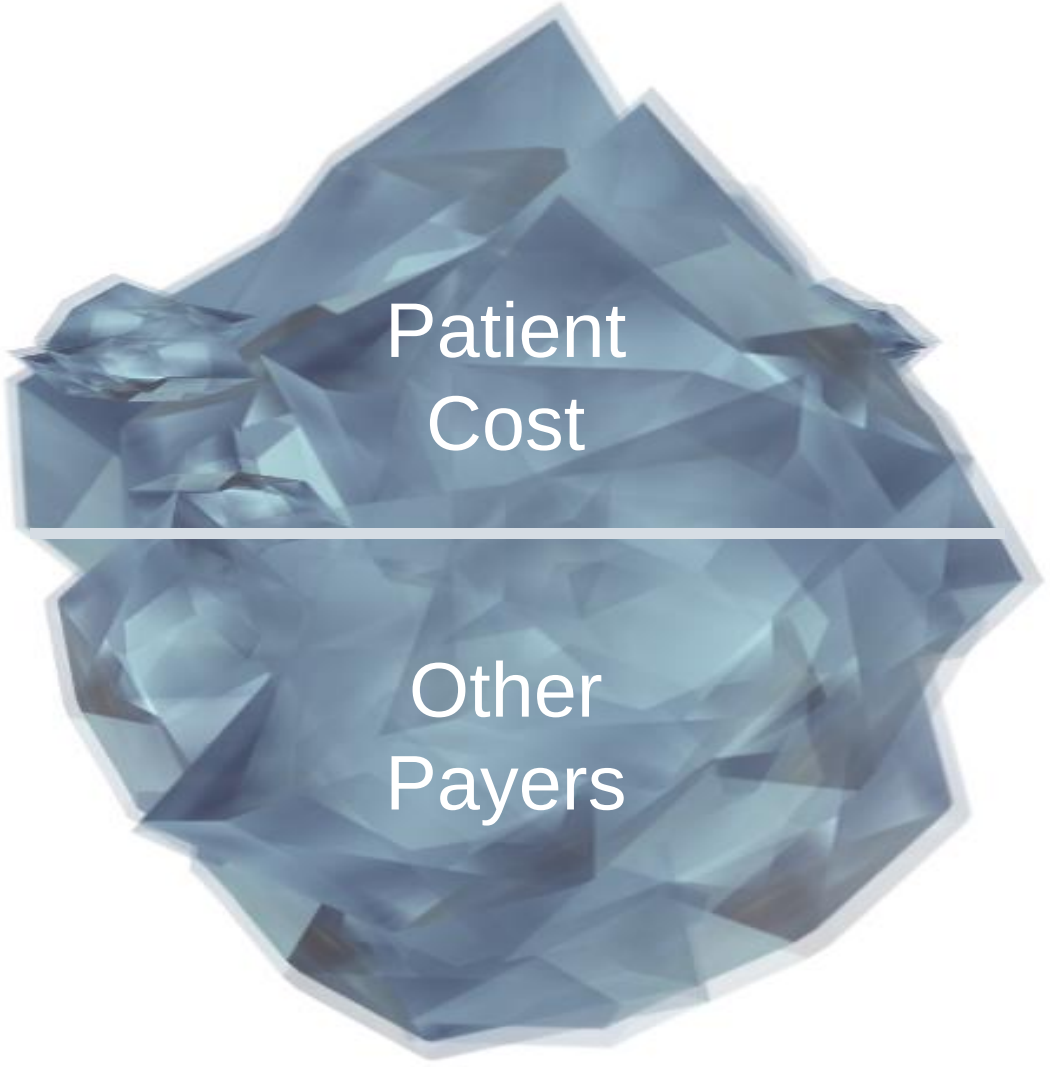
High-Value Health Plan

Amends IRS "Safe Harbor" to allow health plans the flexibility to cover high-value chronic disease services prior to meeting the plan deductible

- Provides millions of Americans a plan option that better meets their clinical and financial needs
- Aligns with provider payment reform incentives
- Offers lower premiums than most PPO and HMO plans
- Substantially reduces aggregate health care expenditures

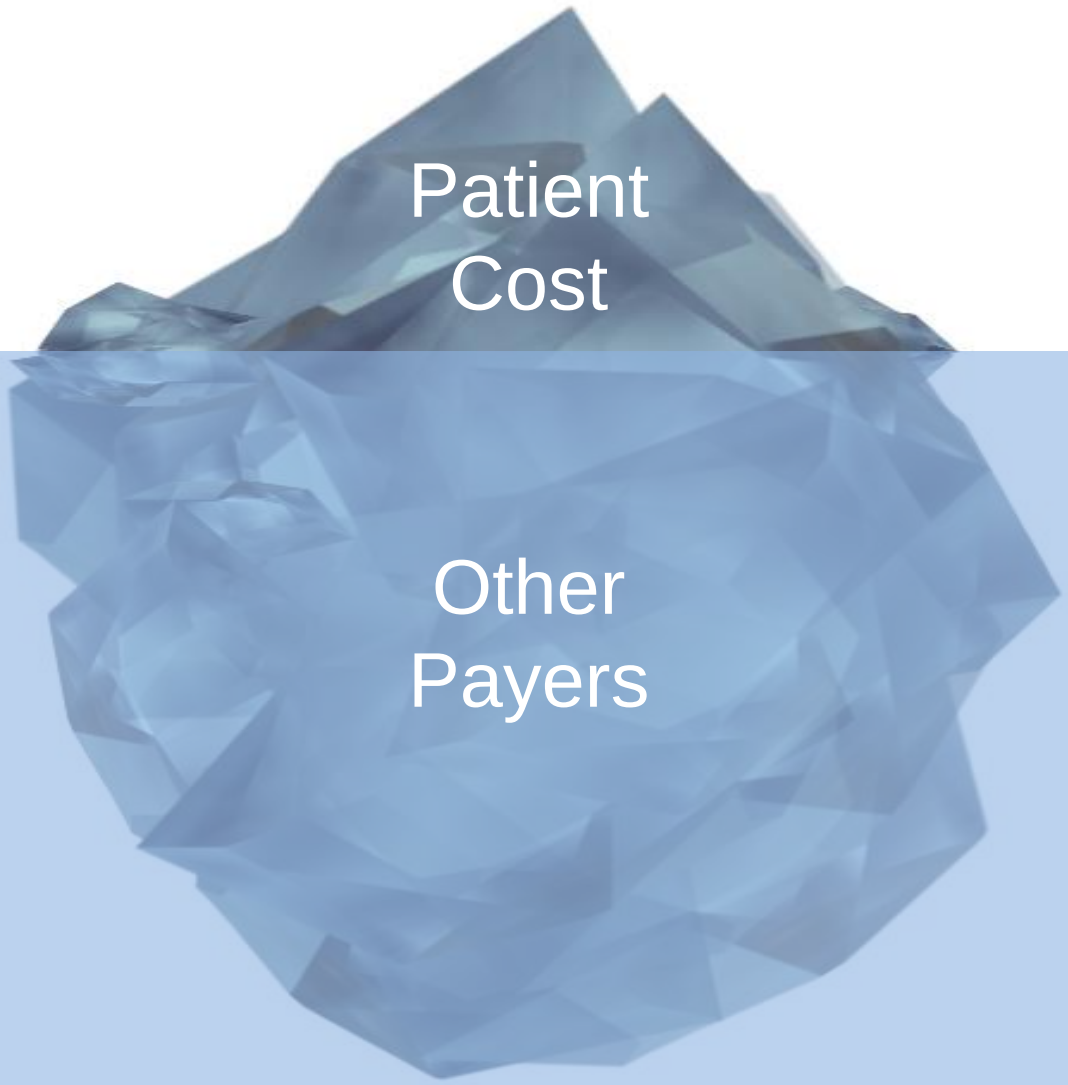
How to Pay for More High Value Care: The Health Care Iceberg

Health care is typically paid in two portions



The amount a consumer pays for a service is determined by their insurance coverage

Health care is typically paid in two portions



Insurance
Coverage

Coverage is often the same for high and low value care

Low Value

High Value

If coverage is not generous; patients pay the entire price

This scenario is typical for individuals who are enrolled in a health plan that includes a deductible

V-BID increases coverage generosity for high value services

Patient Cost

Generous
Insurance
Coverage

How do we pay to provide better coverage for high value care?

Discouraging the use of specific low-value services is necessary to provide better coverage of high value care

Low Value

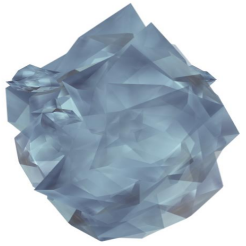
High Value

Melting the ‘Low Value’ Iceberg is necessary to provide better coverage of high value care

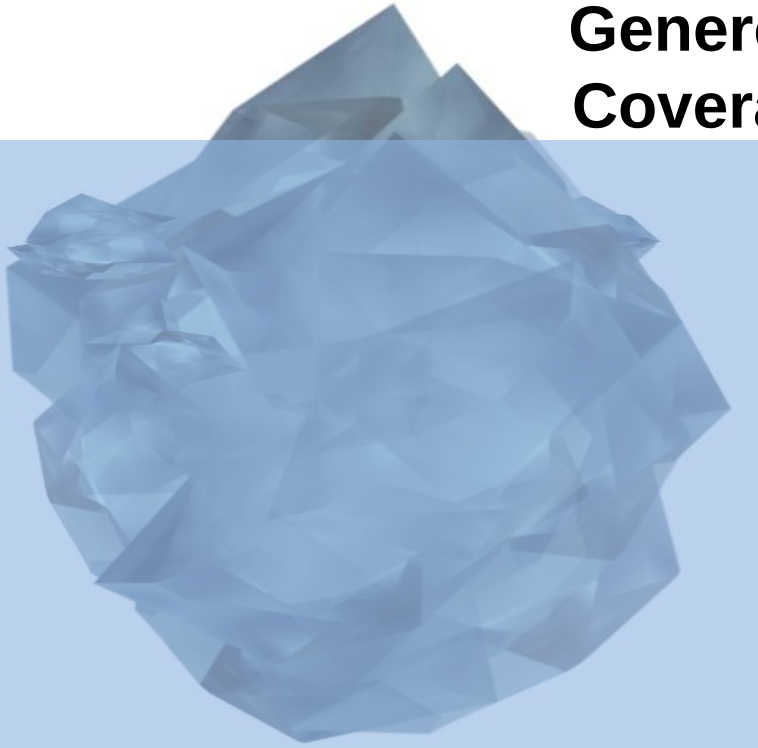
Low Value

High Value

savings from waste elimination are **immediate and substantial**



No Coverage



Generous Coverage

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REDUCING LOW-VALUE CARE

IDENTIFY.

MEASURE.

REDUCE.

REPORT.

Waste in the Healthcare System Comes From Many Places

Category	Sources	Estimate of Excess Costs	% of Waste	% of Total
Unnecessary Services	• Overuse beyond evidence-established levels • Discretionary use beyond benchmarks • Unnecessary choice of higher-cost services	$210 billion	27%	9.15%
Inefficiently Delivered Services	• Mistakes, errors, preventable complications • Care fragmentation • Unnecessary use of higher-cost providers • Operational inefficiencies at care delivery sites	$130 billion	17%	5.66%
Excess Admin Costs	• Insurance paperwork costs beyond benchmarks • Insurers' administrative inefficiencies • Inefficiencies due to care documentation requirements	$190 billion	25%	8.28%
Prices that are too high	• Service prices beyond competitive benchmarks • Product prices beyond competitive benchmarks	$105 billion	14%	4.58%
Missed Prevention Opportunities	• Primary prevention • Secondary prevention • Tertiary prevention	$55 billion	7%	2.40%
Fraud	• All sources – payers, clinicians, patients	$75 billion	10%	3.27%
	Total	**$765 billion**		**33.33%**

SOURCE: "Best Care at Lower Cost: The Path to Continuously Learning Health Care in America." Institute of Medicine (2013)

Reducing Low Value Care: Identify

Choose services:

- **Easily identified in administrative systems**
- **Mostly low value**
- **Reduction in their use would be barely noticed**

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Reducing Low Value Care: Measure

Health Waste Calculator

- Collaboration between Milliman and V-BIDHealth
- Measures potentially unnecessary services
- Analyze cost savings potential
- Generate actionable reports and summaries

Milliman

MedInsight

COSTS & SPENDING

By John N. Mafi, Kyle Russell, Beth A. Bortz, Marcos Dachary, William A. Hazel Jr., and A. Mark Fendrick

DATAWATCH

Low-Cost, High-Volume Health Services Contribute The Most To Unnecessary Health Spending

An analysis of data for 2014 about forty-four low-value health services in the Virginia All Payer Claims Database revealed more than $586 million in unnecessary costs. Among these low-value services, those that were low and very low cost ($538 or less per service) were delivered far more frequently than services that were high and very high cost ($539 or more). The combined costs of the former group were nearly twice those of the latter (65 percent versus 35 percent).

Low Value Care: Reduce

Provider-Facing Levers (Supply)	Patient-Facing Levers (Demand)
Coverage policies	*Value-Based Insurance Design*
Payment rates	*Network design*
Payment models	*Prior authorization*
Profiling data	
Clinical decision support	

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Multi-Stakeholder Task Force on Low Value Care Identifies 5 Commonly Overused Services Ready for Action

1. Diagnostic Testing and Imaging Prior to Low Risk Surgery

2. Vitamin D Screening

3. PSA Screening in Men 70+

4. Imaging in First 6 Weeks of Acute Low Back Pain

5. Branded Drugs When Identical Generics Are Available

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Aligning Payer and Consumer Incentives: As Easy as Peanut Butter and Jelly

Aligning Incentives

Many "supply side" initiatives are restructuring provider incentives to move from volume to value:

- Medical Homes
- Electronic Medical Records
- Accountable Care Organizations
- Bundled Payments/Reference Pricing
- Global Budgets
- High Performing Networks

Aligning Payer and Consumer Incentives: As Easy as Peanut Butter and Jelly

Unfortunately, some “demand-side” initiatives – including consumer cost sharing - discourage consumers from pursuing the “Triple Aim”

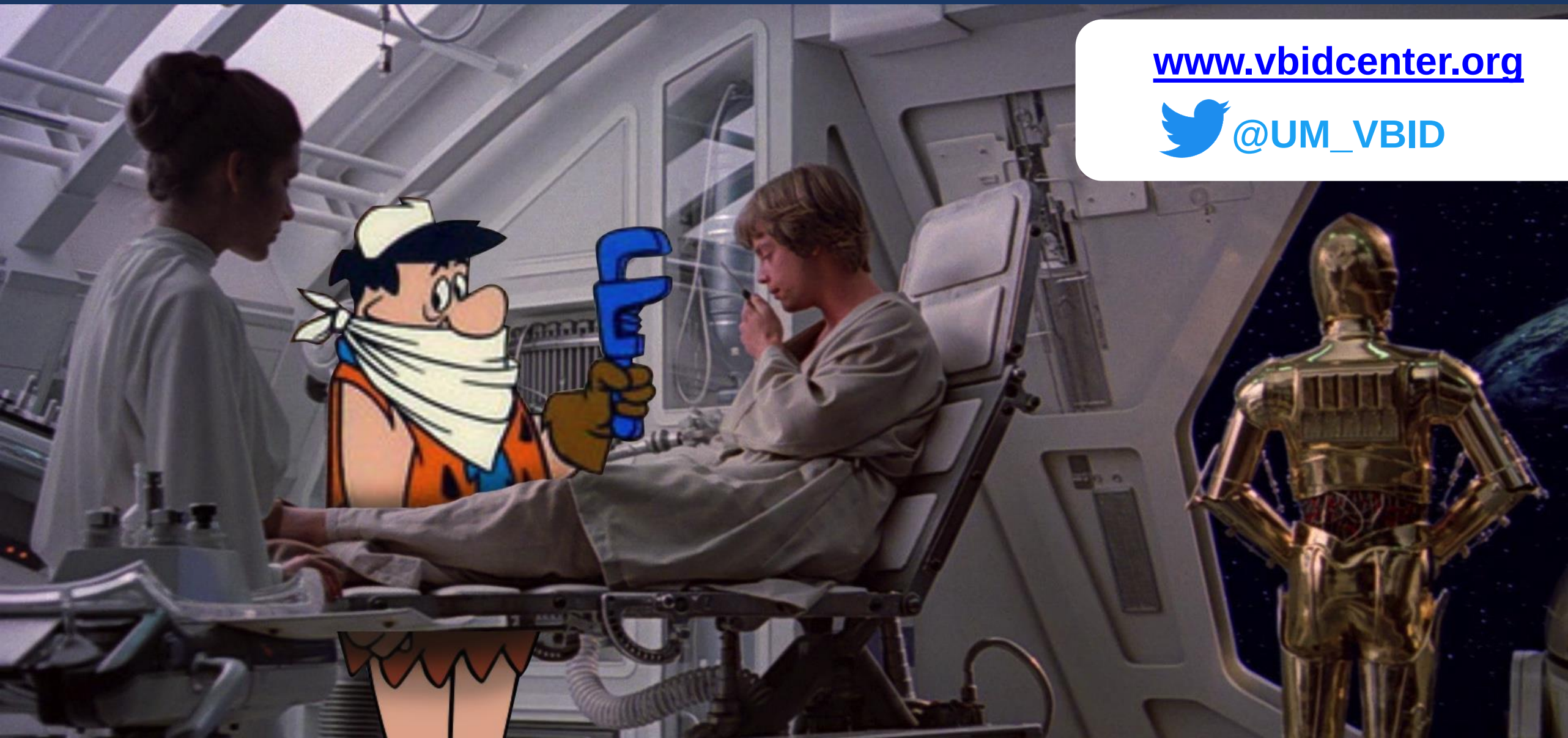
Aligning Payer and Consumer Incentives: As Easy as PB & J

The alignment of clinically driven, provider-facing and consumer engagement initiatives is a necessary and critical step to improve quality of care, enhance patient experience, and contain cost growth

“If we don’t succeed then we will fail.”

Dan Quayle

Questions?



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