Value-Based Insurance Design

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Improving Care and Bending the Cost Curve
Shifting the discussion from “How much” to “How well”

• Innovations to prevent and treat disease have led to impressive reductions in morbidity and mortality

• Regardless of these advances, cost growth is the principle focus of health care reform discussions

• Despite unequivocal evidence of clinical benefit, substantial underutilization of high-value services persists across the entire spectrum of clinical care

• Attention should turn from how much to how well we spend our health care dollars
For today’s discussion, our focus is on costs paid by the consumer, not the employer or third party administrator.

Ideally, consumer cost-sharing levels would be set to encourage the clinically appropriate use of healthcare services.

Instead, archaic “one-size-fits-all” cost-sharing fails to acknowledge the differences in clinical value among medical interventions.

Consumer cost-sharing is rising.

Health Affairs 2014. doi: 10.1377/hlthaff.2014.0792
“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)
A growing body of evidence concludes that increases in consumer cost-sharing leads to a reduction in the use of essential care, which worsens health disparities, and in some cases leads to greater overall costs.

Cost-sharing Affects Mammography Use by Medicare Beneficiaries

Trivedi A. NEJM. 2008;358:375-383
High Copays Reduce Adherence to Appropriate Medication Use

When copays were doubled, patients took less medication in important classes. These reductions in medication levels were profound.

- Reductions in medications supplied were also noted for:
  - NSAIDs 45%
  - Antihistamines 44%
  - Antiulcerants 33%
  - Antiasthmatics 32%
  - Antidepressants 26%

- For patients taking medications for asthma, diabetes, and gastric disorders, there was a 17% increase in annual ER visits and a 10% increase in hospital stays.

ER = emergency room.

A recent *Health Affairs* article investigated whether the gains in affordability for prescription drugs attributable to Part D persisted during the six years that followed its implementation in 2006.

Among elderly beneficiaries with four or more chronic conditions, the prevalence of cost-related non-adherence increased from 14% in 2009 to 17% in 2011, reversing previous downward trends.

The prevalence among the sickest elderly of forgoing basic needs to purchase medicines decreased from 9% in 2007 to 7% in 2009 but rose to 10% in 2011.
Effects of Increased Copayments for Ambulatory Visits for Medicare Advantage Beneficiaries

Copays increased:
- from $7.38 to $14.38 for primary care
- from $12.66 to $22.05 for specialty care
- remained unchanged at $8.33 and $11.38 in controls

In the year after copayment increases:
- 19.8 fewer annual outpatient visits per 100 enrollees
- 2.2 additional hospital admissions per 100 enrollees
- Effects worse in low-income individuals and beneficiaries with chronic illness

By WILLIAM M. BULKELEY

In an unusual bid to cut health-care costs, International Business Machines Corp. plans to stop requiring $20 co-payments by employees when they visit primary-care physicians.

The company said it believed the move would save costs by encouraging people to go to primary-care doctors faster, in order to get earlier diagnoses that could save on expensive visits to specialists and emergency rooms.

IBM said that the action applies to the 80% of its workers who are enrolled in plans in which the company self-insures—that is, programs in which it pays the health-care benefits, not insurers. The new policy doesn’t cover IBM employees in health-maintenance organizations.

One of the nation’s largest employers with 115,000 U.S. workers, IBM spends about $1.3 billion a year on U.S. health care. Its benefit practices are closely watched in the human-resources community, and its actions are sometimes trend-setters.
Rising copayments may worsen disparities and adversely affect health, particularly among patients living in low-income areas.
Solutions Needed to Curb Cost-related Non-adherence
A New Approach: Clinical Nuance

1. Services differ in clinical benefit produced

2. Clinical benefits from a specific service depend on:
   - Who receives it
   - Who provides it
   - Where it's provided
Implementing Clinical Nuance Value-Based Insurance Design

• Sets consumer cost-sharing level on clinical benefit – not acquisition price – of the service
  – Reduce or eliminate financial barriers to high-value clinical services and providers

• Successfully implemented by hundreds of public and private payers
Evidence Supporting Value-Based Insurance Design: Improving Adherence Without Increasing Costs

- Most V-BID programs focus on removing financial barriers to high-value prescription drugs to treat chronic conditions (e.g., diabetes, asthma, heart disease)

- Evidence review
  - Improved adherence
  - Lower consumer out-of-pocket costs
  - No significant increase in total spending
  - Reduction in health disparities

Emerging Best Practices in V-BID Implementation

A 2014 Health Affairs evaluation of 76 V-BID plans reported that programs that:

• were more generous
• targeted high-risk individuals
• offered wellness programs
• avoided disease management
• used mail-order prescriptions

had greater impact on adherence than plans without these features.

Choudhry. N. Health Affairs. 2014;33(3).
MI-FREEE: Better Quality Without Higher Costs

- Assessed impact of free access to preventive medications for Aetna members with history of MI

- Random assignment by plan sponsor

- “Enhanced prescription coverage improved medication adherence and rates of first major vascular events and decreased patient spending without increasing overall health costs.”

Full drug coverage:

- Reduced rates of a post-MI vascular event or revascularization among patients who self-identified as being non-white

- Reduced total health care spending by 70 percent
Value Based Insurance Design
More than High-Value Prescription Drugs

- Prevention/Screening
- Diagnostic tests/Monitoring
- Treatments
- Clinician visits
- High performing networks
- PCMH
- Hospitals
Multi-Stakeholder Support for V-BID

- HHS
- CBO
- SEIU
- MedPAC
- Brookings Institution
- The Commonwealth Fund
- NBCH
- PCPCC
- Partnership for Sustainable Health Care
- Families USA
- AHIP
- National Governor’s Assoc.
- Academy of Actuaries
- Bipartisan Policy Center
- Kaiser Family Foundation
- NBGH
- National Coalition on Health Care
- Urban Institute
- RWJF
- IOM
- PhRMA

Lewin. JAMA. 2013;310(16):1669-1670
Policy Efforts

- Medicare Advantage
- State Health Reform
- Specialty Medications
- HSA-qualified HDHPs
“Value-based insurance designs include the provision of information and incentives for consumers that promote access to and use of higher value providers, treatments, and services.”
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 100 million Americans have received expanded coverage of preventive services
• Directs HHS to establish a demonstration program to test V-BID in MA for beneficiaries with chronic conditions

• MA plans may lower cost-sharing to encourage the use of specific, evidence-based medications or services and/or specific high-performing providers
Value-Based Insurance Design
Growing Role in State Health Reform

- State Employees Benefit Plans
  - Connecticut
  - Oregon
  - Virginia
  - Minnesota
  - Maine
Implementing V-BID for State Employees: Connecticut State Employees Health Benefit Plan

- Participating employees receive a reprieve from higher premiums if they commit to:
  - Yearly physicals, age-appropriate screenings/preventive care, two free dental cleanings
  - If employees have one of five chronic conditions, they must participate in disease management programs (which include free office visits and lower drug co-pays)

- Early results:
  - 99% of employees enrolled and 99% compliant
  - Decrease in ER and specialty care
  - Increase in primary care visits
  - Increase in chronic disease medication adherence
Value-Based Insurance Design
Growing Role in State Health Reform

- State Employees Benefit Plans
  - Connecticut
  - Oregon
  - Virginia
  - Minnesota
  - Maine

- State Exchanges
  - Maryland
  - California

- CO-OPs

- Medicaid
CMS Rules (CMS-2334-F) Enable V-BID in Medicaid

- Plans may vary cost-sharing for drugs, outpatient, inpatient, and emergency department visits

- Plans may target cost-sharing to specific groups of individuals based on clinical information (e.g., diagnosis, risk factors)

- Plans may vary cost-sharing for an outpatient service according to where and by whom the service is provided
Applying V-BID to Specialty Pharmaceuticals Approaches

- Impose no more than modest cost-sharing on high-value services
- Reduce cost-sharing in accordance with patient- or disease-specific characteristics
- Relieve patients from high cost-sharing if clinical goals not achieved on a different medication “reward the good soldier”
- Use cost-sharing to encourage patients to select high-performing providers and settings
HSA-qualified HDHPs: Too Much “Skin in the Game”?

- More than 25% of employers offer HDHPs
- In the individual marketplace, 85% of enrollees purchased either silver or bronze HDHP plans
- Higher out-of-pocket costs hinder the use of evidence-based services
- Individuals with chronic diseases enrolled in HDHPs are more likely to go without care due to cost or experienced financial hardship due to medical bills

Barriers to V-BID in HSA-qualified HDHPs

- IRS guidance documents specifically exclude from the definition of preventive care those services or benefits meant to treat “an existing illness, injury or condition”

- Confusion persists regarding what services can and cannot be covered outside of the deductible
Estimate impact from updating the IRS guidance to allow specific evidence-based, secondary preventive services to be **deductible-exempt**

- **5-6% premiums increase**
- **Uptake in commercial markets**: tens of millions of consumers,
  - those in other types of plans (e.g., PPOs, HMOs) seeking a more cost-effective option or avoid “Cadillac tax”
  - those in high-deductible plans looking for richer coverage

- **Any substantial shift from more expensive, non-HDHP plans to lower cost HVHPs would lead to substantially lower aggregate healthcare expenditures on a population level**
Employers support expanded coverage of prescription drugs within HSA-based HDHPs

If the Treasury Department changed its guidance to make clear that companies could cover a broader list of preventive drugs, what is the likelihood that your company would expand the coverage of preventive drugs for employees enrolled in HSA-based CDHPs?

- Likely to very likely: 40%
- Somewhat likely: 49%
- Not very likely to not at all likely: 11%

n=73
Improving Care and Bending the Cost Curve

- The ultimate test of health reform will be whether it improves health and addresses rising costs
- V-BID should be part of the solution to reduce cost-related non-adherence and health care disparities

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