Improving Consumers’ Access to High-Value Health Care
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
Improving Consumers’ Access to High-Value Health Care
Role of Consumer Cost-Sharing in Clinical Decisions

• 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 health care 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 rapidly.
“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 services, worsens health disparities, and in some cases leads to greater overall costs.

**One in Four** adults with non-group coverage report going without needed care due to cost.

Improving Consumers’ Access to High-Value Health Care Solutions Are Needed to Enhance Efficiency

- Consumers currently do not have the necessary information to make informed health care decisions
- While important, clinician incentives and providing accurate price and quality data does not ensure appropriate care delivery
- Additional consumer engagement solutions are necessary to better allocate health expenditures on the clinical benefit – not only the price or profitability – of services
Potential Solution: Clinically Nuanced Cost-Sharing

What is clinical nuance?

Services differ in clinical benefit produced

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
Value Based Insurance Design
More than High-Value Prescription Drugs

- Prevention/Screening
- Diagnostic tests/Monitoring
- Treatments
- Clinician visits
- High performing networks
- PCMH
- Hospitals
V-BID: Who Benefits and How?

**Consumers**
- Improves access
- Lowers out-of-pocket costs

**Payers**
- Promotes efficient expenditures
- Reduces wasteful spending

**Providers**
- Enhances patient-centered outcomes
- Aligns with provider initiatives

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Lewin, JAMA. 2013;310(16):1669-1670
“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.”
Putting Innovation into Action
Translating Research into Policy

• Medicare Advantage
Medication Affordability After Medicare Part D Implementation

• 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 Beneficiaries

- Copays increased:
  - $7 for primary care visit
  - $10 for specialty care visit
  - remained unchanged in controls
- In the year after copayment increases:
  - 20 fewer annual outpatient visits per 100 enrollees
  - 2 additional hospital admissions per 100 enrollees
- Total cost **higher** for those with increased copayments

Why not lower cost-sharing on high-value services?

The anti-discrimination clause of the Social Security Act does not allow clinically nuanced consumer cost-sharing.

"providers may not deny, limit, or condition the coverage or provision of benefits"
H.R.2570/S.1396: Bipartisan “Strengthening Medicare Advantage Through Innovation and Transparency”

• Directs HHS to establish a V-BID demonstration for MA beneficiaries with chronic conditions

• Passed US House with strong bipartisan support in June 2015

• CMS issues RFI on role of V-BID in Medicare in October 2014
• HSA-qualified HDHPs
HSA-HDHP enrollment and out-of-pocket expenses continue to grow

Maximum Out-of-pocket expense 2006 to 2014

- individual: $5,000 to $6,350
- family: $10,000 to $12,700

HSA-qualified HDHPs:
Expanding the Deductible-Exempt “Safe Harbor”

- More than 25% of employers offer HDHPs
- 85% of enrollees in the individual marketplace purchased either silver or bronze HDHP plans

IRS Safe Harbor Guidance allows zero consumer cost-sharing for specific preventive services

INCLUDING:

✓ periodic health evaluations/screenings
✓ routine prenatal and well-child care
✓ child and adult immunizations
✓ tobacco cessation programs
✓ obesity weight-loss programs

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.
Barriers to V-BID in HSA-qualified HDHPs
Expanding the Deductible-Exempt “Safe Harbor”

- HDHP enrollees with chronic diseases are more likely to go without care due to cost or experienced financial hardship due to medical bills
- Many well-established quality metrics require the entire deductible to be met before coverage begins
- 90% of employers support expanding deductible-exempt definition to include chronic disease care
Potential Solution:
High Value Health Plan

Flexibility to expand IRS "Safe Harbor" to allow coverage of additional evidence-based services prior to meeting the plan deductible
HVHP allows evidence-based, services that manage chronic disease to be deductible-exempt:

• Lower premiums than PPOs and HMOs; slight premium increase over existing HDHPs
• >40 million likely enrollees
High Value Health Plan  
"Smarter Deductibles, Better Value"

- HSA-HDHP with flexibility to cover additional evidence-based services prior to the deductible
- Mitigates cost-related non-adherence leading to enhanced clinical outcomes
- Aligns with provider payment reform incentives
- Lower premiums than most PPOs and HMOs, providing an alternative to health plans subject to the "Cadillac Tax"
- Substantially reduces aggregate health care expenditures
• Many “supply side” initiatives are restructuring provider incentives to move from volume to value

AJAC. 2014;2(3);10.
“Supply side” initiatives are restructuring provider incentives to move from volume to value

Unfortunately, “demand-side” initiatives are moving consumers in the opposite direction
Using Clinical Nuance to Align Payer and Consumer Incentives: As Easy as Peanut Butter and Jelly

• “Supply side” initiatives are restructuring provider incentives to move from volume to value

• Unfortunately, “demand-side” initiatives are moving consumers in the opposite direction

• Adding clinical nuance can improve quality of care, enhance employee experience, and contain cost growth
Discussion

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Coalition for Smarter Healthcare

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