Improving Consumers’ Access to High-Value Health Care: Value-Based Insurance Design and alignment with delivery system reform
Panelists

Gary Bacher, Co-Director Smarter Health Care Coalition
Tom Koutsoumpas, Co-Director Smarter Health Care Coalition
Dr. Mark Fendrick, Director, University of Michigan Center for Value Based Insurance Design
John Rother, President and CEO, National Coalition on Health Care
Tony Brice, Managing Director, Evolent Health
The Smarter Health Care Coalition’s mission is to enhance the patient experience – encompassing access, convenience, affordability, and quality – by working together towards achieving smarter health care, with a focus on integrating benefit design innovations and consumer/patient engagement within broader delivery system reform in order to better align coverage, quality, and value-based payment goals.
Aligning provider-facing efforts with consumer/patient-facing reforms and engagement

Provider-facing efforts in payment and delivery reform
- Payment system and value-based incentive reforms e.g., pay-for-performance
- Clinical guidelines
- Quality metrics
- Targeted outcome measures
- Practice and care transformation
- Shared decision-making

Consumer-facing efforts in benefit and coverage design
- Benefit design to promote high-value evidence-based choices
- Consumer tools and transparency on cost and quality
- Wellness and similar health promotion programs
- Literacy programs
- Shared decision-making

Connect to align and drive progress in the same direction

V-BID as an organizing concept for alignment

What is Value-Based Insurance Design?
Concept to engage consumers in care decisions by aligning out-of-pocket costs (e.g., deductibles, copayments) with the value of care. Furthers consumer access to high-value clinical services while recognizing the importance of maintaining and promoting affordability.

7/22/2015 Smarter Health Care Coalition
Areas of Application and Impact

V-BID and a focus on both connecting and aligning benefit design and payment/delivery system reform can be applied in numerous areas to create smarter healthcare.

Ability to utilize V-BID to encourage management of chronic conditions

Importance of aligning health care delivery and coverage design approaches consistently across the continuum of care pre- and during Medicare eligibility

VBID as an approach and connecting concept

- HSA-HDHP
- Medicare Advantage
- Other possible areas e.g., State-Employee/Retiree plans, 40% Excise Tax, Precision Medicine
Opportunity to apply V-BID to Medicare Advantage Plans

- Treatment of chronic illnesses now estimated to account for nearly 93% of Medicare spending

- MA plans as of 2015 cover 31% of Medicare Beneficiaries, amounting to roughly 16.8 million people

- Importance of allowing incorporation of V-BID principles and encouraging the use of high-quality providers is becoming widely recognized, although barriers remain

- Congressional support in both the House and Senate has been instrumental, and this bipartisan support has already substantially helped advance efforts toward a V-BID demonstration in Medicare Advantage by CMS
V-BID and rules for HSA-HDHPs

**Basic Requirements for HSA-HDHPs**

- HDHP must have a minimum deductible
  - At least $1,300 for 2015 self-only coverage
- The HDHP cannot provide benefits prior to this deductible being met, with limited exceptions*
- Includes rules regarding maximum out-of-pocket (OOP) limit on spending and related requirements

**Exception: The IRS “Preventive Care Safe Harbor” Provision**

- Allows plans to cover certain preventive care services prior to the deductible being met
  - IRS has clarified that preventive services required to be provided by the ACA fall under this safe harbor
- IRS guidance excludes benefits to treat “an existing illness, injury, or condition” which excludes treatment of chronic illnesses
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.

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 services, worsens health disparities, and in some cases leads to greater overall costs.
40% of Democrats and 41% of Republicans said cost is the number one reason they have not utilized preventive care.
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
Putting Innovation into Action: Create Broad Multi-Stakeholder Support

- HHS
- CBO
- SEIU
- MedPAC
- Brookings Institution
- The Commonwealth Fund
- NBCH
- PCPCC
- Partnership for Sustainable Health Care
- Families USA
- AHIP

- National Governor’s Assoc.
- US Chamber of Commerce
- Bipartisan Policy Center
- Kaiser Family Foundation
- NBGH
- National Coalition on Health Care
- Urban Institute
- RWJF
- IOM
- PhRMA
- AARP

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
Precision Medicine Requires Precision Benefit Design

- Mitigates cost-related non-adherence leading to enhanced clinical outcomes
- Reallocates medical spending efficiently and optimizes population health
- Aligns payment reform and consumer engagement initiatives
Improving Consumers’ Access to High-Value Care:

Value-Based Insurance Design and Delivery System Reform

John Rother
President and CEO,
National Coalition on Health Care
Who We Are

The National Coalition on Health Care (NCHC) is a nonpartisan, nonprofit 501(c)(3) organization representing a diverse membership of health care stakeholders, including medical professional groups, hospitals, businesses, faith-based associations, unions, insurers, and patient advocacy organizations. NCHC and its over 80 member organizations are dedicated to a high-quality, affordable health care system.
NCHC believes that ensuring affordability is crucial to reforming the US health care system and improving our overall health outcomes.

By bringing together key stakeholders, NCHC works to target areas of health care where smart, systemic change can be leveraged to improve affordability, value, and efficiency.

NCHC pursues such change through a two-pronged approach of public education, and policy development and advocacy.
# Alarming Growth in National Health Care Expenditures Continues

## Projections of National Health Expenditures and Their Share of Gross Domestic Product, 2012-2021

<table>
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<th>Year</th>
<th>Dollars in Billions</th>
<th>NHE as a Share of GDP</th>
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<tr>
<td>2013</td>
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<td>17.8%</td>
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<td>2014</td>
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</tr>
<tr>
<td>2020</td>
<td>$4,487</td>
<td>19.2%</td>
</tr>
<tr>
<td>2021</td>
<td>$4,781</td>
<td>19.6%</td>
</tr>
</tbody>
</table>

Growing Financial Burden on Workers

“The growth in worker contributions to health insurance premiums has outpaced the overall increases in benefit costs, wages and inflation” (Kaiser Family Foundation/HRET)

This growth is creating access barriers to health care for workers and their families.
Distinguishing High-Value and Low-Value Care: Medicare

Despite innovative reimbursement (ACOs, bundling), Medicare’s benefit design is stuck in 1965

- Any willing provider in traditional Medicare
- No distinction between high and low value services
- Limited Insurance protection (No catastrophic cap; high inpatient deductible)
  - Expands Medigap enrollment (mostly first dollar for any covered service provided by any willing provider)
Distinguishing High-Value and Low-Value Care: Medicare

- 30% of Medicare beneficiaries are enrolled in MA
- A majority of new beneficiaries are choosing Medicare Advantage plans
- Plans have flexibility to establish provider networks, provide supplemental benefits

BUT CURRENTLY

In-network cost-sharing requirements are the same for a high-value test and a low-value test, or for an excellent provider and a sub-par one.
Distinguishing High-Value and Low-Value Care: Employer-Sponsored Insurance & State Exchanges

THE NEW REALITY FOR CONSUMERS: High Deductibles & HSAs

Average General Annual Deductible Among Covered Workers Enrolled in a Plan with a Deductible for Single Coverage, by Firm Size, 2006-2014

Percentage of ESI-Covered Workers Enrolled in Either a HDHP/HRA or HSA-Qualified HDHP, 2006-2014

* Estimate is statistically different from estimate for the previous year shown (p<.05).

Distinguishing High-Value and Low-Value Care: Employer-Sponsored Insurance & State Exchanges

THE NEW REALITY FOR CONSUMERS: High Deductibles & HSAs

2015 Average Deductible in Federally-Facilitated Marketplaces
(Single Coverage, Combined Medical /Drug Deductible)

$2556

Source: Kaiser Family Foundation
One in Four

Adults with non-group coverage report going without needed care due to cost
Result: Patients Forego Needed Care....

Some more than others

- Those with lower to middle income (under 250 percent of poverty)
- Those with high deductibles (>$1,500/person)

Source: Urban Institute HRMS, September and December 2014
Adult with Newly Diagnosed Diabetes, High-deductible Plan

- Receives Diabetes Screening- $0 cost sharing
- Follow-up Appointment- ~$100 out of pocket

→ *Does Patient Arrive at Follow-up Appt?*

- If yes, patient is counseled on behavioral change, may fill a $4 prescription for generic metformin
- But if patient needs insulin (Lantus)?
  - ~$385-390 out of pocket for the drug
  - Syringes, medical supplies, etc

→ *Does Patient Remain Adherent to Therapy?*
Adult with Newly Diagnosed Diabetes, High-deductible Plan

If non-adherent, patient wins a trip to the ER!

Outpatient Charges for ED visit: **$1233**

Source: PLOS One, Feb 27, 2013, cited here for illustrative purposes only.

Now, does patient adhere to an insulin and avoid future hospital or ER visits—despite the monthly $385-$390 cost AND a $1233 ER bill?
That the 2012 Estimated Health Care Costs for Diagnosed Diabetes = $245 billion

Source: American Diabetes Association
In Medicare,

• Pilot VBID in MA, enabling plans to reduce cost-sharing for the most important medical services or the most effective providers

In the private market,

• Expand the preventive services safe harbor, allowing coverage for the highest value services before the deductible for HSA plans.
Thank You

Contact Information

John Rother
President and CEO,
National Coalition on Health Care
jrother@nchc.org

The National Coalition on Health Care
http://www.nchc.org/
• 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.

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.
V-BID HDHP Hybrid with “Smarter Deductibles”: High Value Health Plan

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.
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

AJAC. 2014;2(3);10.
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

AJAC. 2014;2(3);10.
Discussion

University of Michigan Center for Value-Based Insurance Design

www.vbidcenter.org
@um_vbid
vbidcenter@umich.edu

Coalition for Smarter Healthcare

www.smarterhc.org
Value-Based Insurance Design Challenges
Who is Evolent?

• Founded in 2011
• Operations in Arlington, VA
• Strategic investors:
  o University of Pittsburgh Medical Center (UPMC)
  o The Advisory Board Company (based in DC)
  o TPG Growth
• IPO in June 2015 – NYSE (EVH)
• Over 800 employees
• Clients include Hospital and Health Systems that are converting from Fee-For-Service delivery to value-based delivery including:
  o Launching provider-owned health plans to the commercial, Medicare Advantage, private exchange market
  o Establishing Medicare and Commercial payer-risk arrangements
  o Developing direct-to-employer population health products/services
A Successful Provider-Owned Health Plan Model
Includes Value-Based Insurance Plan Designs

- Reduction in population health risk levels
- Lower per-employee-per-month costs

Integrated Population Health, Health Plan Design and Provider Network
Objectives of Value Based Insurance Designs Within Provider Owned Health Plans (POHPs)

- POHPs leverage the principles of Value Based Insurance Design (VBID) to encourage certain types of medical utilization by removing financial barriers in the plan design.
- POHPs engage patients with health care providers to:
  - Close gaps in care (i.e. age appropriate screenings)
  - Improve compliance with medication therapies
  - Initiate behavior changes (i.e. exercise; nutrition)
- POHPs achieve these objectives with VBID techniques:
  - Waiving copays or coinsurance for maintenance medications
  - Waiving deductible for physician visits for chronically ill patients
  - Incenting certain personal behaviors by rewarding plan participants with cash deposits into accounts that can be used to offset medical expenses
    - i.e. participants can earn $500 for completing a health risk assessment, participating in a biometric screen, losing weight, or participating in certain disease management programs
Employer Contributions to Account-Based Plans Are Often Used as a Health Improvement Incentive

85% of large employers surveyed by the National Business Group on Health (August 2014) have a High Deductible Health Plan (HDHP) with a Health Saving Account (HSA), while 18% have an HDHP with a Health Reimbursement Account (HRA)

HSA-Qualified HDHPs
- Require that all expenses including pharmacy (but excluding preventive care) be subject to the high deductible
- Employer and Employee contributions to an HSA count toward the ACA excise “Cadillac” tax
- Contributions are immediately vested and portable
- HSA contributions are triple-tax advantaged to participants

HDHPs with HRAs
- No vesting requirements, not portable
- Only employer funded
- Contributions count towards the excise tax
- Accumulated balances can be capped or forfeited if not used
- HRA funds not considered a plan expense until used – similar to traditional insurance expense
Reform the HSA-/HDHP Preventive-Service Safe Harbor Definition to Include VBID Principles

• Reform of the HSA/HDHP Preventive Service Safe Harbor to include unique VBID principles (like waiving deductibles) will:
  o Provide plan participants with access to evidence-based preventive services prior to satisfaction of the high deductible
  o Allow greater use of “employer-funded” HSA accounts among POHPs who are transitioning to value-based care and using account based plans as an incentive
  o Encourage more participants to join the plan
    • According to the 2014 Kaiser Family Foundation Survey:
      o 31% of covered workers enrolled in an HSA-qualified plan (where the employer makes no contribution)
      o 34% of covered workers are enrolled in an HSA-qualified plan when the employer contributes less than $462
      o 24% of covered workers are enrolled in an HSA-qualified plan when the employer contributes $1,077 or more
      o Comparatively, 44% of covered workers are enrolled in a plan with an employer funded HRA/HDHP of less than $834
Overview: Need and Opportunity

Align provider-facing efforts with consumer/patient-facing reforms and engagement to increase consumers’ access to high value health care.

**Provider-facing efforts in payment and delivery reform**
- Payment system and value-based incentive reforms e.g., pay-for-performance
- Clinical guidelines
- Quality metrics
- Targeted outcome measures
- Practice and care transformation
- Shared decision-making

**Connect to align and drive progress in the same direction**

**Consumer-facing efforts in benefit and coverage design**
- Benefit design to promote high-value evidence-based choices
- Consumer tools and transparency on cost and quality
- Wellness and similar health promotion programs
- Literacy programs
- Shared decision-making

**V-BID as an organizing concept for alignment**
Key Takeaways

Encouraging application of V-BID principles aligned with payment reform

Advance specific proposals in the areas of:

- Medicare Advantage
- HSA-HDHP plans
- Other growing areas such as State-Employee and Retiree Plans and Precision Medicine

Work with us on these issues and to create smarter health care:

Gary Bacher, gbacher@smarterhc.org
Questions? Comments?

FOR MORE INFORMATION:
WWW.SMARTERHC.ORG | INFO@SMARTERHC.ORG