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

Smarter Health Care Coalition
Panelists

Gary Bacher, Co-Director Smarter Health Care Coalition
Tom Koutsoumpas, Co-Director Smarter Health Care Coalition
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Lydia Mitts, Senior Policy Analyst, Families USA
Katy Spangler, Senior Vice President, Health Policy, American Benefits Council
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.
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

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**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

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*Patient must pay out-of-pocket with limited exceptions*

Once deductible has been met, IRS permits HDHP cost-sharing

Deductible: $1,300

OOP Max
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)
Impact of Increases in Consumer Cost-Sharing on Health Care Utilization

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.

Foregoing Care Due to Cost
A Bipartisan Problem

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
• 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

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 Health Care

Lydia Mitts, Senior Policy Analyst
Who We Are and What We Do

- Families USA is a non-profit, non-partisan organization
- Dedicated to the achievement of high-quality, affordable health care for all
- Research and produces timely reports and other informative resources.
- Collaborates with organizations across the political, business, nonprofit and health care sectors.
- Provides technical assistance at the state and community levels.
Insuring Coverage Translates to Care:

• ACA has made landmark achievements in expanding access to affordable coverage and care

• Remaining work ahead to ensure families can afford out-of-pocket costs for needed care once insured

• High deductibles/out-of-pocket costs common prior to ACA
  • Barrier to needed care, particularly for lower and middle-income families
  • Continues to pose problem across all types of coverage

Moving Forward: Need to ensure coverage facilitates access to needed care for low and middle income families
Among adults insured the full year with non-group coverage in 2014:

- One in four adults went without needed care due to affordability problems
- Tests, treatment, follow up care and prescription drugs most common
Report Findings: Who is struggling to afford care?

Who is more likely to skip needed care?

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

Source: Urban Institute, 2014

![Percentage of adults at these income levels who went without some care](chart1.png)

![Percentage of adults at these deductible levels who went without some care](chart2.png)

Source: Urban Institute HRMS, September and December 2014
High deductibles are common, even among lower to middle income adults (under 250% of poverty)

$1,500 = 5.41% of income for individual at 250% of poverty (making $29,200/year)

Lower to middle income: 138-249 percent of poverty
Middle income: 250-400 percent of poverty
Improving Plan Offerings

Families USA Priorities:

• Increase marketplace plan offerings that cover care pre-deductible, including services to manage chronic conditions
  • Emphasis on silver plans
• HSA HDHP flexibility to cover care for chronic conditions pre-deductible
  • Common in employer-based coverage and marketplace
  • May be only affordable coverage option for some
• Expand upfront coverage for high value chronic conditions care across all types of public and private coverage
Additional Families USA Resources:


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Increasing Flexibility in Health Savings Accounts

Katy Spangler
July 21, 2015
IRS 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

- Safe harbor allowing plans to cover certain preventive 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

Patient must pay out-of-pocket with limited exceptions*

Once deductible has been met, IRS permits HDHP cost-sharing

Deductible: $1,300

OOP Max: $6,450
Prevalence of HSA-HDHPs Increasing

<table>
<thead>
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<th>Year</th>
<th>HDHP Enrollment (Millions)</th>
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<td>2014</td>
<td>17.4</td>
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2014 DISTRIBUTION OF HDHP ENROLLEES BY MARKET TYPE

- Large group: 71%
- Small group: 14%
- Individual: 11%
- Other: 4%

Sources: AHIP Center for Policy and Research, 2005 - 2014 HSA/HDHP Census
Why Change the Current Definition?

- According to the CDC, spending on chronic disease encompasses more than 86 percent of total U.S. health expenditures.

- Yet, the “Cadillac” tax and other factors are forcing employers to move to HSA-HDHPs that limit (pre-deductible) coverage of services to treat chronic conditions.

- Employers would love more flexibility to offer (currently excluded) high value services (like insulin, test strips, and eye exams for patients with diabetes) before employees meet deductibles.
Clarify that certain prescription drugs are preventive care that will not be subject to a HSA-eligible plan deductible. Current law includes a safe harbor allowing HSA eligible high deductible plans to cover certain preventive services before the deductible is met. The IRS has too narrowly defined “prevention” to consist of primary preventive services, including some prescription drugs when used in certain instances. This definition should be updated to give employers greater flexibility regarding prescription drugs that may be covered before the deductible.
Next Steps?

- IRS could utilize their existing authority under Internal Revenue Code section 223 and expand the definition of preventive services
- Congress could advance legislation expanding the definition of prevention
Hatch language pulled from S.1031:

SEC. 110. PREVENTIVE CARE PRESCRIPTION DRUG CLARIFICATION.

(a) CLARIFY USE OF DRUGS IN PREVENTIVE CARE.—Subparagraph (C) of section 223(c)(2) is amended by adding at the end the following: “Preventive care shall include prescription and over-the-counter drugs and medicines which have the primary purpose of preventing the onset of, further deterioration from, or complications associated with chronic conditions, illnesses, or diseases.”.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2003.
For more information:

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Putting Innovation into Action: Translating Research into Policy

- **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
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.
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
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.
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Coalition for Smarter Healthcare

www.smarterhc.org
Value-Based Insurance Design Challenges

Summer 2015
Who is Evolent?

- Founded in 2011
- Operations in Arlington, VA
- Strategic investors:
  - University of Pittsburgh Medical Center (UPMC)
  - The Advisory Board Company (based in DC)
  - 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:
  - Launching provider-owned health plans to the commercial, Medicare Advantage, private exchange market
  - Establishing Medicare and Commercial payer-risk arrangements
  - 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:
  - Provide plan participants with access to *evidence-based preventive services prior to satisfaction* of the high deductible
  - 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
  - Encourage more participants to join the plan
- According to the 2014 Kaiser Family Foundation Survey:
  - 31% of covered workers enrolled in an HSA-qualified plan (where the employer makes no contribution)
  - 34% of covered workers are enrolled in an HSA-qualified plan when the employer contributes less than $462
  - 24% of covered workers are enrolled in an HSA-qualified plan when the employer contributes $1,077 or more
  - 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
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Connect to align and drive progress in the same direction

V-BID as an organizing concept for alignment

Consumer-facing efforts in benefit and coverage design
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- Consumer tools and transparency on cost and quality
- Wellness and similar health promotion programs
- Literacy programs
- Shared decision-making
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:
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