Value-Based Insurance Design:
Using “Smarter” Cost-sharing to Align Consumer Incentives with Alternative Payment Models

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University of Michigan Center for Value-Based Insurance Design

www.vbidcenter.org

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

Note: CI = confidence interval.
Shifting the Discussion from “How much” to “How well”

Overview

• Impact of Consumer Cost-sharing
• New Approach: “Clinically Nuanced” Cost-sharing
• Value-Based Insurance Design
• Putting Innovation into Action
• Identifying and Removing Waste
• Synergies with Alternative Payment Models
Getting to Health Care Value
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, the focus is on costs paid by the consumer, not the employer or third party administrator.

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

• Consumer cost-sharing is rising rapidly.
Deductibles on the rise

Percentage of covered workers with an annual deductible of $1,000 or more for single coverage

- Small firms
- All firms
- Large firms

Source: Kaiser Family Foundation and Health Research and Educational Trust
“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.

Americans Reporting Problems Paying Medical Bills in Past Year

- Uninsured: 53%
- Income <$50,000: 47%
- Adults 18-64: 37%
- HDHP: 26%
- All private insurance: 26%

Source: Kaiser Family Foundation/New York Times Medical Bills Survey
• While important, the provision of accurate price and quality data does not address appropriateness of care nor substantially impact consumer behavior.

• Additional solutions are necessary to better allocate health expenditures on the clinical benefit – not only the price or profitability – of services.
Potential Solution to Cost-Related Non-Adherence

Clinically Nuanced Cost-Sharing

What is clinical nuance?

Services differ in clinical benefit produced:

- Medication
- Medical procedure
- Nursing care

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
V-BID Momentum Continues

Source: 19th Annual Towers Watson/National Business Group on Health Employer Survey
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
Broad Multi-Stakeholder Support

- HHS
- CBO
- SEIU
- MedPAC
- Brookings Institution
- The Commonwealth Fund
- NBCH
- PCPCC
- Families USA
- AHIP
- AARP
- 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

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

- Patient Protection and Affordable Care Act
- Medicare
- HSA-qualified HDHPs
- State Health Reform
• 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

- Patient Protection and Affordable Care Act
- Medicare
- HSA-qualified HDHPs
- State Health Reform
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 Announces Medicare Advantage Value-Based Insurance Design Model Test

A 5-year demonstration program will test the utility of structuring consumer cost-sharing and other health plan design elements to encourage patients to use high-value clinical services and providers.

*Red denotes states included in V-BID model test*
• Patient Protection and Affordable Care Act
• Medicare
• HSA-qualified HDHPs
• State Health Reform
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


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.
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.
• Patient Protection and Affordable Care Act
• Medicare
• HSA-qualified HDHPs
• State Health Reform
Getting to Health Care Value - What’s Your State's Path?
V-BID Role in State Health Reform

- State Exchanges – Encourage V-BID (CA, MD)
- CO-OPs - Maine
- Medicaid – Michigan
- State Innovation Models – NY, PA, CT, VA
- State Employee Benefit Plans
Value-Based Insurance Design
Growing Role in State Employee Plans

[Map showing the growing role of Value-Based Insurance Design (V-BID) in state employee plans across the United States, with states in green indicating adoption.]
Implementing V-BID for State Employees: Connecticut State Employees Health Benefit Plan

- Employees receive a reprieve from higher premiums and receive lower cost-sharing if they commit to:
  - Age-appropriate screenings/preventive care
  - Participate in disease management programs for chronic conditions
- Compliance required to remain in plan
- 2 year results:
  - Increased use of preventive services
  - Improved medication adherence
  - Decreased ER visits
  - Inconclusive cost impact
## Removing Waste
### Health Waste Calculator (HWC)

<table>
<thead>
<tr>
<th>Category</th>
<th>Sources</th>
<th>Estimate of Excess Costs</th>
<th>% of Waste</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unnecessary Services</td>
<td>• Overuse beyond evidence-established levels</td>
<td>$210 billion</td>
<td>27%</td>
<td>9.15%</td>
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<tr>
<td></td>
<td>• Discretionary use beyond benchmarks</td>
<td></td>
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<td>• Unnecessary choice of higher-cost services</td>
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<td></td>
<td>• Care fragmentation</td>
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<td>• Primary prevention</td>
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<td>2.40%</td>
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<td>• Tertiary prevention</td>
<td></td>
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<tr>
<td>Fraud</td>
<td>• All sources – payers, clinicians, patients</td>
<td>$75 billion</td>
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<td><strong>Total</strong></td>
<td></td>
<td><strong>$765 billion</strong></td>
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**SOURCE:** “Best Care at Lower Cost: The Path to Continuously Learning Health Care in America.” Institute of Medicine (2013)
## Identifying and Removing Waste

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Removing Waste
Health Waste Calculator (HWC) – Sample Results

- 20% of members exposed to 1+ wasteful service
- 36% of services were wasteful
- 2.4% or $11.94 PMPM in claims wasted
## Health Waste Calculator (HWC)
### Top 5 Measures by Cost

<table>
<thead>
<tr>
<th>Waste Measure Description</th>
<th>Total Wasteful Services Overall</th>
<th>Total Wasteful Dollars Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline laboratory studies in patients without systemic disease undergoing low-risk surgery</td>
<td>938,814</td>
<td>$365,847,701.78</td>
</tr>
<tr>
<td>Stress cardiac imaging or advanced non-invasive imaging in the initial evaluation of patients w/o cardiac symptoms</td>
<td>54,702</td>
<td>$185,997,938.76</td>
</tr>
<tr>
<td>Annual electrocardiograms (EKGs) or any other cardiac screening for low-risk patients without symptoms.</td>
<td>276,698</td>
<td>$113,615,026.14</td>
</tr>
<tr>
<td>Routine annual cervical cytology screening (Pap tests) in women 21–65 years of age.</td>
<td>334,184</td>
<td>$73,369,640.80</td>
</tr>
<tr>
<td>PSA-based screening for prostate cancer in all men regardless of age.</td>
<td>272,015</td>
<td>$63,137,698.98</td>
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Identifying and Removing Waste
Levers to Create Change

• Claim Adjudication
• Analytics & Reporting
• Education & Promotion
• Provider Network
• Pay for Performance
• Medical Management
• Purchasing Criteria
• Benefit Design
Many “supply side” initiatives are restructuring provider incentives to move from volume to value:

- Medical Homes
- Accountable Care
- Bundled Payments
- Reference Pricing
- Global Budgets
- High Performing Networks
- Health Information Technology
Unfortunately, some “demand-side” initiatives – including consumer cost sharing and a lack of incentives to stay within an ACO - discourage consumers from pursuing the “Triple Aim”
Impact of Aligning Physicians and Patients: Financial Incentives to Lower Cholesterol

Mean LDL Reduction (mg/dL)

Control... 25.1
Patient... 25.1
Physician... 27.9
Physician-Patient... 33.6

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

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