SCHOOL OF PUBLIC HEALTH

CENTER FOR VALUE-BASED INSURANCE DESIGN

UNIVERSITY OF MICHIGAN

State of Michigan

Senate Health and Human Services Subcommittee

Testimony of

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- Amount of medical spending is the principle focus of health care reform discussions
- 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

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- Moving from a volume-driven to value-based system requires a change in both how we pay for care and how we engage consumers to seek care
- Much of the policy focus is on the importance of reforming care delivery and payment policies
- Applaud this committee for the consistent attention to how we can alter consumer behavior to bring about a more effective and efficient system
- Cost sharing is a common and important policy lever

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- National attention is being paid to the consumer cost sharing levels included in the Healthy Michigan Plan
- Most cost sharing is implemented in a “one size fits all way” that fails to acknowledge the differences in clinical value among medical interventions
- A growing body of evidence concludes that *increases* in cost-sharing leads to a reduction in the use of essential services, worsens health disparities, and in some cases leads to greater overall costs
- Conversely, *decreases* in cost-sharing applied to all services can lead to overuse or misuse of services that are harmful or provide little clinical value

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- I support high cost sharing levels for those services – but only those services - that do not make Michiganders healthier. It does not make sense to impose high levels of cost-sharing on the services I beg my patients to do
- Thus, there is a need for smarter cost sharing approached that encourage the use of high value services and discourage the use of low value ones.

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- Instead of blunt, price-driven cost sharing increases, we propose that the basic tenets of **clinical nuance** should be considered. These tenets recognize that:
  - medical services differ in the benefit provided;
  - the clinical benefit derived from a specific service depends on the patient using it

- Services that are identified as high quality in certain clinical scenarios are considered low-value when used in other patient populations or delivery settings
- Cardiac catheterization and imaging for back pain can each be classified as a high- or low-value service depending on the characteristics of the person receiving the care, as well as by whom and where the care is delivered

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- More than a decade ago the private sector began to implement plans based on our clinical nuance idea; these plans referred to as Value-Based Insurance Design
- The V-BID premise calls for reducing financial barriers to evidence-based services and high-performing providers and imposing disincentives to discourage use of low value care
- The published results of such plans report a win for patients by improving access to high value care, a win for providers by aligning with quality based payment programs, and a win for payers – and taxpayers - by promoting efficient spending

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- V-BID has been successfully implemented by hundreds of payers and has broad multi-stakeholder support
- Recent announcement of a V-BID demonstration in Medicare – driven by federal bipartisan legislation
- Increasing role in State Health Reform
    - State Employee Benefit Plans
    - State Innovation Models
    - Incorporating V-BID into the Healthy Michigan Plan follows a recent CMS rule giving Medicaid programs greater flexibility to vary cost-sharing for drugs as well as certain outpatient, emergency, and inpatient visits

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V-BID principles are included Healthy Michigan Plan

- 105d.1e: Copayments may be waived by the contracted health plan if the desired outcome is to promote greater access to services that prevent the progression and complications related to chronic disease
- 105d.1f: Design and implement a copay structure that encourages the use of high value services, while discouraging low-value services such as non-urgent Emergency Department utilization."
- 105D5: Implement a pharmaceutical benefit that utilizes copays at appropriate levels allowable by CMS to encourage the use of high-value, low cost prescriptions.

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March 15, 2016. Plans will submit a narrative description of how they encourage the use of high-value services and discourage the use of low-value services. This may include a copay structure that:

- –Eliminates copays for services and prescriptions related to chronic conditions
- –Increases copays for non-emergent use of the emergency department

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- We need to work harder to eliminate waste ($210B)
- Key stakeholders—including a large number of medical professional societies—agree that discouraging consumers from using specific low-value services must be part of the strategy
- One of the many merits of data aggregator – such as the one funded by this committee - can be used to identify wasteful spending
  - –20% exposed to 1+ wasteful services
  - –2.4% or $11.94 PMPM in claims wasted
- Unlike delay for cost offsets from improved quality, savings from waste elimination are immediate

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- Many “supply side” initiatives are restructuring provider incentives to move from volume to value (key activity of our SIM grant)
- Unfortunately, some “demand-side” initiatives – including consumer cost sharing discourage consumers from pursuing those same services (HDHPs)
- Insurance coverage must offer easy access for those exact services for which I am benchmarked

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- 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