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

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@um_vbid
#NASHCOVBID
<table>
<thead>
<tr>
<th>Factor</th>
<th>Odds ratio (and 95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Environmental</strong></td>
<td></td>
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<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>
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<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>
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<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
Getting to Health Care Value
Role of Consumer Cost-Sharing in Clinical Decisions

- 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.

Health Affairs 2014. doi: 10.1377/hlthaff.2014.0792
Deductibles on the rise

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

- Small firms: 63%
- All firms: 46%
- Large firms: 39%

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**: 37%
- **Adults 18-64**: 26%
- **HDHP**: 26%
- **All private insurance**: 23%

Source: Kaiser Family Foundation/New York Times Medical Bills Survey
Getting to Health Care Value
Consumer Solutions Needed to Enhance Efficiency

• 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
Understanding Clinical Nuance
A Solution to "One-Size-Fits-All" Cost-Sharing
Clinical Services Differ in the Benefit Produced

- Office Visits
- Diagnostic Tests
- Prescription Drugs
Despite these differences in clinical value, consumer out-of-pocket costs are the same for every clinician visit within a network...
...for all diagnostic tests...

- Blood Sugar Monitoring
- CT Imaging for Back Pain
Consumer out-of-pocket costs are the same for all drugs within a formulary tier.

- Statins
- Anti-Depressants
- Toenail Fungus Rx
- Heartburn Treatment
The Clinical Benefit Derived From a Service Depends On...

Who receives it
Who provides it
Where it's provided
Clinical benefit depends on **who** receives it.

**Screening for Colorectal Cancer**

- First-degree relative of colon cancer sufferer: Exceptional Value
- Average risk 50 year old: High Value
- 30 year old with no family history of colon cancer: Low Value
who provides it...

High Performance

- Certified

Poor Performance

- Poor
- Average
- Excellent
Clinical benefit depends on where care is provided.

- **Ambulatory Care Center**
  - Lower cost ($)

- **Hospital**
  - Higher cost ($$$)
Implementing Clinical Nuance

Value-Based Insurance Design

Sets cost-sharing to encourage greater utilization of high-value services and providers and discourage use of low-value care.
• Successfully implemented by hundreds of public and private payers
V-BID Momentum Continues

- Pharmacy Plan: 26% Planned for 2015, 15% In place in 2014
- Networks: 13% Planned for 2015, 20% In place in 2014
- Medical Plan: 9% Planned for 2015, 19% In place in 2014

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
Putting Innovation into Action: Translating Research into Policy

• Patient Protection and Affordable Care Act
• Medicare
• HSA-qualified HDHPs
• State Health Reform
AC0A Sec 2713: Selected Preventive Services be Provided without Cost-Sharing

• 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
• 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*
Putting Innovation into Action: Translating Research into Policy

- 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)
• Medicaid – Michigan
• State Innovation Models – NY, PA, CT, VA
• State Employee Benefit Plans
• CO-OPs - Maine
Value-Based Insurance Design
Growing Role in State Employee Plans
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
Combining ‘Carrots’ and ‘Sticks’ to Enhance the Financial Impact of V-BID Programs: Identify Waste

<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>
</tr>
<tr>
<td></td>
<td>• Discretionary use beyond benchmarks</td>
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<td></td>
<td></td>
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<td></td>
<td>• Unnecessary choice of higher-cost services</td>
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<tr>
<td></td>
<td><strong>Total</strong></td>
<td><strong>$630 billion</strong></td>
<td><strong>30%</strong></td>
<td><strong>10.95%</strong></td>
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<tr>
<td>Inefficiently Delivered Services</td>
<td>• Mistakes, errors, preventable complications</td>
<td>$130 billion</td>
<td>17%</td>
<td>5.66%</td>
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<tr>
<td></td>
<td>• Care fragmentation</td>
<td></td>
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<td>• Operational inefficiencies at care delivery sites</td>
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<td>Excess Admin Costs</td>
<td>• Insurance paperwork costs beyond benchmarks</td>
<td>$190 billion</td>
<td>25%</td>
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<td>• Insurers’ administrative inefficiencies</td>
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<td>Prices that are too high</td>
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<tr>
<td>Missed Prevention Opportunities</td>
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<td>$55 billion</td>
<td>7%</td>
<td>2.40%</td>
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<td>• Tertiary prevention</td>
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<tr>
<td>Fraud</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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Software tool designed to identify wasteful medical spending:

- U.S. Preventive Services Task Force
- Choosing Wisely

Underlying algorithms process claims, billing or EMR data to identify waste

Defines services with a degree of appropriateness of care

- Necessary
- Likely to be wasteful
- Wasteful
Removal Waste
Health Waste Calculator – Sample Results Large Payer

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 or advanced non-invasive imaging in the initial evaluation of patients w/o symptoms</td>
<td>54,702</td>
<td>$185,997,938.76</td>
</tr>
<tr>
<td>Annual electrocardiograms (EKGs) or 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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</table>
Identifying and Removing Waste
Levers to Create Change

- Education & Promotion
- Analytics & Reporting
- Provider Networks
- Pay for Performance Programs
- Medical Management
- Purchasing Criteria
- Benefit Design
Aligning Payer and Consumer Incentives: As Easy as Peanut Butter and Jelly

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

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

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