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

A. Mark Fendrick, MD
University of Michigan Center for Value-Based Insurance Design

www.vbidcenter.org

@um_vbid
#CAHPVBID
<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

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

#1 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**: $ 
- **Hospital**: $$$

The cost and accessibility of care vary depending on the location.
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.
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

Source: 19th Annual Towers Watson/National Business Group on Health Employer Survey
V-BID Intervention Types

1. Change cost sharing for specific services for all members
2. Change cost sharing for specific services by clinical condition
3. Change cost sharing for visits to high value providers
4. Change cost sharing for participation in chronic disease management programs
5. Change cost sharing for specific services only if member visits a high value provider

Other Intervention Options

- Enhanced coverage of supplemental benefits
- Increased cost-sharing for low-value services
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

• 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; over **76 million** have accessed preventive services without cost-sharing
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*
March 8th: CMS Proposed a Rule for Part B Drugs includes V-BID principles including indication-specific pricing and consumer cost-sharing.
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.
Putting Innovation into Action: Translating Research into Policy

• Patient Protection and Affordable Care Act
• Medicare
• HSA-qualified HDHPs
• State Health Reform
State Exchanges – Encourage V-BID (CA, MD)
Medicaid – Michigan
State Innovation Models – NY, PA, CT, VA
State Employee Benefit Plans
Value-Based Insurance Design
Growing Role in State Employee Plans
Connecticut’s Value-Based Insurance Plan Increased The Use Of Targeted Services And Medication Adherence
Value-Based Insurance Design

V-BID sets cost-sharing to encourage use of high-value services and providers and discourage use of low-value care.

Current Plans vs V-BID Plans

**Current Plans**
- Increase out-of-pocket costs
  - Offer one-size-fits-all cost-sharing
  - Misalign consumer and provider incentives

**V-BID Plans**
- Lower cost-sharing for high-value services and providers
  - Enhance patient-centered outcomes
  - Align with provider initiatives
Motivation for Benefit Design Change

- Address state budget deficits
- Reduce disparities and quality gaps
- Encourage employee engagement
- Improve individual and population health
Key Features of the HEP
Align out-of-pocket costs with healthy behaviors

Voluntary Enrollment

Full Preventive Care Coverage

Reduced cost-sharing for visits & medications to better manage specific clinical conditions

Increased cost-sharing for non-emergent ED visits

Participatory Requirement:
to maintain enrollment, members must complete age-appropriate preventive care & recommended chronic disease services
Relative change for HEP members compared to enrollees in control states
HEP Impact: 2 Year Results

Preventive Care Utilization

Lipid Screening

- HEP
- Comparison

Mammography

- HEP
- Comparison

% Using Service

Baseline | Year 1 | Year 2
---------|--------|--------
50       | 70     | 50     
90       |        |        

Baseline | Year 1 | Year 2
---------|--------|--------
25       | 45     | 25     
65       |        |        

HEP Impact: 2 Year Results

[3] Resource Use

ED Visits per 1,000 enrollees

- Baseline
- Year 1
- Year 2

HEP | Comparison
---|---

Spending - Year 2

- Full Sample
- Chronic Conditions

Total Spending | Out-of-pocket
---|---

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>
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<tbody>
<tr>
<td>Unnecessary Services</td>
<td>• Overuse beyond evidence-established levels&lt;br&gt;• Discretionary use beyond benchmarks&lt;br&gt;• Unnecessary choice of higher-cost services</td>
<td>$210 billion</td>
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<td>Inefficiently Delivered Services</td>
<td>• Mistakes, errors, preventable complications&lt;br&gt;• Care fragmentation&lt;br&gt;• Unnecessary use of higher-cost providers&lt;br&gt;• Operational inefficiencies at care delivery sites</td>
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<td>• Insurance paperwork costs beyond benchmarks&lt;br&gt;• Insurers’ administrative inefficiencies&lt;br&gt;• Inefficiencies due to care documentation requirements</td>
<td>$190 billion</td>
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<td>8.28%</td>
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<tr>
<td>Prices that are too high</td>
<td>• Service prices beyond competitive benchmarks&lt;br&gt;• Product prices beyond competitive benchmarks</td>
<td>$105 billion</td>
<td>14%</td>
<td>4.58%</td>
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<td>• Primary prevention&lt;br&gt;• Secondary prevention&lt;br&gt;• Tertiary prevention</td>
<td>$55 billion</td>
<td>7%</td>
<td>2.40%</td>
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<td>• All sources – payers, clinicians, patients</td>
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<td>10%</td>
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<td><strong>Total</strong></td>
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<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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**Total** $765 billion

% of Total 33.33%

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Removing Waste
Health Waste Calculator

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
Removing Waste
Health Waste Calculator – Sample Results Large Payer

- 20% of members exposed to 1+ wasteful service
- 36% of services were wasteful
- 2.4% or $11.94 PMPM in claims wasted
<table>
<thead>
<tr>
<th>Waste Measure</th>
<th>Wasteful Services (#)</th>
<th>Waste Index (%)</th>
<th>Wasteful Spending ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline laboratory studies in patients without systemic disease undergoing low-risk surgery</td>
<td>938,814</td>
<td>79%</td>
<td>$365,847,701</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>12%</td>
<td>$185,997,938</td>
</tr>
<tr>
<td>Annual electrocardiograms (EKGs) or other cardiac screening for low-risk patients without symptoms.</td>
<td>276,698</td>
<td>6%</td>
<td>$113,615,026</td>
</tr>
<tr>
<td>Routine annual cervical cytology screening (Pap tests) in women 21–65 years of age</td>
<td>334,184</td>
<td>80%</td>
<td>$73,369,640</td>
</tr>
<tr>
<td>PSA-based screening for prostate cancer in all men regardless of age.</td>
<td>272,015</td>
<td>41%</td>
<td>$63,137,698</td>
</tr>
</tbody>
</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
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

<table>
<thead>
<tr>
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<th>Mean LDL Reduction (mg/dL)</th>
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<tr>
<td>Control</td>
<td>25.1</td>
</tr>
<tr>
<td>Patient</td>
<td>25.1</td>
</tr>
<tr>
<td>Physician</td>
<td>27.9</td>
</tr>
<tr>
<td>Physician-Patient</td>
<td>33.6</td>
</tr>
</tbody>
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Beyond SGR: Aligning The Peanut Butter Of Payment Reform With The Jelly Of Consumer Engagement

Gary Bacher, Arielle Zina, and A. Mark Fendrick

April 22, 2015
Toward Lower Costs and Better Care — Averting a Collision between Consumer- and Provider-Focused Reforms

Elliott S. Fisher, M.D., M.P.H., and Peter V. Lee, J.D.

Over the past 20 years, two major approaches to slowing the growth of health care costs have emerged. One focuses on the delivery system, encouraging physicians, hospitals, and others to improve the way they deliver care. The other targets consumers, hoping to turn patients into more price-sensitive shoppers. Although both have had some success, it's increasingly clear that these approaches are on a collision course: poorly structured benefit designs will sharply limit the effectiveness of efforts to promote higher-value care through payment and delivery-system reform. But a crash is not inevitable.

Interest in reforming care delivery grew out of observations regarding the relative efficiency of integrated medical group practices, growing concern about variation in quality of care, and evidence that the greater use of specialist and hospital-based care in high-cost U.S. regions and health systems did not translate...
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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