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

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@um_vbid
#SALGBAVBID
<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>
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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>
<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.

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
- 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: 29%
- Uninsured, HDHP: 26%
- All private insurance: 23%
- All private insurance, income <$50,000: 19%

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.
Understanding Clinical Nuance

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.
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
  - Outpatient
  - $$

- Hospital
  - $$$$
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
<table>
<thead>
<tr>
<th>Putting Innovation into Action</th>
<th>Broad Multi-Stakeholder Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>• HHS</td>
<td>• National Governor’s Assoc.</td>
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<tr>
<td>• CBO</td>
<td>• US Chamber of Commerce</td>
</tr>
<tr>
<td>• SEIU</td>
<td>• Bipartisan Policy Center</td>
</tr>
<tr>
<td>• MedPAC</td>
<td>• Kaiser Family Foundation</td>
</tr>
<tr>
<td>• Brookings Institution</td>
<td>• NBGH</td>
</tr>
<tr>
<td>• The Commonwealth Fund</td>
<td>• National Coalition on Health Care</td>
</tr>
<tr>
<td>• NBCH</td>
<td>• Urban Institute</td>
</tr>
<tr>
<td>• PCPCC</td>
<td>• RWJF</td>
</tr>
<tr>
<td>• Families USA</td>
<td>• IOM</td>
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<tr>
<td>• AHIP</td>
<td>• PhRMA</td>
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</table>
Putting Innovation into Action: Translating Research into Policy

- Patient Protection and Affordable Care Act
- Medicare
- HSA-qualified HDHPs
- State Health Reform
ACA 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; 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*
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
• 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
• 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
V-BID sets cost-sharing to encourage use of high-value services and providers and discourage use of low-value care.

<table>
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<th>Current Plans</th>
<th>V-BID Plans</th>
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<tbody>
<tr>
<td>Increase out-of-pocket costs</td>
<td>Lower cost-sharing for high-value services and providers</td>
</tr>
<tr>
<td>Offer one-size-fits-all cost-sharing</td>
<td>Enhance patient-centered outcomes</td>
</tr>
<tr>
<td>Misalign consumer and provider incentives</td>
<td>Align with provider initiatives</td>
</tr>
</tbody>
</table>
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
[1] Office Visit Increases

Preventive Visits

- Year 1: 13.5%
- Year 2: 4.8%

Chronic Condition Visits

- Year 1: 1.6%
- Year 2: 1.2%
HEP Impact: 2 Year Results

Preventive Care Utilization

Lipid Screening

- % Using Service
  - Baseline: 50
  - Year 1: 90
  - Year 2: 70

Mammography

- % Using Service
  - Baseline: 25
  - Year 1: 45
  - Year 2: 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

US Dollars ($)

- 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>
</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>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Unnecessary choice of higher-cost services</td>
<td></td>
<td></td>
<td></td>
</tr>
<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>
<td></td>
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<tr>
<td></td>
<td>- Operational inefficiencies at care delivery sites</td>
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<td>- Insurers’ administrative inefficiencies</td>
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<td>- Inefficiencies due to care documentation requirements</td>
<td></td>
<td></td>
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<td>Prices that are too high</td>
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<tr>
<td></td>
<td>- Product prices beyond competitive benchmarks</td>
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<td></td>
<td></td>
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<tr>
<td>Missed Prevention Opportunities</td>
<td>- Primary prevention</td>
<td>$55 billion</td>
<td>7%</td>
<td>2.40%</td>
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<tr>
<td></td>
<td>- Secondary prevention</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>- Tertiary prevention</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fraud</td>
<td>- All sources – payers, clinicians, patients</td>
<td>$75 billion</td>
<td>10%</td>
<td>3.27%</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Total</td>
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**SOURCE:** “Best Care at Lower Cost: The Path to Continuously Learning Health Care in America.” Institute of Medicine (2013)
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
# Health Waste Calculator (HWC)

## Top 5 Measures by Cost

<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

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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