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

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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.

Consumer cost-sharing is rising rapidly.
“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)
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
Percentage of Workers Enrolled in HDHPs

Source: Kaiser/HRET Survey of Employer Sponsored Health Benefits
Distribution of Cost-Sharing Payments by Type (2004-2014)

Source: Kaiser Family Foundation
Enrollee Cost Sharing & Health Plan Payments for Individuals with Large Employer Health Plans

<table>
<thead>
<tr>
<th>Payments by Enrollees</th>
<th>Payments by Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payments towards deductibles</td>
<td>256%</td>
</tr>
<tr>
<td>Payments towards Coinsurance</td>
<td>107%</td>
</tr>
<tr>
<td>Payments for Copays</td>
<td>-26%</td>
</tr>
<tr>
<td>Payments by Health Plans</td>
<td>58%</td>
</tr>
</tbody>
</table>

Source: Kaiser Family Foundation
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: 29%
- 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

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

Screening Recipients

- 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

Poor Performance

CERTIFIED

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

- Ambulatory Care Center: $
- Hospital: $$$$

The cost of care varies 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

- 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: 20% Planned for 2015, 13% In place in 2014

Medical Plan: 19% Planned for 2015, 9% In place in 2014

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
A sharp uptick in use of preventive care coincided with the Affordable Care Act’s preventive services provision.

U.S. per capita disease-based health spending, cost per case, and treated prevalence indexes for CCS Condition Category, Exam or Evaluation, 2005 - 2012.

Source: Kaiser Family Foundation and Bureau of Economic Analysis (BEA) analysis of BEA’s Health Care Satellite Account (Blended Account), which combines data from the Medical Expenditure Panel Survey and large claims databases. Notes: Beginning in September 2010, the ACA mandated that most insurers cover certain recommended preventive services. Many of these services are included in the "exam or evaluation" category shown in this chart. The requirement that most plans cover contraceptives went into effect in August 2012. Contraceptives are not included in this chart.
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.

- Office visits
- Diagnostic tests
- Drugs

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.
How Enrollees Judge the Value of Their Health Plans

Lower-Deductible Health Plans
- Excellent Value: 19%
- Good Value: 49%
- Only a Fair Value: 22%
- Poor Value: 9%

High-Deductible Health Plans
- Excellent Value: 32%
- Good Value: 30%
- Only a Fair Value: 28%
- Poor Value: 7%

Source: Kaiser Family Foundation
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
**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.

<table>
<thead>
<tr>
<th>Current Plans</th>
<th>V-BID Plans</th>
</tr>
</thead>
<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
Relative change for HEP members compared to enrollees in control states.
HEP Impact: 2 Year Results

Preventive Care Utilization

Lipid Screening

Mammography

% Using Service

Baseline | Year 1 | Year 2

HEP
Comparison

Baseline | Year 1 | Year 2

HEP
Comparison
HEP Impact: 2 Year Results

[3] Resource Use

ED Visits per 1,000 enrollees

Spending - Year 2

City overhauls health plans for municipal workers in shift toward preventive care

Changes to employees' co-pays will make primary care cheaper while ER visits and urgent care will be pricier
City overhauls health plans for municipal workers in shift toward preventive care

Changes to employees' co-pays will make primary care cheaper while ER visits and urgent care will be pricier.

“These changes will not only secure the promised health savings, but will also promote better utilization of health care resources and improved health outcomes for City employees”
Putting Innovation into Action
Selected Elements of NYC Plan Changes

GHI CBP plan
• ER copayment - Increased
• PCP and Mental Health Copayment – Unchanged
  – Lowered to $0 for preferred provider network
• Preventive Care Visits and Services - $0 (ACA)
• Urgent Care copayment – set between PCP and ER
• High cost imaging – Increased
• Diagnostic testing and physical therapy – Increased

HMO plan
• Increase copayment for non-preferred PCP
Selected Elements of NYC Plan Changes
Opportunities for “Clinical Nuance”

GHI CBP plan

- **ER copayment**
- **PCP and Mental Health copayment** – Unchanged
  - Lowered to $0 for preferred provider network
- **Preventive Care Visits and Services** - $0 (ACA)
- **Urgent Care copayment** – set between PCP and ER
- **High cost imaging**
- **Diagnostic testing and physical therapy**
- **Identifying and removing waste**
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>
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<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</td>
<td>• Mistakes, errors, preventable complications</td>
<td>$130 billion</td>
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<td>5.66%</td>
</tr>
<tr>
<td>Services</td>
<td>• Care fragmentation</td>
<td></td>
<td></td>
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<tr>
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<td>• Operational inefficiencies at care delivery sites</td>
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<td>Excess Admin Costs</td>
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<td>• Insurers’ administrative inefficiencies</td>
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<td>• Inefficiencies due to care documentation requirements</td>
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<td>Prices that are too high</td>
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<td>• Product prices beyond competitive benchmarks</td>
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<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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<td></td>
<td>• Secondary prevention</td>
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<td></td>
<td>• Tertiary prevention</td>
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</table>

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
<table>
<thead>
<tr>
<th>ID #</th>
<th>Waste Headline</th>
<th>Waste Mnemonic</th>
<th>ID #</th>
<th>Waste Headline</th>
<th>Waste Mnemonic</th>
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<tbody>
<tr>
<td>1</td>
<td>Antibiotics for Acute Rhinosinusitis</td>
<td>AI01b</td>
<td>16</td>
<td>Dexa</td>
<td>AFP03</td>
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<td>2</td>
<td>Coronary Artery Calcium Scoring for known CAD</td>
<td>SCCT01</td>
<td>17</td>
<td>Diagnostics Chronic Urticaria</td>
<td>AI03</td>
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<td>3</td>
<td>Headache Image</td>
<td>ACR01</td>
<td>18</td>
<td>Echocardiography as Routine Follow-Up</td>
<td>AC02</td>
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<td>4</td>
<td>Immunoglobulin G/ immunoglobulin E Testing</td>
<td>AI02</td>
<td>19</td>
<td>ED CT Scans For Dizziness</td>
<td>JH001</td>
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<td>5</td>
<td>Lower Back Pain Image</td>
<td>AFP02</td>
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<td>Electroencephalography (EEG) for Headaches</td>
<td>AN01</td>
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<td>6</td>
<td>PSA</td>
<td>URG01</td>
<td>21</td>
<td>Exercise Electrocardiogram</td>
<td>ACPY02</td>
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<td>7</td>
<td>Radiographic Imaging for Uncomplicated Acute Rhinosinusitis</td>
<td>AOHN04</td>
<td>22</td>
<td>Imaging of the Carotid Arteries for Simple Syncope</td>
<td>AN02</td>
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<td>8</td>
<td>Routine Annual Stress Testing</td>
<td>NMMI02</td>
<td>23</td>
<td>Neuroimaging in a Child with Simple Febrile Seizure</td>
<td>AP04</td>
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<td>9</td>
<td>* Sinus CT</td>
<td>AI01a</td>
<td>24</td>
<td>NSAID$s for Hypertension, Heart Failure, or CKD</td>
<td>SNP04</td>
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<tr>
<td>10</td>
<td>Stress Cardiac Imaging or Advanced Non-Invasive Imaging</td>
<td>AC01</td>
<td>25</td>
<td>Oral Antibiotics for Uncomplicated Acute External Otitis</td>
<td>AOHN03</td>
</tr>
<tr>
<td>11</td>
<td>AnnualEKGs or Cardiac Screening</td>
<td>AFP05</td>
<td>26</td>
<td>Pap Smear Hysterectomy</td>
<td>AFP04</td>
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<td>12</td>
<td>Antibiotics for Adenoviral Conjunctivitis</td>
<td>AO03</td>
<td>27</td>
<td>Pap Smear Under 21</td>
<td>AFP01</td>
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<td>13</td>
<td>Colonoscopy</td>
<td>GE01</td>
<td>28</td>
<td>Radionuclide Imaging</td>
<td>SNC01</td>
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<td>14</td>
<td>CT Head/Brain for Sudden Hearing Loss</td>
<td>AOHN01</td>
<td>29</td>
<td>Routine Pap in Women 30–65 Years of Age</td>
<td>COGY02</td>
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<td>15</td>
<td>CT Scans for Pediatric Headache</td>
<td>AAP06</td>
<td>30</td>
<td>Syncope Image</td>
<td>ACPY01</td>
</tr>
</tbody>
</table>
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
## Top 5 Measures by Cost Overall - 2014

<table>
<thead>
<tr>
<th>Measure</th>
<th>Total Services Measured</th>
<th>Waste Index (%)</th>
<th>Unnecessary Services (#)</th>
<th>Unnecessary Spending ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline laboratory studies in patients without systemic disease undergoing low-risk surgery</td>
<td>571,600</td>
<td>79%</td>
<td>453,447</td>
<td>$184,781,018</td>
</tr>
<tr>
<td>Stress cardiac or advanced non-invasive imaging in the initial evaluation of patients w/o symptoms</td>
<td>219,878</td>
<td>13%</td>
<td>27,817</td>
<td>$185,997,938</td>
</tr>
<tr>
<td>Annual electrocardiograms (EKGs) or other cardiac screening for low-risk patients without symptoms.</td>
<td>2,268,194</td>
<td>6%</td>
<td>147,423</td>
<td>$60,499,385</td>
</tr>
<tr>
<td>Routine annual cervical cytology screening (Pap tests) in women 21–65 years of age</td>
<td>199,865</td>
<td>81%</td>
<td>161,539</td>
<td>$37,558,706</td>
</tr>
<tr>
<td>PSA-based screening for prostate cancer in all men regardless of age.</td>
<td>313,011</td>
<td>42%</td>
<td>132,793</td>
<td>$31,501,675</td>
</tr>
</tbody>
</table>

*Certain measure had a waste index of 100%*
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
Aligning Payer and Consumer Incentives: As Easy as Peanut Butter and Jelly

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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