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

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#VBID
• 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
• 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.

• We also much bring attention to how we can alter consumer behavior to bring about a more effective and efficient system.

• Consumer cost sharing is a common and important policy lever.
Deductibles on the rise
Percentage of covered workers with an annual deductible of $1,000 or more for single coverage

Source: Kaiser Family Foundation and Health Research and Educational Trust
• Outside of Michigan, cost sharing is implemented in a “one size fits all way” that fails to acknowledge the differences in clinical value among medical interventions

• When low cost-sharing is applied to all services, this can lead to overuse or misuse of services that are harmful or provide little clinical value

• However, 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
“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)
Impact of Cost-Sharing on Health Care Disparities

Effects of Increased Patient Cost Sharing on Socioeconomic Disparities in Health Care

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• Rising copayments worsen disparities and adversely affect health, particularly among economically vulnerable individuals and those with chronic conditions

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.

• There is a need for a smarter cost-sharing approach that encourages consumers to use more high value services and providers, but discourages the use of low value ones.
It is counter-intuitive to impose high levels of cost-sharing on those services that are identified as health plan quality measures.

Thus, instead of imposing blunt, price-driven cost-sharing increases on all services, consider high cost sharing on only those services that do not make Michiganders healthier.
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
A clinical service is never always high or low value.

What benefits one person...

...Can harm another

HIGH-VALUE

LOW-VALUE
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

Poor Performance

Certified

Poor

Average

Excellent
Clinical benefit depends on **where** care is provided.

- **Ambulatory Care Center**
  - Cost: $

- **Hospital**
  - Cost: $$$$

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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: 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

Lewin. JAMA. 2013;310(16):1669-1670
Putting Innovation into Action: Translating Research into Policy

- Patient Protection and Affordable Care Act
- Medicare
- HSA-qualified HDHPs
- High Cost Drugs
- 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
- High Cost Drugs
- 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**
• High Cost Drugs
• 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.
Bipartisan legislation amends IRS Code to allow HDHPs the flexibility to provide coverage for services that manage chronic disease prior to meeting the plan deductible.
Putting Innovation into Action: Translating Research into Policy

- Patient Protection and Affordable Care Act
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Motivation for "Dynamic" Benefit Design

- The natural history of chronic conditions often necessitate multiple therapies to achieve desired clinical outcomes
- Health plans frequently require certain steps be performed before access to additional therapies
- Increasing out-of-pocket costs for alternative therapies may prevent consumers from accessing recommended treatment

RIGHT DRUG. RIGHT PERSON. RIGHT TIME. RIGHT PRICE.
REWARD THE GOOD SOLDIER

RIGHT DRUG. RIGHT PERSON. RIGHT TIME. RIGHT PRICE.

A benefit design that lowers consumer cost-sharing for those who diligently follow the required steps for their condition, but require an alternative option.
Reward the Good Soldier™
A Dynamic Approach to Consumer Cost-sharing

- Commitment to established policies that encourage lower cost, first-line therapies
- Acknowledgment that clinical scenarios may require multiple treatment options
- Reduces cost-related non-adherence
- Enhances access to effective therapies when clinically appropriate

RIGHT DRUG. RIGHT PERSON. RIGHT TIME. RIGHT PRICE.
Putting Innovation into Action: Translating Research into Policy

• Patient Protection and Affordable Care Act
• Medicare
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• High Cost Drugs
• State Health Reform
Getting to Health Care Value
V-BID Role in State Health Reform

• Medicaid – Healthy Michigan Plan
• State Exchanges – Encourage V-BID (CA, MD)
• State Innovation Models – NY, PA, CT, VA
• State Employee Benefit Plans
V-BID Principles Included in the 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.
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
• Medicaid – Healthy Michigan Plan
• State Exchanges – Encourage V-BID (CA, MD)
• 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
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

[2] Preventive Care Utilization

**Lipid Screening**
- **Baseline**: 50
- **Year 1**: 70
- **Year 2**: 90

**Mammography**
- **Baseline**: 25
- **Year 1**: 45
- **Year 2**: 65

- **HEP**
- **Comparison**
HEP Impact: 2 Year Results

[3] Resource Use

ED Visits per 1,000 enrollees

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>Year 1</th>
<th>Year 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comparison</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Spending - Year 2

<table>
<thead>
<tr>
<th></th>
<th>Full Sample</th>
<th>Chronic Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>US Dollars ($)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Our Health Care Spending

$2.6 TRILLION

$765 BILLION

$340 BILLION

WASTE
Excess Administration, Fraud, & Low-Value Care

TOTAL
Hospitals, Clinical Services, Insurance, Equipment, Drugs

LOW-VALUE CARE
We spend $340 billion a year on services that don't make us healthier. These services are unnecessary, inefficient, or both.

Source: "Best Care at Lower Cost: The Path to Continuously Learning Health Care in America." Institute of Medicine (2013)
Identifying and Removing Waste

• 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.

• Unlike delay for cost offsets from improved quality, savings from waste elimination are immediate and substantial.
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
20% of members exposed to 1+ wasteful service

2.4% or $11.94 PMPM wasted
# Removing Low Value Care:
## Sample Results Large Payer - Top 5 Measures

<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>
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
- HighPerforming Networks
- Health Information Technology
Unfortunately, some “demand-side” initiatives – including consumer cost sharing - discourage consumers from pursuing the “Triple Aim”
Impact of Aligning Physicians and Patients: Financial Incentives to Lower Cholesterol

Source: *JAMA. 2015;314(18):1926-1935*
Aligning Payer and Consumer Incentives: As Easy as PB & J

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.
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