



SCHOOL OF PUBLIC HEALTH

CENTER FOR VALUE-BASED INSURANCE DESIGN

UNIVERSITY OF MICHIGAN

**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**

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#VBID



Table 1: Risk factors for nodding off at lectures

Factor	Odds ratio (and 95% CI)
Environmental	
Dim lighting	1.6 (0.8–2.5)
Warm room temperature	1.4 (0.9–1.6)
Comfortable seating	1.0 (0.7–1.3)
Audiovisual	
Poor slides	1.8 (1.3–2.0)
Failure to speak into microphone	1.7 (1.3–2.1)
Circadian	
Early morning	1.3 (0.9–1.8)
Post prandial	1.7 (0.9–2.3)
Speaker-related	
Monotonous tone	6.8 (5.4–8.0)
Tweed jacket	2.1 (1.7–3.0)
Losing place in lecture	2.0 (1.5–2.6)

Note: CI = confidence interval.

Getting to Health Care Value

Shifting the discussion from “How much” to “How well”

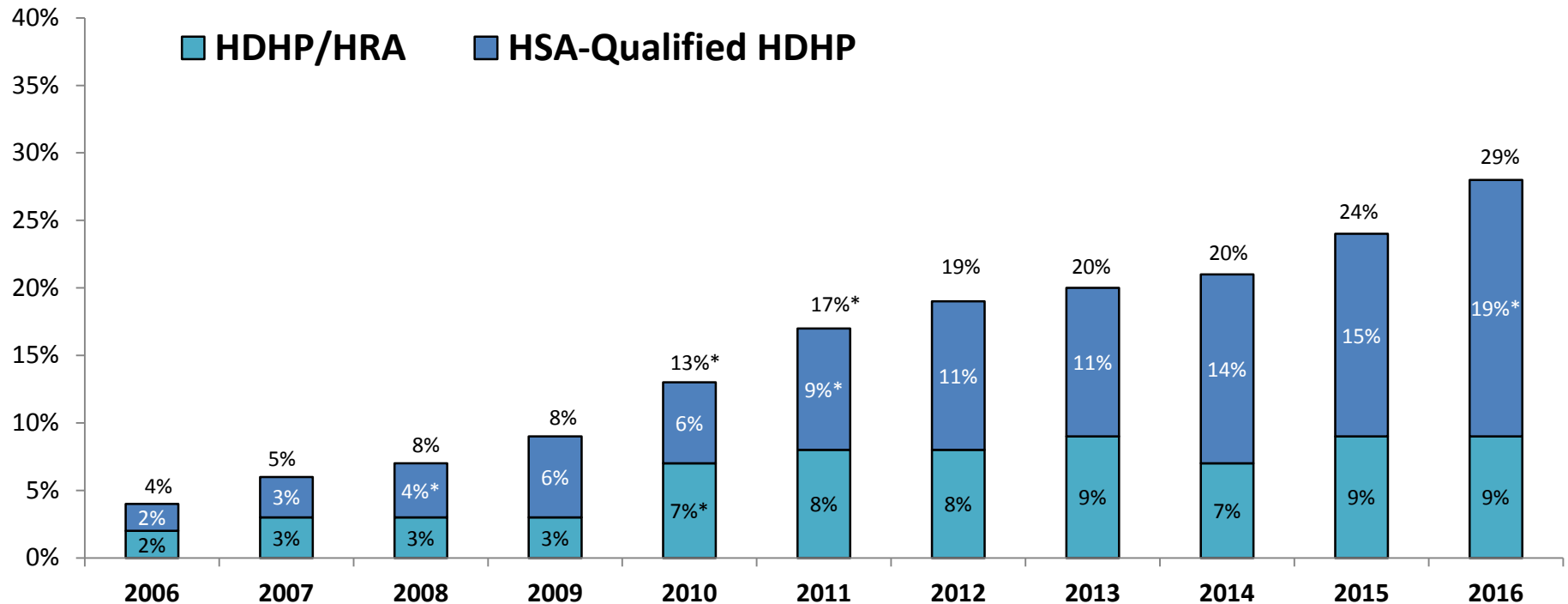
- **Innovations to prevent and treat disease have led to impressive reductions in morbidity and mortality**
- **Regardless of these advances, cost growth is the principle focus of health care reform discussions**
- **Despite unequivocal evidence of clinical benefit, substantial underutilization of high-value 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

Shifting the discussion from “How much” to “How well”

- **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**

Percentage of Covered Workers Enrolled in an HDHP/HRA or an HSA-Qualified HDHP, 2006-2016



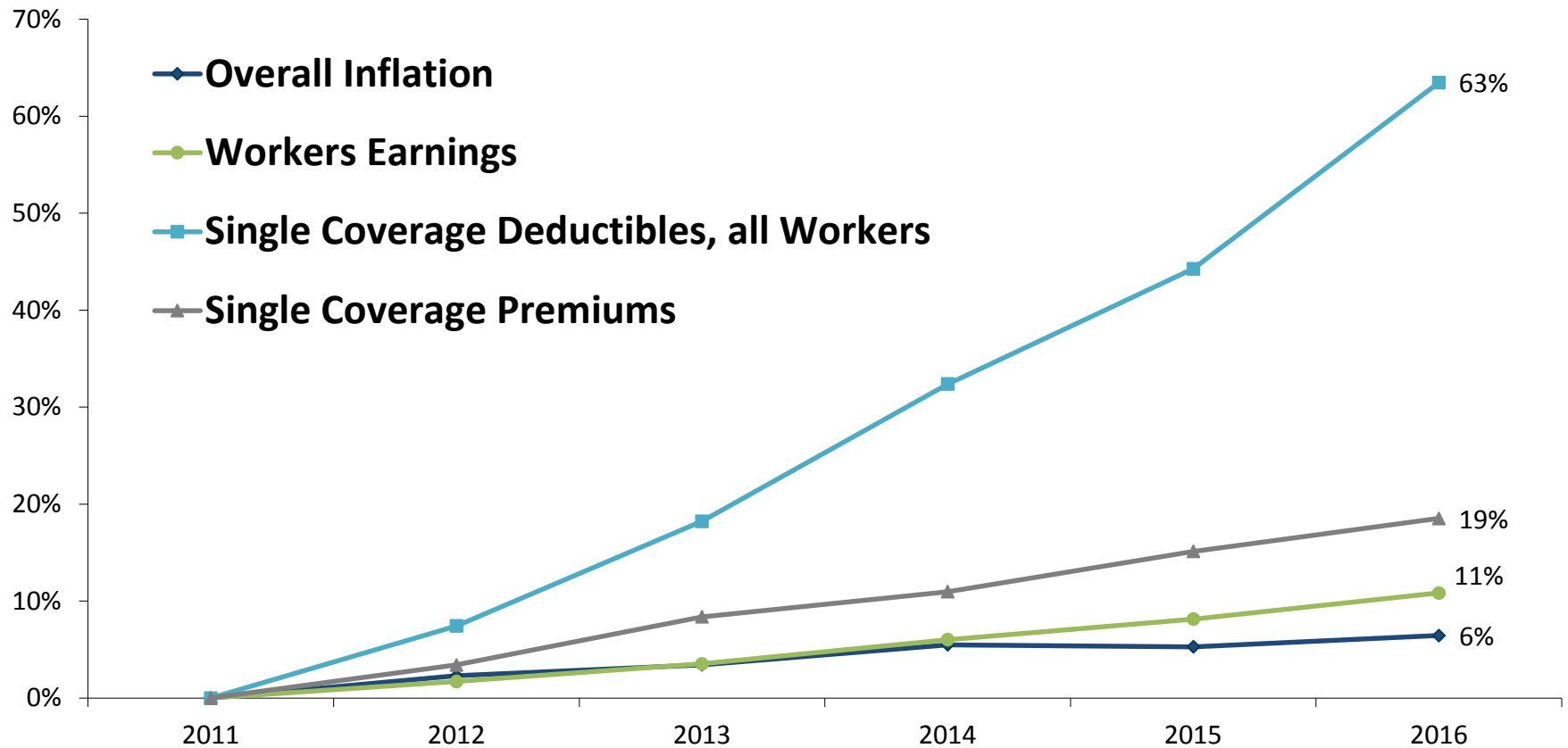
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).

NOTE: Covered Workers enrolled in an HDHP/SO are enrolled in either an HDHP/HRA or a HSA-Qualified HDHP. For more information, see the Survey Methodology Section. The percentages of covered workers enrolled in an HDHP/SO may not equal the sum of HDHP/HRA and HSA-Qualified HDHP enrollment estimates due to rounding.

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2016.



Increases in Health Insurance Premiums, General Annual Deductibles, Inflation, and Workers' Earnings, 2011-2016



NOTE: Average general annual deductible is among all covered workers. Workers in plans without a general annual deductible for in-network services are assigned a value of zero.

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2011-2016. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 2011-2016; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 2011-2016 (April to April).



Pathway to Better Health and Lower Costs Inspiration

“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

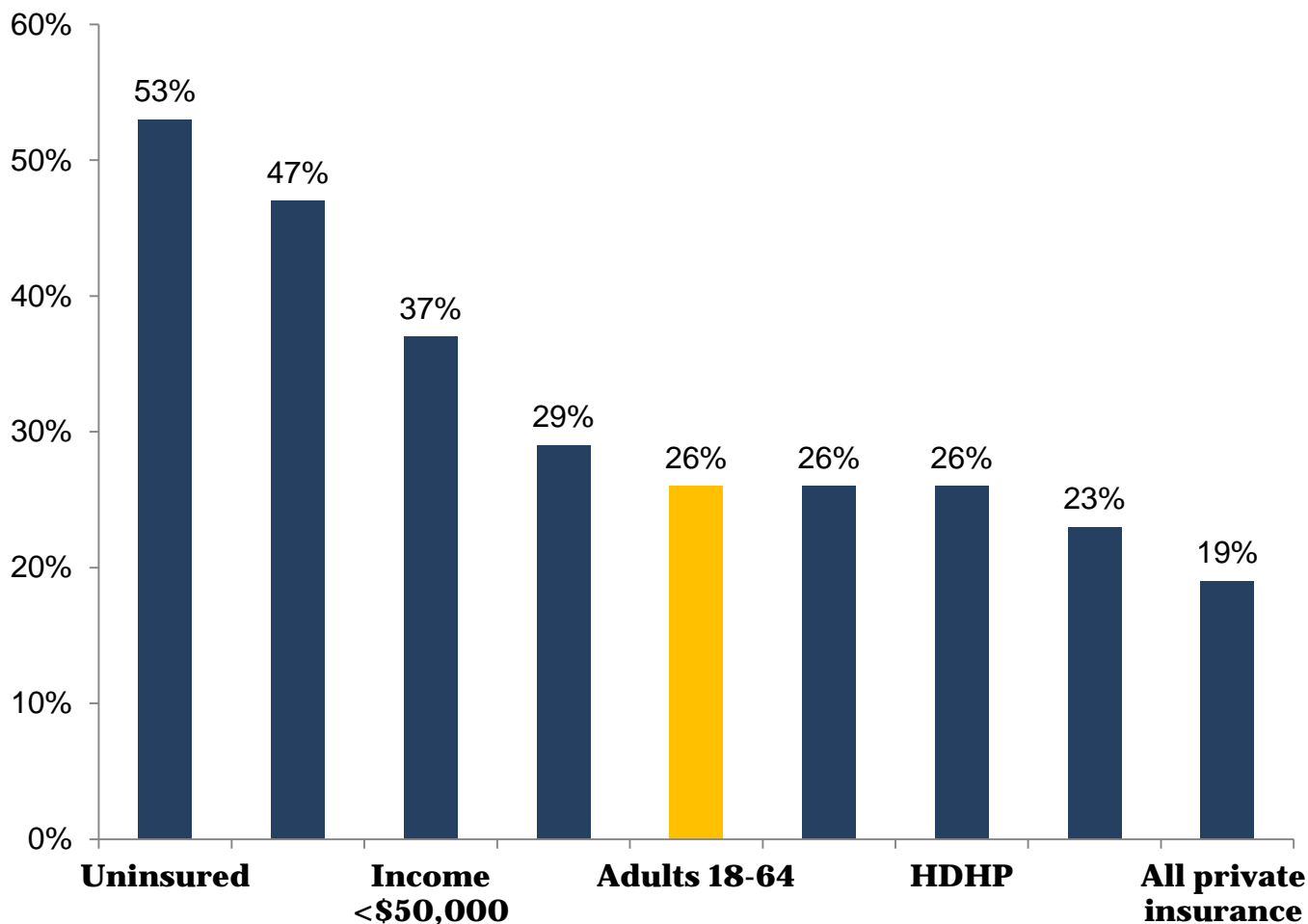
Effects of Increased Patient Cost Sharing on Socioeconomic Disparities in Health Care

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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**

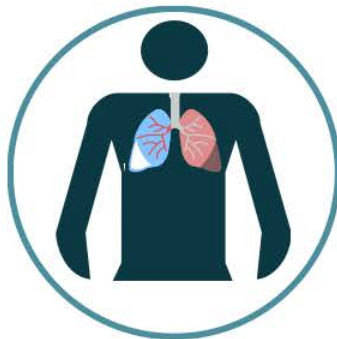
Understanding CLINICAL NUANCE

#1

Clinical Services Differ
in the Benefit Produced



Office
Visits



Diagnostic
Tests



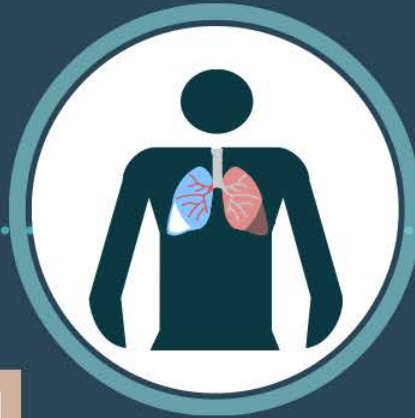
Prescription
Drugs

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



#2

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**



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



Ambulatory Care Center



\$

Hospital



\$\$\$

Clinical Nuance: Key Takeaway



What benefits one person...



...may harm another

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**

WSJ.com THE WALL STREET JOURNAL ONLINE
June 16, 2004

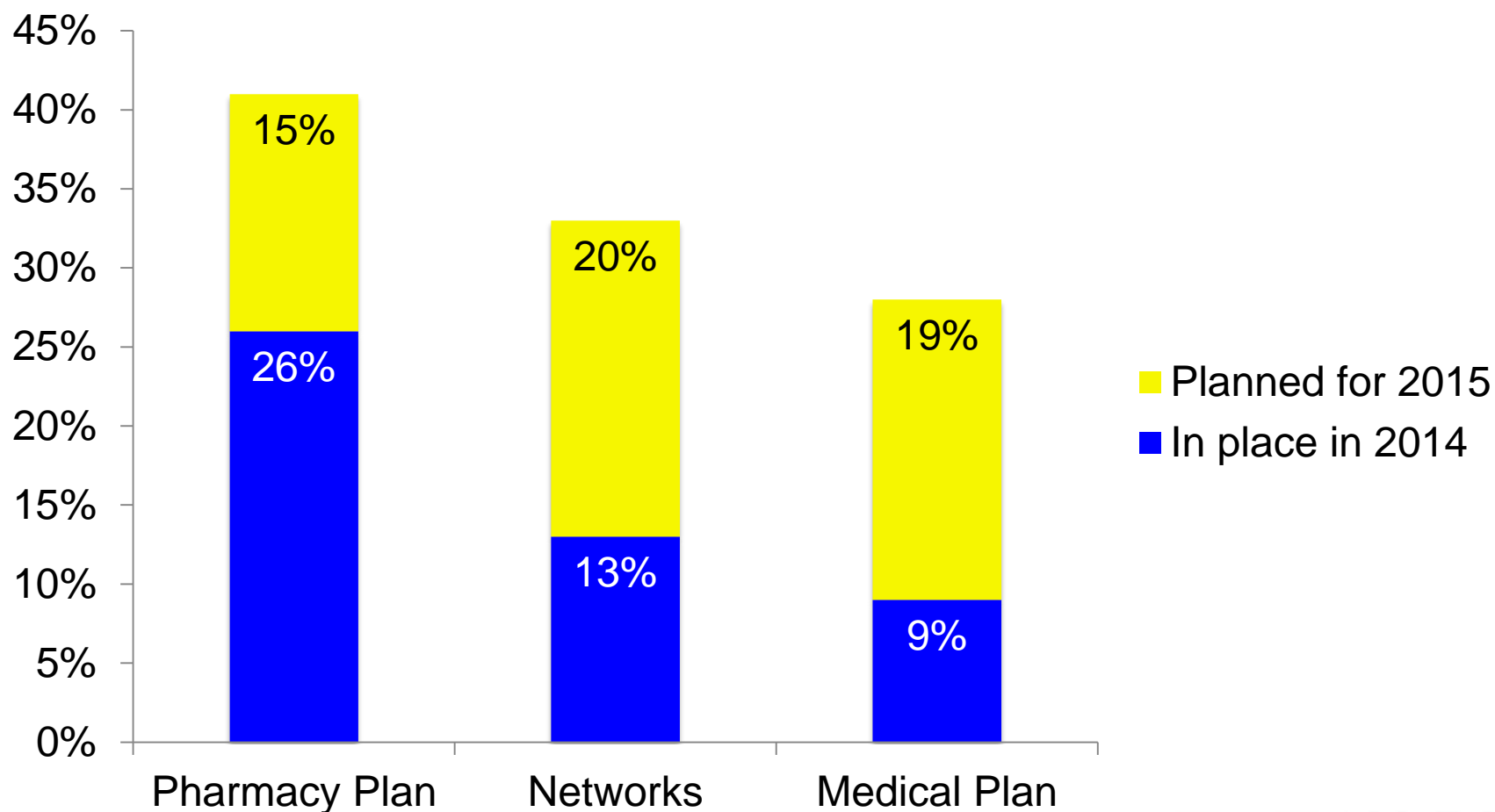
FOLLOW THE MONEY

From 'One Size Fits All' To Tailored Co-Payments

June 16, 2004

University of Michigan researchers say a patient drug should depend on how much he or she will a move that would likely lower c

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



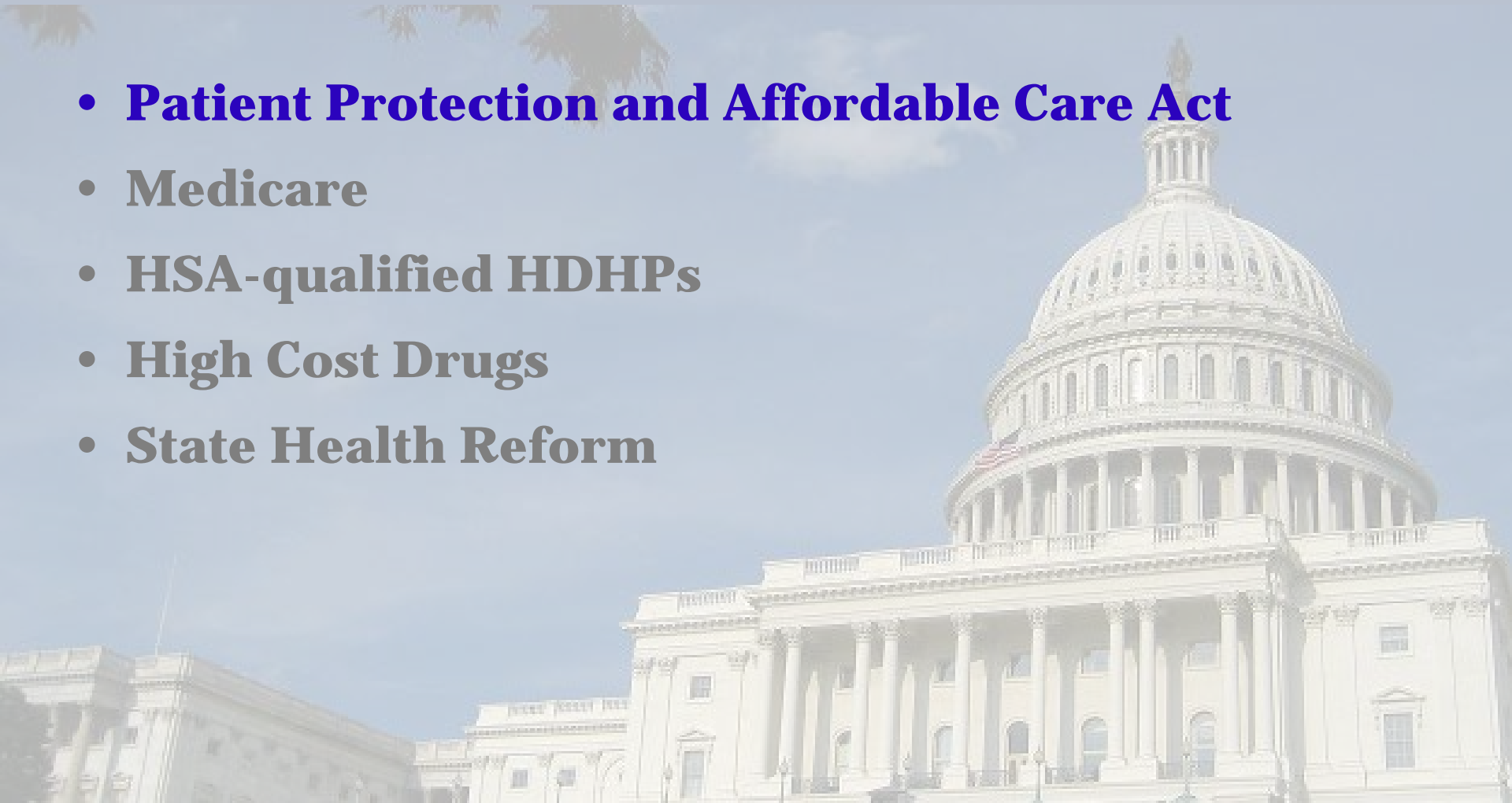
Putting Innovation into Action

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**

Putting Innovation into Action: Translating Research into Policy

- **Patient Protection and Affordable Care Act**
- **Medicare**
- **HSA-qualified HDHPs**
- **High Cost Drugs**
- **State Health Reform**



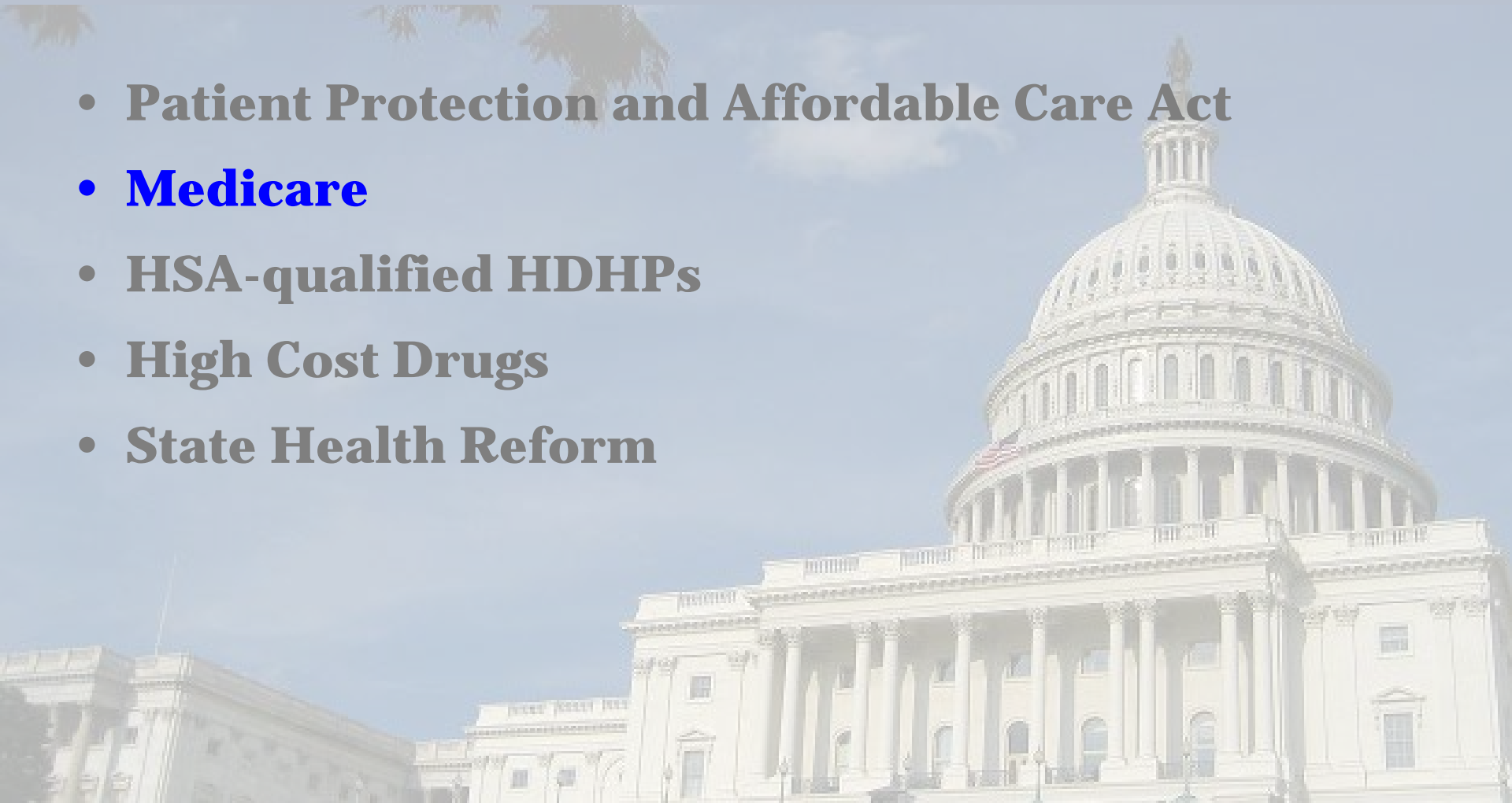
ACA Sec 2713: Selected Preventive Services be Provided without Cost-Sharing

- **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
- High Cost Drugs
- State Health Reform



Translating Research into Policy: Implementing V-BID in Medicare

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**

HR 2570: Strengthening Medicare Advantage Through Innovation and Transparency

114TH CONGRESS
1ST SESSION

H. R. 2570

IN THE SENATE OF THE UNITED STATES

JUNE 18, 2015

Received; read twice and referred to the Committee on Finance

AN ACT

To amend title XVIII of the Social Security Act with respect to the treatment of patient encounters in ambulatory surgical centers in determining meaningful EHR use, establish a demonstration program requiring the utilization of Value-Based Insurance Design to demonstrate that reducing the copayments or coinsurance charged to Medicare beneficiaries for selected high-value prescription medications and clinical services can increase their utilization and ultimately improve clinical outcomes and lower health care expenditures, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the “Strengthening Medicare Advantage through Innovation and Transparency for Seniors Act of 2015”.

SEC. 2. TREATMENT OF PATIENT ENCOUNTERS IN AMBULATORY SURGICAL CENTERS IN DETERMINING MEANINGFUL EHR USE.



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

Incorporating Value-Based Insurance Design to Improve Chronic Disease Management in the Medicare Advantage Program

Actuarial modeling estimated the financial impact of V-BID on consumer, plan, and societal costs for three common conditions: diabetes mellitus (DM), chronic obstructive pulmonary disease (COPD), and congestive heart failure (CHF)

- **Consumer out-of-pocket costs fell for 3 conditions**
- **Plan costs increased slightly for DM and COPD; savings resulted to the plan for CHF**
- **Societal perspective, the DM program was close to cost neutral; net savings resulted in the COPD and CHF programs**



CMS Expands Medicare Advantage Value-Based Insurance Design Model Test

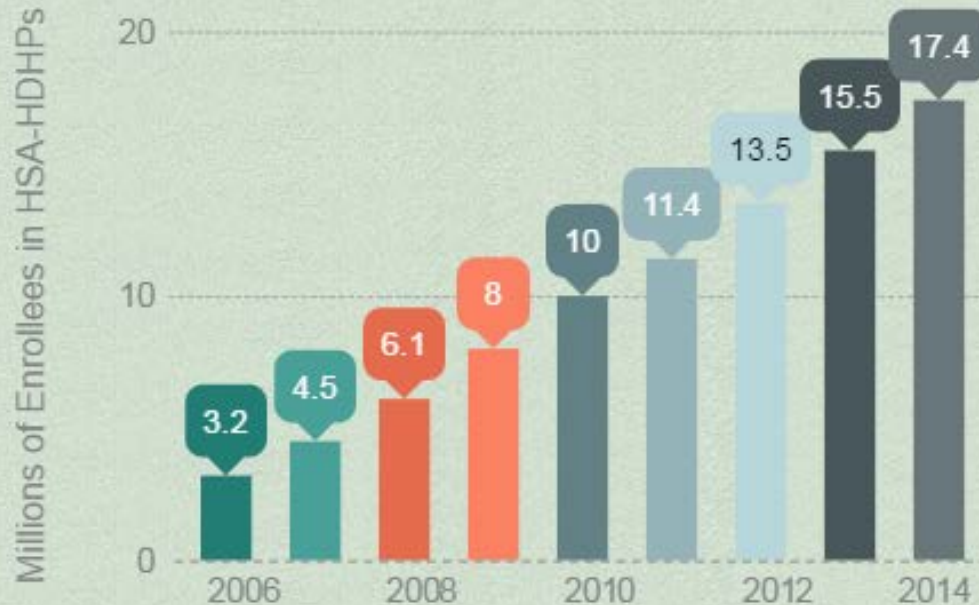
- Diabetes
- Congestive Heart Failure
- COPD
- Past Stroke
- Hypertension
- Coronary Artery Disease
- Mood Disorders
- Dementia
- Rheumatoid Arthritis



Putting Innovation into Action: Translating Research into Policy

- 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 2015**

individual: \$5,000 to \$6,450

family: \$10,000 to \$12,900

http://www.ahipcoverage.com/wp-content/uploads/2013/06/HSAinfographic_V9_FV.jpg

<http://kff.org/report-section/ehbs-2015-section-eight-high-deductible-health-plans-with-savings-option/>

<http://www.irs.gov/pub/irs-drop/n-04-2.pdf>

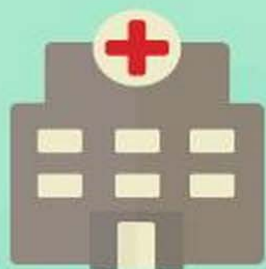
***IRS Safe Harbor Guidance allows zero
consumer cost-sharing for specific
preventive services***

INCLUDING:

- ✓ periodic health evaluations/screenings
- ✓ routine prenatal and well-child care
- ✓ child and adult immunizations
- ✓ tobacco cessation programs
- ✓ obesity weight-loss programs

www.irs.gov/pub/irs-drop/n-04-23.pdf

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

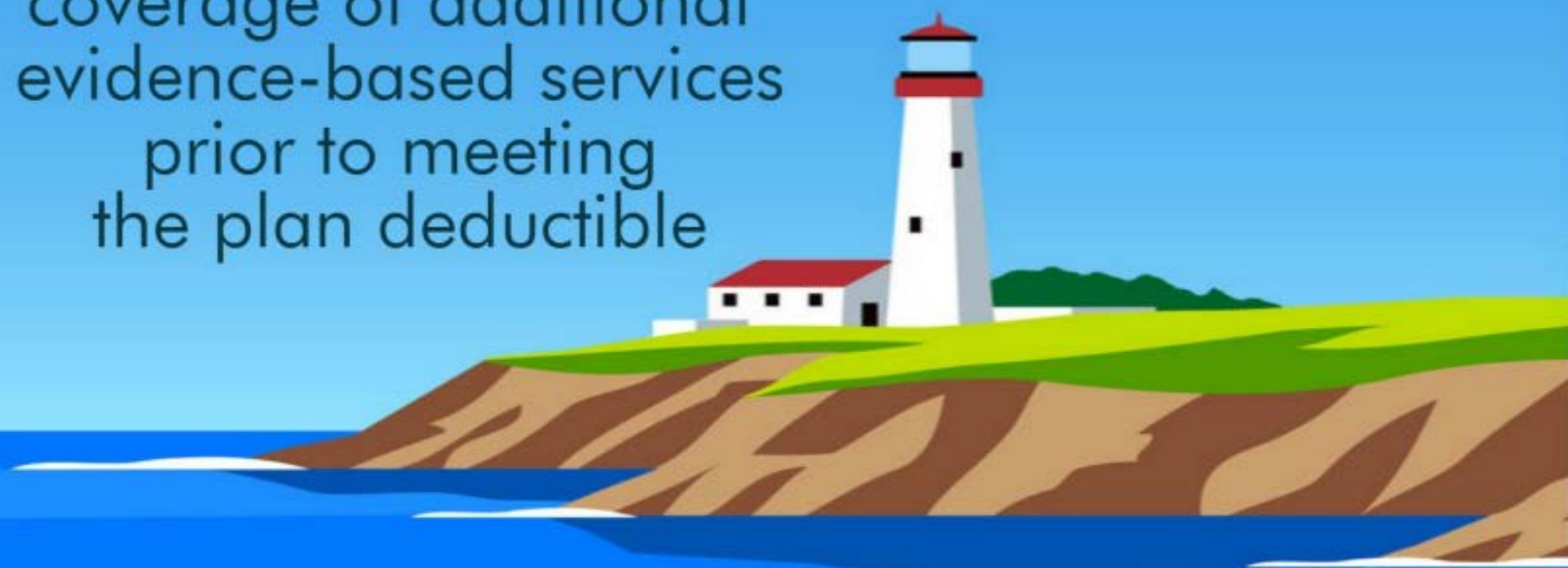


drugs

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

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



H.R. 5652: "Access to Better Care" Act

114TH CONGRESS
2^D SESSION

H. R. _____

To amend the Internal Revenue Code of 1986 to provide for coverage by high deductible health plans of medical management of a chronic disease without deductible.

IN THE HOUSE OF REPRESENTATIVES

Mrs. BLACK (for herself and Mr. BLUMENAUER) introduced the following bill; which was referred to the Committee on _____

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
- Medicare
- HSA-qualified HDHPs
- **High Cost Drugs**
- State Health Reform

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



[VIEW NEW WHITEBOARD VIDEO »](#)

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**
- **HSA-qualified HDHPs**
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- **State Health Reform**



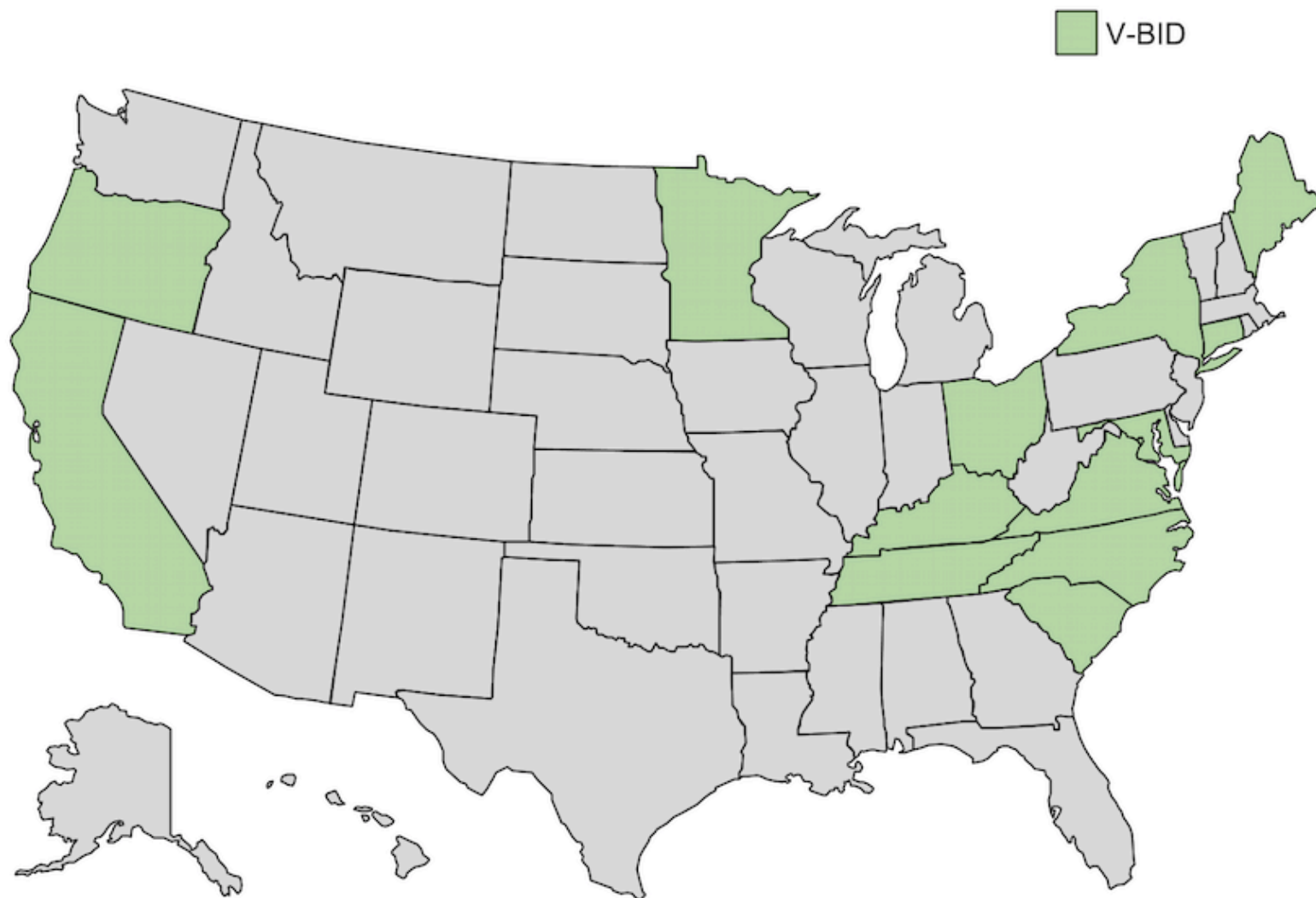
Getting to Health Care Value

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**

Value-Based Insurance Design

Growing Role in State Employee Plans



ENGAGING PATIENTS ON PRICE & QUALITY

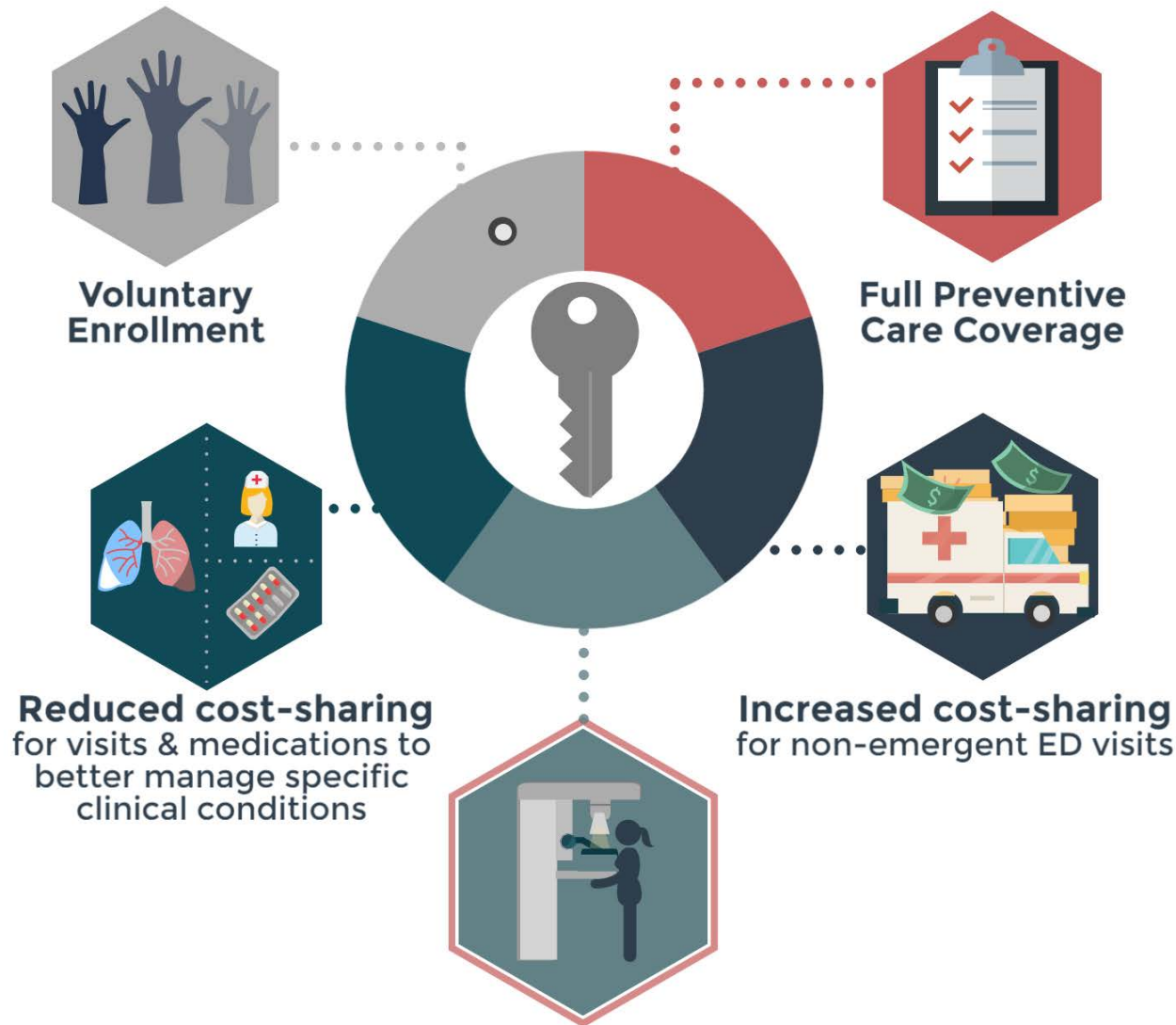
By Richard A. Hirth, Elizabeth Q. Cliff, Teresa B. Gibson, M. Richard McKellar, and A. Mark Fendrick

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

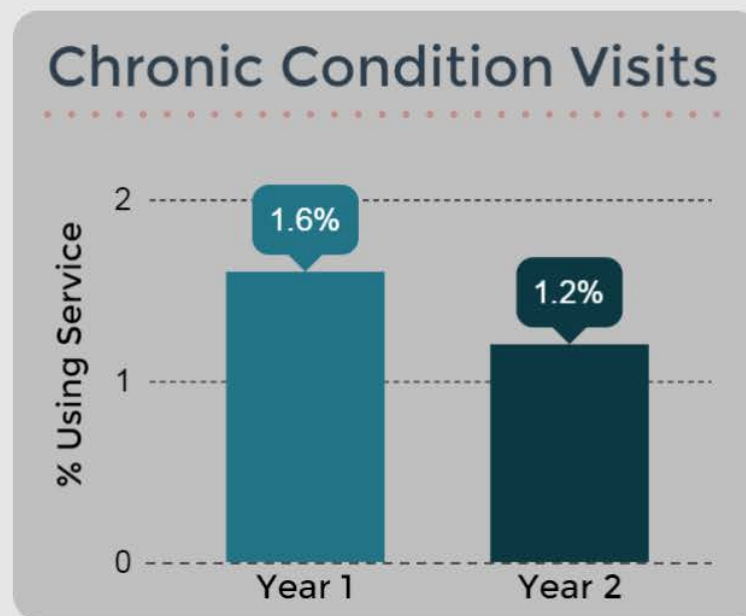
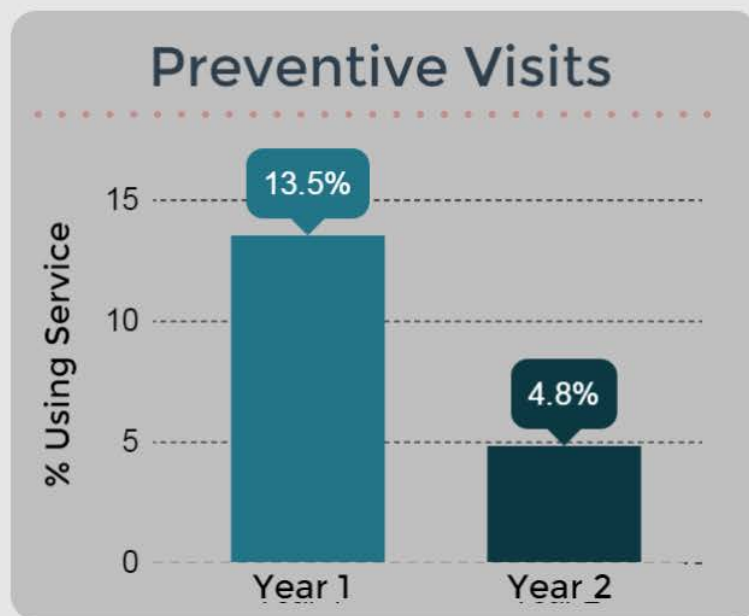


Participatory Requirement:

to maintain enrollment, members must complete age-appropriate preventive care & recommended chronic disease services

HEP Impact: 2 Year Results

[1] Office Visit Increases

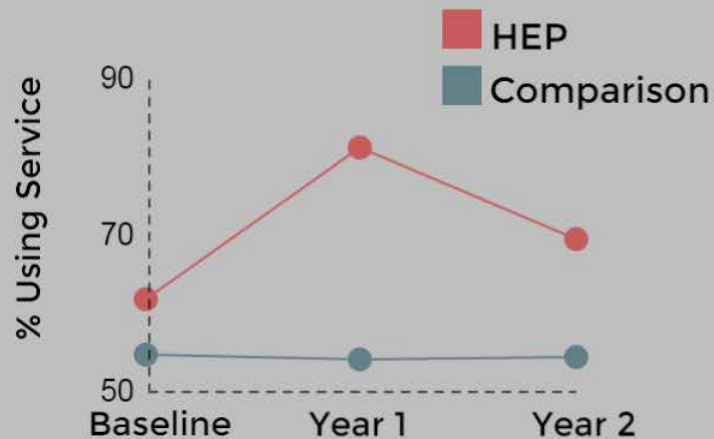


Relative change for HEP members compared to enrollees in control states

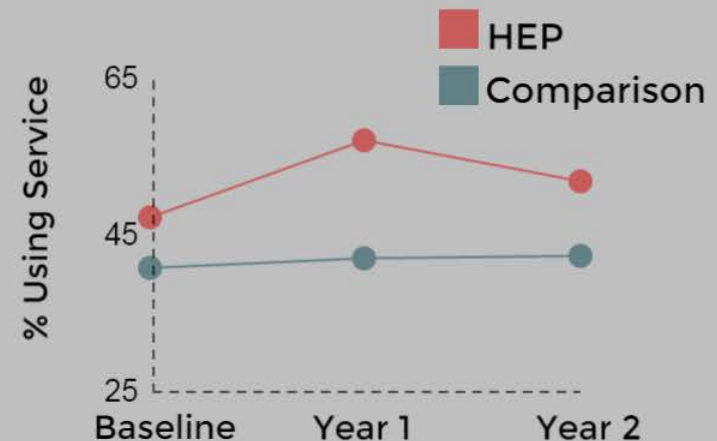
HEP Impact: 2 Year Results

[2] Preventive Care Utilization

Lipid Screening

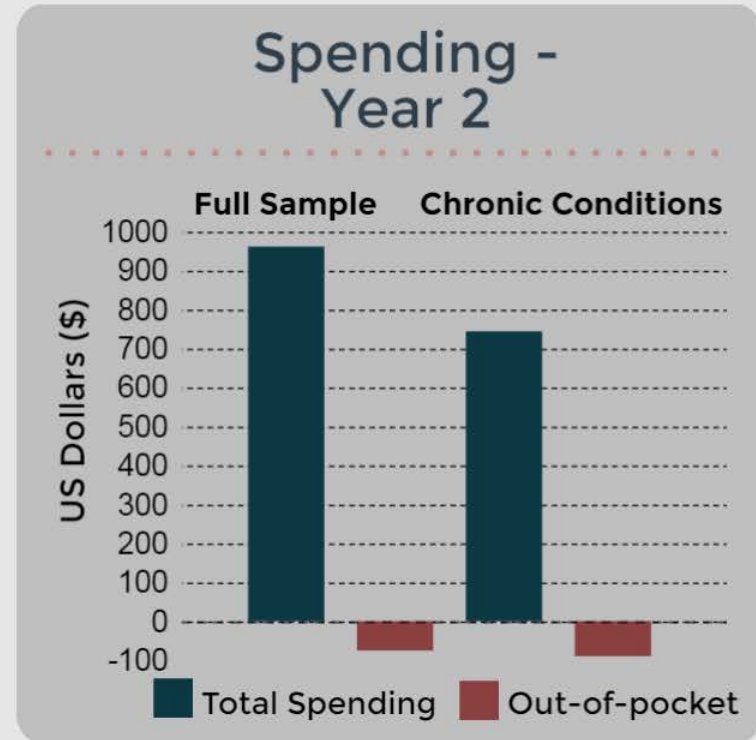
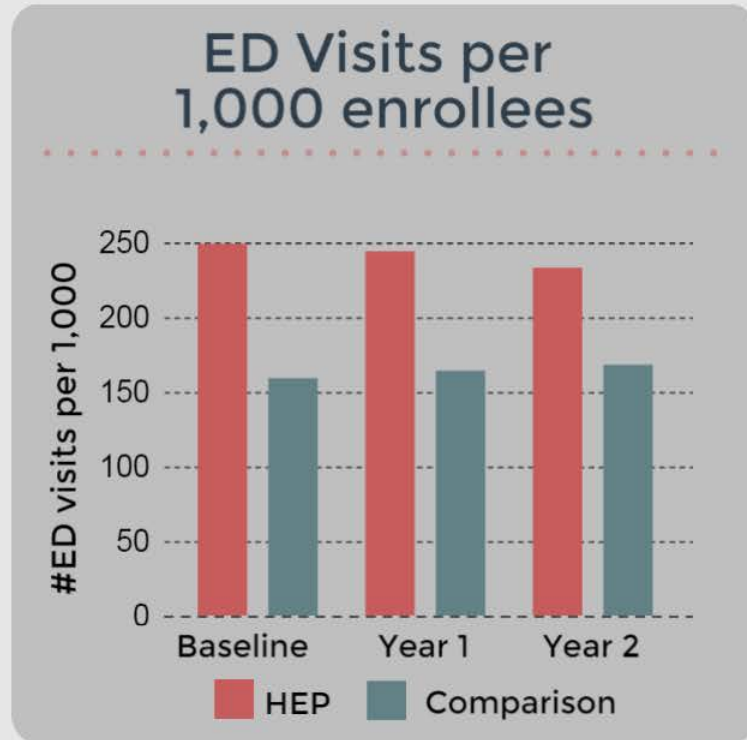


Mammography



HEP Impact: 2 Year Results

[3] Resource Use



Health Affairs. 2016;35(4):637-46.

Getting to Health Care Value

Smarter Cost-Sharing

- **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 people healthier****

Our Health Care Spending

TOTAL

Hospitals,
Clinical Services,
Insurance,
Equipment,
Drugs

\$2.6 TRILLION

\$765 BILLION

\$340 BILLION

WASTE

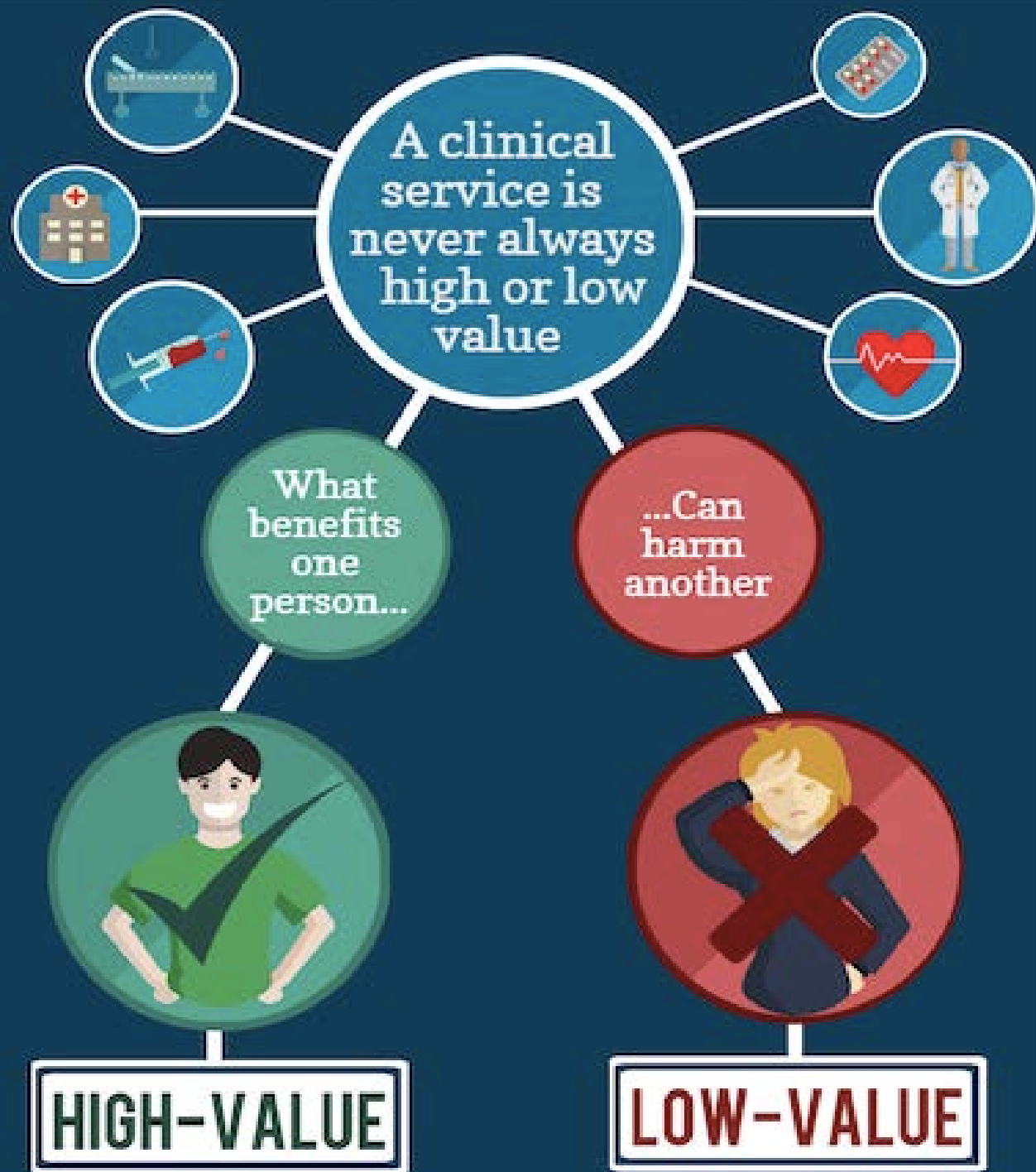
Excess
Administration,
Fraud, & Low-
Value Care

LOW-VALUE CARE

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

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****
- **Identification, measurement, and removal of low-value care has proven challenging**



Who benefits from a 'clinically nuanced' approach to measure, identify, and reduce **low-value care**?



CONSUMERS



Reduces harm



Expands coverage for high-value care

PAYERS



Promotes efficient expenditures



Reduces wasteful spending

PROVIDERS



Enhances patient-centered outcomes



Improves quality of care

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**

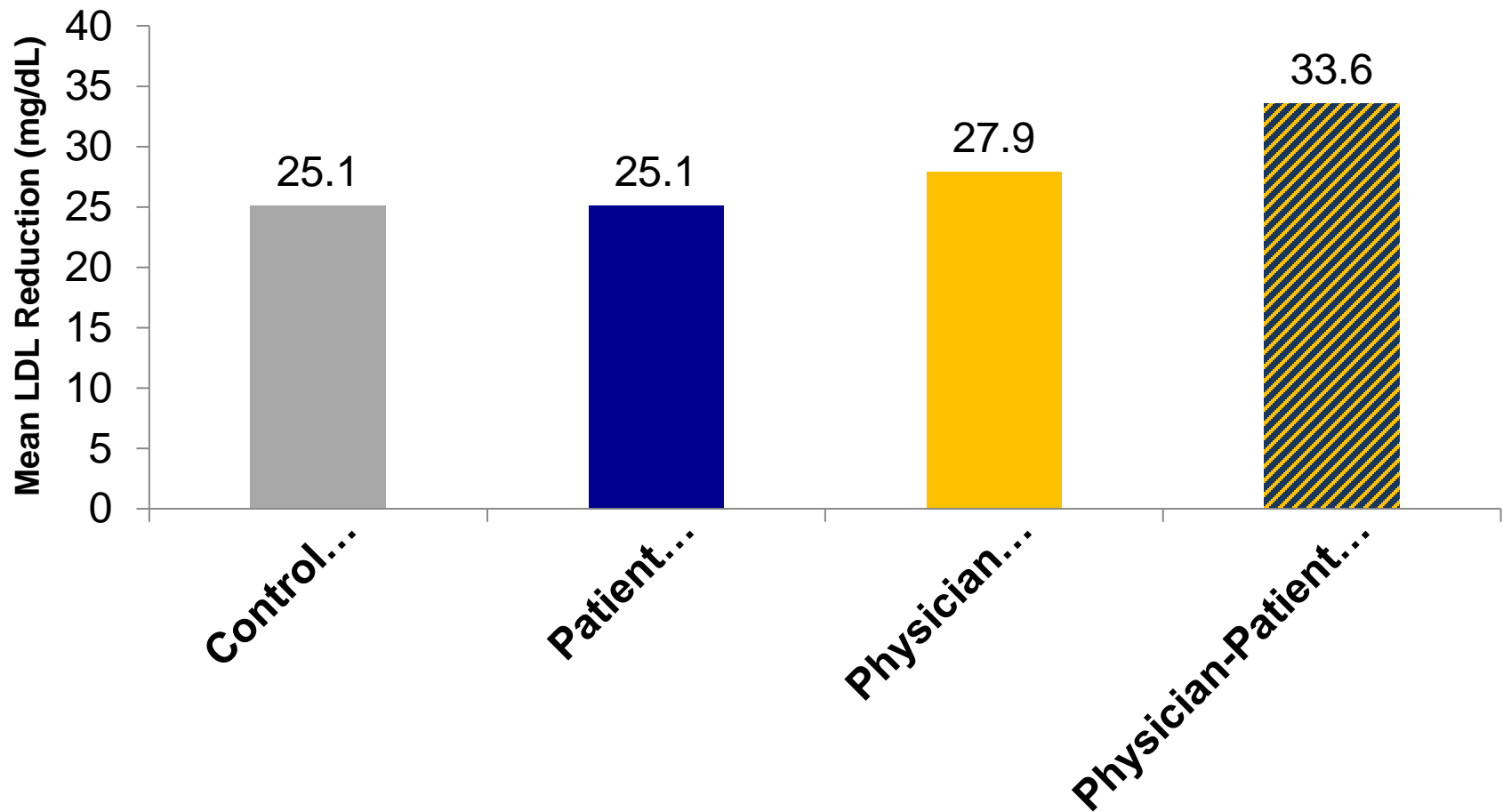


Aligning Payer and Consumer Incentives: As Easy as Peanut Butter and Jelly

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



Discussion

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