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

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@um_vbid
#VBID
<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.
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.
• 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.
* 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.

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.

“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)
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

Uninsured: 53%
Income <$50,000: 47%
Adults 18-64: 37%
HDHP: 29%
All private insurance: 26%

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.

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

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**  

#2
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**
  - Certified
  - Checkboxes for Poor, Average, Excellent

- **Poor Performance**
  - Checkmark for Poor
Clinical benefit depends on where care is provided.

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

[Diagram showing the comparison between Ambulatory Care Center and Hospital with corresponding cost tags]
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
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
• **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*
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

Map of the United States showing states with the expansion: 2017 in red, 2018 in blue.
• 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


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

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.
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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- 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
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
HEP Impact: 2 Year Results

[1] Office Visit Increases

Preventive Visits

<table>
<thead>
<tr>
<th>Year</th>
<th>% Using Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>13.5%</td>
</tr>
<tr>
<td>Year 2</td>
<td>4.8%</td>
</tr>
</tbody>
</table>

Chronic Condition Visits

<table>
<thead>
<tr>
<th>Year</th>
<th>% Using Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>1.6%</td>
</tr>
<tr>
<td>Year 2</td>
<td>1.2%</td>
</tr>
</tbody>
</table>

Relative change for HEP members compared to enrollees in control states

HealthAffairs
HEP Impact: 2 Year Results

[2] Preventive Care Utilization

Lipid Screening

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

Mammography

- % Using Service
  - Baseline: 25
  - Year 1: 45
  - Year 2: 65

[Image: M V-BID]
HEP Impact: 2 Year Results

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>250</td>
<td>220</td>
<td>200</td>
</tr>
<tr>
<td>Comparison</td>
<td>180</td>
<td>155</td>
<td>130</td>
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</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>Total Spending</td>
<td>Out-of-pocket</td>
</tr>
<tr>
<td></td>
<td>1000</td>
<td>900</td>
</tr>
</tbody>
</table>

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

$2.6 TRILLION

TOTAL
Hospitals, Clinical Services, Insurance, Equipment, Drugs

$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.

Source: "Best Care at Lower Cost: The Path to Continuously Learning Health Care in America." Institute of Medicine (2013)
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.
A clinical service is never always high or low value

What benefits one person...

...can harm another

HIGH-VALUE

LOW-VALUE
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

M | V-BID
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

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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