SCHOOL OF PUBLIC HEALTH
CENTER FOR VALUE-BASED INSURANCE DESIGN
UNIVERSITY OF MICHIGAN

Value-Based Insurance Design

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#VBID

Outline

- Impact of Consumer Cost-sharing
- Clinical Nuance
- Value-Based Insurance Design
- Translating Research into Policy
- Addressing Unnecessary Care
- Aligning Provider and Consumer Incentives

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Making Health Care Great (Again ;)

- **Innovations to prevent and treat disease have led to impressive reductions in morbidity and mortality**
- **Irrespective of these advances, cutting health care spending growth is a focus of reform discussions**
- **Underutilization of high-value services persists across the entire spectrum of clinical care**
- **Our ability to deliver high-quality health care lags behind the rapid pace of scientific innovation**

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Star Wars Science

Flintstones Delivery

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 deliberations is on alternative payment and pricing models
- Consumer engagement is an essential and important lever to enhance efficiency
- Consumer cost-sharing is a common and important policy lever

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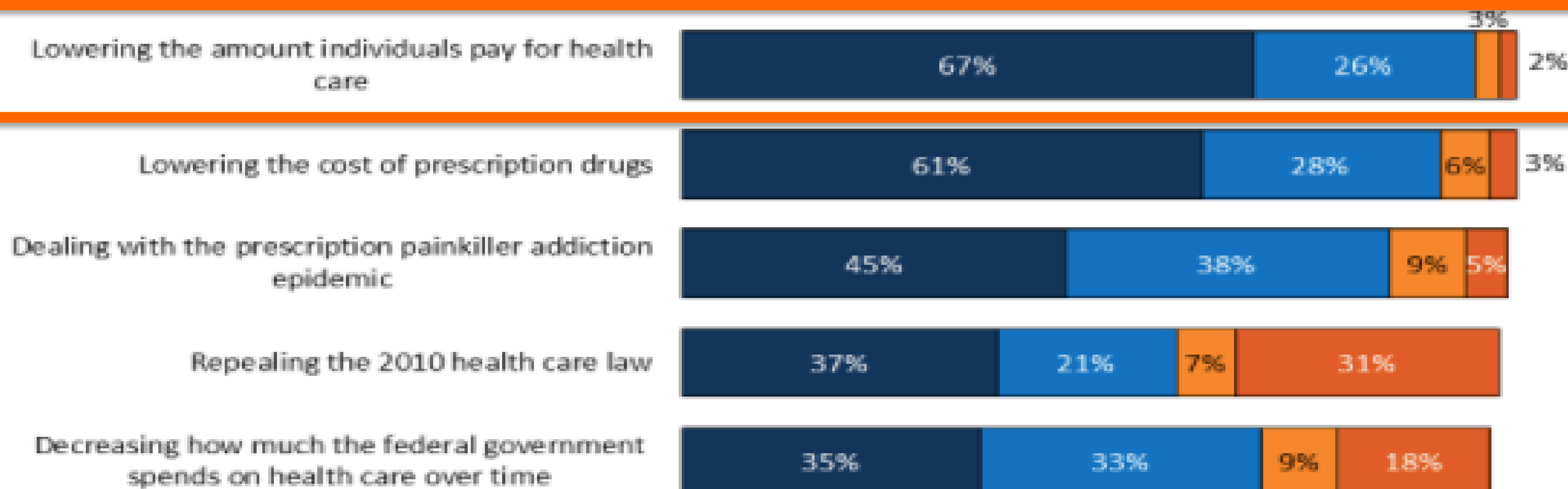
Americans Do Not Care About Health Care Costs; They Care About What It Costs Them



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)

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Impact of Cost-Sharing on Health Care Disparities

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

Michael Chernew, PhD[1] Teresa B. Gibson, PhD[2] Kristina Yu-Isenberg, PhD, RPh[3] Michael C. Sokol, MD, MS[4] Allison B. Rosen, MD, ScD[5], and A. Mark Fendrick, MD[5]

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

Chernew M. J Gen Intern Med 23(8):1131–6.

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"Far Better, Far Less Expensive" Next Generation Plan "Clinically Nuanced" Cost-Sharing

A "smarter" cost-sharing approach that encourages consumers to use more high value services and providers, but discourages the use of low value ones

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Understanding CLINICAL NUANCE

#1 Clinical Services Differ in the Benefit Produced

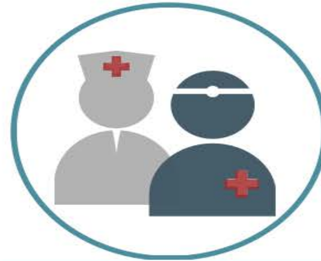
Office Visits

Diagnostic Tests

Prescription Drugs

#2 The Clinical Benefit Derived From a Service Depends On...

Who receives it



Who provides it

Where it's provided

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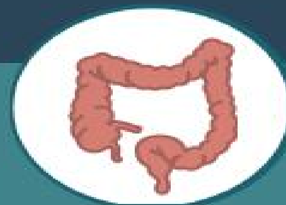
Clinical benefit depends on **who** receives it

Screening for Colorectal Cancer

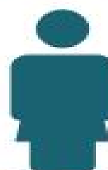


Screening Recipients

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

Potential Solution to Cost Related Non-Adherence of Essential Services: Value-Based Insurance Design (V-BID)

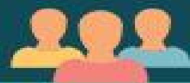
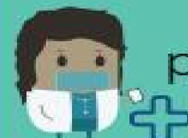
- **Sets consumer cost-sharing level on clinical benefit – not acquisition price – of the service**
- **Successfully implemented by hundreds of public and private payers**

Health Plans That Nudge Patients to Do the Right Thing

Austin Frakt
THE NEW HEALTH CARE JULY 10, 2017

RELATED COVERAGE

V-BID: Who Benefits and How?

CONSUMERS	PAYERS	PROVIDERS
		
Improves access	Promotes efficient expenditures	 Enhances patient-centered outcomes
Lowers out-of-pocket costs	Reduces wasteful spending	Aligns with provider initiatives

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V-BID: Bipartisan Political and Broad Multi-Stakeholder Support

- HHS
- CBO
- SEIU
- MedPAC
- Brookings Institution
- Commonwealth Fund
- NBCH
- American Fed Teachers
- Families USA
- AHIP
- AARP
- DOD
- BCBSA
- National Governor's Assoc.
- US Chamber of Commerce
- Bipartisan Policy Center
- Kaiser Family Foundation
- American Benefits Council
- National Coalition on Health Care
- Urban Institute
- RWJF
- IOM
- Smarter Health Care Coalition
- PhRMA
- EBRI

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Putting Innovation into Action: Translating Research into Policy

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

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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 without cost-sharing

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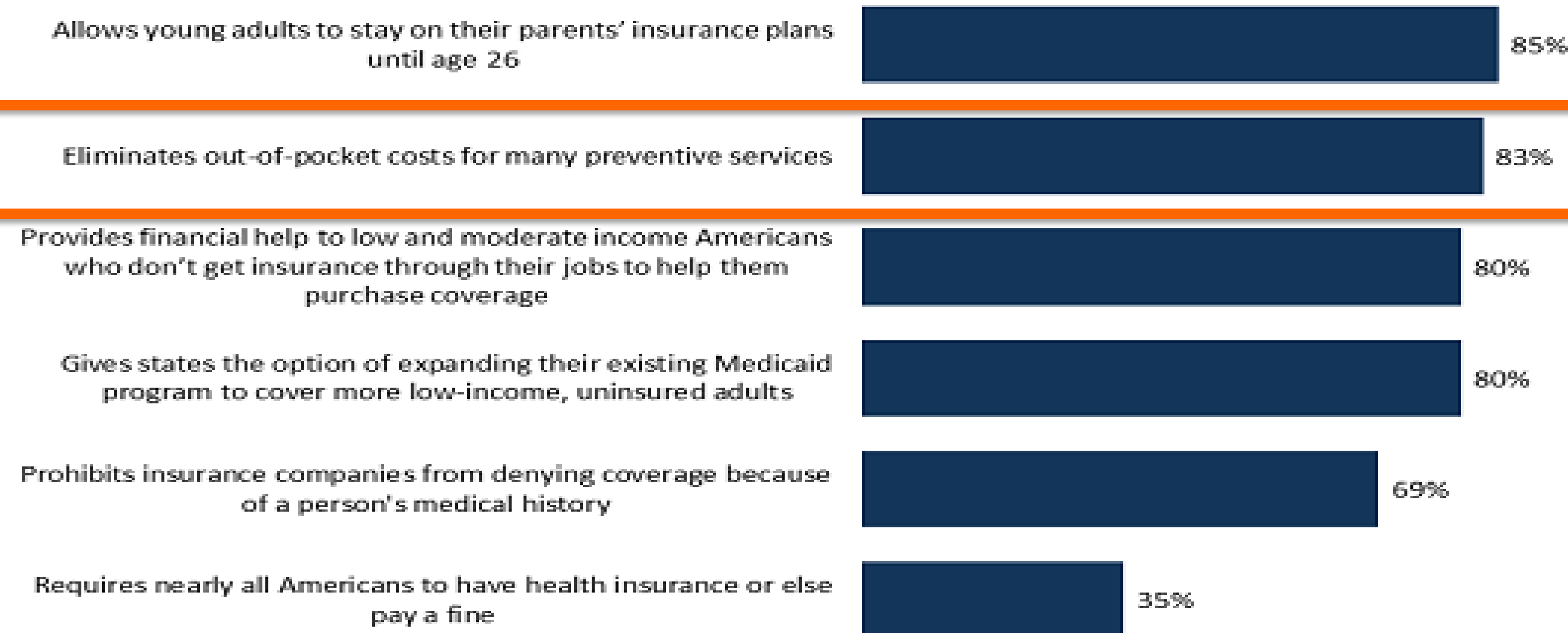
Majorities Favor Many Key ACA Provisions, But Not Its Individual Mandate

Percent who favor each of the following specific elements of the health care law:



NOTE: Some items asked of half samples. Question wording abbreviated, see topline for full question wording.
SOURCE: Kaiser Family Foundation Health Tracking Poll (conducted November 15-21, 2016)

Putting Innovation into Action: Translating Research into Policy

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Translating Research into Policy: Implementing V-BID in Medicare

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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

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.

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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

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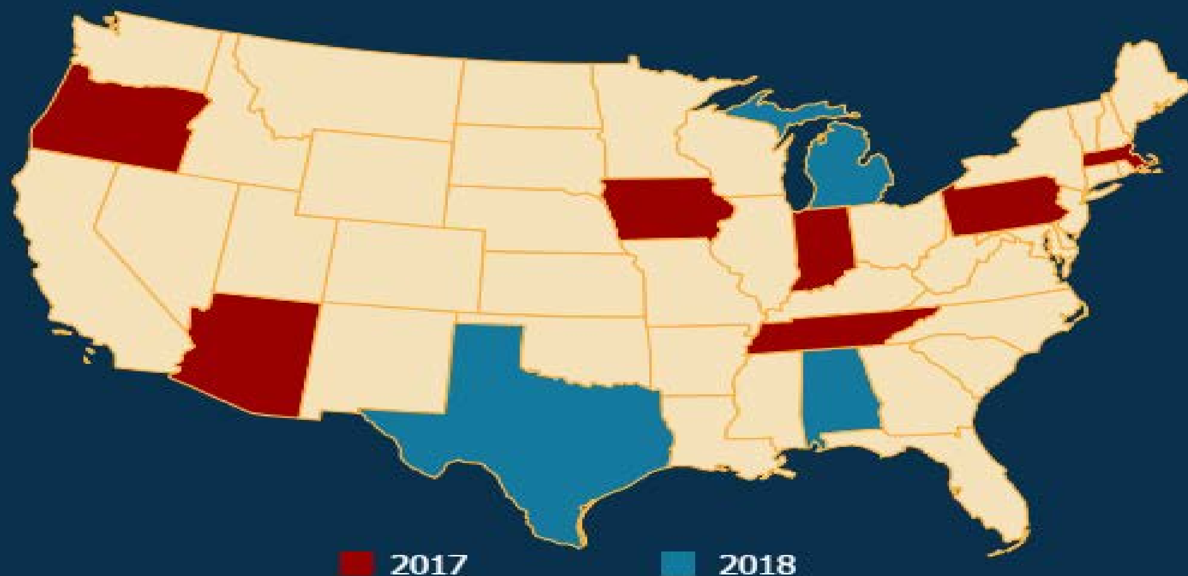
CMS Expands Medicare Advantage Value-Based Insurance Design Model Test

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



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US House and Senate call for Expansion of MA VBID Demonstration to all 50 States

UNITED STATES SENATE
COMMITTEE ON FINANCE

ABOUT HEARINGS LEGISLAT

Hatch, Wyden, Isakson, Warner Release Proposals to Improve Treatment for Chronic Illness

Finance Committee Members Offer Bipartisan Legislative Language to Improve Chronic Care Outcomes in Medicare

(Original Signature of Member)

115TH CONGRESS
1ST SESSION

H. R. ______

A BILL

To amend title XVIII of the Social Security to provide for national testing of a model of Medicare Advantage value-based insurance design to meet the needs of chronically ill Medicare Advantage enrollees.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

Reps. Black, Blumenauer, McMorris-Rodgers, Dingell

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Putting Innovation into Action: Translating Research into Policy

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

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Value-based insurance coming to millions of people in Tricare

By Shelby Livingston | December 27, 2016

The annual defense bill signed last week by President Barack Obama included a pilot program to test value-based insurance coverage in Tricare, the U.S. Defense Department's health benefits program.

Putting Innovation into Action: Translating Research into Policy

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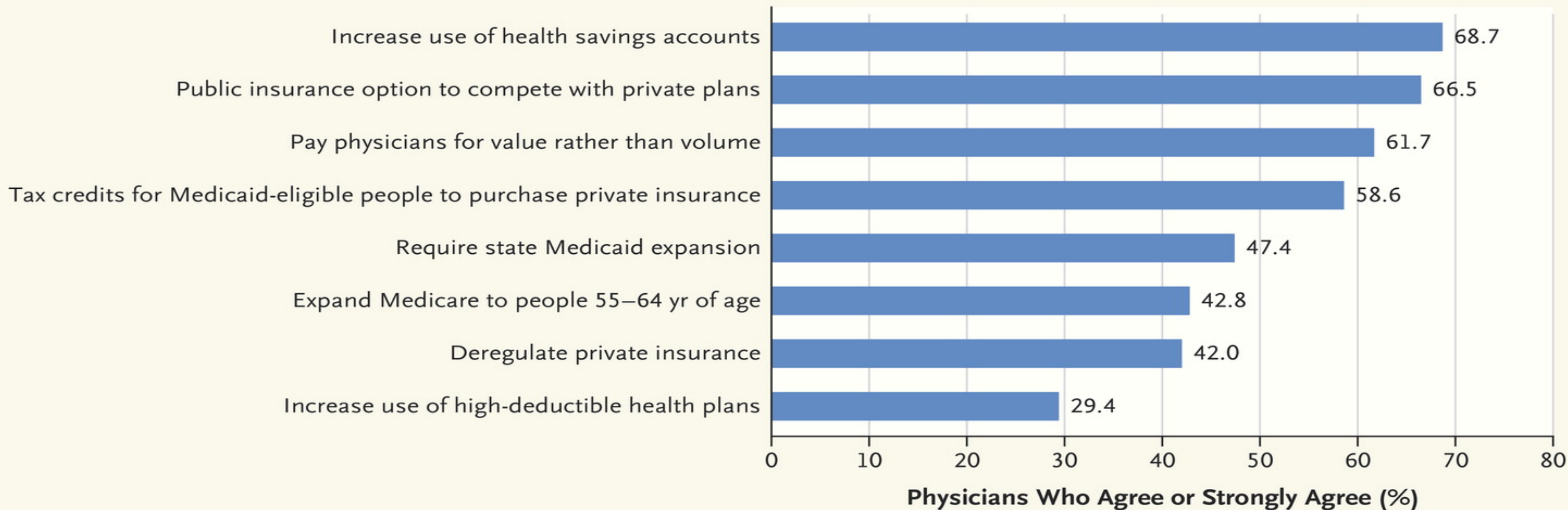
NEJM Jan 2017, PCP Survey Responses Regarding Potential Health Reform



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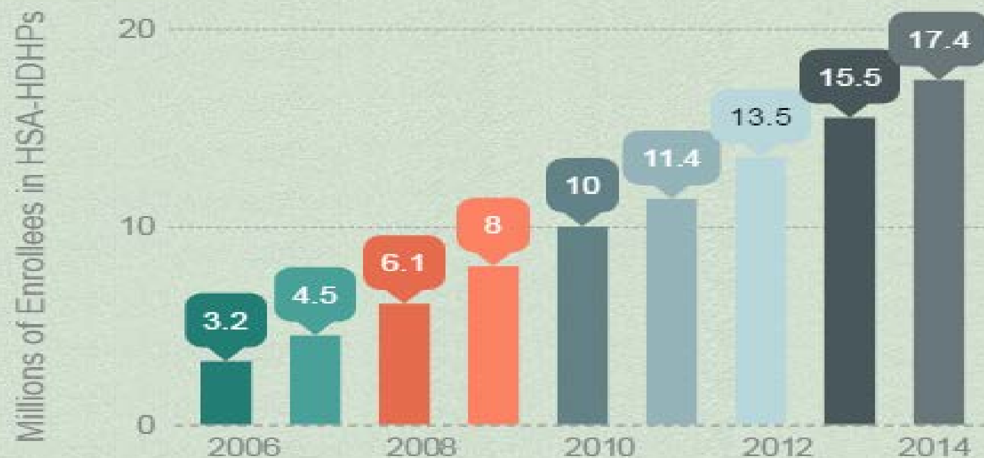
HSA-HDHP enrollment and out-of-pocket expenses continue to grow



Maximum Out-of-pocket expense 2006 to 2015

individual: $5,000 to $6,450

family: $10,000 to $12,900

http://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

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

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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

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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

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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

Invited Commentary

Precision Benefit Design—Using "Smarter" Deductibles to Better Engage Consumers and Mitigate Cost-Related Nonadherence

A. Mark Fendrick, MD; Michael E. Chernew, PhD

"To enable the continued growth of HSA-HDHPs, insurers need flexibility to provide pre-deductible coverage for high-quality services across the spectrum of clinical care."

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

114TH CONGRESS
2D SESSION

H. R. 5652

IN THE HOUSE OF REPRESENTATIVES

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.

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EXECUTIVE ORDER

REDUCING THE COST OF MEDICAL PRODUCTS AND ENHANCING AMERICAN BIOMEDICAL INNOVATION

6. Internal Revenue Service.

The Commissioner of the Internal Revenue Service shall update the preventive care safe harbor under Section 223(c)(2)(C) of the Internal Revenue Code to include services or benefits, including medications, intended to prevent chronic disease progression or complications, for the purpose of helping patients adhere to clinical regimens and thereby reducing costs of healthcare.

Draft executive order would enhance high-deductible coverage for chronic disease care

By Shelby Livingston | June 26, 2017

While all eyes were on Senate Republicans last week as they rushed to assemble their bill to repeal the Affordable Care Act, a draft version of a White House executive order surfaced that would allow patients enrolled in high-deductible health plans to access care for chronic conditions before they meet their deductible.Patients enrolled in high-deductible plans linked to tax-exempt health

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Motivation for "Precision" Benefit Design

- Advances in precision medicine may specify immediate use of targeted therapies, nullifying recommendations for use of standard first line treatment
- The natural history of chronic conditions often necessitates multiple therapies to achieve desired clinical outcomes
- Current consumer cost-sharing levels are fixed and do not reflect the varying nature of clinical conditions
- Increasing out-of-pocket costs for alternative therapies may prevent consumers from accessing recommended treatment

Precision Benefit Design

Removes administrative barriers and lowers cost-sharing to improve access to effective therapies when indicated

Precision Benefit Design

A Nuanced Approach to Consumer Cost-sharing

- ✓ Commits to established policies that encourage lower cost, first-line therapies
- ✓ Enhances access to effective therapies when clinically appropriate
- ✓ Increases access to recommended treatments by removing administrative barriers and lowering cost-sharing
- ✓ Supports precision medicine initiatives by encouraging use of targeted therapies when clinically indicated

Putting Innovation into Action: Translating Research into Policy

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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

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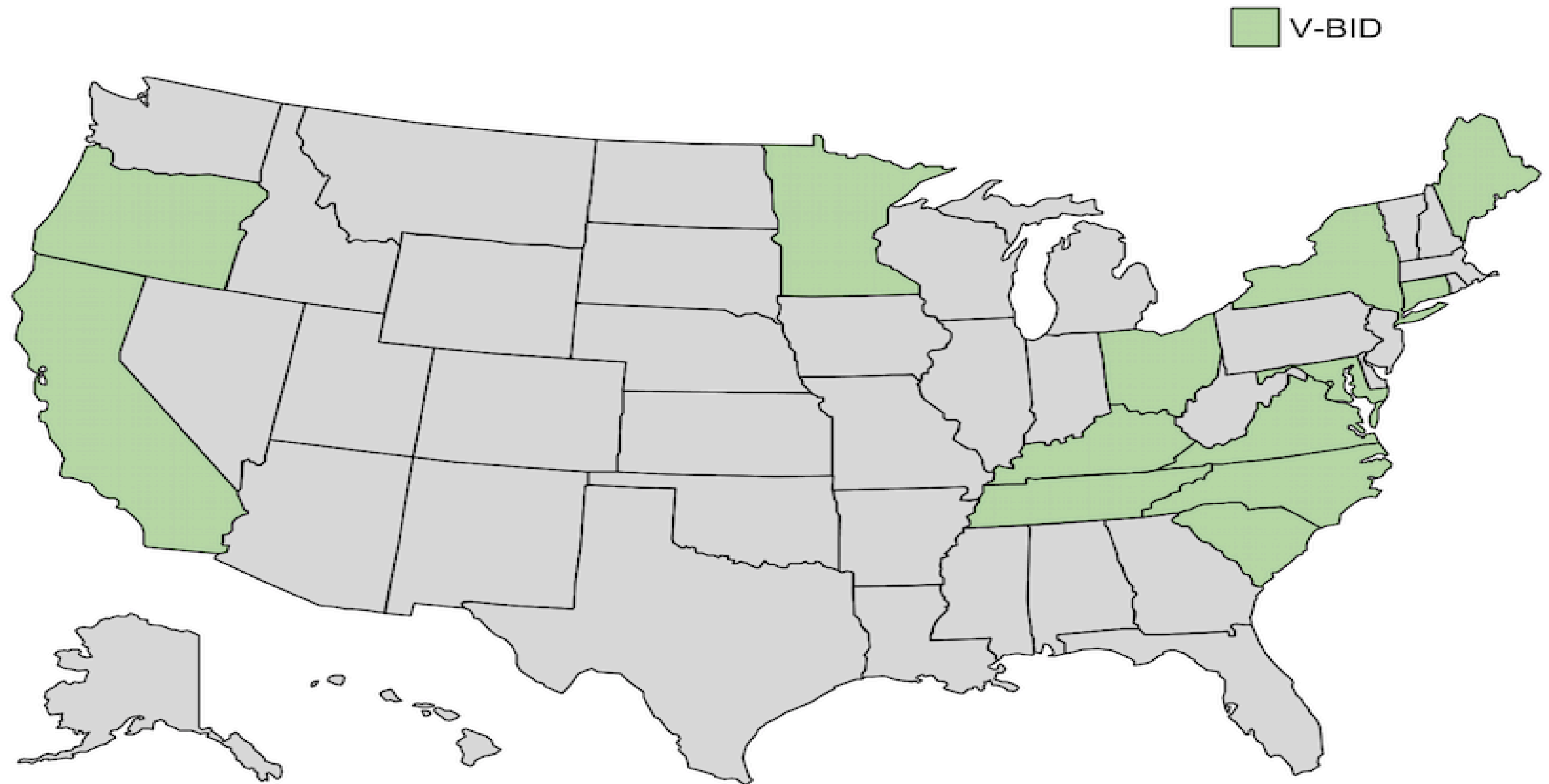
Value-Based Insurance Design Growing Role in State Employee Plans



Getting to Health Care Value
Focus Cost-Sharing Increases on Unnecessary Care

- 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

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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.

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

Identifying and Removing Unnecessary Care

- 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
- Savings from waste elimination are immediate and substantial
- Identification, measurement, and removal of unnecessary care has proven challenging

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ACA Sec 4105: Selected No-Value Preventive Services Shall Not Be Paid For

SEC. 4105. EVIDENCE-BASED COVERAGE OF PREVENTIVE SERVICES IN MEDICARE.

(a) AUTHORITY TO MODIFY OR ELIMINATE COVERAGE OF CERTAIN PREVENTIVE SERVICES.—Section 1834 of the Social Security Act (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:

"(n) AUTHORITY TO MODIFY OR ELIMINATE COVERAGE OF CERTAIN PREVENTIVE SERVICES.—Notwithstanding any other provision of this title, effective beginning on January 1, 2010, if the Secretary determines appropriate, the Secretary may—

"(1) modify—

"(A) the coverage of any preventive service described in subparagraph (A) of section 1861(ddd)(3) to the extent that such modification is consistent with the recommendations of the United States Preventive Services Task Force; and

"(B) the services included in the initial preventive physical examination described in subparagraph (B) of such section; and

"(2) provide that no payment shall be made under this title for a preventive service described in subparagraph (A) of such section that has not received a grade of A, B, C, or I by such Task Force.".

(b) CONSTRUCTION.—Nothing in the amendment made by paragraph (1) shall be construed to affect the coverage of diagnostic or treatment services under title XVIII of the Social Security Act.

HHS granted authority to not pay for USPSTF 'D' Rated Services

Multi-Stakeholder Task Force Identifies 'Top Five' Low-Value Services

- Diagnostic testing and imaging for low-risk patients prior to low-risk surgery
- More expensive branded drugs when chemically identical generic options are available
- Prostate-specific antigen (PSA) screening in men 75 and older
- Imaging for low-back pain for the first six weeks after onset, unless clinical warning signs are present ("red flags")
- Vitamin D screening

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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 Organizations
- Bundled Payments
- Reference Pricing
- Global Budgets
- High Performing Networks
- Electronic Medical Records

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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

Mean LDL Reduction (mg/dL)

Group	Mean LDL Reduction (mg/dL)
Control…	25.1
Patient…	25.1
Physician…	27.9
Physician-…	33.6

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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Discussion

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