Using Value-Based Insurance Design to Reduce Low-Value Care

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www.vbidcenter.org
@um_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.
Innovations to prevent and treat disease have led to impressive reductions in morbidity and mortality.

Irrespective of these advances, cutting health care spending is the main 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.
Flintstones Delivery
Outline

- Consumer Cost-sharing
- Value-Based Insurance Design
- Clinical Nuance
- Translate Research into Policy
- Low Value Care
Shifting the Discussion from “How much” to “How well”
Moving from Volume to Value

Requires a change in both how we pay for care and how we engage consumers to seek care.

- **Alternative payment and pricing models**: Principal focus of deliberations
- **Consumer engagement**: Essential strategy to enhance efficiency
- **Consumer cost-sharing**: Commonly used policy lever
Impact of Consumer Cost-Sharing: Paying More for ALL Care Regardless of Value

- Deductibles
- Co-insurance
- Co-payments
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.
One in Four Patients Have Difficulty Affording Their Prescription Medicines

Kaiser Family Foundation Tracker Sept 2016
Americans Do Not Care About Health Care Costs; They Care About **What It Costs Them**

<table>
<thead>
<tr>
<th>Priority Level</th>
<th>Lowering the amount individuals pay for health care</th>
<th>Lowering the cost of prescription drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Top priority</td>
<td>67%</td>
<td>61%</td>
</tr>
<tr>
<td>Important but not a top priority</td>
<td>26%</td>
<td>28%</td>
</tr>
<tr>
<td>Not too important</td>
<td>3%</td>
<td>6%</td>
</tr>
<tr>
<td>Should not be done</td>
<td>2%</td>
<td>3%</td>
</tr>
</tbody>
</table>
Alternative to ‘Blunt’ Cost-Sharing Strategies

Understanding Clinical Nuance

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

Who receives it

Who provides it

Where it's provided
Implementing Clinical Nuance: Value-Based Insurance Design (V-BID)

Sets consumer cost-sharing on clinical benefit – not price
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
• 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
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:

- Allows young adults to stay on their parents’ insurance plans until age 26: 85%
- Eliminates out-of-pocket costs for many preventive services: 83%
- Provides financial help to low and moderate income Americans who don’t get insurance through their jobs to help them purchase coverage: 80%
- Gives states the option of expanding their existing Medicaid program to cover more low-income, uninsured adults: 80%
- Prohibits insurance companies from denying coverage because of a person’s medical history: 69%
- Requires nearly all Americans to have health insurance or else pay a fine: 35%

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
2018 Budget Bill Expands MA V-BID Model Test to all 50 States
Putting Innovation into Action: Translating Research into Policy
Further incorporates V-BID principles in TRICARE by...

- Giving preferential status to high-value, non-generic medications by treating them as generics for cost-sharing purposes

- Excluding from the pharmacy benefits program any medication that provides little or no value, so as to encourage the use of high-value services
IRS Rules Prohibit Coverage of Chronic Disease Care Until HSA-HDHP Deductible is Met

PREVENTIVE CARE COVERED
Dollar one

CHRONIC DISEASE CARE
NOT covered until deductible is met

V-BID
Percentage of People under 65 Enrolled in HDHPs

NOTES: CDHP is consumer-directed health plan, which is a high-deductible health plan (HDHP) with a health savings account (HSA). HDHP no HSA is a high-deductible health plan without an HSA. The individual components of HDHPs may not add up to the total due to rounding. Data are based on household interviews of a sample of the civilian noninstitutionalized population.
Share of Households with Liquid Assets Less than Their Plan Deductible

Among people with private health insurance

- **Mid-range plan**
  - $1,500 Single / $3,000 Family

- **High-range plan**
  - $3,000 Single / $6,000 Family

<table>
<thead>
<tr>
<th>Category</th>
<th>Mid-range Plan</th>
<th>High-range Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>All non-elderly households</td>
<td>28%</td>
<td>40%</td>
</tr>
<tr>
<td>Less than 150% of Fed. poverty level</td>
<td></td>
<td>63%</td>
</tr>
<tr>
<td>150-400%</td>
<td>44%</td>
<td>60%</td>
</tr>
<tr>
<td>400% or more</td>
<td>10%</td>
<td>20%</td>
</tr>
</tbody>
</table>

Reproduced from Kaiser Family Foundation analysis of the 2016 Survey of Consumer Finance; Note: Liquid assets include the sum of checking and saving accounts, money market accounts, certificates of deposit, savings bonds, non-retirement mutual funds, stocks, and bonds. Chart: Axios Visuals.
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.
Chronic Disease Management Act of 2018

S.2410 and H.R.4978
Bipartisan, Bicameral Legislation
To amend the Internal Revenue Code of 1986 to permit high deductible health plans to provide chronic disease prevention services to plan enrollees prior to satisfying their plan deductible.
• Discouraging the use of 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 unnecessary 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
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
Identifying and Removing Unnecessary Care: Milliman Health Waste Calculator

- Collaboration between Milliman and V-BIDHealth
- Measure 44 potentially unnecessary services
- Analyze cost savings potential
- Generate actionable reports and summaries
Commonwealth of Virginia Unnecessary Care Initiative

• Among 5.5 million beneficiaries, 1 in 5 Virginians received at least 1 low-value service in 2014

• The 44 low-value services were delivered 1.7 million times, which cost $586 million (~2% of healthcare costs) in Virginia
## Commonwealth of Virginia Unnecessary Care Initiative

<table>
<thead>
<tr>
<th>Clinical Measure</th>
<th>Total Services Measured</th>
<th>Low Value Index (%)</th>
<th>Low Value Services (#)</th>
<th>Unnecessary Spending ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline labs for patients 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>EKGs or other cardiac screening for low-risk patients w/o symptoms</td>
<td>2,268,194</td>
<td>6%</td>
<td>147,423</td>
<td>$60,499,385</td>
</tr>
<tr>
<td>Routine 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>
Volume of low-value services in Virginia in 2014, by quartiles of cost

Blue colors signify low-cost services

John N. Mafi et al. Health Aff 2017;36:1701-1704
Expenditures on low-value services in Virginia in 2014, by quartiles of cost

Surprising lesson: don’t discount the “little ticket” items, because they tend to add up!!

John N. Mafi et al. Health Aff 2017;36:1701-1704
Approximately 1.3 MM individuals received one of the 47 services, and almost half (47.9%) of them received a wasteful service.

An estimated $282 MM in wasteful spending.

This is surprising, given that Washington State leads the nation in providing integrated, high-value care in largely capitated payment systems.
Reducing Low Value Care
Why so difficult?

• **Clinician factors**: e.g., training, fear of lawsuit, time pressures, intolerance of uncertainty

• **Patient factors**: lack of knowledge or financial consequences

• **Healthcare system factors**: institutional culture, pricing, fee-for-service payment models
Strategies to Reduce Low Value Care

• From the top:
  – Light touch financial incentives (ala ACOs)
  – Prioritize focus (e.g., top 5 list)
  – Empower trainees to lead projects
  – Promote a culture of high-value care

• From the bottom:
  – Rigorous (and local) performance measurement
  – Attack multiple factors at once (educate, culture)
  – Integrate seamlessly into workflow
  – Monitor and adapt to unintended consequences

Where to Start?

- Most focus has been on high-cost services, but this gives us leverage to begin a pragmatic path forward
- Low-cost items less likely to threaten particular clinical specialty or advocacy group
- Choose services that easily identified services that no stakeholder would complain about
Multi-Stakeholder Task Force Identifies 5 Commonly Overused Services Ready for Action

1. Diagnostic Testing and Imaging Prior to Surgery
2. Vitamin D Screening
3. PSA Screening in Men 75+
4. Imaging in First 6 Weeks of Low Back Pain
5. Branded Drugs When Identical Generics Are Available
Many “supply side” initiatives are restructuring provider incentives to move from volume to value:

- Medical Homes
- Electronic Medical Records
- Accountable Care Organizations
- Bundled Payments/Reference Pricing
- Global Budgets
- High Performing Networks
Unfortunately, some “demand-side” initiatives – including consumer cost sharing - discourage consumers from pursuing the “Triple Aim”
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.