



SCHOOL OF PUBLIC HEALTH

CENTER FOR VALUE-BASED INSURANCE DESIGN  
UNIVERSITY OF MICHIGAN

# Value-Based Insurance Design: Landscape for 2019

**A. Mark Fendrick, MD**

**University of Michigan Center for  
Value-Based Insurance Design**

**[www.vbidcenter.org](http://www.vbidcenter.org)**



**@um\_vbid**



# **Health Care Costs Are a Top Issue For Voters:**

## **Policy solutions must protect consumers and preserve innovation**

- 1 Innovations to prevent and treat disease have led to impressive reductions in morbidity and mortality**
- 2 Irrespective of remarkable clinical advances, cutting health care spending is the main focus of reform discussions**
- 3 Underutilization of high-value persists across the entire spectrum of clinical care leading to poor health outcomes**
- 4 Our ability to deliver high-quality health care lags behind the rapid pace of scientific innovation**

# Star Wars Science



# Flintstones Delivery





# Changing the discussion from “How much” to “How well” we spend our health care dollars

- **Everyone (almost) agrees there is enough money in the system**
- **Three-quarters of Americans say that our country doesn’t get good value for what it spends on healthcare**
- **Policy deliberations focus primarily on alternative payment and pricing models**
- **Americans are paying more for ALL care regardless of value**
- **“One size fits all” increases in consumer cost-sharing are ‘blunt’ instruments that reduce the use of high value care and adversely affect health, particularly among economically vulnerable individuals and those with chronic conditions**

# 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)**

**”**

# Alternative to 'Blunt' Cost Sharing: Value-Based Insurance Design (V-BID)

- Sets consumer cost-sharing on clinical benefit – not price
- Little or no out-of-pocket cost for high value care
- Successfully implemented by hundreds of public and private payers





# 5

## Center benefits around the needs of the individual

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- Use designs that incentivize beneficiaries to seek appropriate preventive, diagnostic, acute and maintenance care from high quality providers at the right place and time
- **Do not** use penalties to incentivize consumers
- Encourage consumers to establish and maintain a primary care provider relationship
- Provide ability for consumers to opt in to high-performance networks
- Promote improved care coordination and reduced duplication of services



# **V-BID:**

## **Rare 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**
- **ASCO**
- **AMA**

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

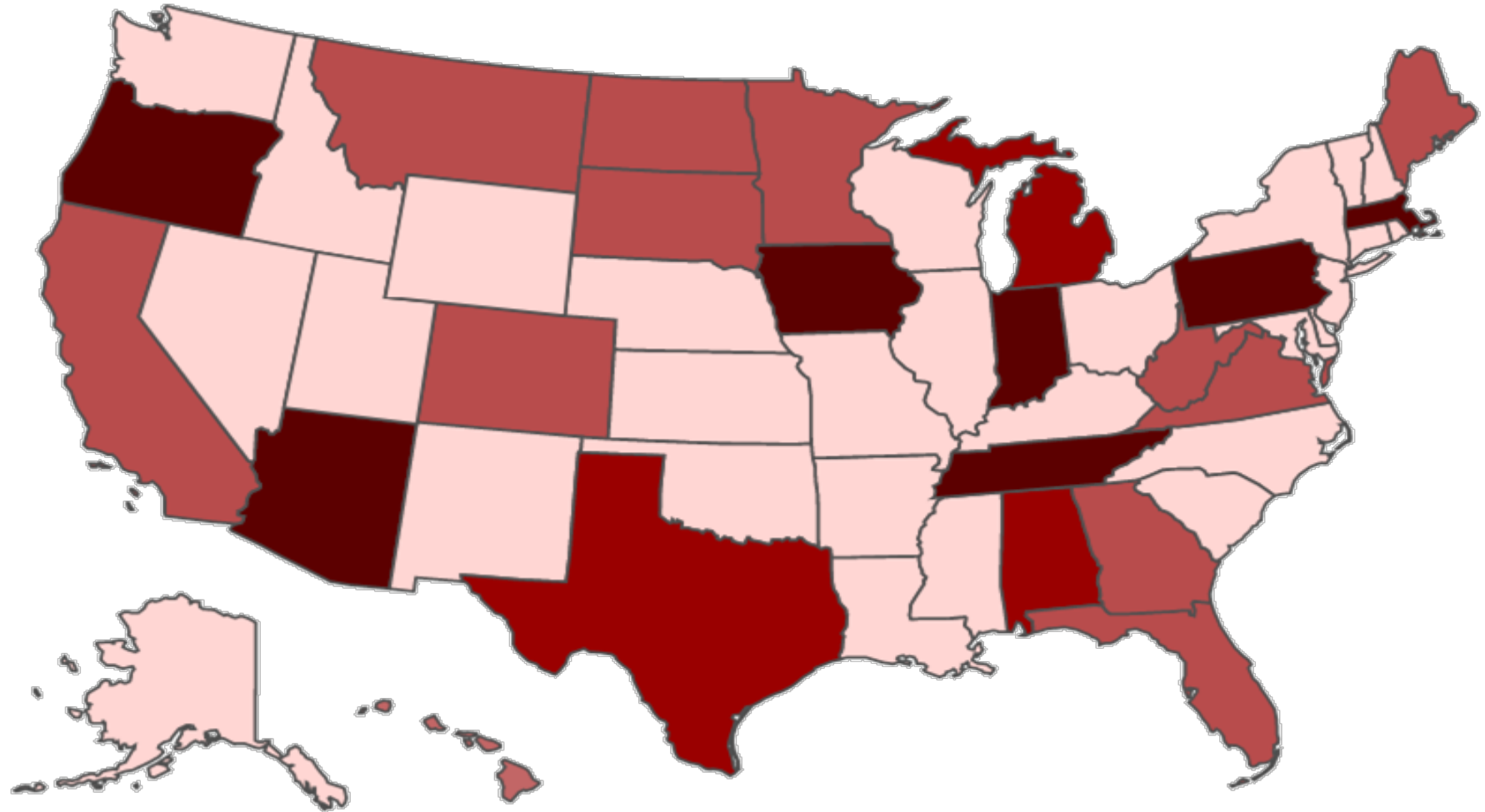
- Receiving an A or B rating from the United States Preventive Services Taskforce (USPSTF)
- Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP)
- Preventive care and screenings supported by the Health Resources and Services Administration (HRSA)

Over **154 million Americans** have received expanded coverage of preventive services as a result of this provision

# MA V-BID Model Test – 1<sup>st</sup> CMS Demonstration Allowing Cost-Sharing Reductions for Individuals with Specific Clinical Conditions

**MA V-BID Model expanded to all 50 States by 2020, includes:**

- Telemedicine
- Hospice



2017

2018

2019

2020

# **Value-based insurance coming to millions of people in Tricare**

- **2017 NDAA: Obama Administration - reduce or eliminate co-pays and other cost sharing for certain high services and providers**
- **2018 NDAA: Trump Administration – reduce cost sharing for high value drugs on the uniform formulary**

# 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





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

# Chronic Disease Management Act of 2018

115TH CONGRESS  
2D SESSION



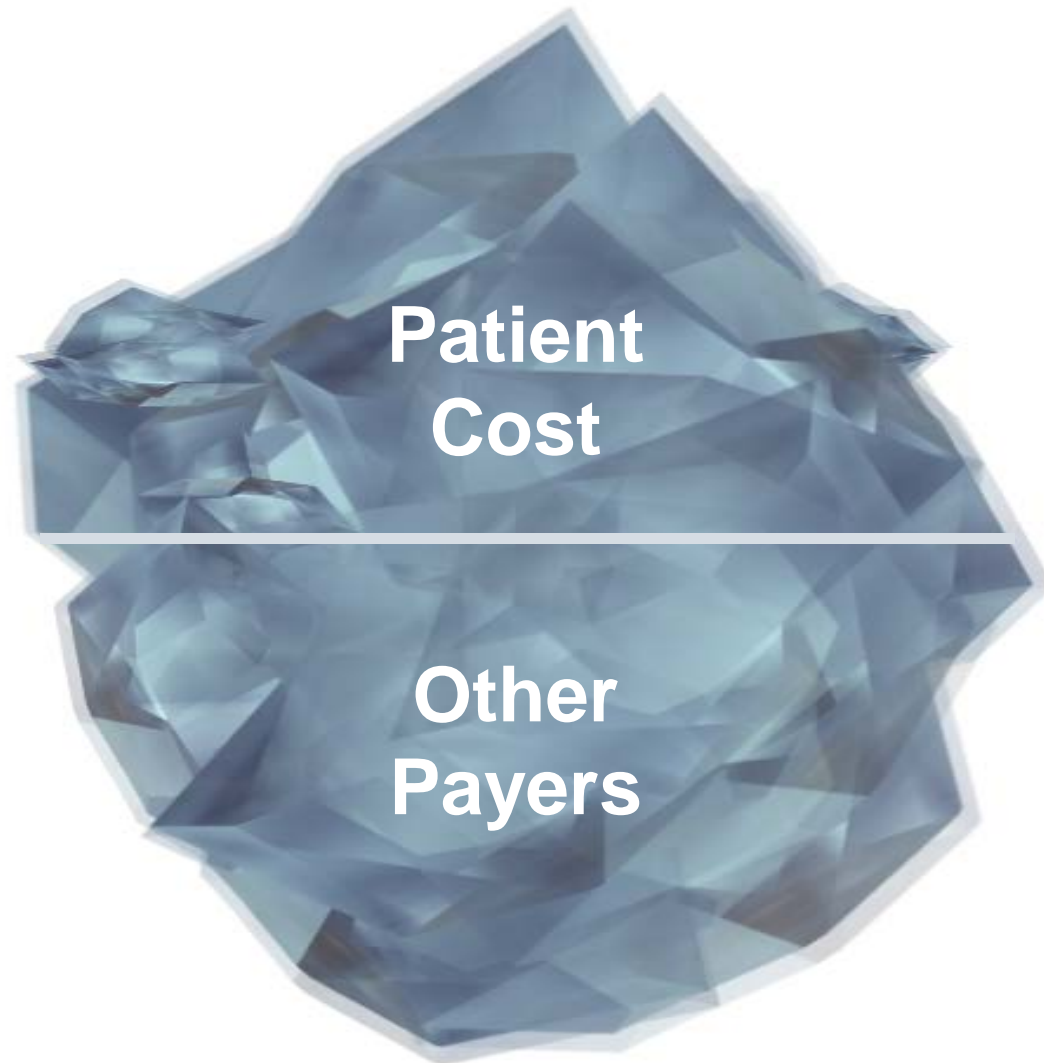
## **S.2410 and H.R.4978** **Bipartisan, Bicameral Legislation**

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.

# Drugs

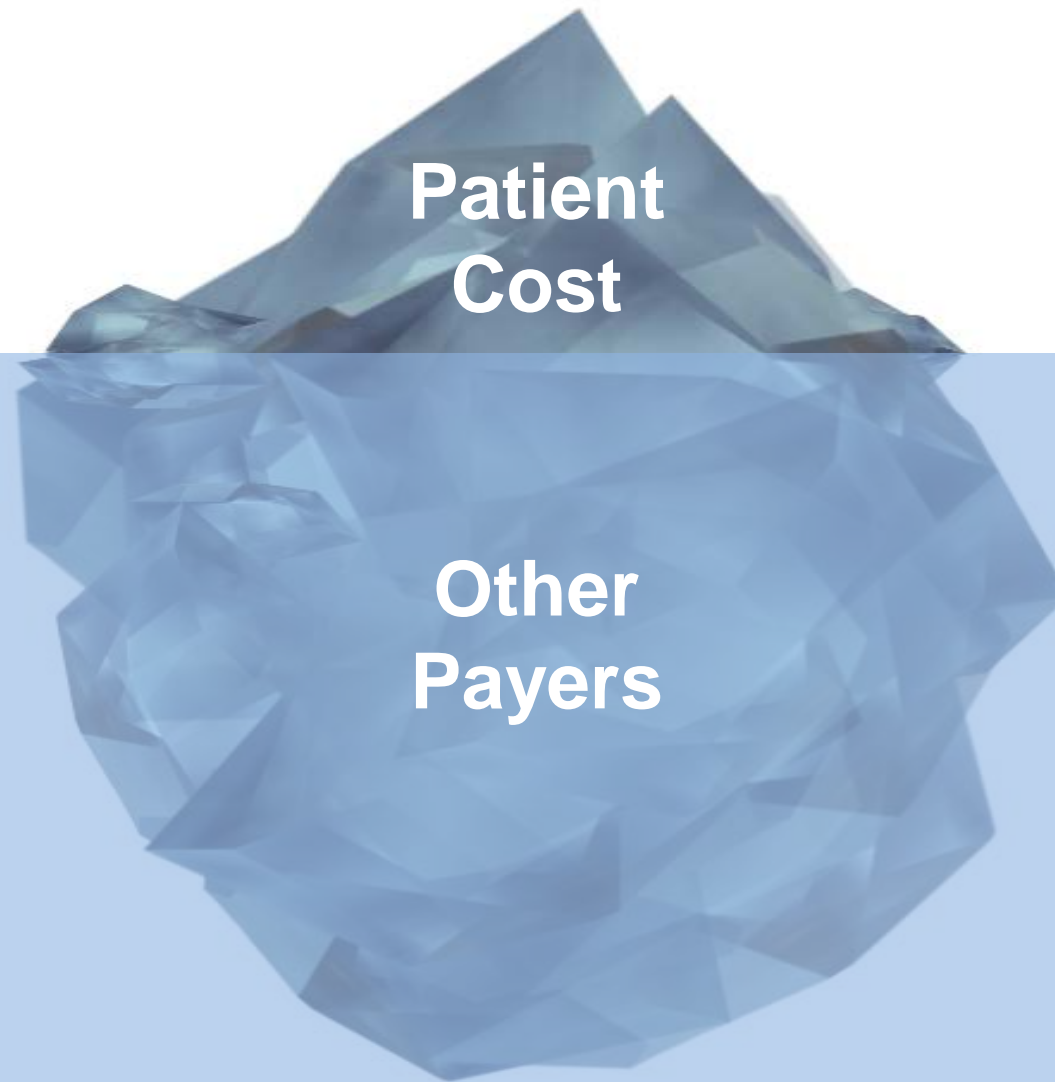
- Nearly 3 in 5 American adults take at least 1 prescription drug
- Percentage of American adults taking **5 or more** prescription drugs nearly doubled between 2000 and 2012, from 8% to 15%
- Certain expensive drugs are of extremely high clinical value, whereas some commonly used diagnostic tests, procedures, and inexpensive drugs are of no value, and are sometimes harmful
- Drug prices change over time in a way unlike prices of other clinical services

# Drug prices are typically paid in two portions





**The amount a patient pays for drugs is determined by their insurance coverage**



**Insurance  
Coverage**



**If coverage is not generous; patients can pay the entire drug price**



**This scenario is typical for individuals who are enrolled in a health plan that includes a deductible**

**Skimpy Insurance Coverage**

# Two ways to lower patient out-of-pocket drug costs: Both approaches can be tried simultaneously



The diagram features a blue, low-poly iceberg floating on a light blue rectangular base. The top, smaller portion of the iceberg is labeled 'Patient Cost', while the larger, submerged portion is labeled 'Other Payers'.

Patient  
Cost

Other  
Payers

# Two ways to lower patient out-of-pocket drug costs: Both approaches can be tried simultaneously

**Lower drug price  
(Melt the iceberg)**

**Patient  
Cost**



**Other  
Payers**

**Patient  
Cost**



**Other  
Payers**

# Two ways to lower patient out-of-pocket drug costs: Both approaches can be tried simultaneously

**Lower drug price  
(Melt the iceberg)**

**Enhance coverage  
(Raise the water line)**

**Patient  
Cost**

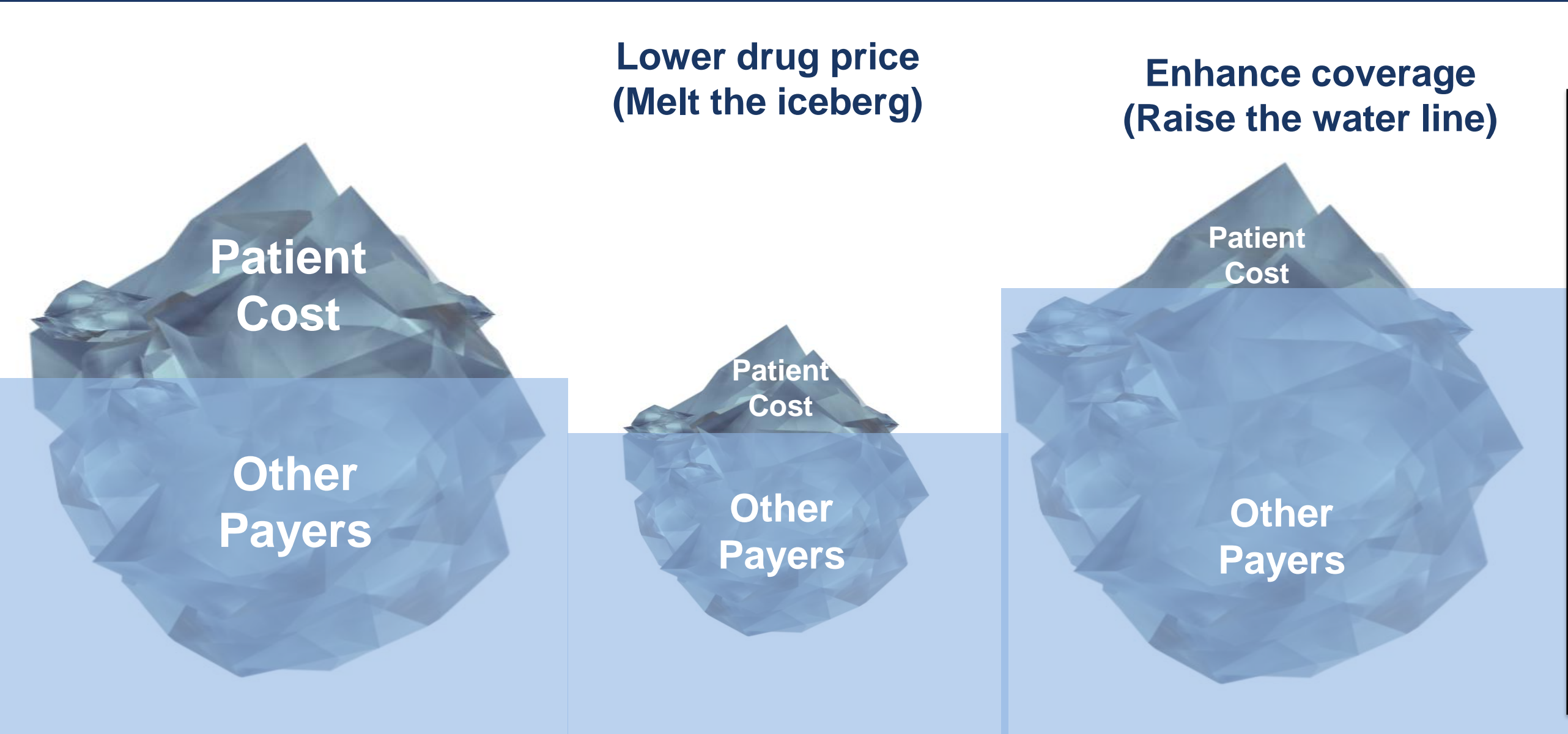
**Other  
Payers**

**Patient  
Cost**

**Other  
Payers**

**Patient  
Cost**

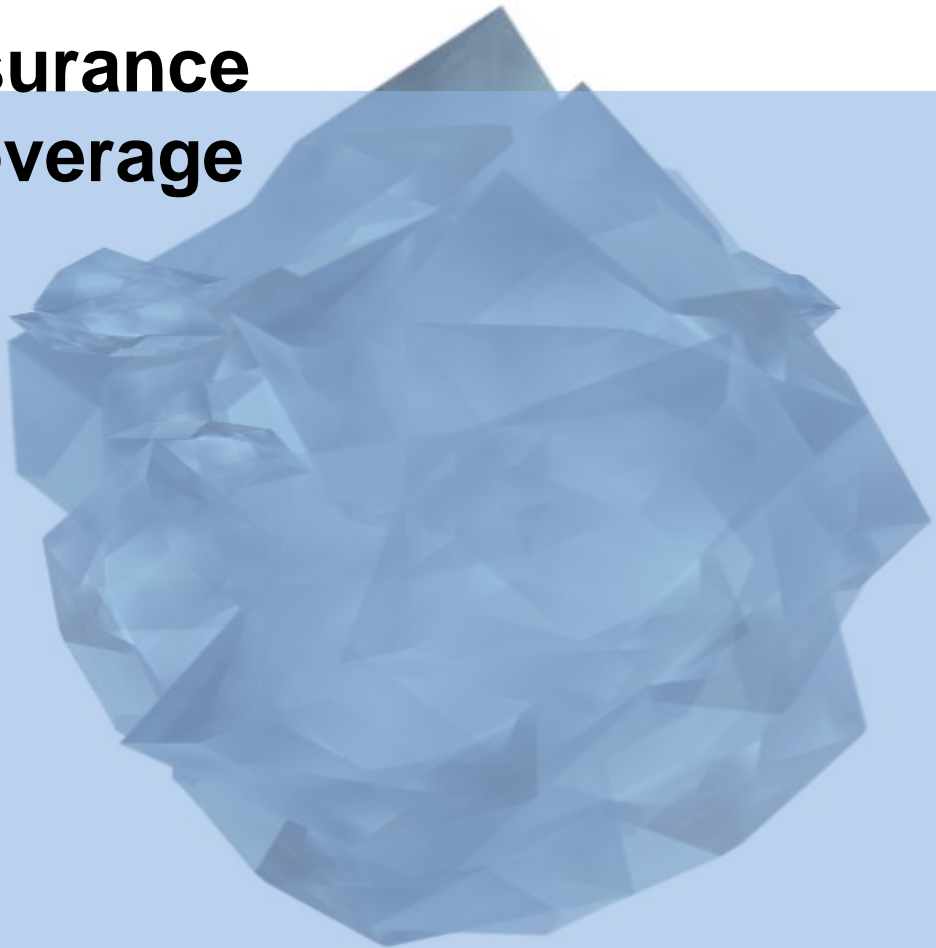
**Other  
Payers**



# **Policies that reduce prices - but do not lower out-of-pocket costs - do not address the main challenge facing most Americans**

**Patient Cost**

**Insurance  
Coverage**



**Simultaneously consider popular, easy to implement, policies that would quickly lower out-of-pocket drug costs for tens of millions of Americans with chronic conditions**

- **Value-Based Insurance Design (V-BID)**
- **Allow HSA-HDHPs the flexibility to cover medications that treat chronic diseases on a pre-deductible basis (HR 4978, S 2410)**



# Creating 'Headroom' to Pay for High-Value Care

## Identifying /Removing Unnecessary Services

- Discouraging the use of specific low-value services must be part of the strategy to pay for high-value care
- Unlike delayed cost offsets that result from improved quality, **savings from waste elimination are immediate and substantial**
- Identification, measurement, and removal of unnecessary care has proven challenging

# 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.

**The ACA grants HHS  
the authority to not  
pay for USPSTF ‘D’  
Rated Services in  
Medicare**

# Reducing Low Value Care: Where to Start?

- Although much of the low-value care discussion has focused on high-cost services, low-cost items are less likely to draw attention by particular clinicians or patient advocacy groups
- Choose services:
  - Easily identified in administrative systems
  - Almost always low value
  - Reduction in their use would be barely noticed

# Multi-Stakeholder **Task Force on Low Value Care** Identifies 5 Commonly Overused Services Ready for Action



1. Laboratory Testing Prior to Low Risk Surgery



2. Vitamin D Screening



3. PSA Screening in Men 70+



4. Imaging in First 6 Weeks of Acute Low Back Pain



5. Branded Drugs When Identical Generics Are Available

# **VBID-X:**

## **Lower Premiums, Better Coverage**

- **Lowers cost-sharing for selected high value services**
  - Retinopathy screening for individuals with diabetes
  - Rehabilitation after cardiac surgery and joint replacement
  - High value generic drug classes
- **Increases out of pocket costs on specified no- and low value services**
  - Vitamin D screening
  - Spinal surgery
  - Proton beam therapy
- **Savings from reduced low value care exceed added spending on high value care - a lower actuarial value results**



# 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**
- **Electronic Medical Records**
- **Accountable Care Organizations**
- **Bundled Payments/Reference Pricing**
- **Global Budgets**
- **High Performing Networks**



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

**Unfortunately, some “demand-side” initiatives – including blunt consumer cost sharing – undermine a transformation to patient centered, value-driven system**



# Aligning Payer and Consumer Incentives: As Easy as PB & J

**“We believe that relying on clinically informed financial incentives – for patients and providers – will be useful in achieving improved health outcomes for any level of health care expenditures.”**



**Fendrick and Chernew. *JGIM*. 2007.**

An aerial photograph of a large, oval-shaped stadium, likely a football or soccer stadium, with a green field in the center. The word "MICHIGAN" is visible in large yellow letters on the field. The stadium is surrounded by parking lots, roads, and some buildings. The seating area is mostly empty, with some blue seats visible in the upper tiers.

*“If we don’t succeed then we will fail.”*

Dan Quayle



# My Hope for the Future

[www.vbidcenter.org](http://www.vbidcenter.org)

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