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

Value-Based Insurance Design:
A Fiscally Responsible, Clinically Driven Approach to Help Employers Disrupt the Healthcare System

A. Mark Fendrick, MD

University of Michigan Center for Value-Based Insurance Design

w.vbidcenter.org

@um_vbid

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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.

Making Health Care Great … Again ;)

1. Innovations to prevent and treat disease have led to impressive reductions in morbidity and mortality

2. Irrespective of these advances, cutting health care spending is the main focus of reform discussions

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Where Does Your Health Care Dollar Go?

Your premium—how much you pay for your health insurance coverage each month—helps cover the costs of the medications and care you receive. It also helps to improve health care quality and affordability for all Americans. Here is where your health care dollar really goes.

23.3¢ Prescription Drugs

22.2¢ Doctor Services

20.2¢ Office & Clinic Visits

16.1¢ Hospital Stays

4.7¢ Taxes

Making Health Care Great … Again ;)

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

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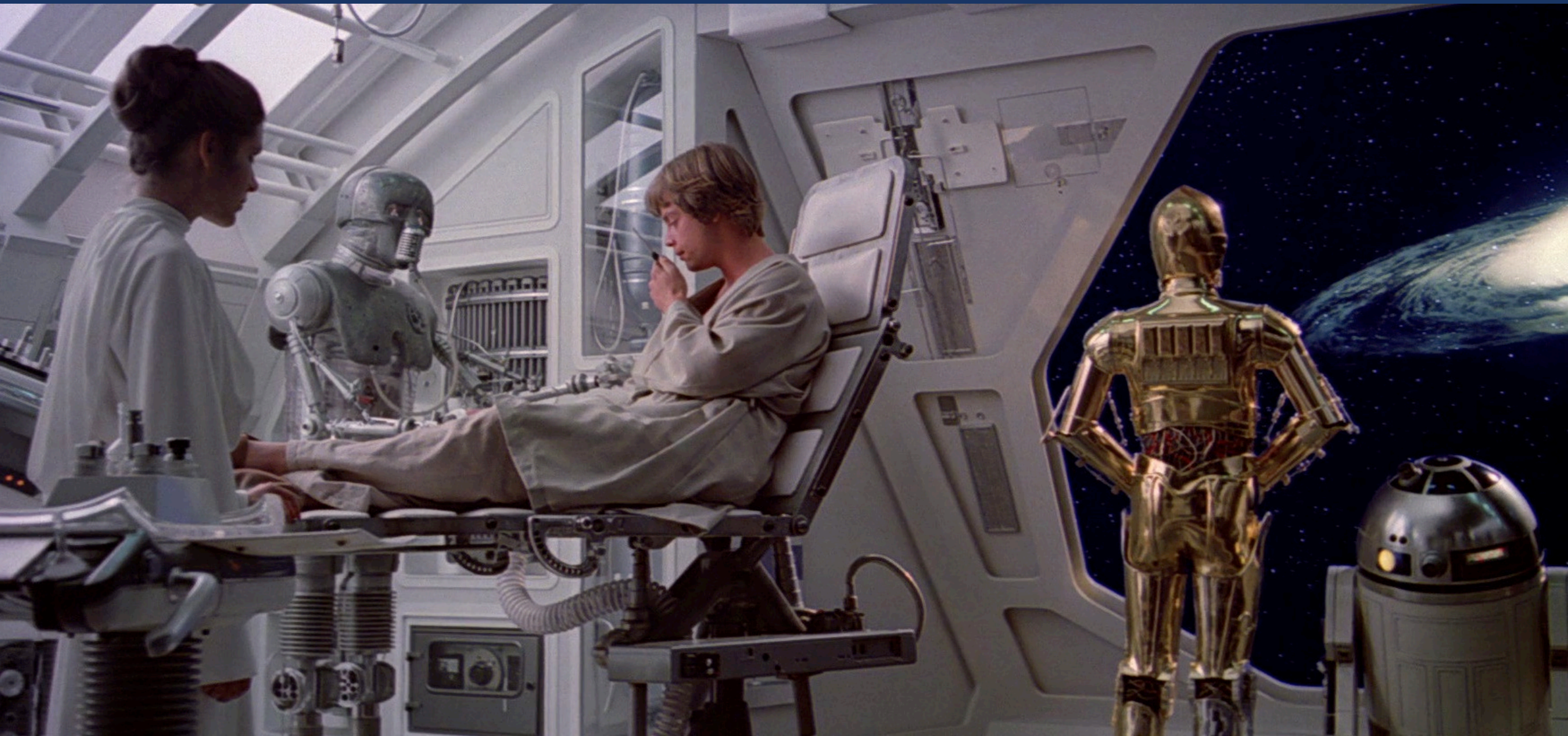
Star Wars Science



Flintstones Delivery

Outline

- Consumer Cost-sharing
- Value-Based Insurance Design
- Aligning Incentives
- Clinical Nuance
- Translating Research into Policy

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Moving from the Stone Age to the Space Age: Change the discussion from “How much” to “How well”

- Three-quarters of Americans say that our country doesn’t get good value for what it spends on healthcare
- 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
- Policy deliberations focus primarily on alternative payment and pricing models
- Consumer engagement is an essential and important lever to enhance efficiency
- Consumer cost-sharing is a common policy lever

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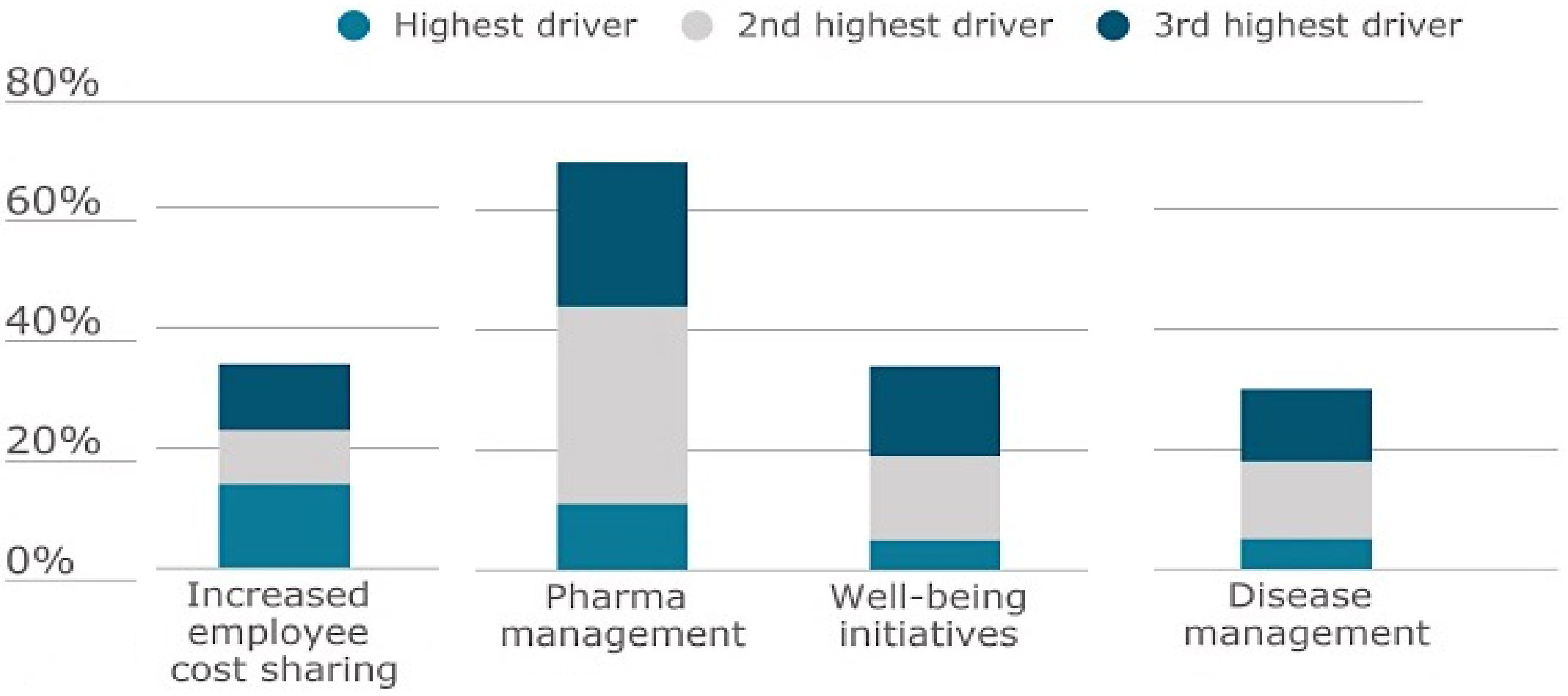
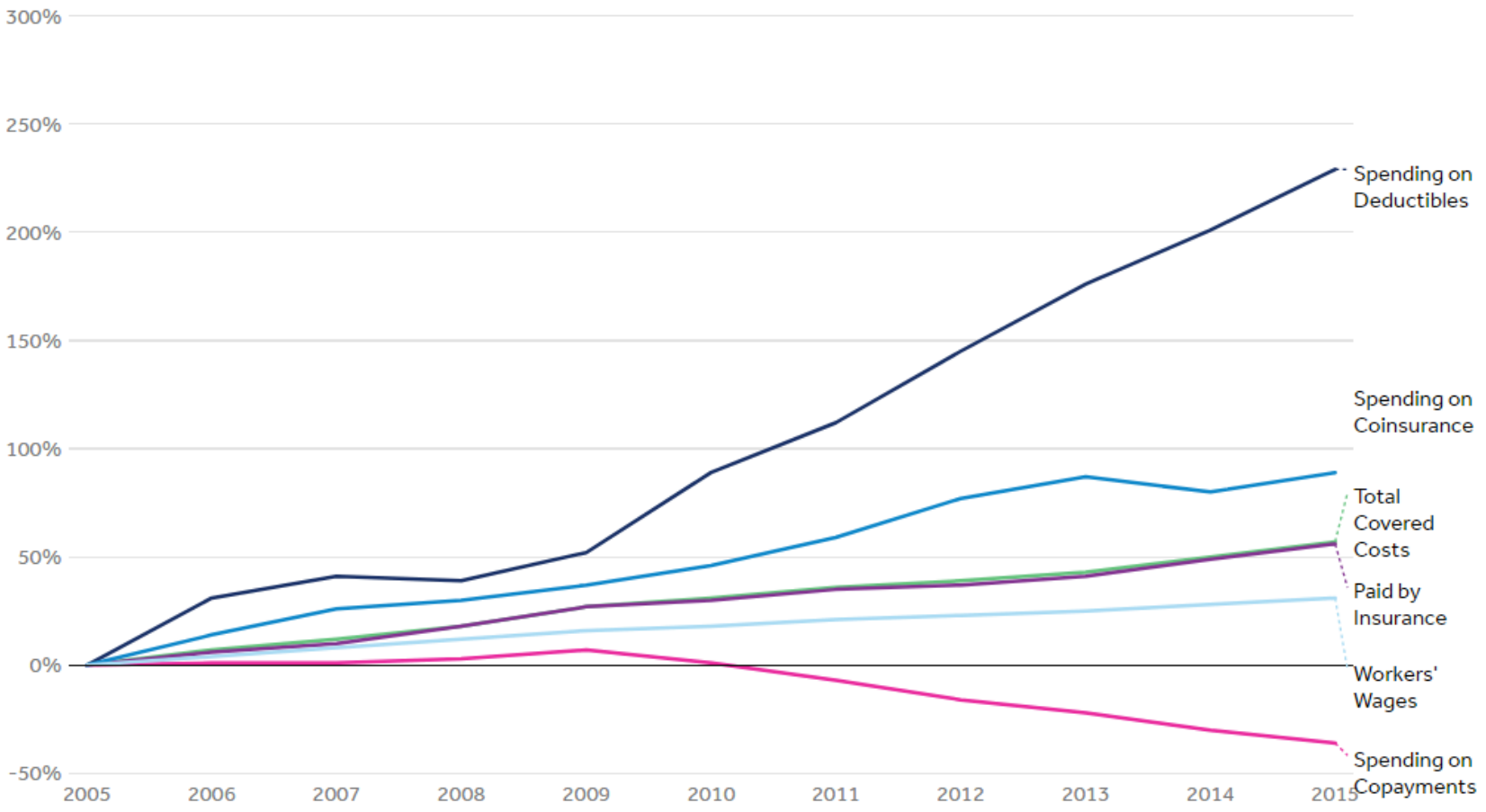
Employer Tactics to Control Health Expenditures
Consumer cost-sharing is a common policy lever



Source: NBGH

Consumer Cost-Sharing: Paying More for ALL Care Regardless of Value

Impact of Consumer Cost-sharing



Deductibles

Co-insurance

Co-payments

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

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]

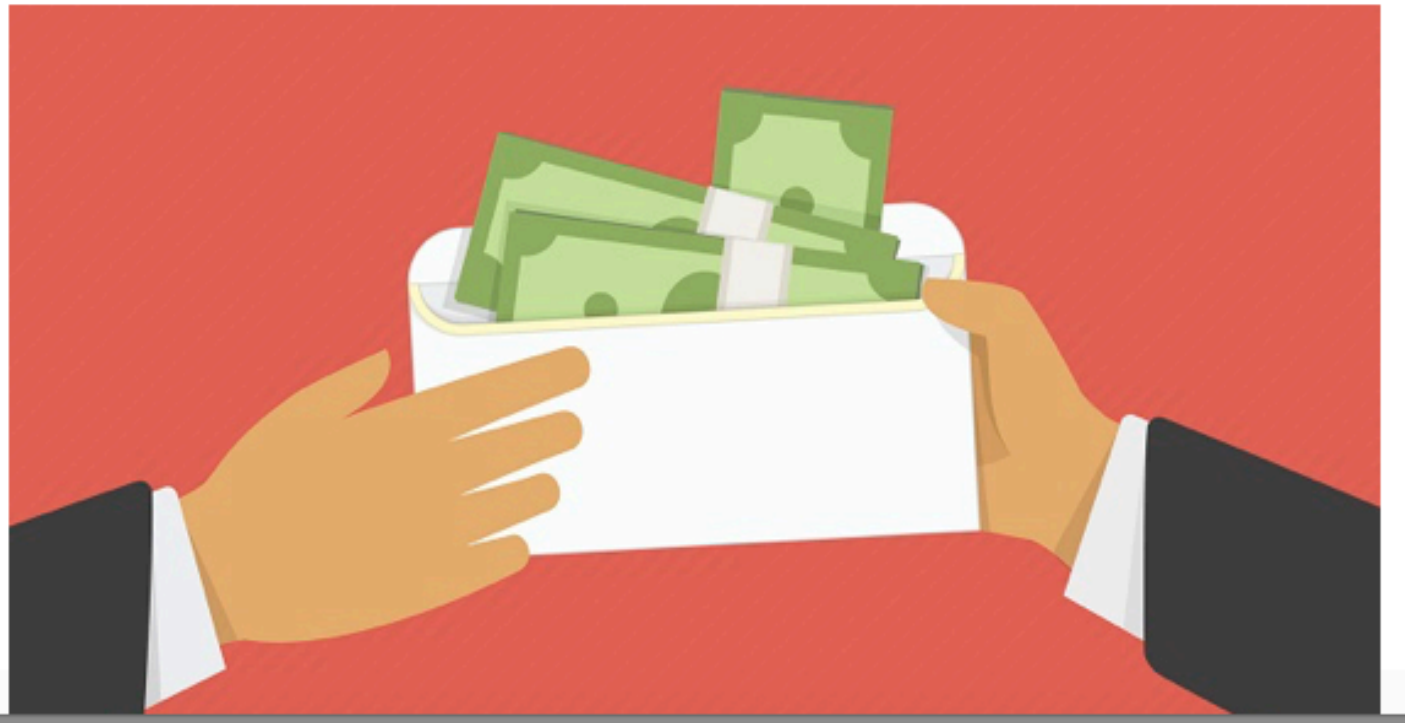
[1]Department of Health Care Policy, Harvard Medical School, Boston, MA, USA; [2]Thomson Healthcare, Ann Arbor, MI, USA; [3]Managed Markets Division, GlaxoSmithKline, Research Triangle Park, NC, USA; [4]Managed Markets Division, GlaxoSmithKline, Montvale, NJ, USA; [5]Departments of Internal Medicine and Health Management and Policy, Schools of Medicine and Public Health, University of Michigan, Ann Arbor, MI, USA.

- **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.

Patient Worry About Out-of-Pocket Healthcare Costs at All-Time High

A report from the Commonwealth Fund noted that patients are not confident they can afford high out-of-pocket healthcare costs.



One in Four Patients Have Difficulty Affording Their Prescription Medicines

Kaiser Family Foundation Tracker Sept 2016

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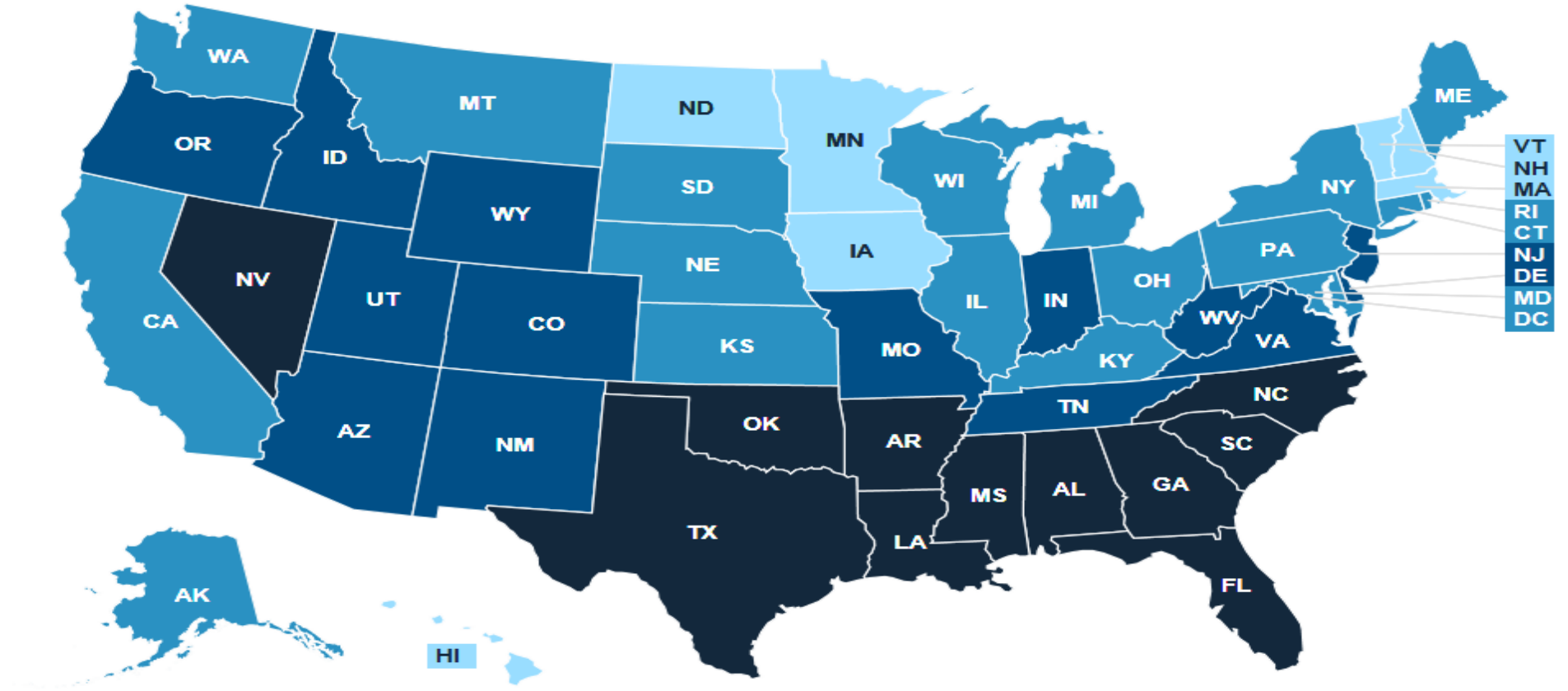
Percent of Adults Reporting Not Seeing a Doctor in the Past 12 Months Because of Cost



SOURCE: KFF Health

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Moving from the Stone Age to the Space Age: Change the discussion from “How much” to “How well”

- “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
- Americans do not care about the cost of health care; they care about what it costs them 

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Clinical Nuance:
An Alternative to 'Blunt' Cost-Sharing

- **A clinical service is never always high or low value**
- **The clinical value of a specific clinical service depends on:**
  - **Who receives it**
  - **When in the course of disease**
  - **Who provides it**
  - **Where it is provided**

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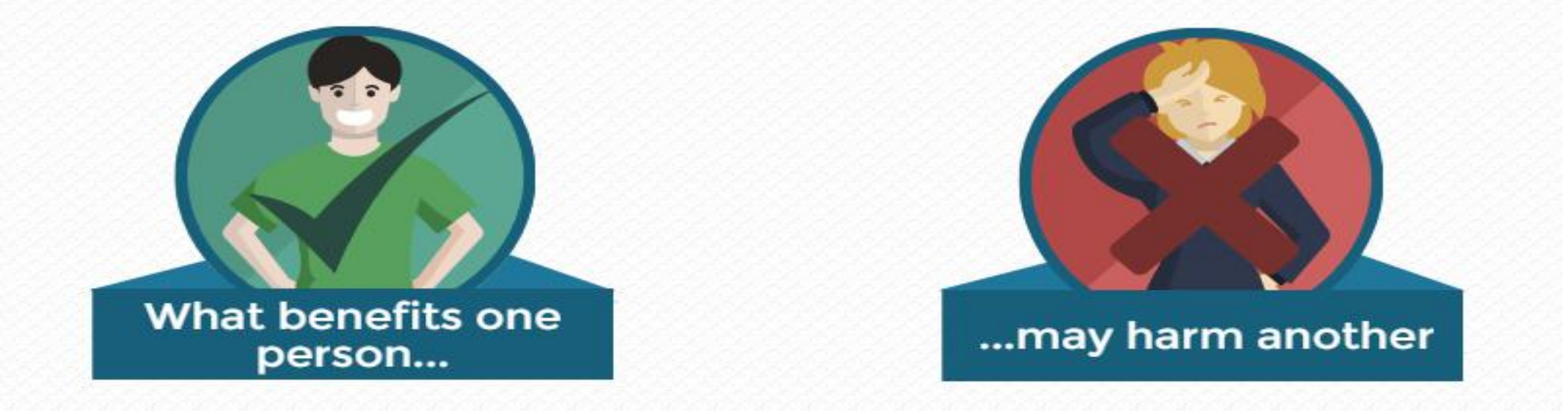
Clinical Nuance: Key Takeaway



Implementing Clinical Nuance: 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**

The Upshot

Health Plans That Nudge Patients to Do the Right Thing

Austin Frakt
THE NEW HEALTH CARE JULY 10, 2017

RELATED COVERAGE

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
- EBRI
- AMA

Putting Innovation into Action: Translating Research into Policy

Translating Research into Policy

THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

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)

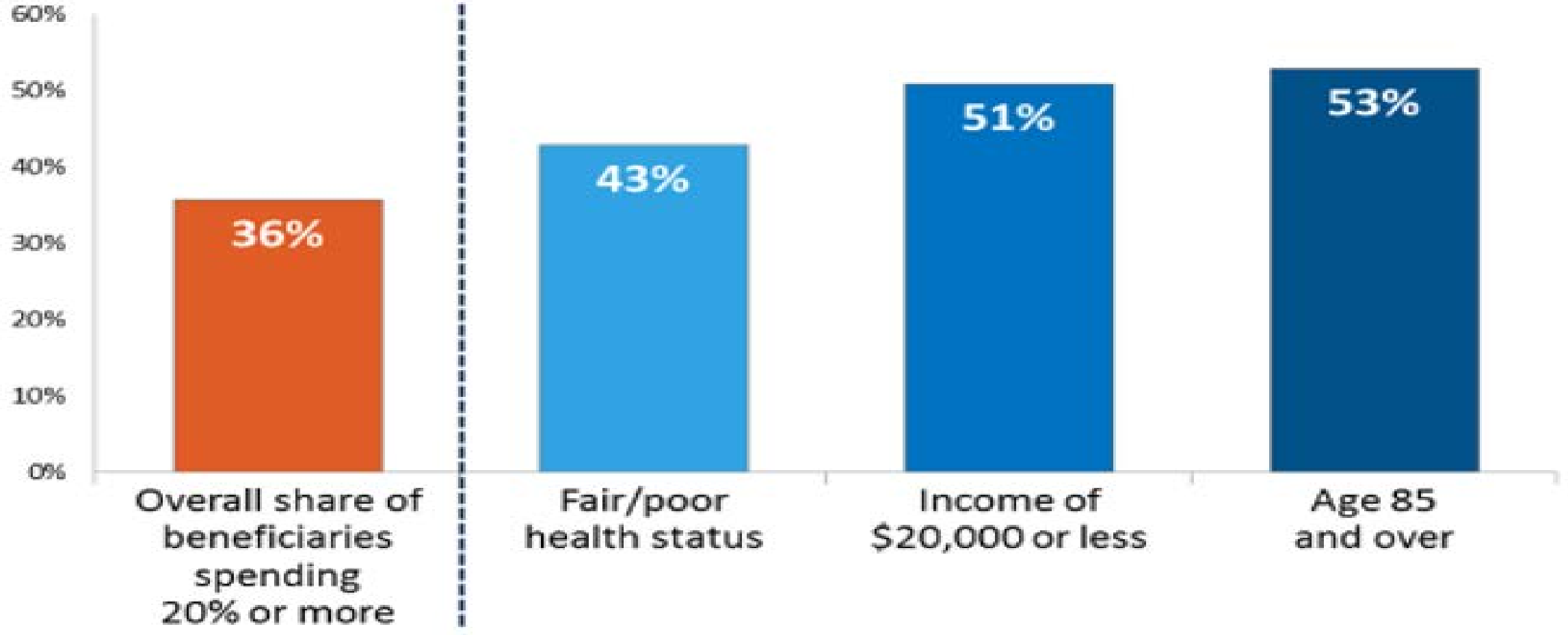
Over 137 million Americans have received expanded coverage of preventive services

Putting Innovation into Action: Translating Research into Policy

Translating Research into Policy

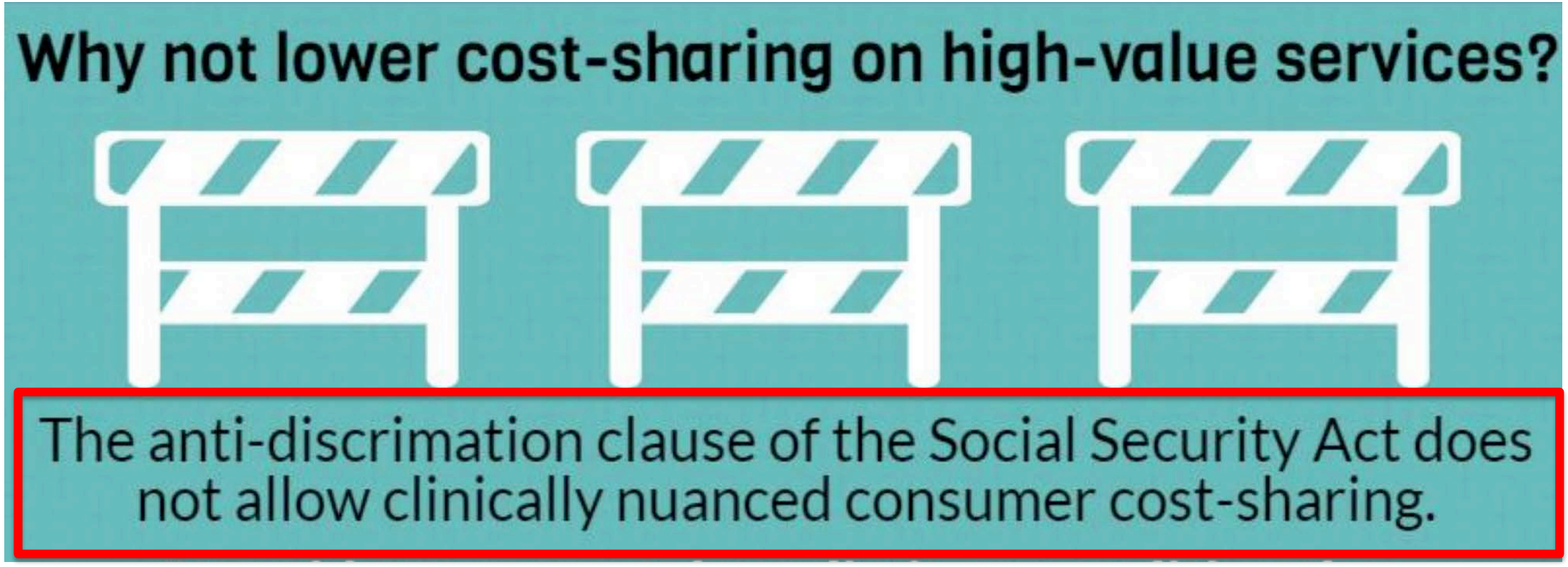
Medicare

More Than One-Third of Medicare Beneficiaries Spent 20% or More of Their Income on Out-of-Pocket Costs in 2013



NOTE: Estimates based on spending and income amounts in 2016 dollars. Excludes Medicare Advantage enrollees and beneficiaries enrolled in Part A or B only. Total out-of-pocket health care spending includes spending on services and premiums for Medicare and private health insurance premiums. Income is measured on a per person basis, which for married couples is income for the couple divided in half.
SOURCE: Kaiser Family Foundation analysis based on CMS Medicare Current Beneficiary Survey 2013 Cost and Use file.

Implementing V-BID in Medicare: Policy Barriers Ahead



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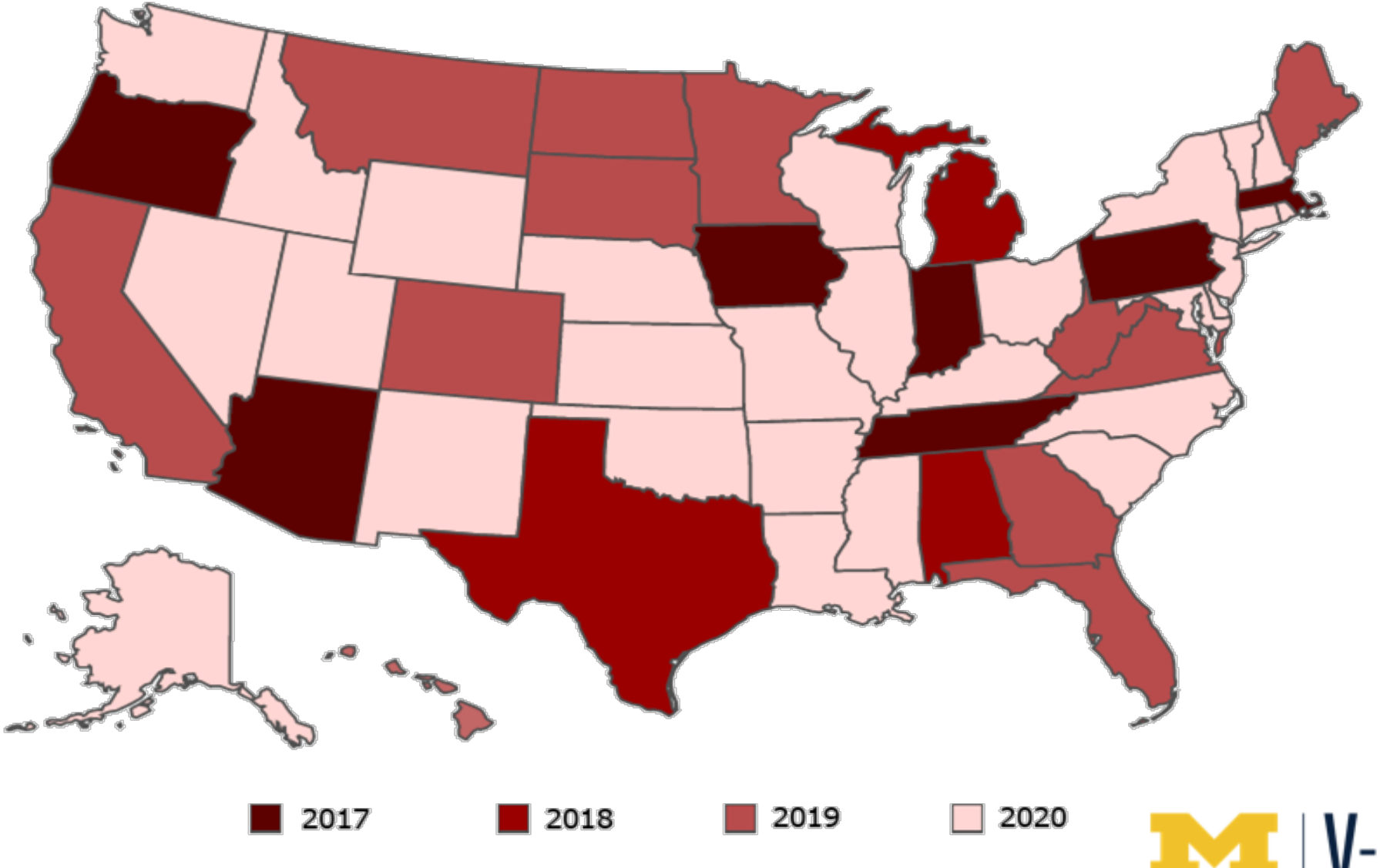
MA V-BID – 1st CMS Demonstration Allowing Cost-Sharing Reductions for Individuals with Specific Clinical Conditions

2018 Budget Expands MA V-BID Model Test to all 50 States by 2020



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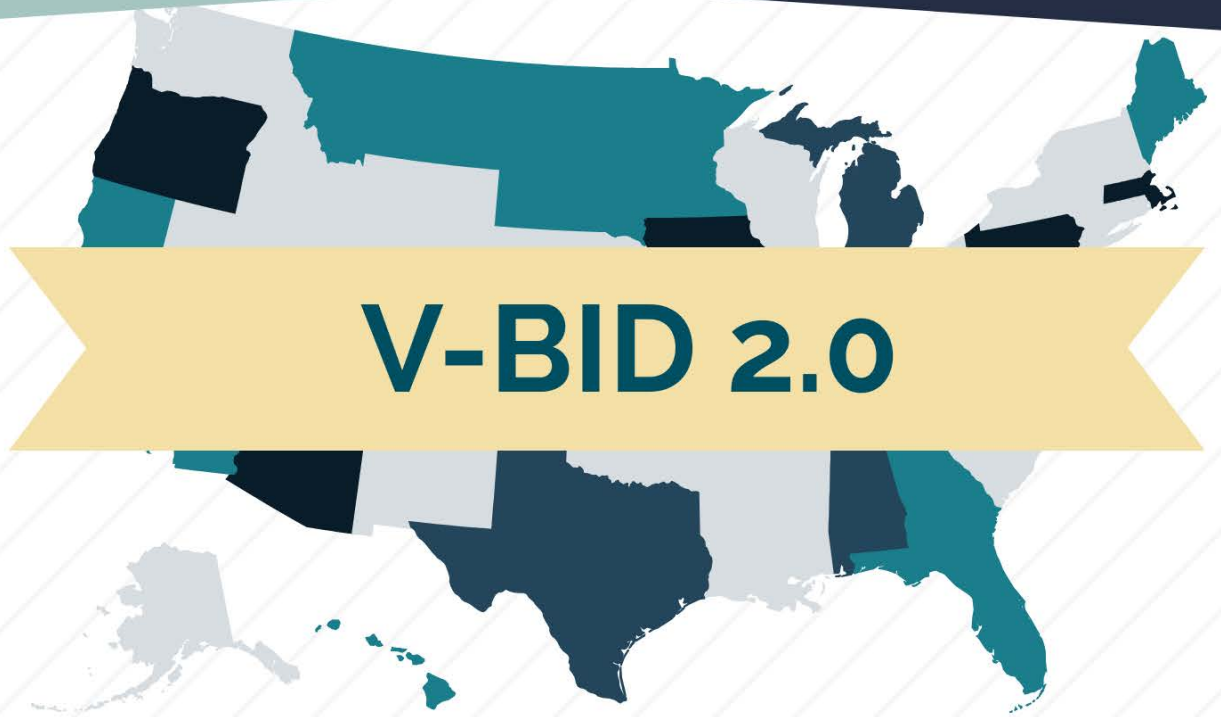
THE EXPANDED ROLE OF V-BID IN MEDICARE ADVANTAGE



CMS announced transformative updates to the **Medicare Advantage Value-Based Insurance Design model**, including its expansion to all 50 states

V-BID 2.0 allows MA plans to...

- Provide reduced cost-sharing and supplemental benefits in a more targeted fashion
- Increase access to new interventions like telehealth services, and wellness and healthcare planning
- Expand eligibility to include Dual Eligible SNPs, Institutional SNPs, and Regional PPOs
- Broaden rewards programs that improve beneficiaries' health

Putting Innovation into Action: Translating Research into Policy

Translating Research into Policy

TRICARE®

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**

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Health Affairs

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

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HSA-HDHP Reform

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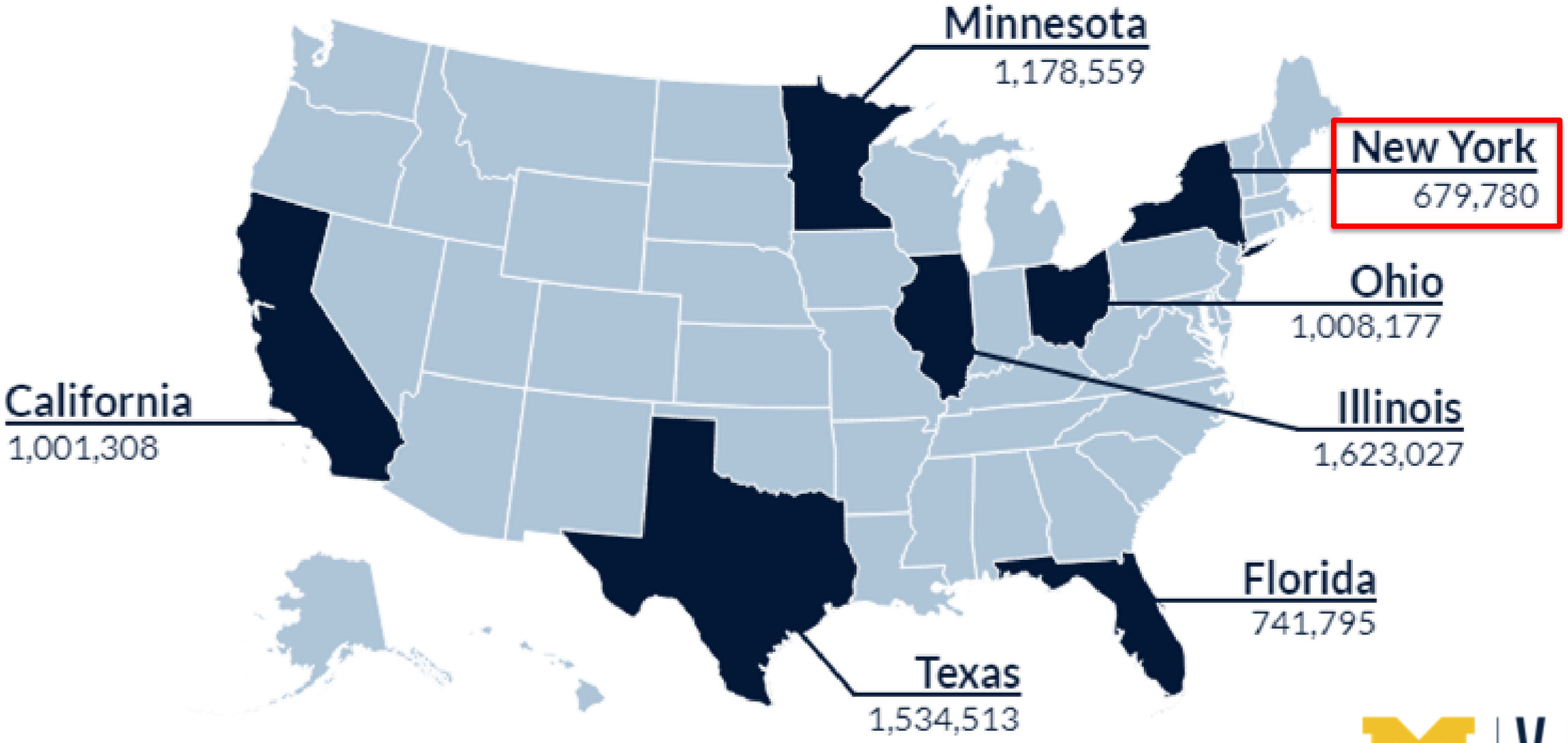
States with the Highest HSA-HDHP Enrollment



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Bloomberg

Sky-High Deductibles Broke the U.S. Health Insurance System

Employers are questioning a system they say costs patients too much.

40% of Americans face a deductible of $1,300+

More than 70M Americans enrolled in an HDHP

HDHP is only option for 13% of Americans with employer-sponsored coverage

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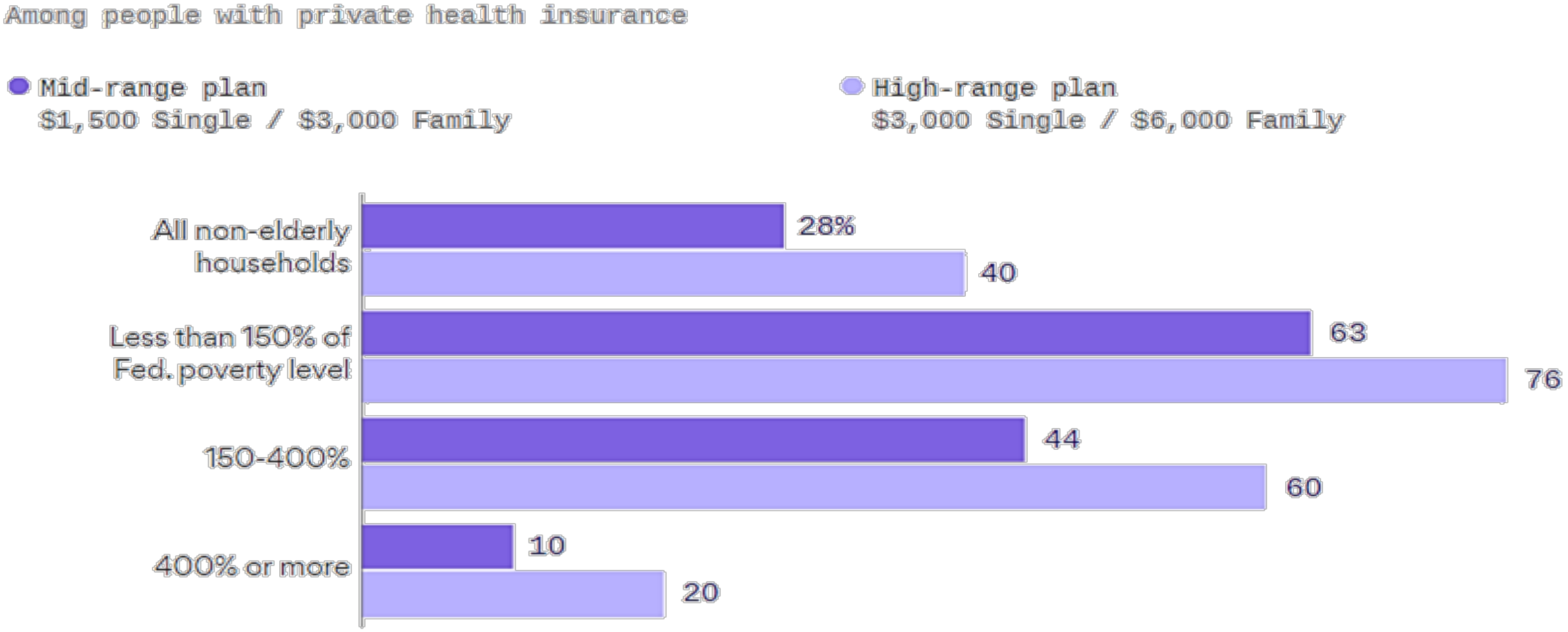
A Significant Number of Households Do NOT Have Liquid Assets to Cover Their Plan Deductible



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

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

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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

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

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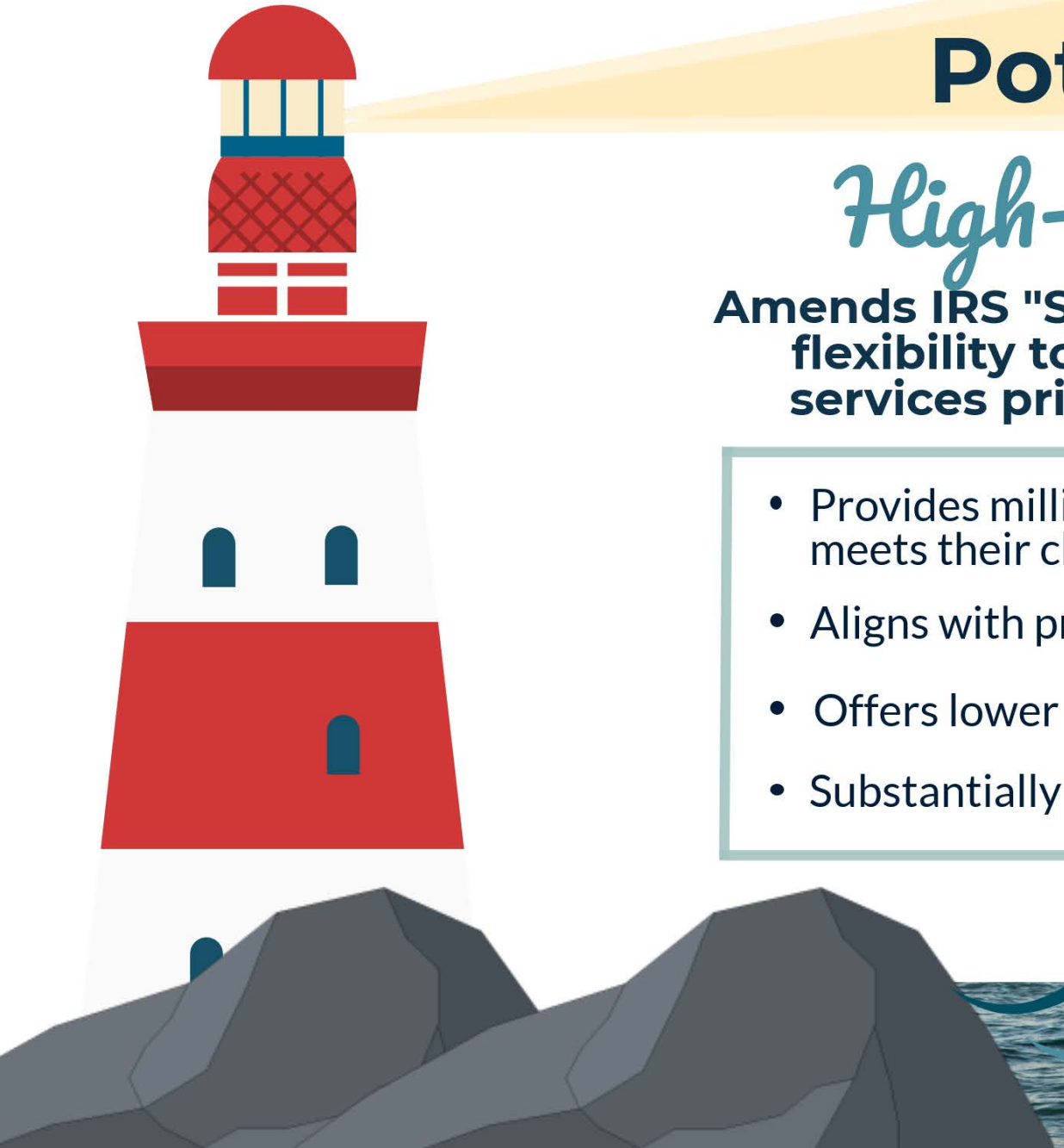


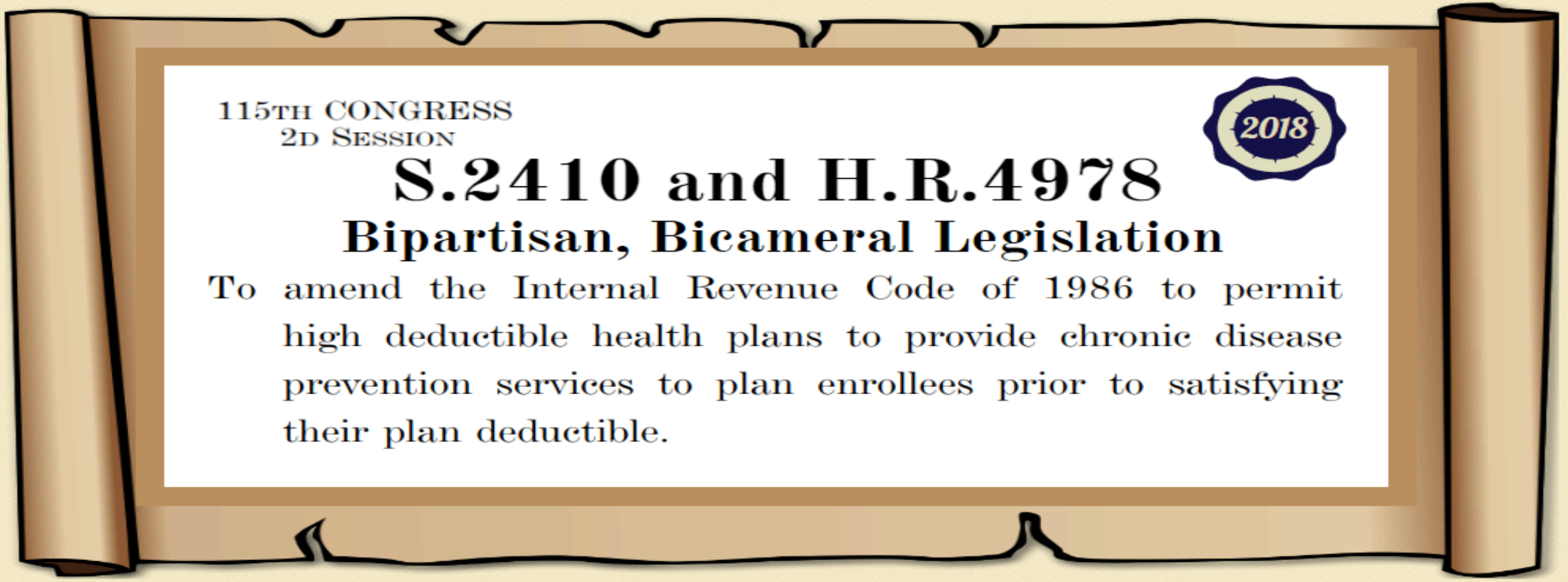
Potential Solution:

High-Value Health Plan

Amends IRS "Safe Harbor" to allow health plans the flexibility to cover high-value chronic disease services prior to meeting the plan deductible

- Provides millions of Americans a plan option that better meets their clinical and financial needs
- Aligns with provider payment reform incentives
- Offers lower premiums than most PPO and HMO plans
- Substantially reduces aggregate health care expenditures

Chronic Disease Management Act of 2018



"The administration should explore ways to administratively expand consumers' abilities to benefit from HSAs, including by interpreting preventive services to allow HSA-qualified plans greater ability to cover preventive low-cost treatments for chronic conditions."

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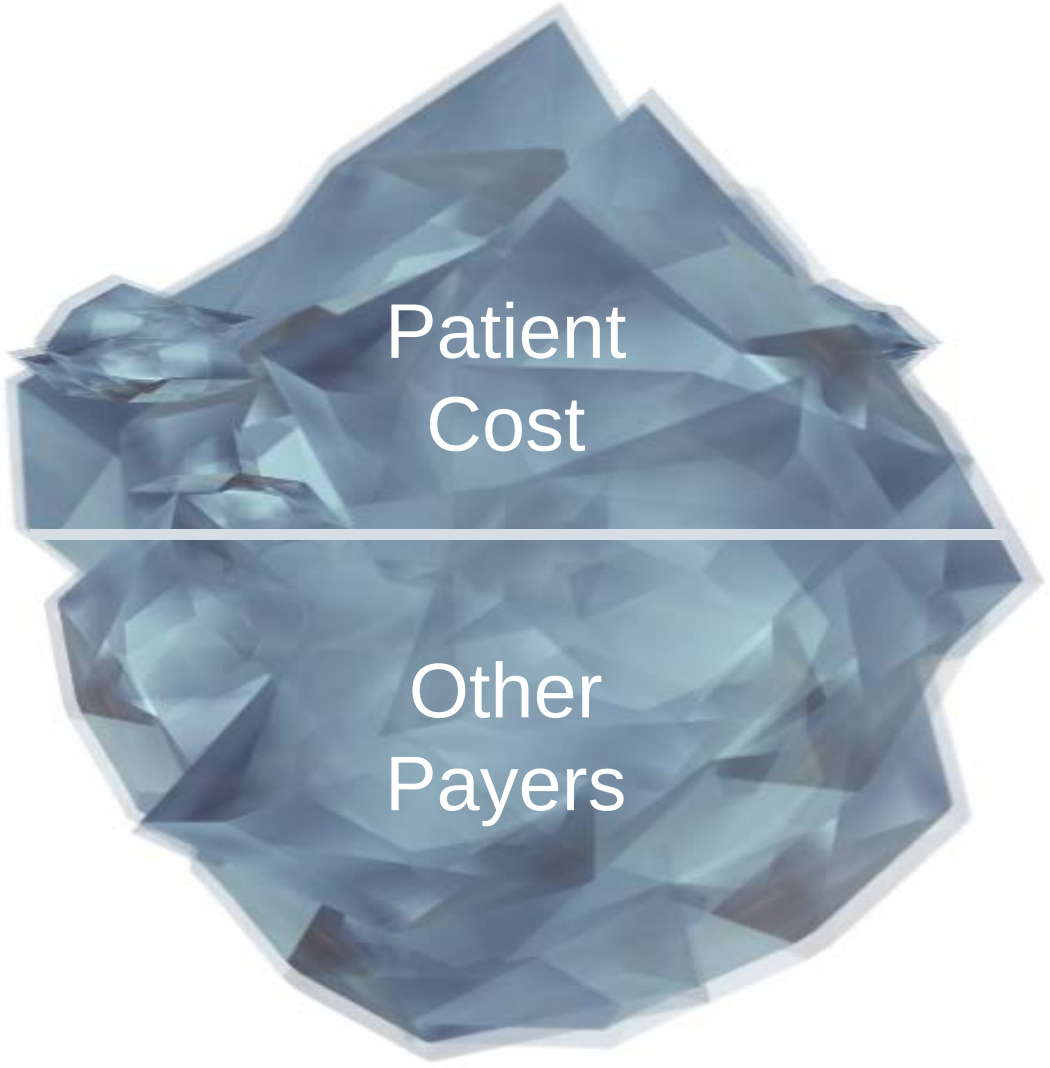
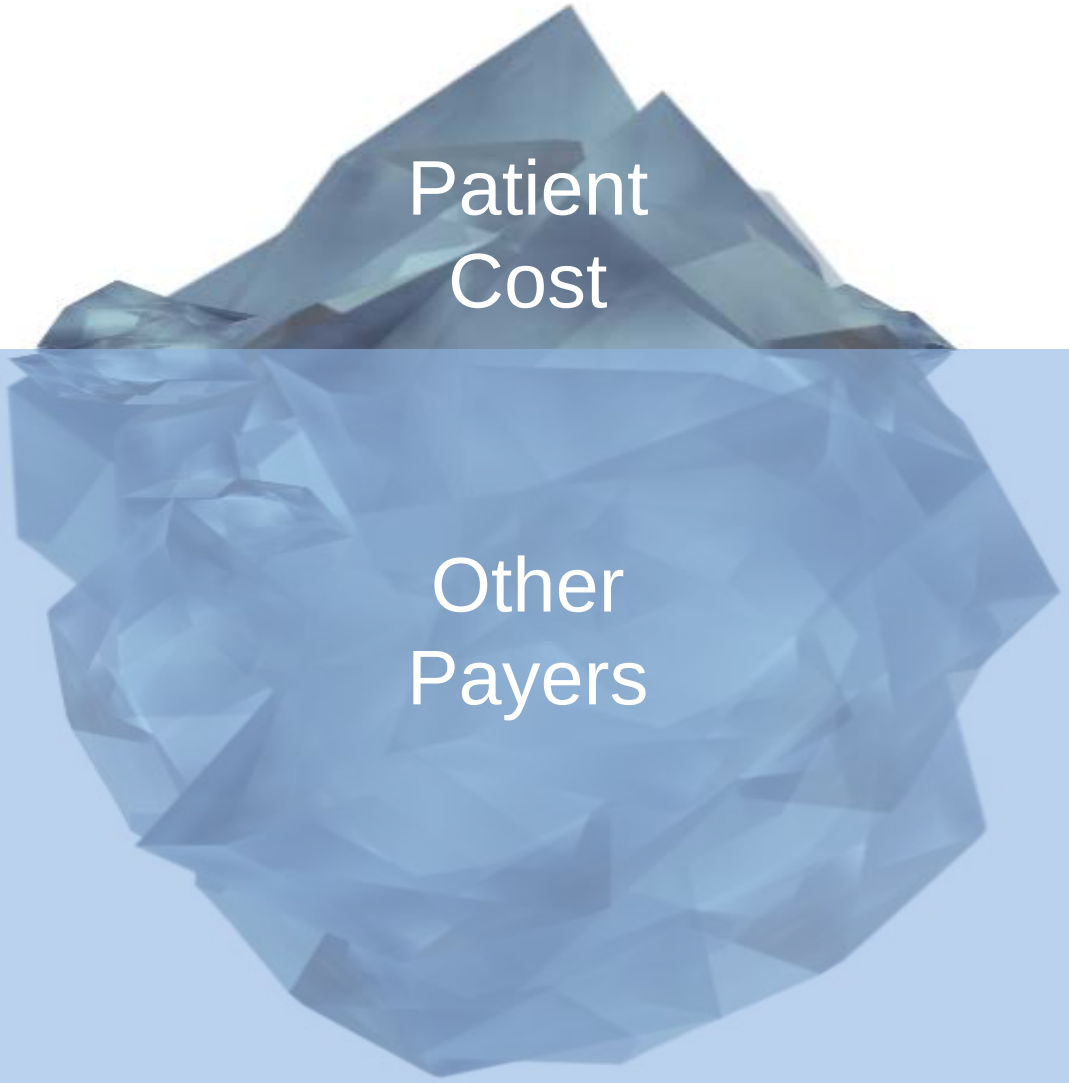
Motivation for Low Value Care Removal: The Health Care Iceberg

Health care is typically paid in two portions



The amount a consumer pays for care is determined by their insurance coverage



Insurance
Coverage

If coverage is not generous; patients pay the entire p

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

Skimpy Insurance Coverage

V-BID increases generosity of coverage for high valu services

Patient Cost

Generous Coverage – such As ACA Sec 2713

V-BID increases generosity of coverage for high valu services

Patient Cost

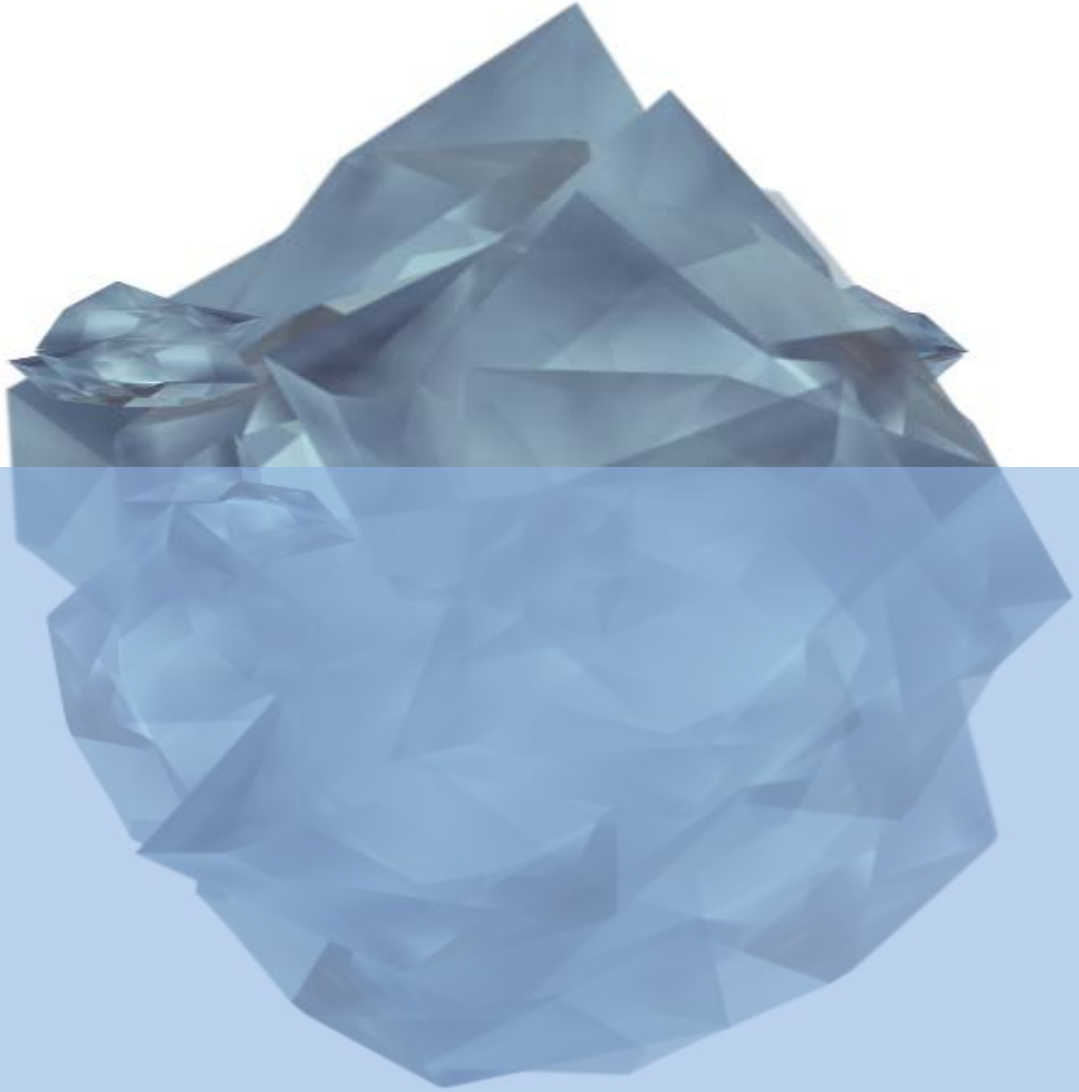
Generous
Insurance
Coverage

How do we pay to provide better coverage for high value care?

Creating ‘Headroom’ for Better Coverage of High Value Care Removing Billions Spent on Low Value Care

High Value

Low Value



Melting Low Value Care Iceberg Allows Water Level to Rise Paying for Better Coverage of High Value Care

High Value – Generous Coverage

Low Value – No Coverage

Patient Cost

Other Payers

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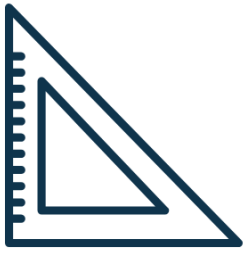
REDUCING
LOW-VALUE CARE

IDENTIFY.

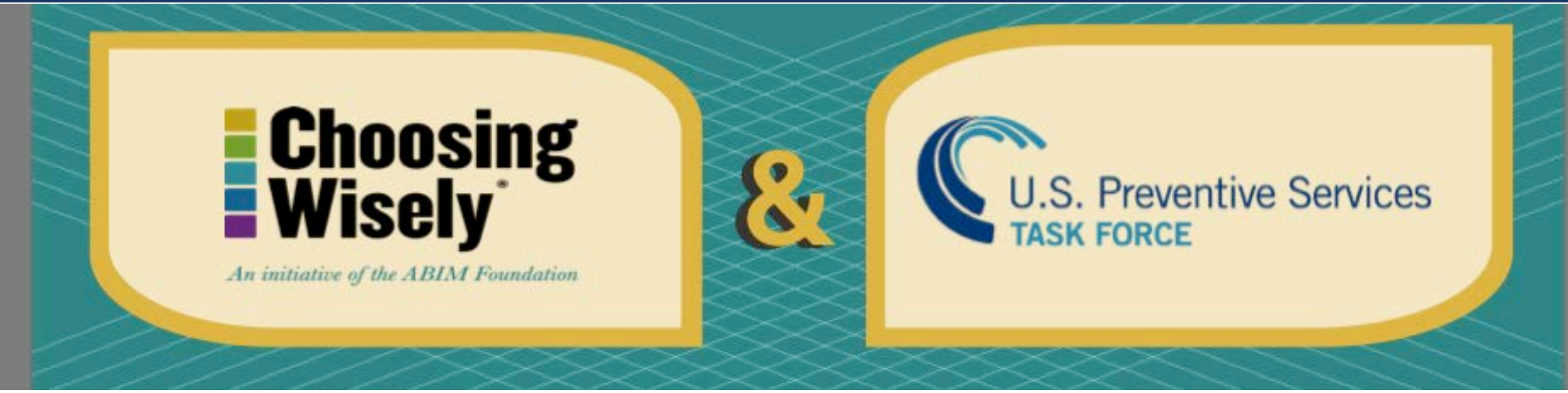


MEASURE.

REDUCE.

REPORT.

Low Value Care: Identify



- Choose services:
  - Easily identified in administrative systems
  - Mostly low value (little or no clinical nuance)
  - 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. Diagnostic Testing and Imaging 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

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Measure:
Commonwealth of Virginia Unnecessary Care Initiative

- **Among 5.5 million Virginia beneficiaries, 1 in 5 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 spend)**

COSTS & SPENDING

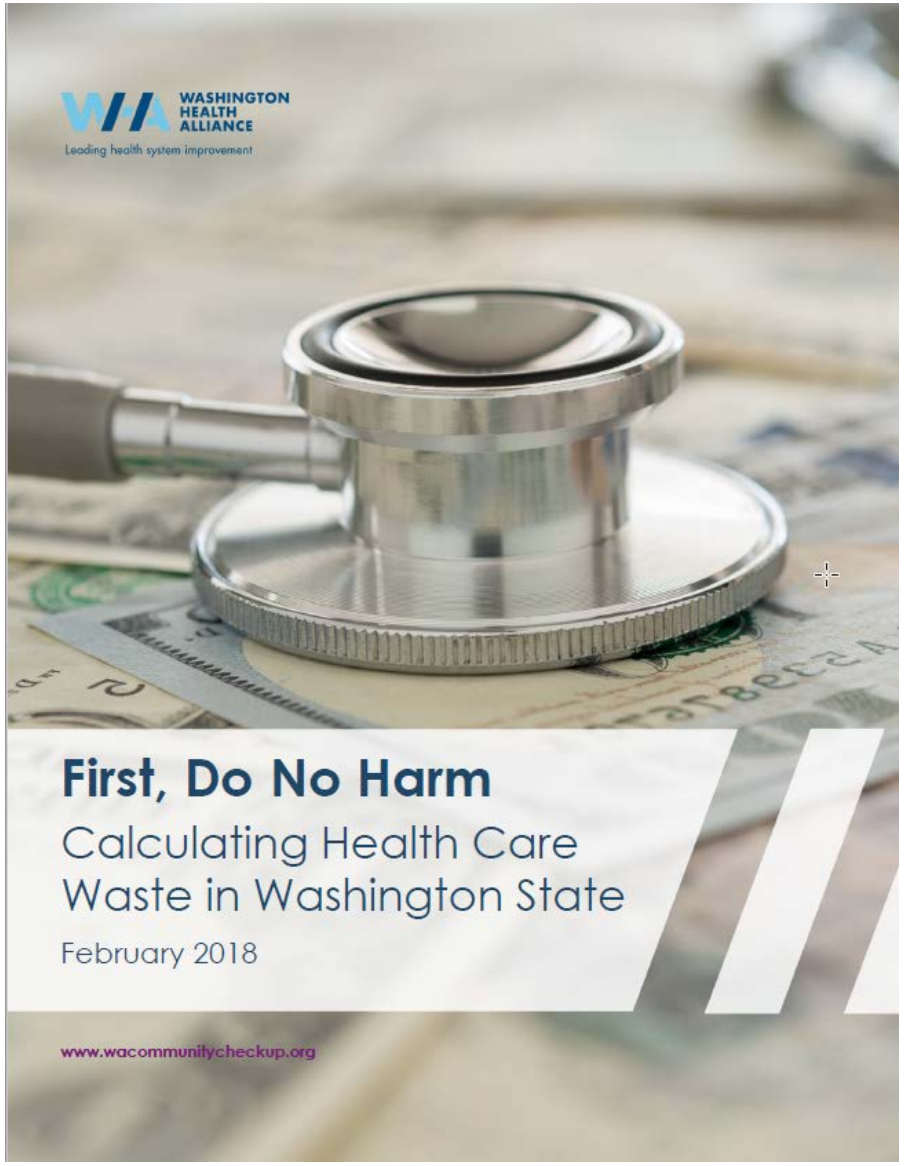
By John N. Mafi, Kyle Russell, Beth A. Bortz, Marcos Dachary, William A. Hazel Jr., and A. Mark Fendrick

DATAWATCH

Low-Cost, High-Volume Health Services Contribute The Most To Unnecessary Health Spending

An analysis of data for 2014 about forty-four low-value health services in the Virginia All Payer Claims Database revealed more than $586 million in unnecessary costs. Among these low-value services, those that were low and very low cost ($538 or less per service) were delivered far more frequently than services that were high and very high cost ($539 or more). The combined costs of the former group were nearly twice those of the latter (65 percent versus 35 percent).

Measure:
State of Washington Health Alliance



- **Approximately 1.3 MM individuals received one of the 47 services, and almost half (47.9%) of them received at least one wasteful service.**
- **An estimated $282 MM in wasteful spending**

ACA Sec 4105: Modify or Eliminate Coverage of Certain Preventive Services

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 eliminate coverage for USPSTF 'D' Rated Services in Medicare

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

Aligning Incentives

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

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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”

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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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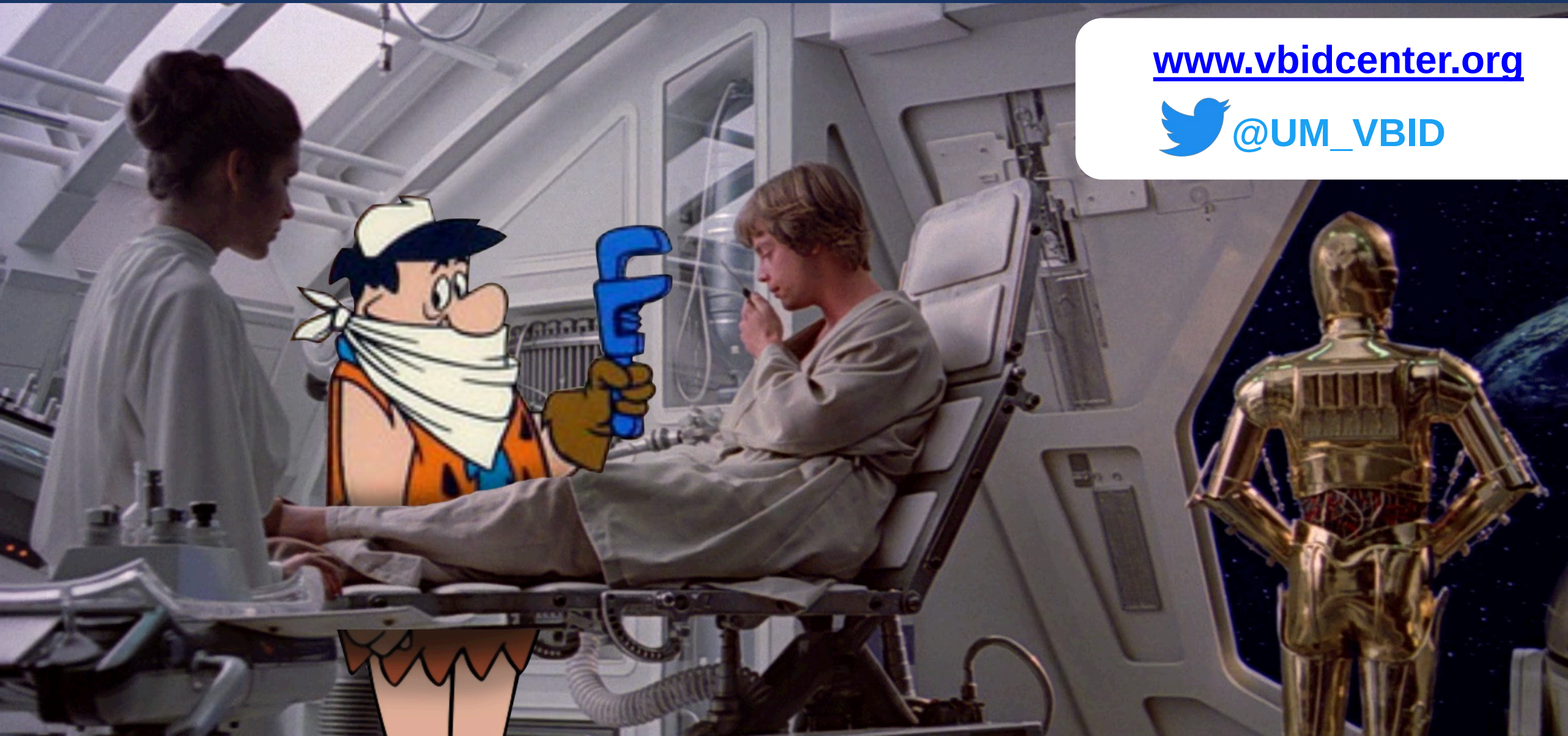
My Hope for the Future



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