Value-Based Insurance Design: Enhancing Access and Affordability to Essential Clinical Services

A. Mark Fendrick, MD

University of Michigan Center for Value-Based Insurance Design

www.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.

Health Care Costs Are a Top Issue For Purchasers and Policymakers: Solutions must protect consumers, reward providers 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

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Star Wars Science

Flintstones Delivery

Outline

- Value-Based Insurance Design
- Low Value Care
- Aligning Incentives
- Translating Research into Policy
- V-BID X

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International Journal of Technology Assessment in Health Care

Article Metrics

Volume 12, Issue 1 January 1996, pp. 1-8

The Tension Between Cost Containment and the Underutilization of Effective Health Services

Bernard S. Bloom [a1] and A. Mark Fendrick [a2]

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

- Everyone (almost) agrees there is enough money in the US health care system; we just spend it on the wrong services
- Policy deliberations focus primarily on alternative payment and pricing models
- 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
- Consumer cost-sharing is a common policy lever

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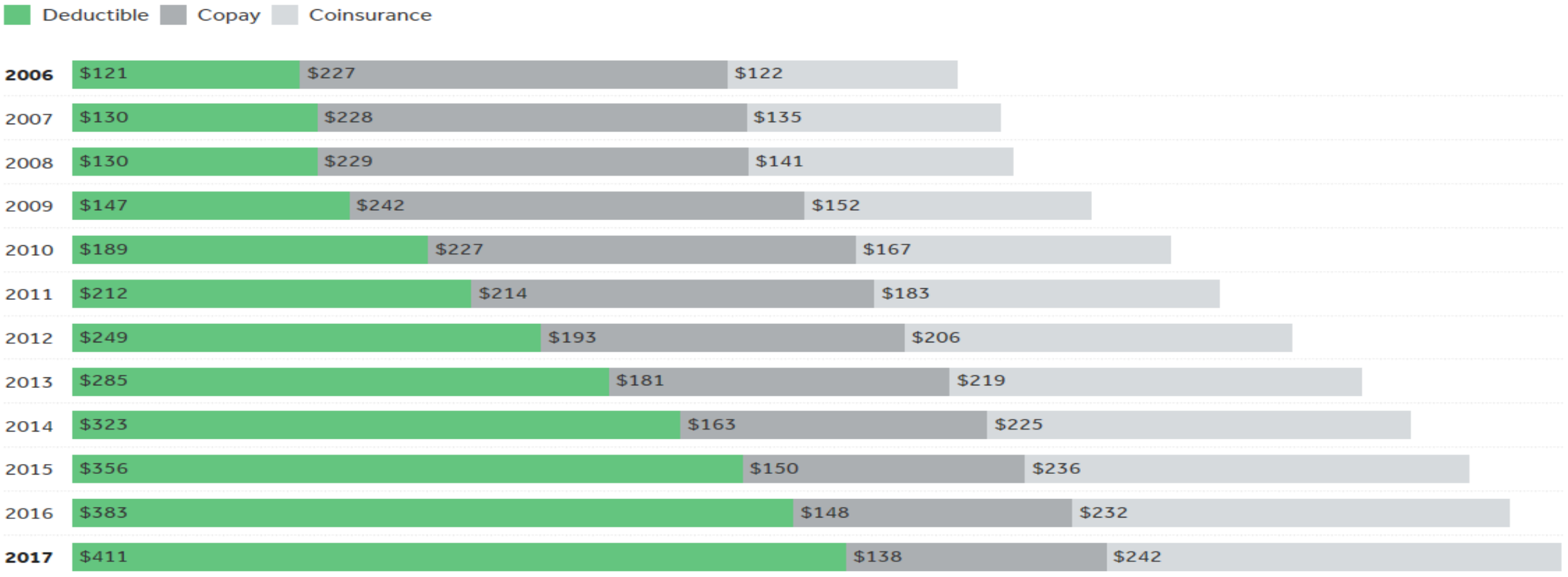
Out-of-pocket spending among people with large employer coverage, Paying More for ALL Care Regardless of Value



Source: KFF analysis of data from IBM MarketScan Database and the KFF Employer Health Benefit Survey

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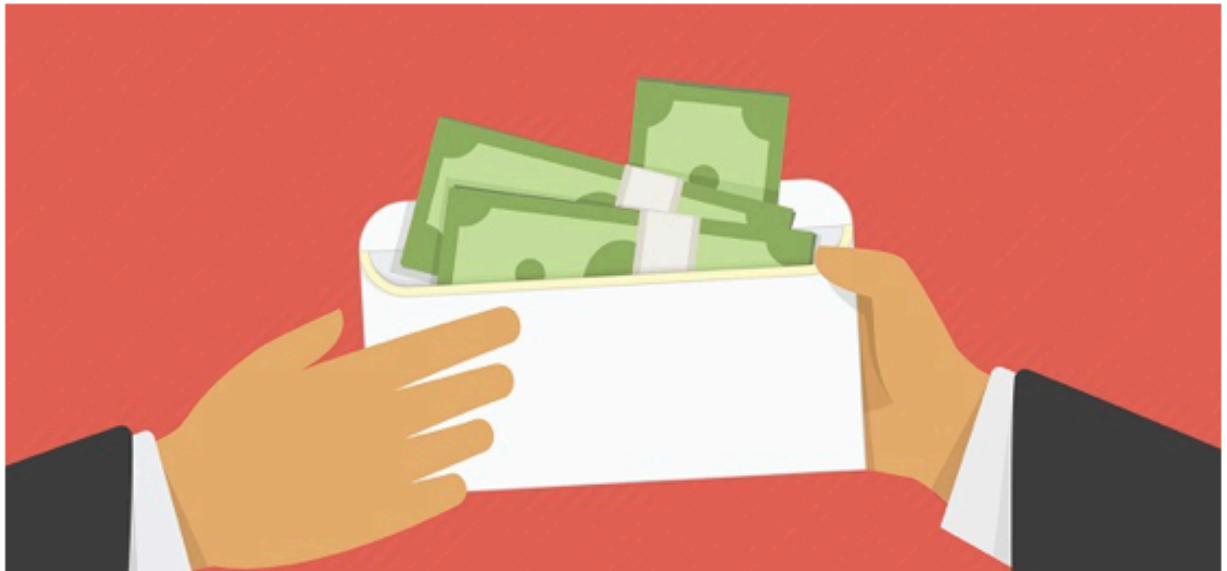
Americans Do Not Care About Health Care Costs; They Care About What It Costs Them

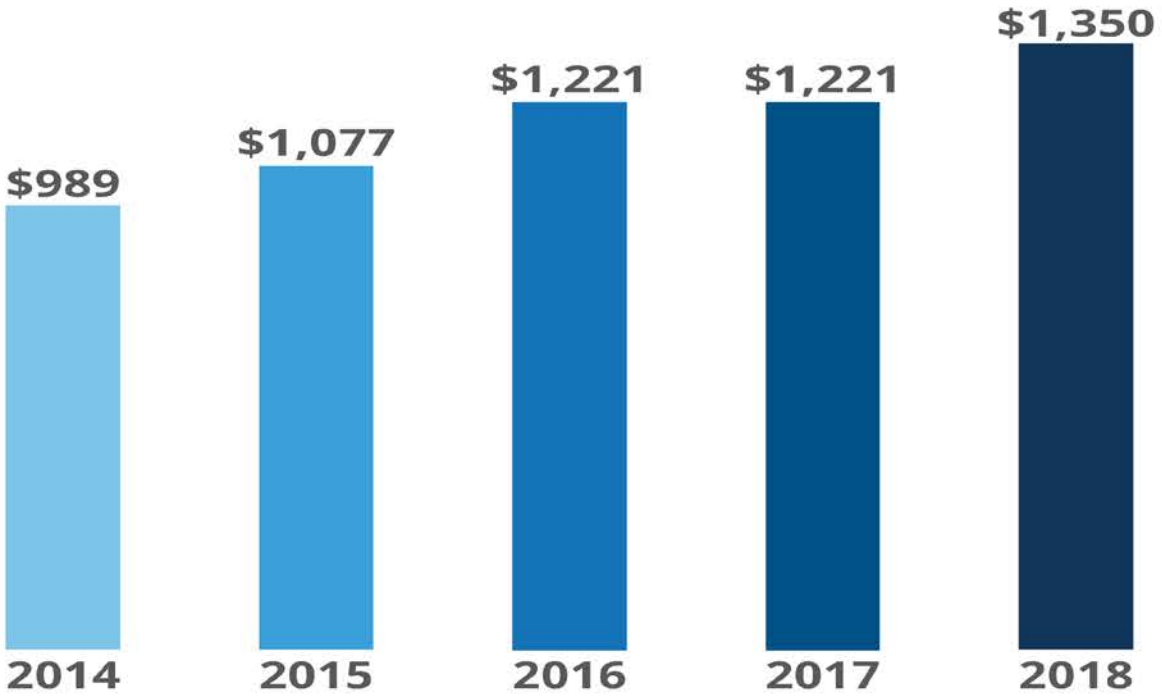
Patient Worry About Out-of-Pocket Healthcare Costs at All-Time High

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

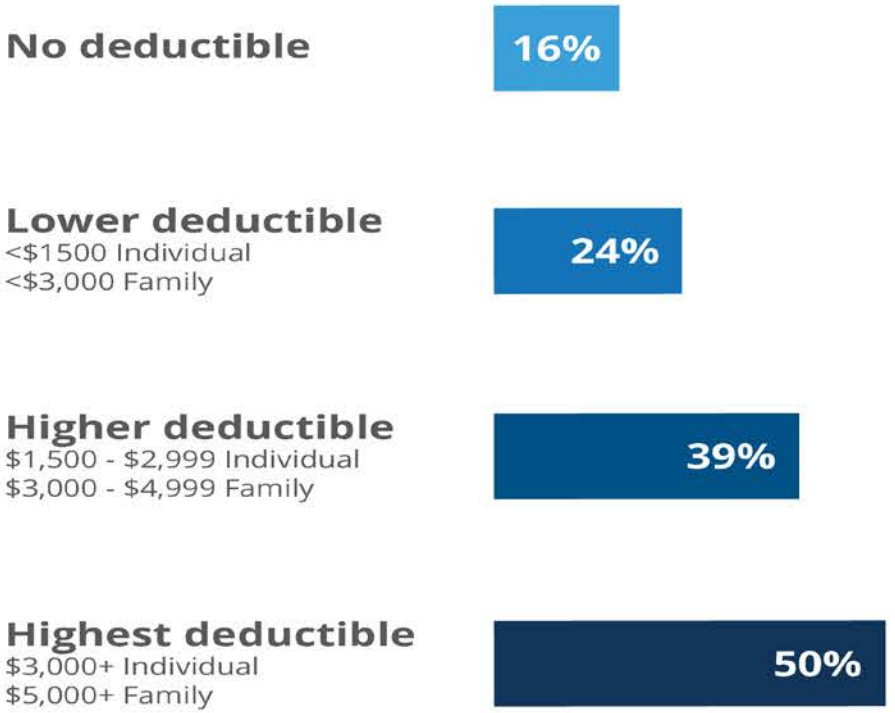


Dissatisfaction With Employer Coverage Rises As Deductibles Climb

Average deductible among large employer plans, including those with $0 deductibles



Percent who say their health insurance has gotten worse over the past 5 years



SOURCE: KFF analysis of data from KFF Employer Health Benefits Survey, 2018. KFF/LA Times Survey of Adults with Employer-Sponsored Health Insurance (Sept. 25-Oct. 9, 2018).

KFF
HENRY J KAISER FAMILY FOUNDATION

Inspiration (Still)

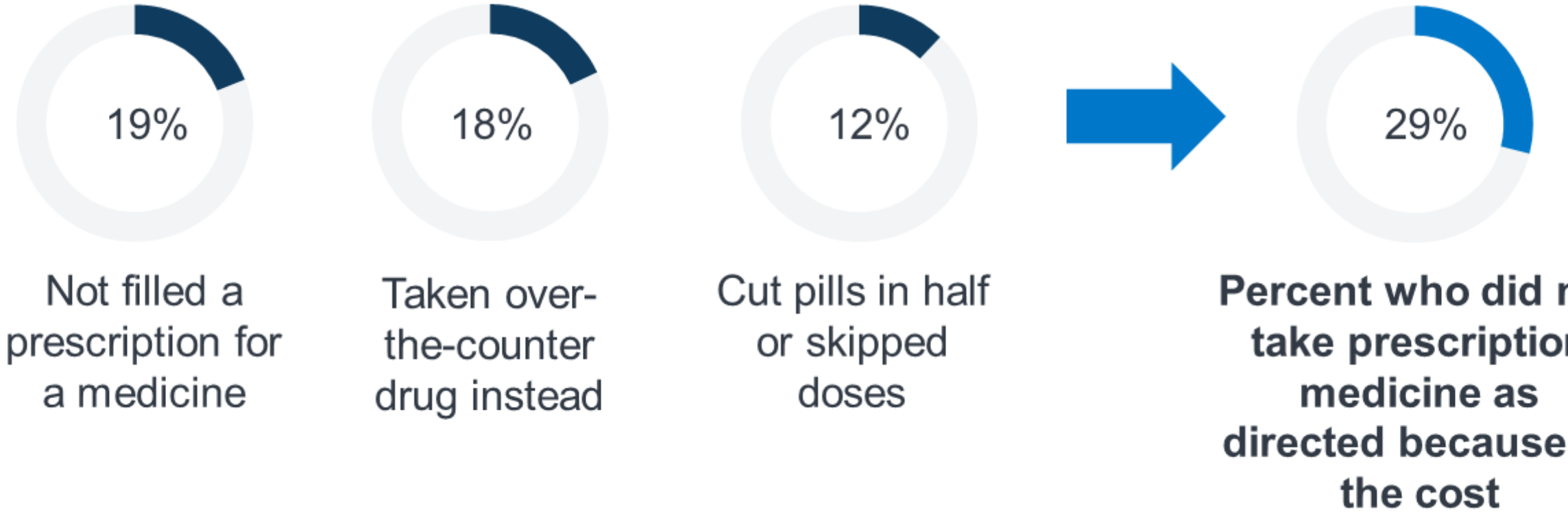
“I can’t believe you had to spend a million dollars to show that if you make people pay more for something, they will buy less of it.”

- Barbara Fendrick (my mother)

Figure 10

Three In Ten Say They Haven't Taken Their Medicine As Prescribed Due To Costs

Percent who say they have done the following in the past 12 months because of the cost:



SOURCE: KFF Health Tracking Poll (conducted February 14-24, 2019). See topline for full question wording and response options.

KFF
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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]

[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.

Next Generation Plan Option: “ 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

An Alternative to ‘Blunt’ Cost-Sharing: Clinical Nuance

- **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

Alternative to "Blunt" Consumer 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; high cost share for low value care**
- **Successfully implemented by hundreds of public and private payers**

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

Chicago Tribune | Health
Powered by: HEALTHKEY

Co-pays becoming a thing of the past for preventive services

Health law mandates many common screenings be free; companies embracing change as way to save costs down the road

Edward Gardula, an employees at Wolters Kluwer on Chicago's north side, works out in the company fitness center at lunch time. ((Nancy Stone/Chicago Tribune) / October 18, 2010)

By Bruce Japsen, Tribune reporter

October 26, 2010

V-BID

U.S. Preventive Services Task Force Recommends Expanding Use Of PrEP In High Risk People To Prevent Infection

In an effort to eliminate nearly 40,000 new HIV infections in the U.S. each year, the U.S. Preventive Services Task Force recommended Truvada, which can reduce the risk of infection by 92% when taken daily, should be offered to more patients. High cost has been a barrier, and so far fewer than 10% of high-risk people take the medication.

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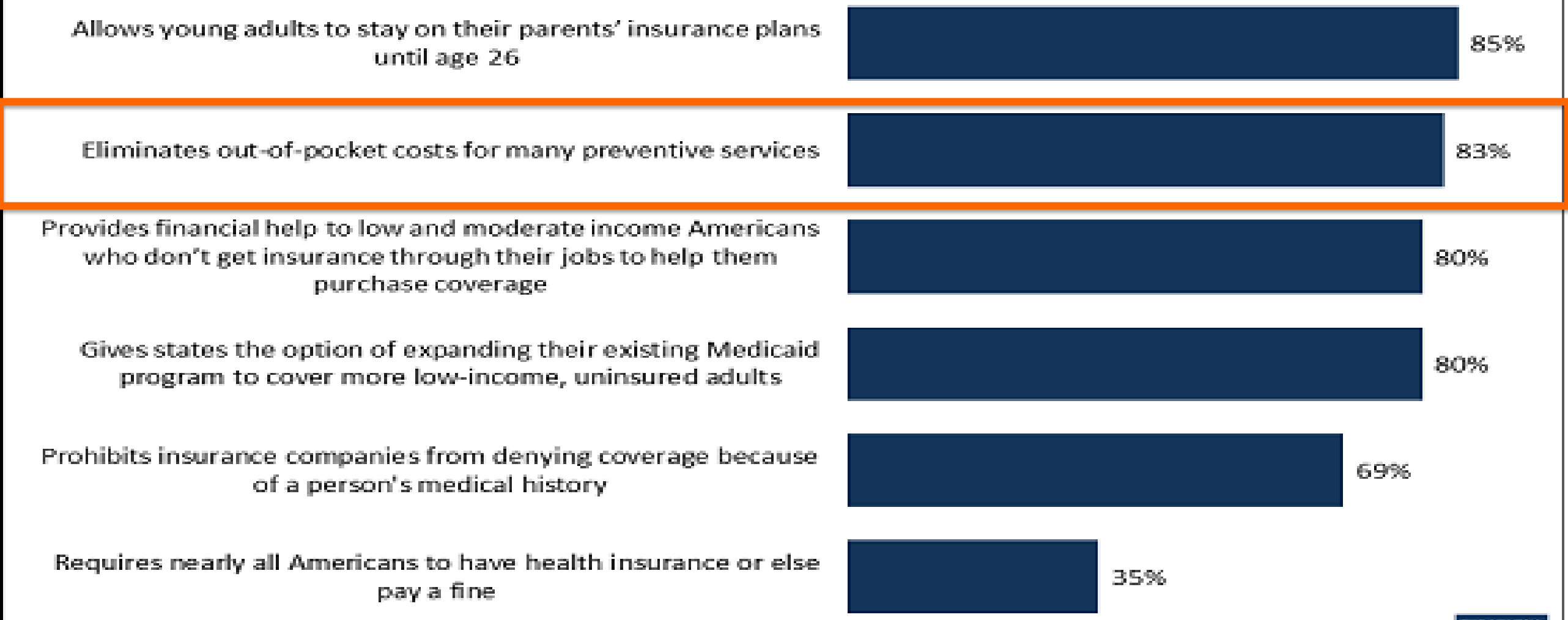
Majorities Favor Many Key ACA Provisions, But Not Its Individual Mandate

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)

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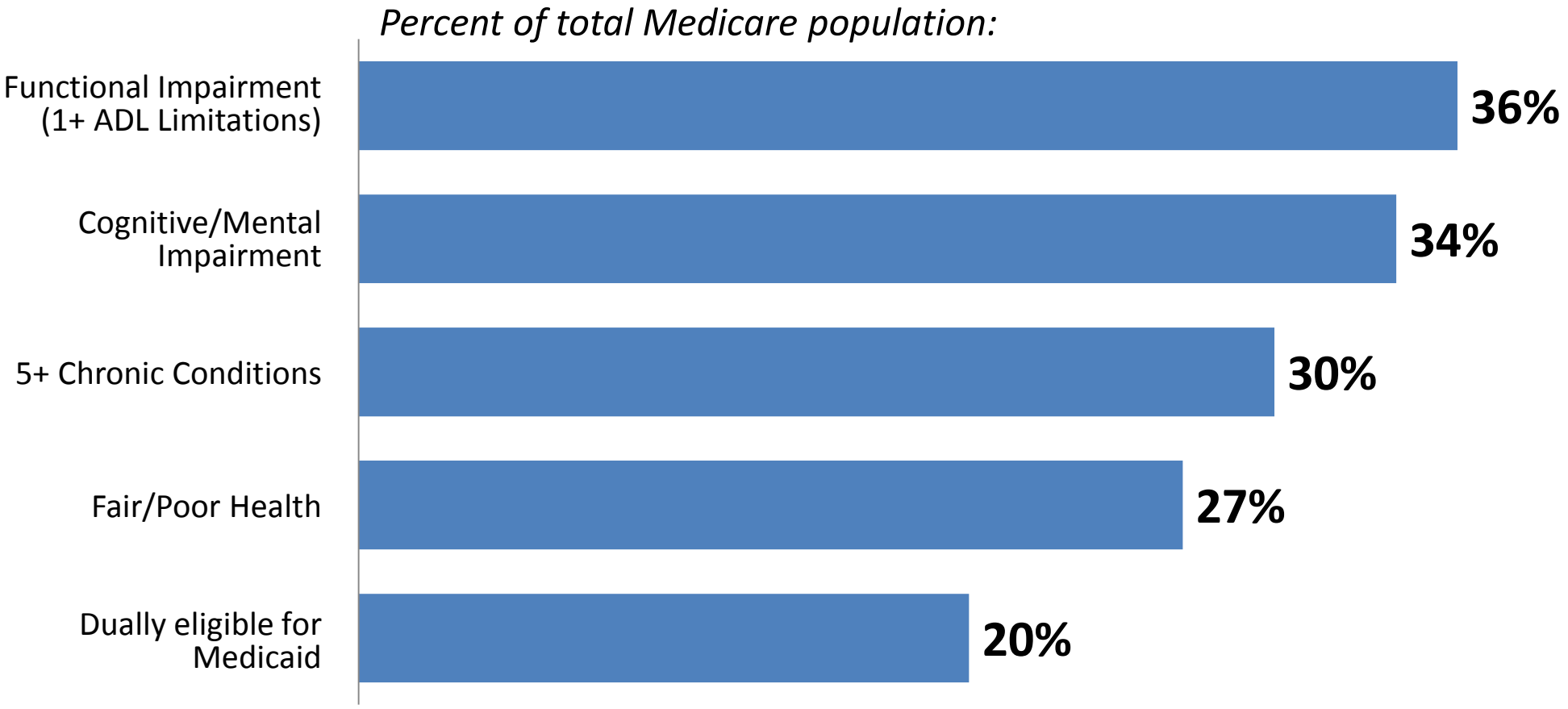
Putting Innovation into Action: Translating Research into Policy

Medicare

Many on Medicare live with functional limits, cognitive impairments, multiple chronic conditions, and fair/poor health

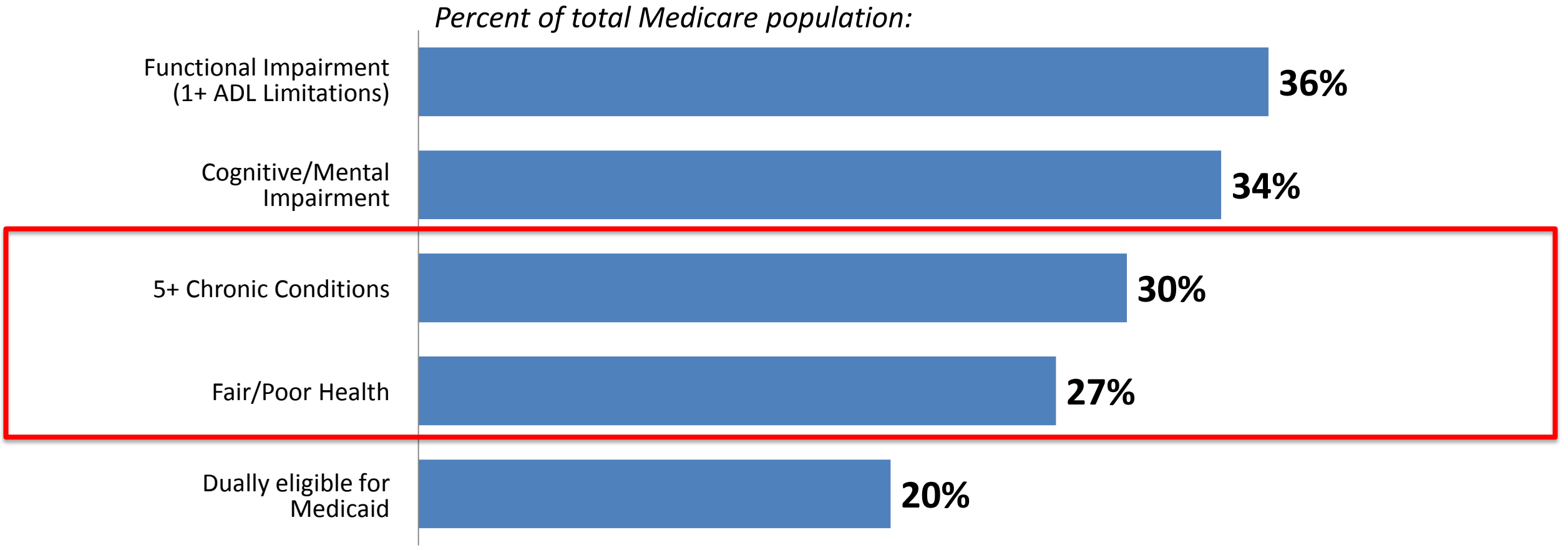


Medicare covered 57 million people in 2016

NOTE: ADL is activity of daily living.
SOURCE: Kaiser Family Foundation

V-BID

Many on Medicare Live with Multiple Chronic Conditions, and Fair/Poor Health

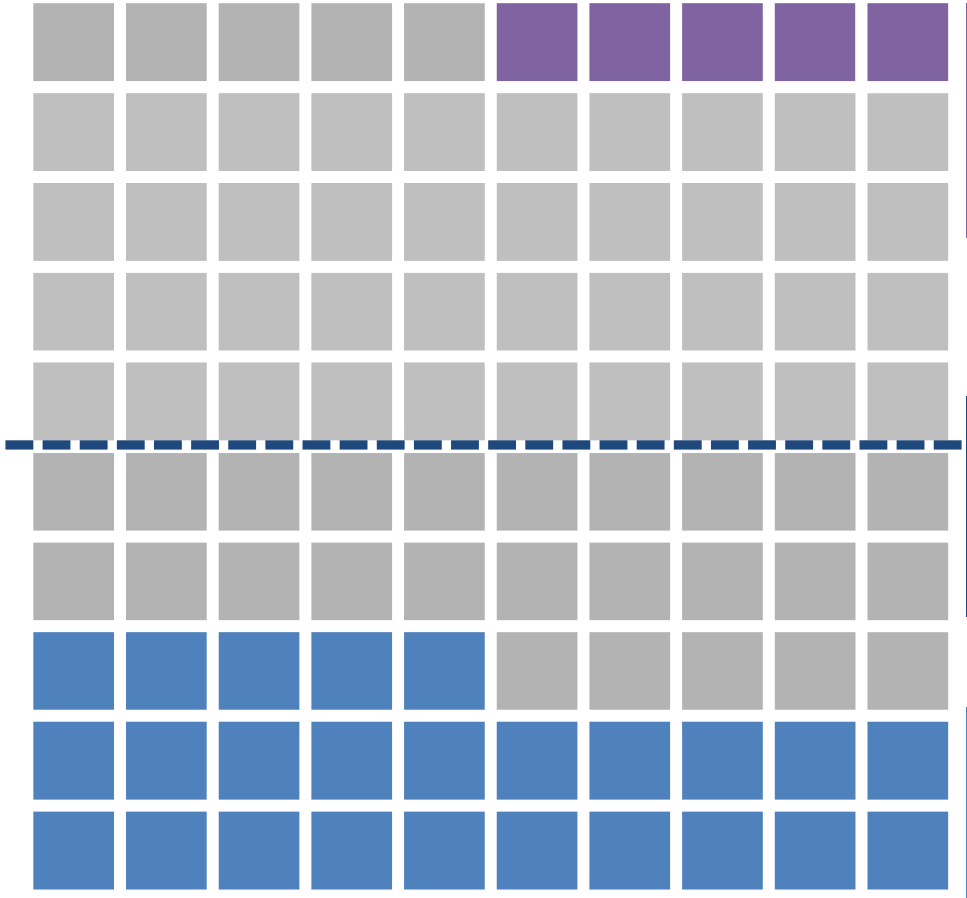


Medicare covered 57 million people in 2016

NOTE: ADL is activity of daily living.
SOURCE: Kaiser Family Foundation

V-BID

Half of Medicare Beneficiaries Live on Incomes at or Below $24,150 per person (2014)



5% had incomes above **$93,000**

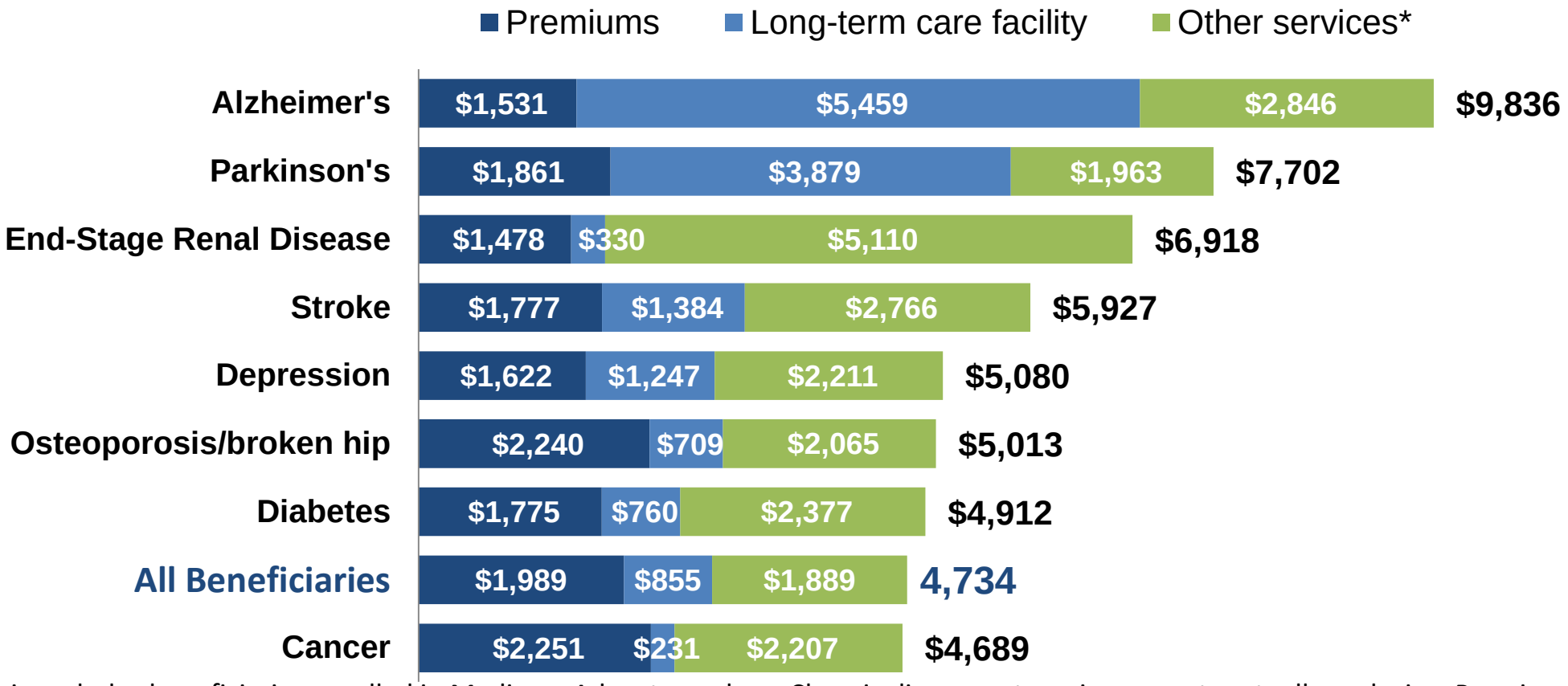
50% had incomes below **$24,150**

25% had incomes below **$14,350**

SOURCE: Urban Institute / Kaiser Family Foundation analysis of DYNASIM data, 2015.

Out-of-pocket Spending is Higher for Medicare Beneficiaries with Chronic Conditions

Medicare Beneficiaries' Out-of-Pocket Spending on Services and Premiums, by Chronic Condition, 2010



NOTE: Analysis excludes beneficiaries enrolled in Medicare Advantage plans. Chronic disease categories are not mutually exclusive. Premiums includes Medicare Parts A and B and other types of health insurance beneficiaries may have (Medigap, employer-sponsored insurance, and other public and private sources). *Other includes dental, home health, inpatient and outpatient hospital, medical providers/supplies, prescription drugs, and skilled nursing facility. Sums may not equal totals due to rounding.

SOURCE: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2010 Cost & Use file.

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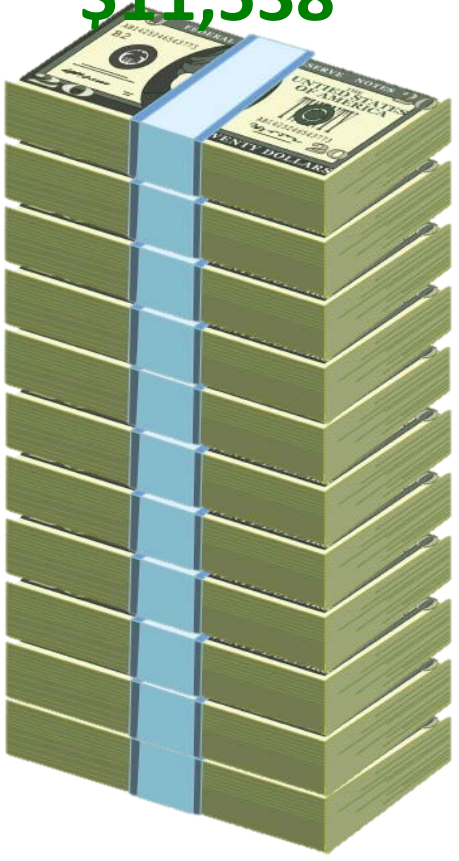
Medicare Beneficiaries Can Pay Thousands of Dollars Annually for Specialty and Other High-priced Drugs

Median annual out-of-pocket costs, 2016:

HUMIRA: $4,864

SOVALDI: $6,608

REVLIMID: $11,538



NOTE: Analysis includes 20 national and near-national stand-alone prescription drug plans in Baltimore, MD (zip code 21201) and reflects pricing at a Rite Aid pharmacy in this zip code.
SOURCE: Georgetown/Kaiser Family Foundation

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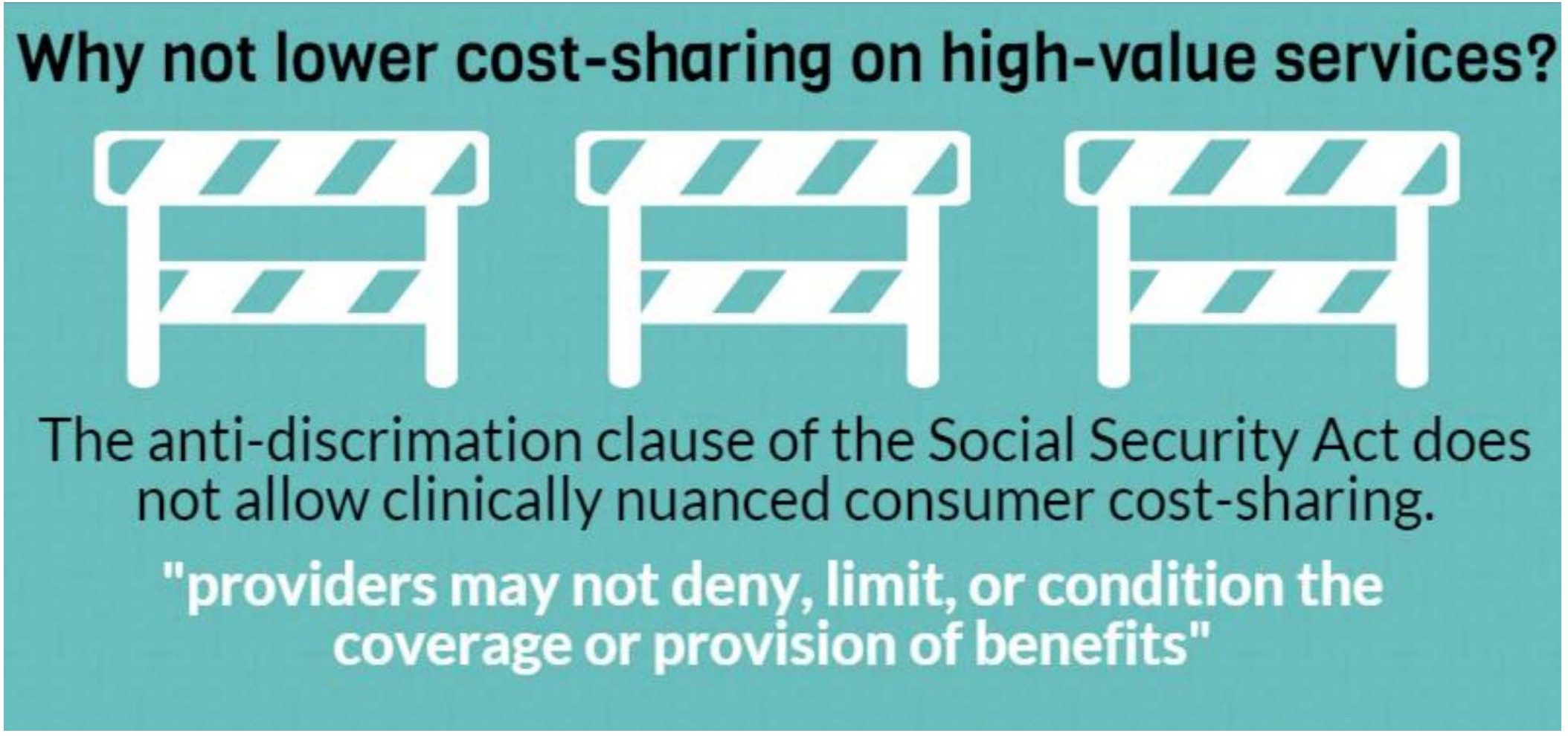
Implementing V-BID in Medicare



Implementing V-BID in Medicare

“Implementing V-BID in Medicare will take an act of Congress”

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 Transparency

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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(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.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

Reps. Black, Blumenauer, McMorris-Rodgers, Dingell

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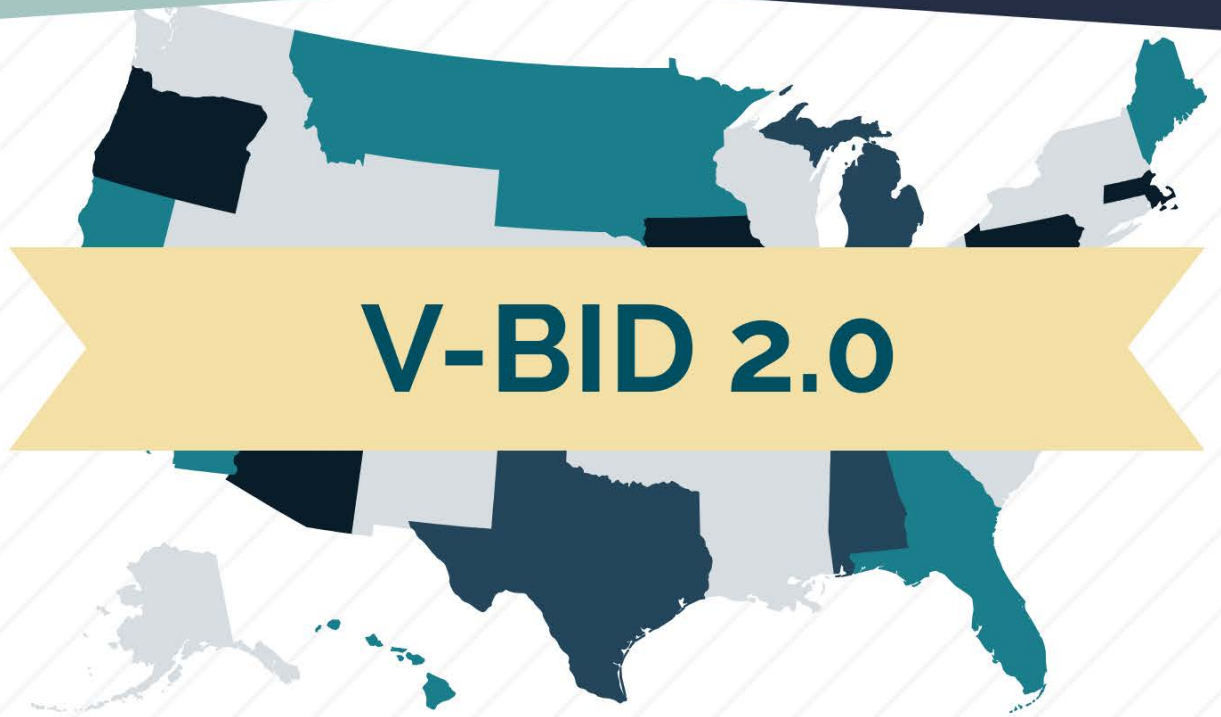
THE EXPANDED ROLE OF V-BID IN MEDICARE ADVANTAGE



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

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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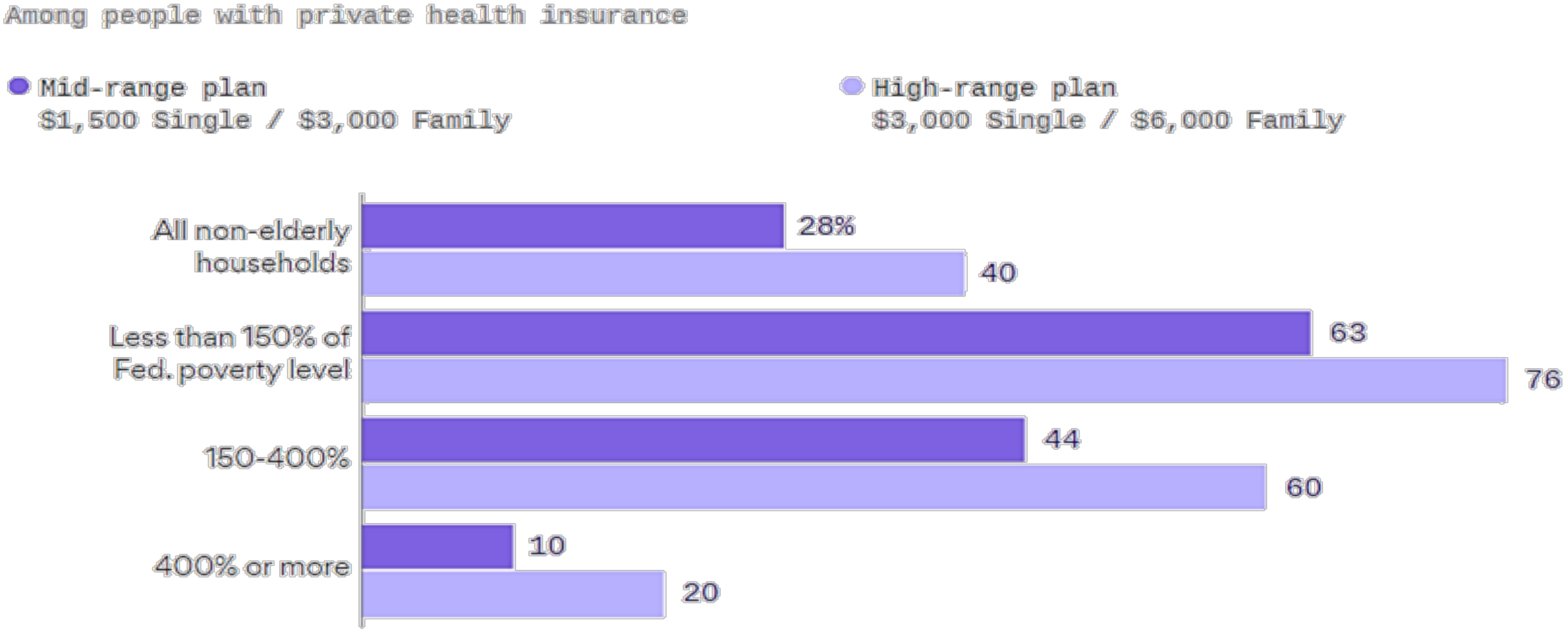
HSA-HDHP Reform

V-BID

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

However, IRS guidance requires that services used to treat
"existing illness, injury or conditions"
are not covered until the minimum deductible is met

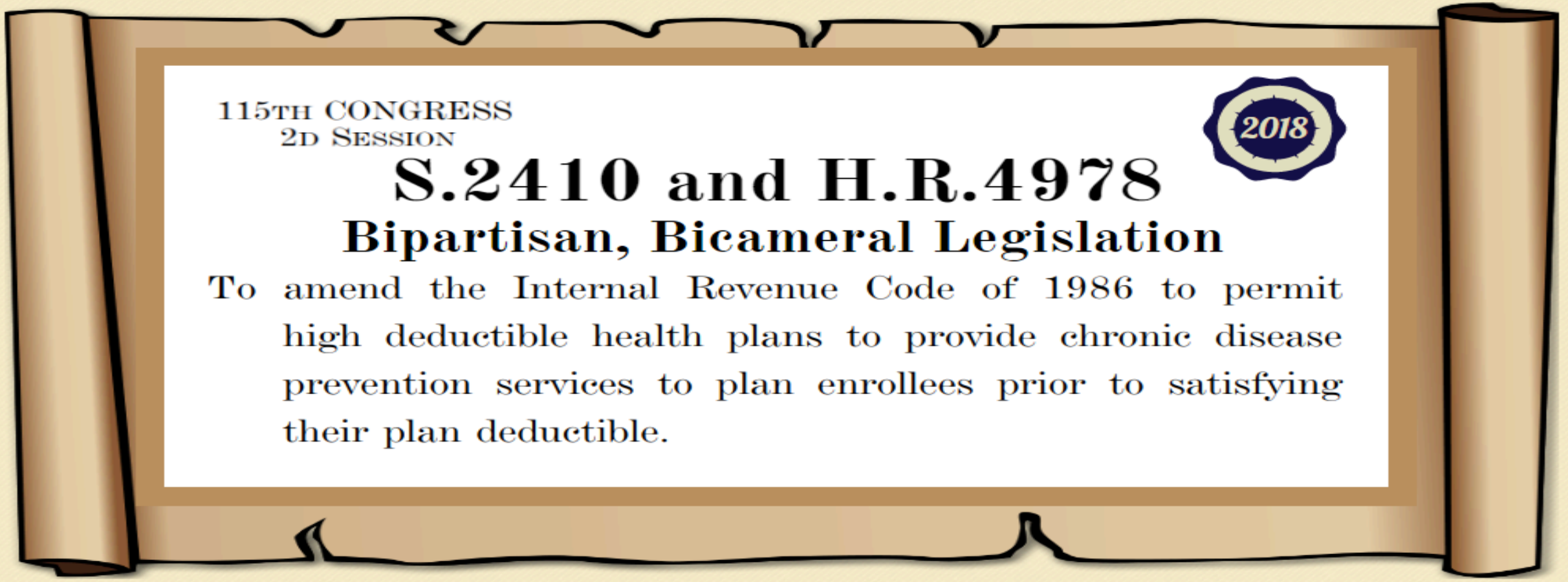
office visits

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 2019



U.S. DEPARTMENT OF THE TREASURY

PRESS RELEASES

Treasury Expands Health Savings Account Benefits for Individuals Suffering from Chronic Conditions

U.S. DEPARTMENT OF THE TREASURY

Additional Preventive Care Benefits Permitted to be Provided by a High Deductible Health Plan Under § 223

NOTICE 2019-45

PURPOSE

This notice expands the list of preventive care benefits permitted to be provided by a high deductible health plan (HDHP) under section 223(c)(2) of the Internal Revenue Code (Code) without a deductible, or with a deductible below the applicable minimum deductible (self-only or family) for an HDHP.

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List of services and drugs for certain chronic conditions that will be classified as preventive care under Notice 2019-45

Preventive Care for Specified Conditions	For Individuals Diagnosed with
Angiotensin Converting Enzyme (ACE) inhibitors	Congestive heart failure, diabetes, and/or coronary artery disease
Anti-resorptive therapy	Osteoporosis and/or osteopenia
Beta-blockers	Congestive heart failure and/or coronary artery disease
Blood pressure monitor	Hypertension
Inhaled corticosteroids	Asthma
Insulin and other glucose lowering agents	Diabetes
Retinopathy screening	Diabetes
Peak flow meter	Asthma
Glucometer	Diabetes
Hemoglobin A1c testing	Diabetes
International Normalized Ratio (INR) testing	Liver disease and/or bleeding disorders
Low-density Lipoprotein (LDL) testing	Heart disease
Selective Serotonin Reuptake Inhibitors (SSRIs)	Depression
Statins	Heart disease and/or diabetes

OPINION | REVIEW & OUTLOOK

Trump's Diabetic Shock

The reality behind Bernie's wailing about the price of insulin.

By The Editorial Board
July 22, 2019 7:36 pm ET

- **"The previous guidance said such plans could only cover certain 'preventive' services before the patient met the deductible—which can run several thousand dollars for a family."**

- **…"The new Trump Administration guidance stipulates that [HSA-HDHPs] can cover certain preventive treatments for chronic conditions before the patient hits the deductible."**

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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

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Precision Benefit Design

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

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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

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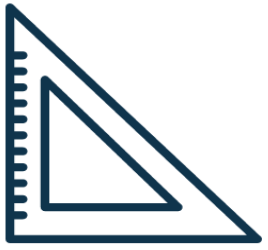
REDUCING
LOW-VALUE CARE

IDENTIFY.



MEASURE.

REPORT.

REDUCE.

Waste in the Healthcare System Comes From Many Places

Category	Sources	Estimate of Excess Costs	% of Waste	% of Total
Unnecessary Services	• Overuse beyond evidence-established levels • Discretionary use beyond benchmarks • Unnecessary choice of higher-cost services	$210 billion	27%	9.15%
Inefficiently Delivered Services	• Mistakes, errors, preventable complications • Care fragmentation • Unnecessary use of higher-cost providers • Operational inefficiencies at care delivery sites	$130 billion	17%	5.66%
Excess Admin Costs	• Insurance paperwork costs beyond benchmarks • Insurers' administrative inefficiencies • Inefficiencies due to care documentation requirements	$190 billion	25%	8.28%
Prices that are too high	• Service prices beyond competitive benchmarks • Product prices beyond competitive benchmarks	$105 billion	14%	4.58%
Missed Prevention Opportunities	• Primary prevention • Secondary prevention • Tertiary prevention	$55 billion	7%	2.40%
Fraud	• All sources – payers, clinicians, patients	$75 billion	10%	3.27%
	Total	**$765 billion**		**33.33%**

Reducing Low Value Care: Identify

Choose services:

- Easily identified in administrative systems
- Mostly low value
- Reduction in their use would be barely noticed

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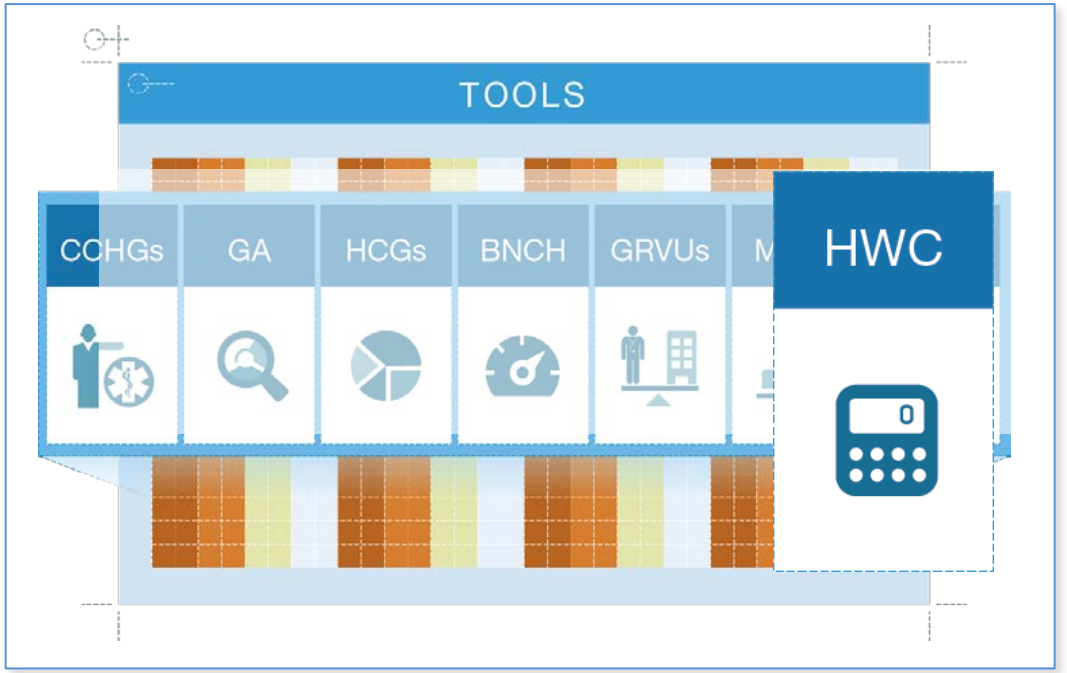
Measuring Unnecessary Care: Milliman Health Waste Calculator

- Collaboration between Milliman and V-BIDHealth
- Measures 47 potentially unnecessary services
- Analyze cost savings potential
- Generate actionable reports and summaries



Milliman MedInsight

VBIDHEALTH

Reducing Low Value Care: Measure

Health Waste Calculator

- Collaboration between Milliman and V-BIDHealth
- Measures potentially unnecessary services
- Analyze cost savings potential
- Generate actionable reports and summaries

Milliman

MedInsight

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).

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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Impact of reducing Vitamin D testing in the general population

Cost 1 Vitamin D test =

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

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V-BID X aims to reduce consumer cost-sharing for targeted high-value services and increase cost-sharing for specific low-value services while avoiding increases in premiums and deductibles.

Increased cost-sharing on low-value services reduces spending...

Spinal Fusions

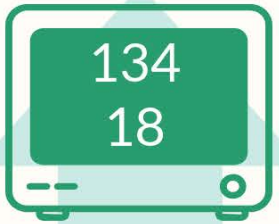
Vitamin D screening tests

Proton beam for prostate cancer

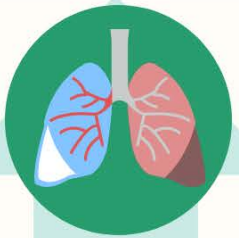
High-cost diagnostic imaging

...and allows for lower cost-sharing and increased spending on high-value services

Hemoglobin A1c tests



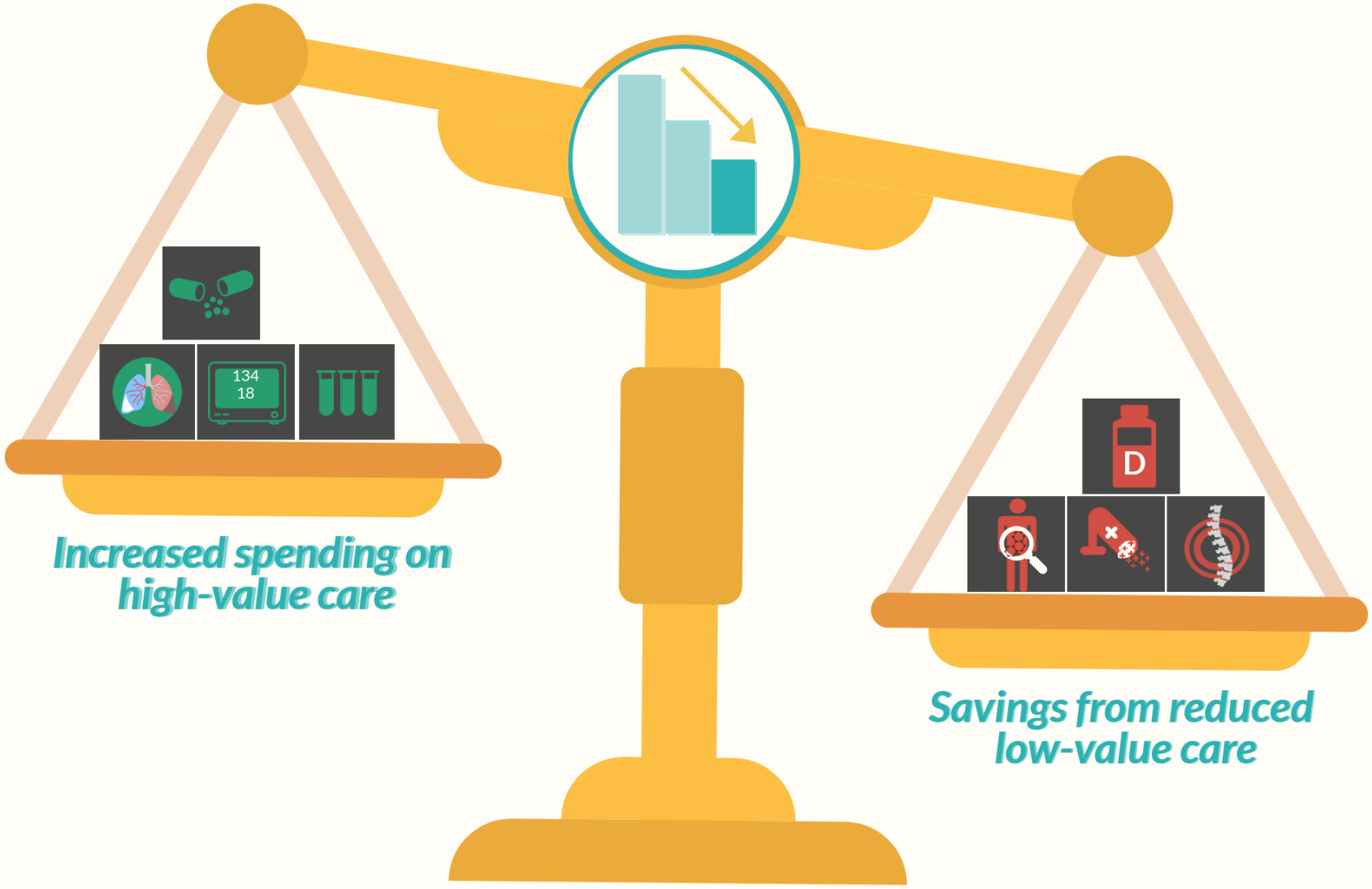
Blood pressure monitors



Pulmonary rehabilitation

High-value prescription drugs

When savings from reduced use of low-value care exceed extra spending on high-value services, **premiums will decrease**



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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**
- **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 consumer cost sharing - discourage consumers from pursuing the “Triple Aim”

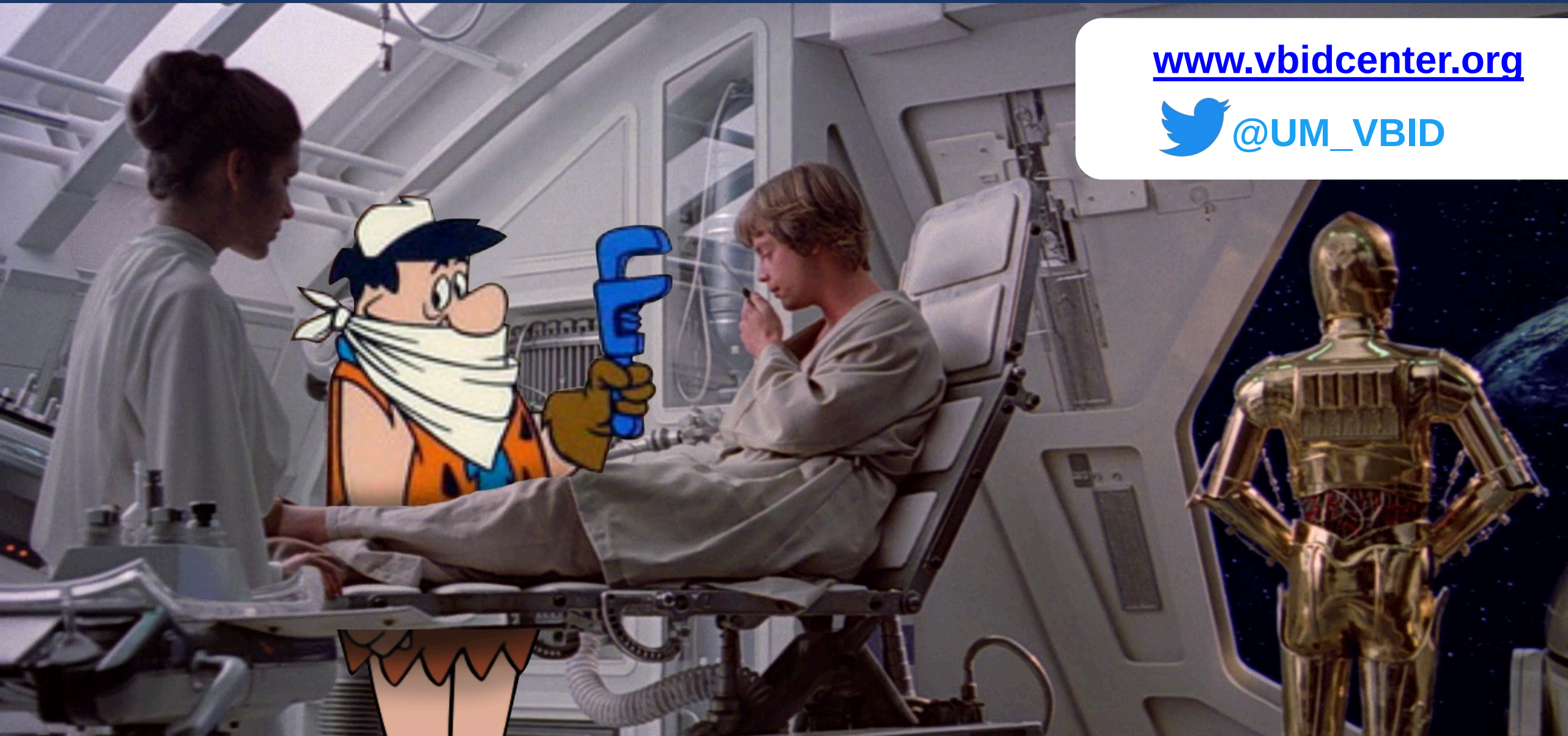
Aligning Payer and Consumer Incentives: As Easy as PB & J

The alignment of clinically driven, provider-facing and consumer engagement initiatives is a necessary and critical step to improve quality of care, enhance patient experience, and contain cost growth

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

Dan Quayle

Questions?



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