



SCHOOL OF PUBLIC HEALTH

CENTER FOR VALUE-BASED INSURANCE DESIGN
UNIVERSITY OF MICHIGAN

Using Value-Based Insurance Design to Improve Patient-Centered Outcomes and Reduce Healthcare Costs

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www.vbidcenter.org (slides available)

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

- 1 Innovations to prevent, diagnose, manage, and treat HTN 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 evidence-based HTN services persists across the entire spectrum of care leading to poor health outcomes**

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- 2 Irrespective of remarkable clinical advances, cutting health care spending is the main focus of reform discussions**
- 3 Underutilization of evidence-based HTN care persists across the entire spectrum of care leading to poor health outcomes**
- 4 Our ability to deliver high-quality health care lags behind the rapid pace of scientific innovation**

Outline

**Consumer
Cost-
sharing**

**Translatin
g
Research
into Policy**

**Aligning
Incentives**

**Value-
Based
Insurance
Design**

**Low Value
Care**

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**

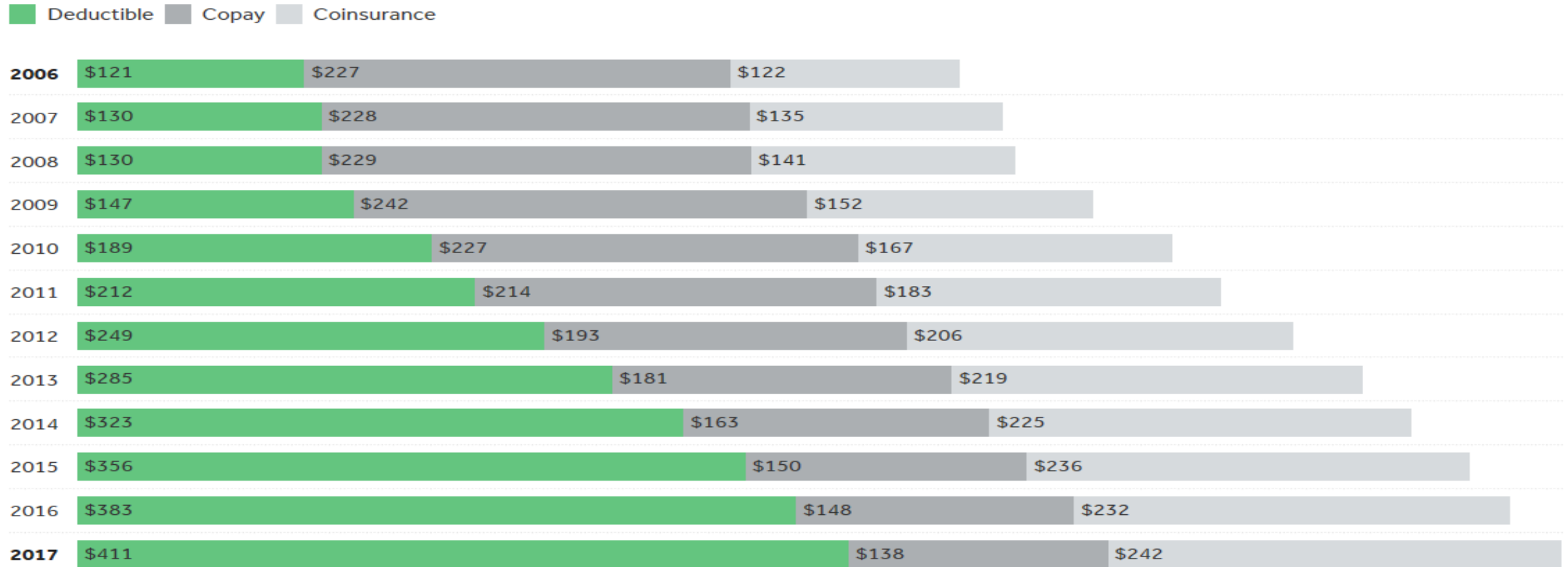
Americans Do Not Care About Health Care Costs; They Care About **What It Costs Them**

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.



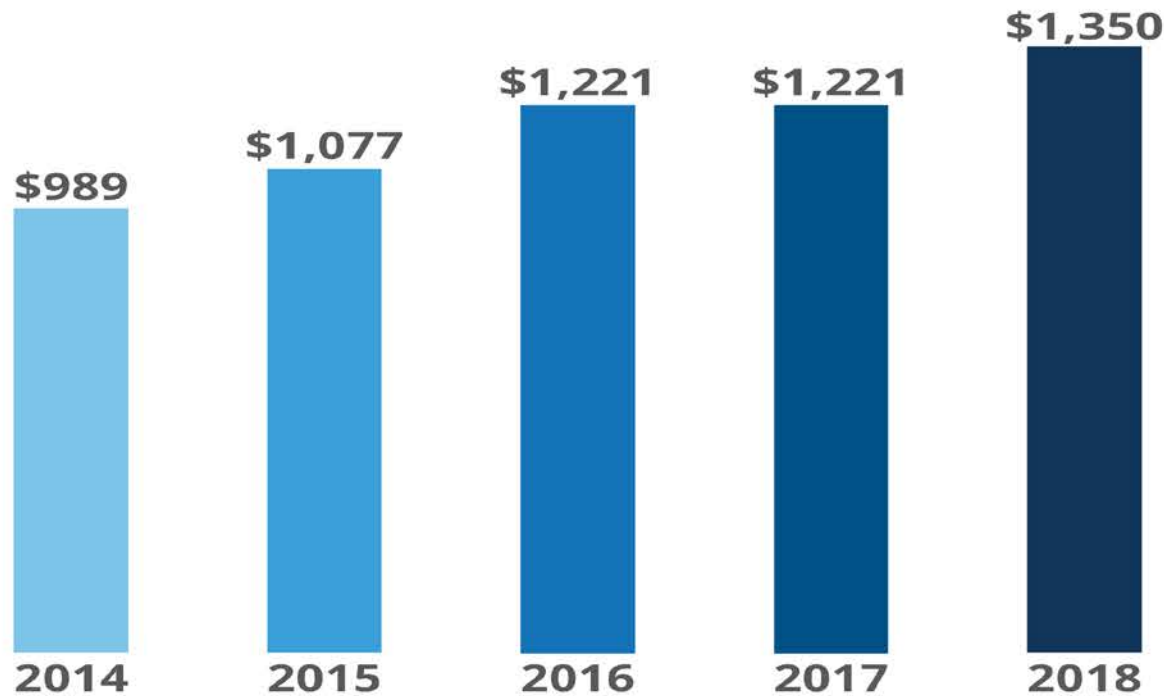
Out-of-pocket spending among people with large employer coverage, Paying More for ALL Care Regardless of Value



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

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

No deductible

16%

Lower deductible

<\$1500 Individual
<\$3,000 Family

24%

Higher deductible

\$1,500 - \$2,999 Individual
\$3,000 - \$4,999 Family

39%

Highest deductible

\$3,000+ Individual
\$5,000+ Family

50%

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).

Six of ten people with a chronic condition and employer coverage have skipped or postponed care due to cost

Percent who say they or a family member have done the following in the past year

	NO CHRONIC CONDITION IN FAMILY	WITH CHRONIC CONDITION	
		All	Highest deductible
Postponed or put off care	23%	42%	60%
Treated at home instead of seeing doctor	28	41	58
Avoided doctor-recommended test or treatment	15	31	44
Not filled a prescription or skipped doses	12	23	35
Yes to any	40	60	75

Impact of Cost-Sharing on Health Care Disparities

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

*Michael Chernew, PhD¹ Teresa B. Gibson, PhD² Kristina Yu-Isenberg, PhD, RPh³
Michael C. Sokol, MD, MS⁴ Allison B. Rosen, MD, ScD⁵, and A. Mark Fendrick, MD⁵*

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

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**

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

TheUpshot

Health Plans That Nudge Patients to Do the Right Thing



Austin Frakt

THE NEW HEALTH CARE JULY 10, 2017



RELATED COVERAGE



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A HEALTH
How I
Better

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



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



Final Recommendation Statement

High Blood Pressure in Adults: Screening

Recommendations made by the USPSTF are independent of the U.S. government. They should not be construed as an official position of the Agency for Healthcare Research and Quality or the U.S. Department of Health and Human Services.

Recommendation Summary

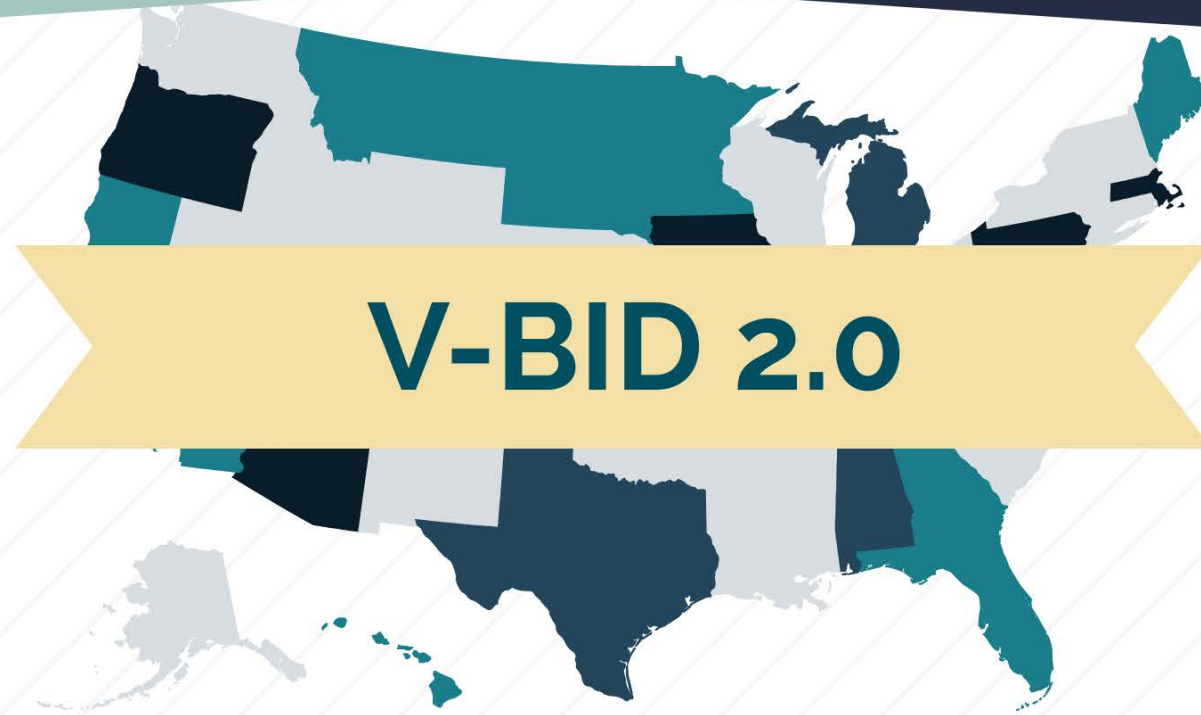
Population	Recommendation	Grade (What's This?)
Adults aged 18 years or older	The USPSTF recommends screening for high blood pressure in adults aged 18 years or older. The USPSTF recommends obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment (see the Clinical Considerations section).	A

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Putting Innovation into Action: Translating Research into Policy



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



Value-based insurance coming to millions of people in Tricare



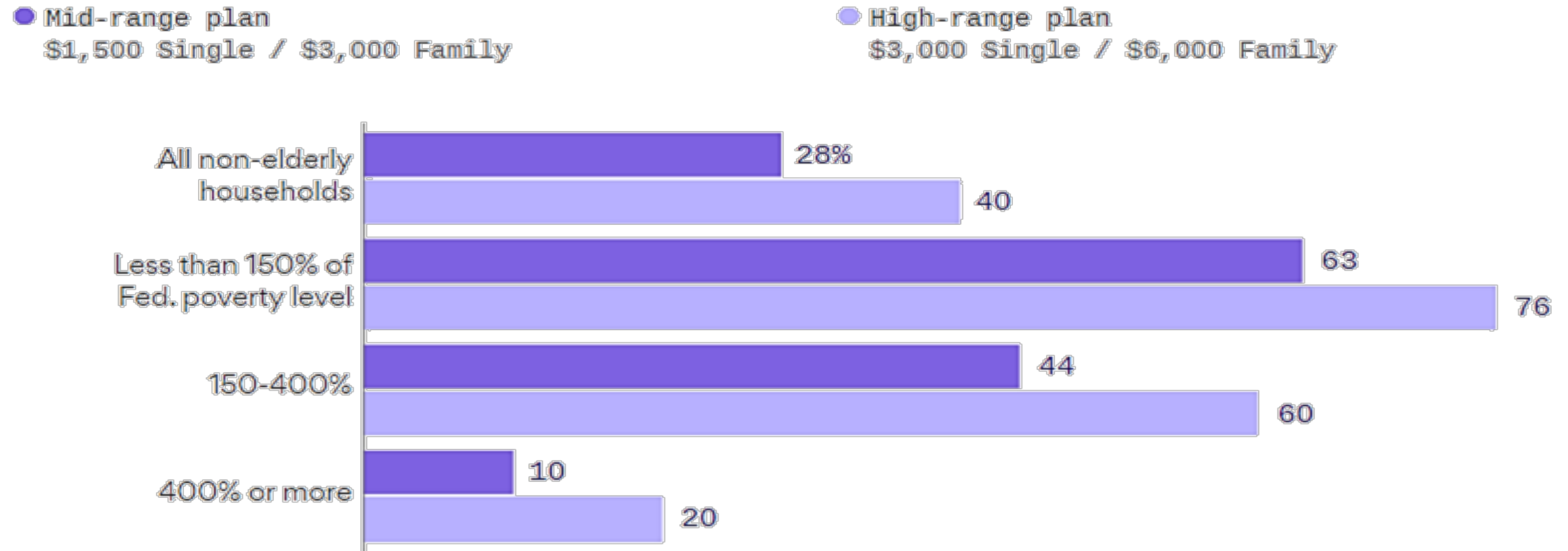
- **2017 NDAA: Obama Administration - reduce or eliminate co-pays and other cost sharing for certain high services and providers**
- **2018 NDAA: Trump Administration – reduce cost sharing for high value drugs on the uniform formulary**

HSA-HDHP Reform



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

Among people with private health insurance



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



U.S. DEPARTMENT OF THE TREASURY

PRESS RELEASES

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



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

Chronic Disease Management Act of 2019

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.



Reducing Out-of-Pocket Costs for Medications

Reducing out-of-pocket costs (ROPC) for patients with hypertension and hyperlipidemia involves program and policy changes that make medications for cardiovascular disease (CVD) prevention more affordable. Costs for medications can be reduced by providing new or expanded coverage and lowering or eliminating out-of-pocket payments by patients (e.g., copayments, coinsurances, deductibles).¹



Reducing Out-of-Pocket Costs for Medications



Reducing

involves
(CVD) pre
or expand
copayments, coinsurance, deductibles,

and hyperlipidemia
vascular disease
by providing new
ts by patients (e.g.,

Where does the money come from to provide better coverage for evidence-based HTN care?

- **Raise Premiums**

Where does the money come from to provide better for coverage for evidence-based HTN care?

- ~~Raise Premiums~~
- Increase Deductibles, Copayments and Coinsurance

Where does the money come from to provide better coverage for evidence-based HTN care?

- ~~Raise Premiums~~
- ~~Increase Deductibles, Copayments and Coinsurance~~
- Reduce Spending on Low Value Care



REDUCING LOW-VALUE CARE



IDENTIFY.



MEASURE.



REDUCE.



REPORT.

Reducing Low Value Care: Identify

The logo for 'Choosing Wisely' features a vertical stack of five colored squares (yellow, green, blue, purple, and red) to the left of the text 'Choosing Wisely' in a bold, black, sans-serif font.

An initiative of the ABIM Foundation

&



U.S. Preventive Services
TASK FORCE

Choose services:

- Easily identified in administrative systems
- Mostly 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. 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

Reduce: Multiple Levers to Remove Low Value Care

Provider-Facing Levers (Supply)

Coverage policies

Payment rates

Payment models

Profiling data

Clinical decision support

Patient-Facing Levers (Demand)

Value-Based Insurance Design

Network design

Prior authorization



Reduce:

ACA Sec 4105

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

Final Recommendation Statement:**Pancreatic Cancer: Screening**

Release Date: August 2019

Recommendation Summary***Recommendation Summary***

Population	Recommendation	Grade (What's This?)
Adults	The USPSTF recommends against screening for pancreatic cancer in asymptomatic adults.	D

V-BID X:

Better Coverage, Same Premiums and Deductibles



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



Spinal Fusions



Vitamin D
screening tests



Proton beam for
prostate cancer

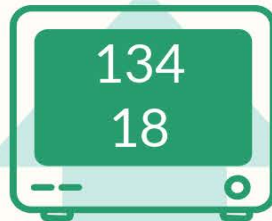


High-cost
diagnostic imaging

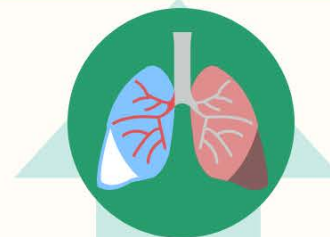
...and allows for lower cost-sharing and increased spending on **high-value services**



Hemoglobin
A1c tests



Blood pressure
monitors

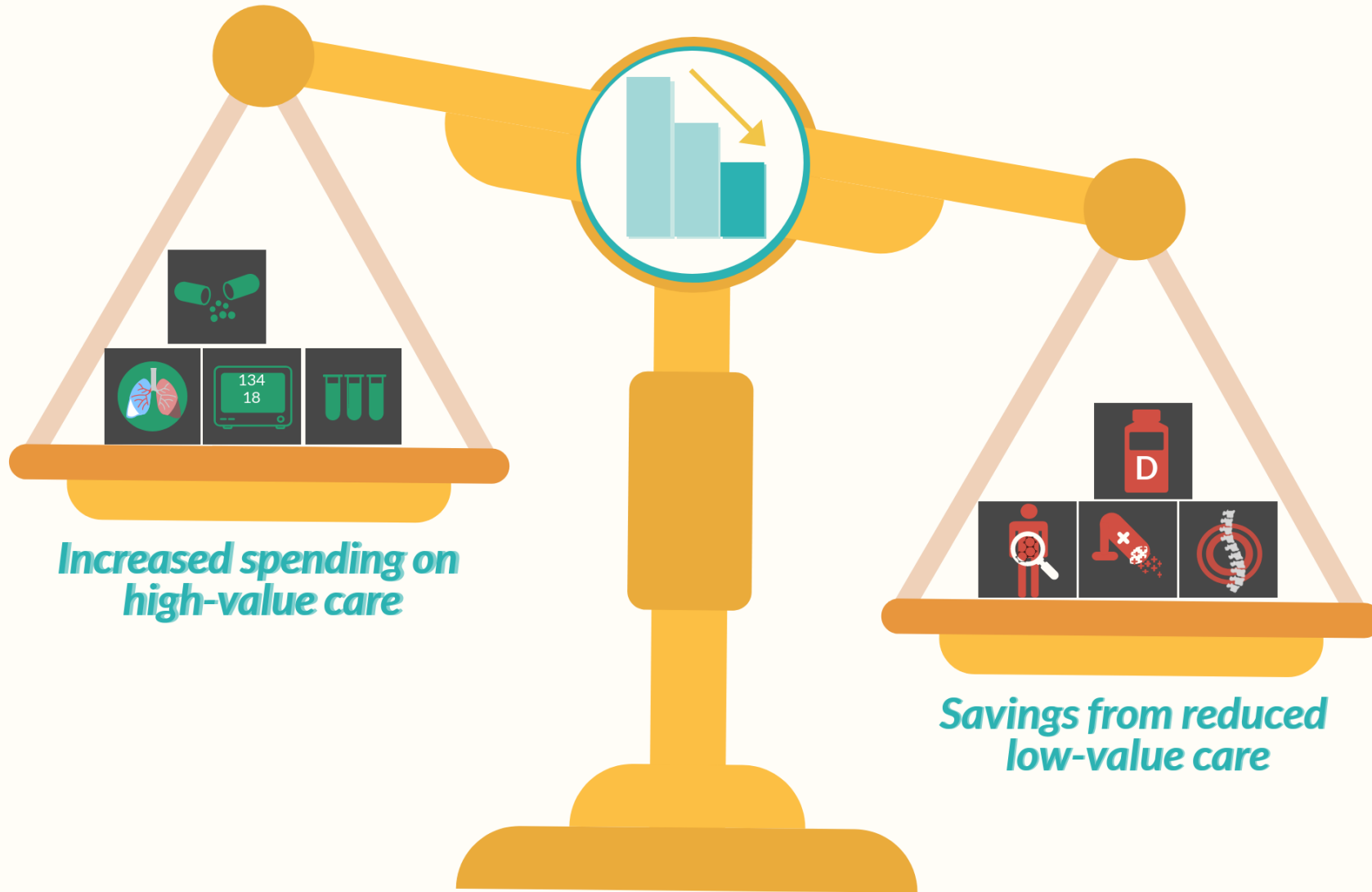


Pulmonary
rehabilitation



High-value
prescription drugs

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



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
Incentives**



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”**



Align Payer and Consumer Incentives to Improve HTN Care: 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 HTN care, enhance patients' experience, and contain cost growth



An aerial photograph of a large, oval-shaped stadium, likely a football or soccer stadium. The stadium is mostly empty, with blue seats visible in the stands. The field is green with white yard lines, and the word 'MICHIGAN' is written in large yellow letters across the field. The stadium is surrounded by parking lots, roads, and some trees. A semi-transparent white box is overlaid on the center of the image, containing the text "If we don't succeed then we will fail." in white, italicized font.

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

Dan Quayle

Questions?

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