Ensuring Access and Affordability to High Value Medical Care: Value-Based Insurance Design

A. Mark Fendrick, MD
University of Michigan Center for
Value-Based Insurance Design

www.vbidcenter.org

(slides available here)

Health Care Costs Are a Top Issue For Consumers, Payers, and Policymakers: Solutions must protect patients, 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

Moving from the Stone Age to the Space Age: Change the medical 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
- Cost-sharing is a common consumer-facing policy lever

Out-of-pocket spending among people with employer coverage: Consumers are Paying More for ALL Care Regardless of Clinical Value

Year	Deductible	Copay	Coinsurance
2006	$121	$227	$122
2007	$130	$228	$135
2008	$130	$229	$141
2009	$147	$242	$152
2010	$189	$227	$167
2011	$212	$214	$183
2012	$249	$193	$206
2013	$285	$181	$219
2014	$323	$163	$225
2015	$356	$150	$236
2016	$383	$148	$232
2017	$411	$138	$242

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

17% of people with employer coverage say they had to **make a difficult sacrifice** in the past year to pay health care and insurance costs. Here are the sacrifices some of them described:

I had to work **3 jobs at once**. 1 full time and 2 part time jobs. Working from 4:30AM until 11PM.

I was **homeless** for 4 months to pay bills.

Allowing my **health to deteriorate** because it's too expensive to keep up with the cost of care.

We pay all our bills **late** and several have gone to **collections**.

I had to **let my child remain ill** for longer than I was comfortable with because I couldn't afford the $10 co-pay for her to see her pediatrician.

Me **not eating** so my kids can.

SOURCE: KFF/LA Times Survey of Adults with Employer-Sponsored Health Insurance (Sept. 25-Oct. 9, 2018). See topline for full question wording.

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.

An Alternative to 'Blunt' Cost-Sharing Approaches: 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 Approaches: 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

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

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

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.

Putting Innovation into Action: Translating Research into Policy

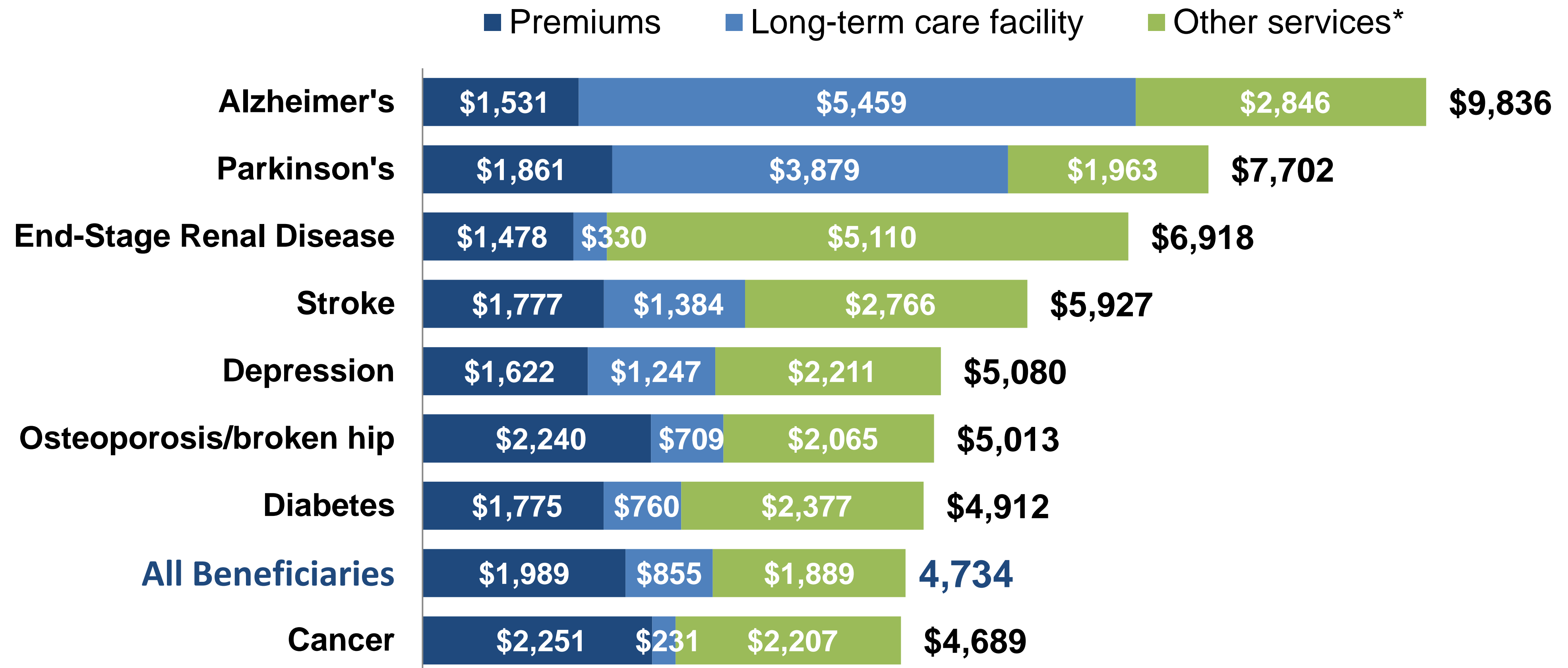
More Than One-Third of Medicare Beneficiaries Spent 20% or More of Their Income on Out-of-Pocket Costs in 2013

	Share
Overall share of beneficiaries spending 20% or more	36%
Fair/poor health status	43%
Income of $20,000 or less	51%
Age 85 and over	53%

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.

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



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.

THE HENRY J. KAISER FAMILY FOUNDATION

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.

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

V-BID 2.0: Expanded Opportunities

Permissible interventions:

Reduced cost-sharing for
- high-value services
- high-value providers
- enrollees participating in disease management or related programs
- additional supplemental benefits (non-health related)

Wellness and Health Care Planning
Advanced care planning
Incentivize better health behaviors

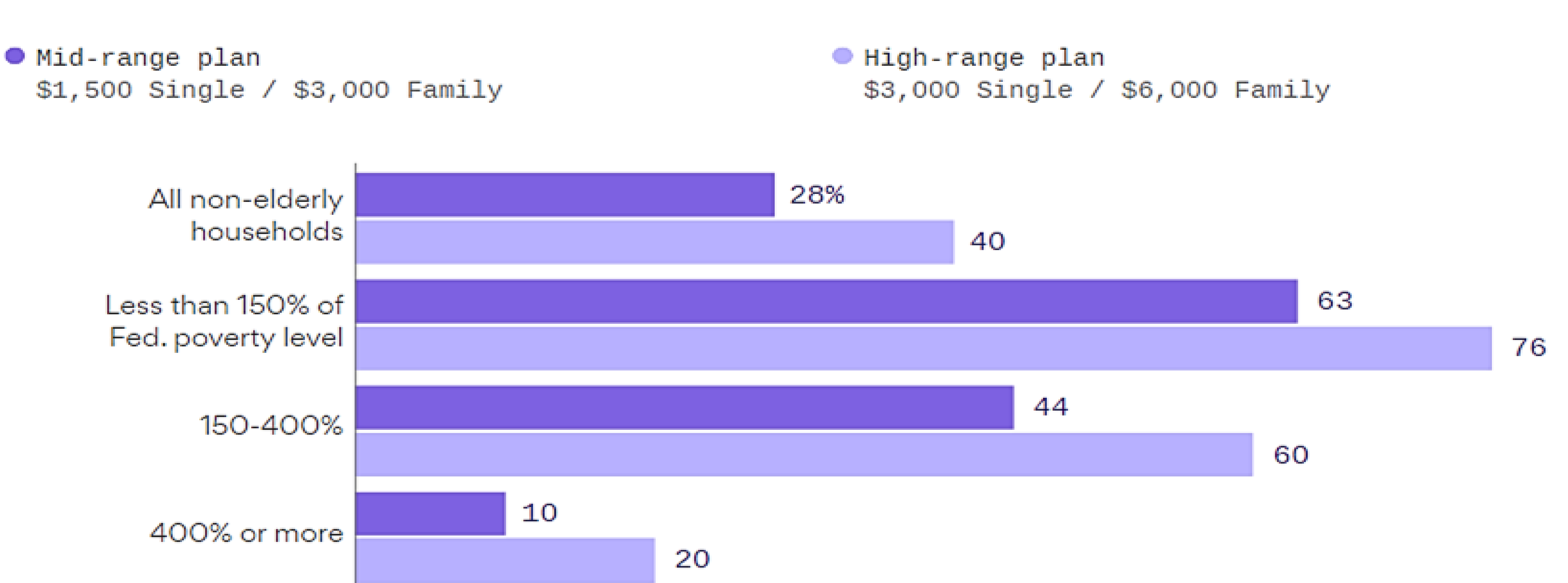
Targeting Socioeconomic Status
Low-income subsidy
Improve quality, decrease costs

Rewards and Incentives
$600 annual limit
Increase participation
Available for Part D

Telehealth
Service delivery innovations
Augment existing provider networks

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

Until Recently, 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

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

115TH CONGRESS
2D SESSION

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.

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

Where does the money come from to provide better coverage for high value care?

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

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.

MEASURE.

REDUCE.

REPORT.

Reducing Low Value Care: Identify

Choosing Wisely®

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

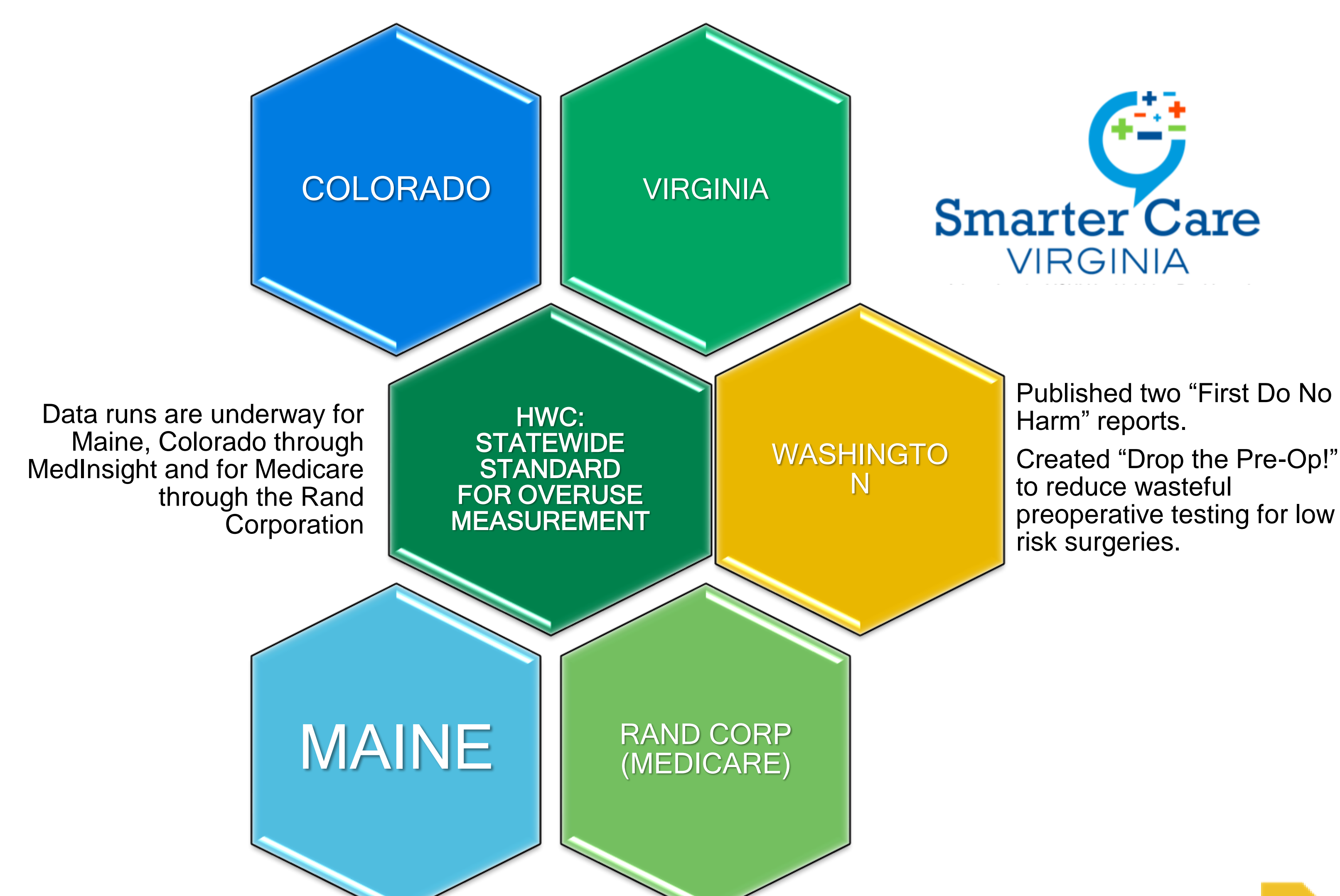
2. Population Based Vitamin D Screening

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

Reducing Low Value Care: State and National Initiatives



Data runs are underway for Maine, Colorado through MedInsight and for Medicare through the Rand Corporation

Published two “First Do No Harm” reports.

Created “Drop the Pre-Op!” to reduce wasteful preoperative testing for low risk surgeries.

M | V-BID

Report:
Low Value Care in Virginia

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

DATAWATCH

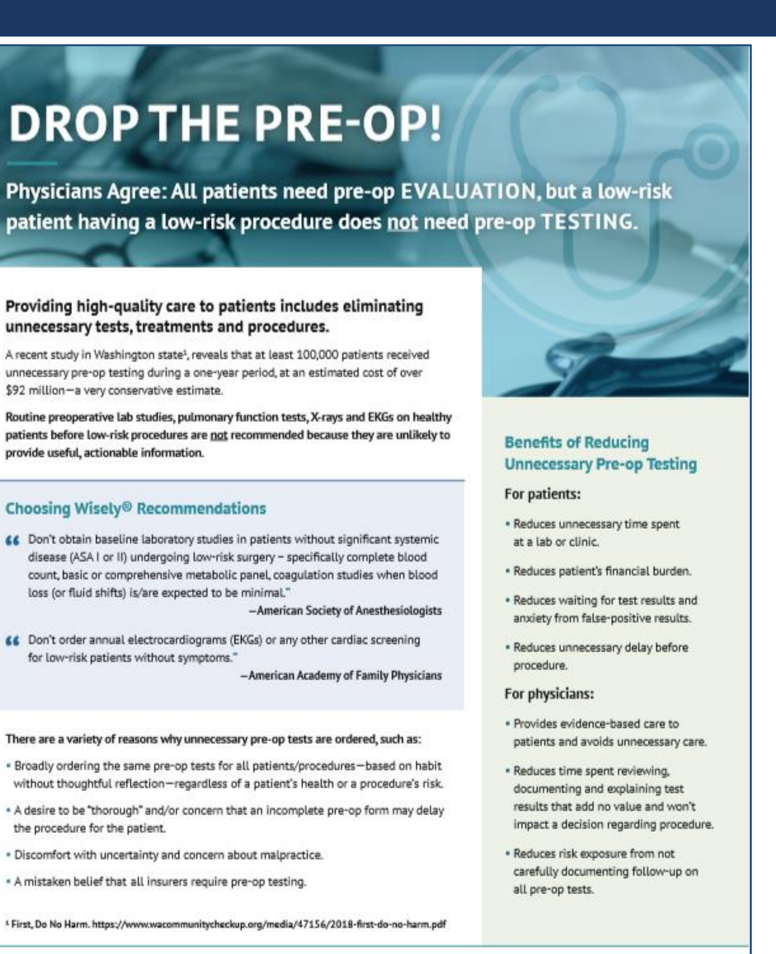
Low-Cost, High-Volume Health Services Contribute The Most To Unnecessary Health Spending

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).

More than $586 MM in unnecessary costs in 2014 from the Virginia All Payer Claims Database

Report: Washington Health Alliance #DropThePreOp

The Washington Health Alliance identified over $92 MM in spending on Unnecessary Pre-Op Testing



DROP THE PRE-OP!

Physicians Agree: All patients need pre-op EVALUATION, but a low-risk patient having a low-risk procedure does not need pre-op TESTING.

Providing high-quality care to patients includes eliminating unnecessary tests, treatments and procedures.

A recent study in Washington state[1], reveals that at least 100,000 patients received unnecessary pre-op testing during a one-year period, at an estimated cost of over $92 million—a very conservative estimate.

Routine preoperative lab studies, pulmonary function tests, X-rays and EKGs on healthy patients before low-risk procedures are not recommended because they are unlikely to provide useful, actionable information.

Choosing Wisely® Recommendations

"Don't obtain baseline laboratory studies in patients without significant systemic disease (ASA I or II) undergoing low-risk surgery – specifically complete blood count, basic or comprehensive metabolic panel, coagulation studies when blood loss (or fluid shifts) is/are expected to be minimal."
—American Society of Anesthesiologists

"Don't order annual electrocardiograms (EKGs) or any other cardiac screening for low-risk patients without symptoms."
—American Academy of Family Physicians

There are a variety of reasons why unnecessary pre-op tests are ordered, such as:

- Broadly ordering the same pre-op tests for all patients/procedures—based on habit without thoughtful reflection—regardless of a patient's health or a procedure's risk.
- A desire to be "thorough" and/or concern that an incomplete pre-op form may delay the procedure for the patient.
- Discomfort with uncertainty and concern about malpractice.
- A mistaken belief that all insurers require pre-op testing.

Benefits of Reducing Unnecessary Pre-op Testing

For patients:

- Reduces unnecessary time spent at a lab or clinic.
- Reduces patient's financial burden.
- Reduces waiting for test results and anxiety from false-positive results.
- Reduces unnecessary delay before procedure.

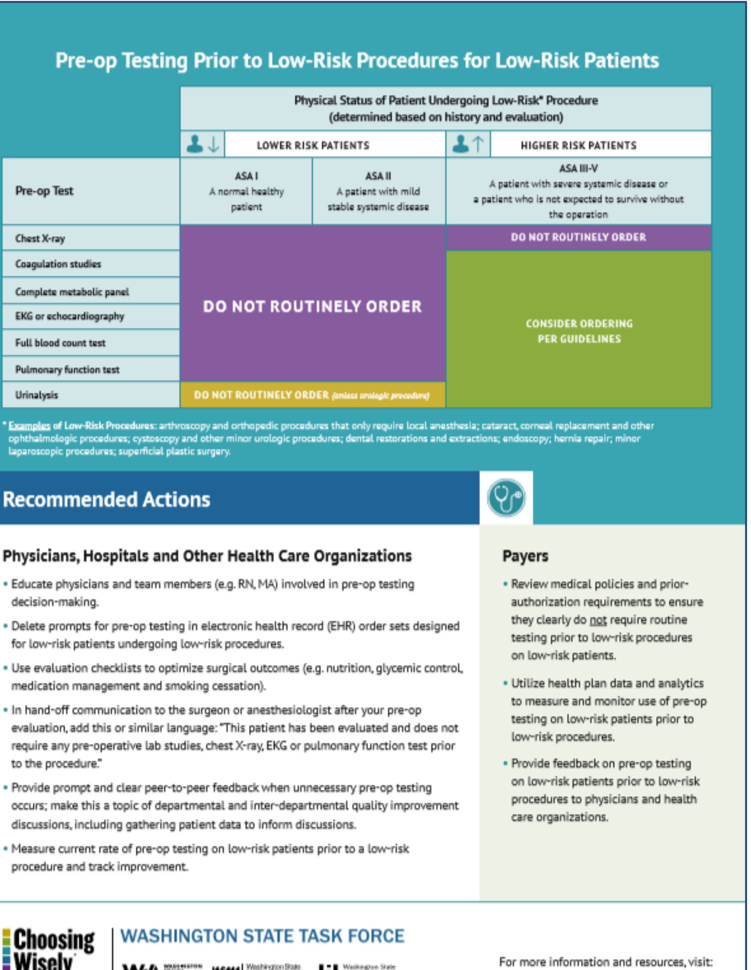
For physicians:

- Provides evidence-based care to patients and avoids unnecessary care.
- Reduces time spent reviewing, documenting and explaining test results that add no value and won't impact a decision regarding procedure.
- Reduces risk exposure from not carefully documenting follow-up on all pre-op tests.

[1] First, Do No Harm. https://www.wacommunitycheckup.org/media/47156/2018-first-do-no-harm.pdf

Choosing Wisely | WASHINGTON STATE TASK FORCE

For more information and resources, visit: wsma.org/Choosing-Wisely



Pre-op Testing Prior to Low-Risk Procedures for Low-Risk Patients

Pre-op Test	Physical Status of Patient Undergoing Low-Risk* Procedure (determined based on history and evaluation): LOWER RISK PATIENTS – ASA I: A normal healthy patient	LOWER RISK PATIENTS – ASA II: A patient with mild stable systemic disease	HIGHER RISK PATIENTS – ASA III-V: A patient with severe systemic disease or a patient who is not expected to survive without the operation
Chest X-ray	DO NOT ROUTINELY ORDER	DO NOT ROUTINELY ORDER	DO NOT ROUTINELY ORDER
Coagulation studies	DO NOT ROUTINELY ORDER	DO NOT ROUTINELY ORDER	CONSIDER ORDERING PER GUIDELINES
Complete metabolic panel	DO NOT ROUTINELY ORDER	DO NOT ROUTINELY ORDER	CONSIDER ORDERING PER GUIDELINES
EKG or echocardiography	DO NOT ROUTINELY ORDER	DO NOT ROUTINELY ORDER	CONSIDER ORDERING PER GUIDELINES
Full blood count test	DO NOT ROUTINELY ORDER	DO NOT ROUTINELY ORDER	CONSIDER ORDERING PER GUIDELINES
Pulmonary function test	DO NOT ROUTINELY ORDER	DO NOT ROUTINELY ORDER	CONSIDER ORDERING PER GUIDELINES
Urinalysis	DO NOT ROUTINELY ORDER (unless urologic procedure)	DO NOT ROUTINELY ORDER (unless urologic procedure)	CONSIDER ORDERING PER GUIDELINES

* Examples of Low-Risk Procedures: arthroscopy and orthopedic procedures that only require local anesthesia; cataract, corneal replacement and other ophthalmologic procedures; cystoscopy and other minor urologic procedures; dental restorations and extractions; endoscopy; hernia repair; minor laparoscopic procedures; superficial plastic surgery.

Recommended Actions

Physicians, Hospitals and Other Health Care Organizations

- Educate physicians and team members (e.g. RN, MA) involved in pre-op testing decision-making.
- Delete prompts for pre-op testing in electronic health record (EHR) order sets designed for low-risk patients undergoing low-risk procedures.
- Use evaluation checklists to optimize surgical outcomes (e.g. nutrition, glycemic control, medication management and smoking cessation).
- In hand-off communication to the surgeon or anesthesiologist after your pre-op evaluation, add this or similar language: "This patient has been evaluated and does not require any pre-operative lab studies, chest X-ray, EKG or pulmonary function test prior to the procedure."
- Provide prompt and clear peer-to-peer feedback when unnecessary pre-op testing occurs; make this a topic of departmental and inter-departmental quality improvement discussions, including gathering patient data to inform discussions.
- Measure current rate of pre-op testing on low-risk patients prior to a low-risk procedure and track improvement.

Payers

- Review medical policies and prior-authorization requirements to ensure they clearly do not require routine testing prior to low-risk procedures on low-risk patients.
- Utilize health plan data and analytics to measure and monitor use of pre-op testing on low-risk patients prior to low-risk procedures.
- Provide feedback on pre-op testing on low-risk patients prior to low-risk procedures to physicians and health care organizations.

Choosing Wisely | WASHINGTON STATE TASK FORCE

For more information and resources, visit: wsma.org/Choosing-Wisely

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

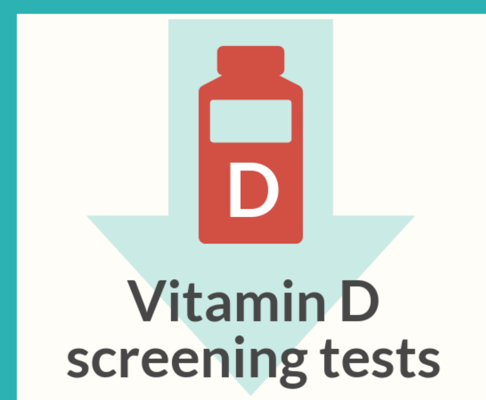
"(B) the services included in the initial preventive physical examination described in subparagraph (B) of such section; and

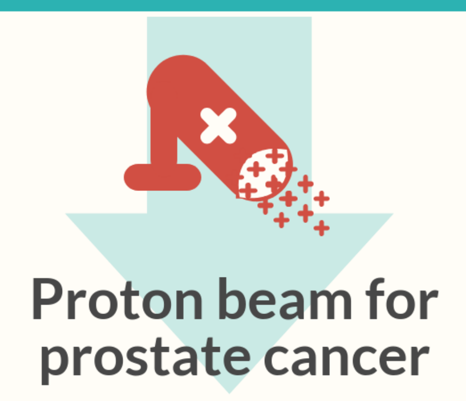
"(2) provide that no payment shall be made under this title for a preventive service described in subparagraph (A) of such section that has not received a grade of A, B, C, or I by such Task Force.".

(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.

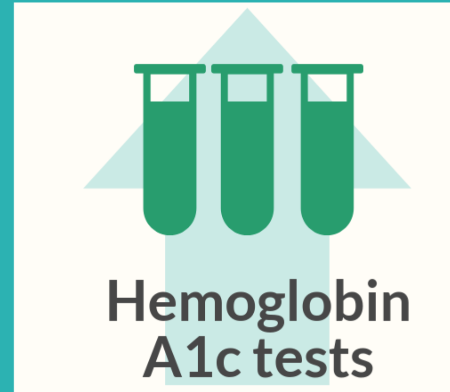
The ACA grants HHS the authority to eliminate coverage for USPSTF 'D' Rated Services in Medicare

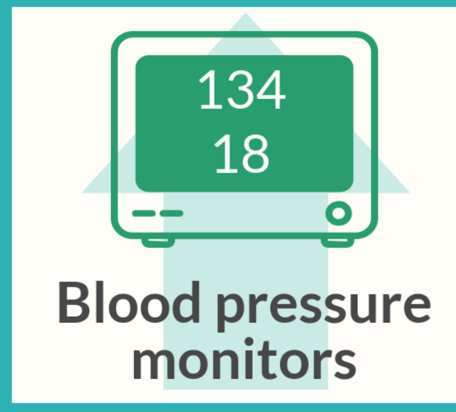
Increased cost-sharing on low-value services reduces spending...

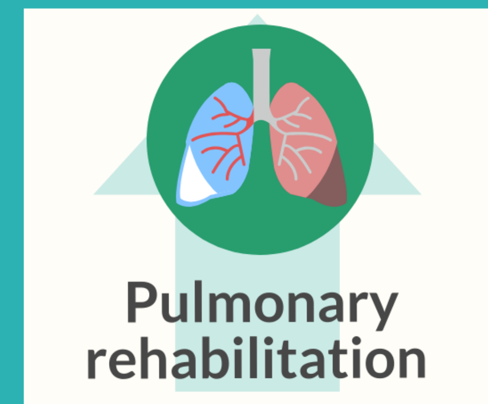




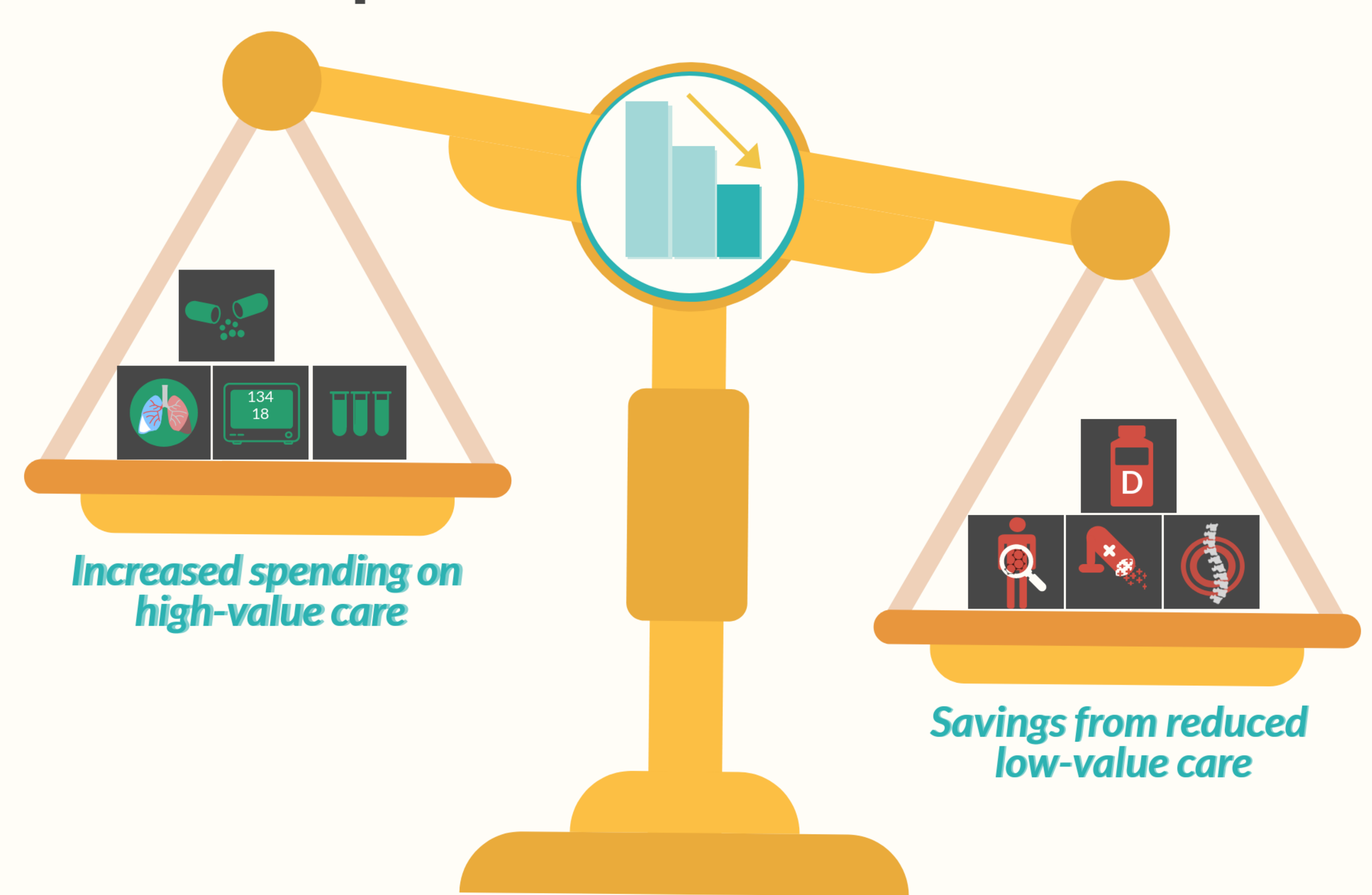
...and allows for lower cost-sharing and increased spending on high-value services







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 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