

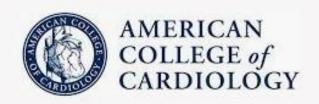
### Current (and Better) Approaches to Benefit Design: The Good, the Bad, and the Ugly

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www.vbidcenter.org

(slides available here)





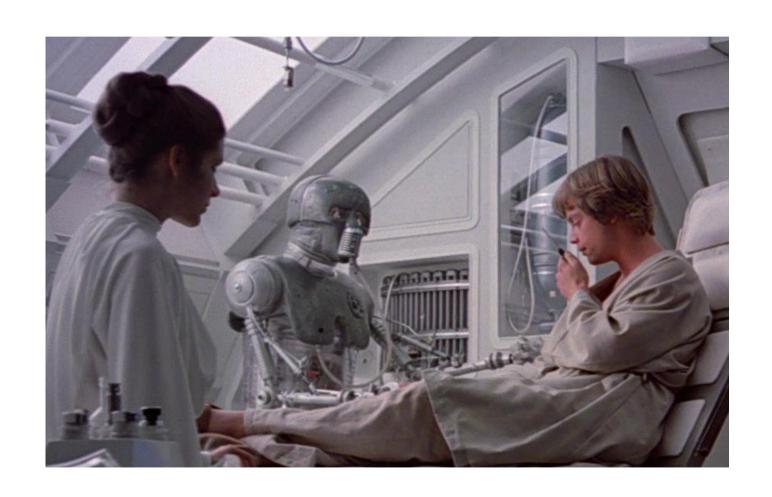


### Health Care Costs Are a Top Issue For Consumers, Payers, and Policymakers: Solutions must protect patients, reward providers and preserve innovation

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

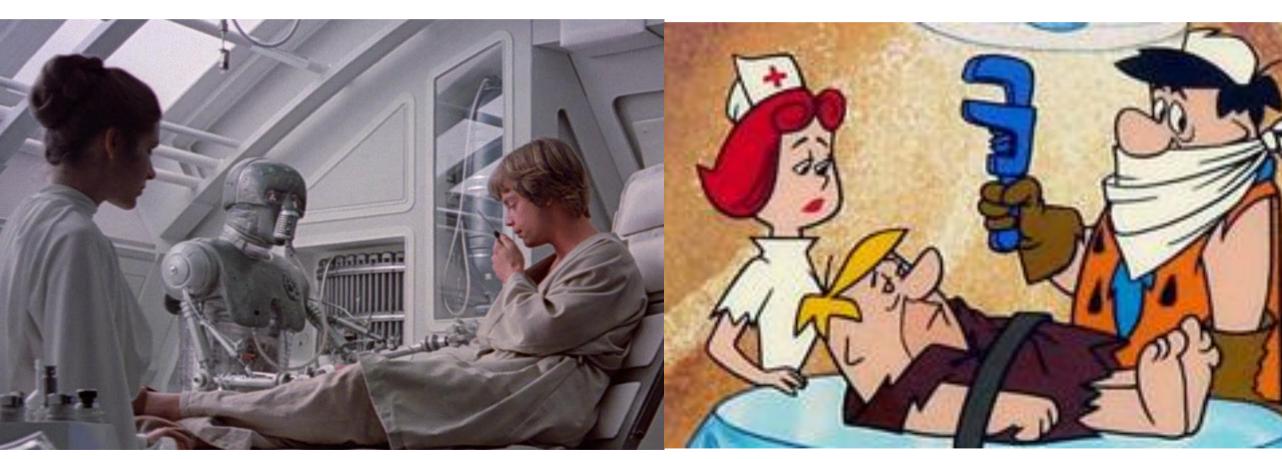


### **Star Wars Science**



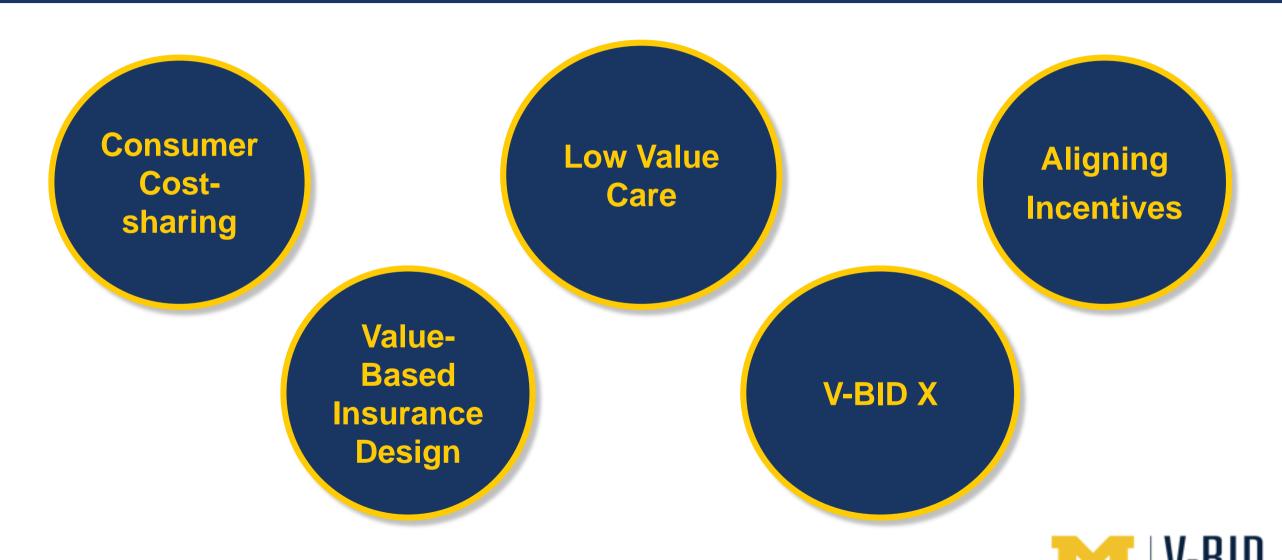


### **Star Wars Science meets Flintstones Delivery**





## Moving from the Stone Age to the Space Age Key Issues - each addressed in 1 minute



### 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



## 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 employer coverage: Consumers are Paying More for ALL Care Regardless of Clinical Value



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





### 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)

### Increasing Cost-Sharing worsens Health Care Disparities

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

Michael Chernew, PhD<sup>1</sup> Teresa B. Gibson, PhD<sup>2</sup> Kristina Yu-Isenberg, PhD, RPh<sup>3</sup> Michael C. Sokol, MD, MS<sup>4</sup> Allison B. Rosen, MD, ScD<sup>5</sup>, and A. Mark Fendrick, MD<sup>5</sup>

<sup>1</sup>Department of Health Care Policy, Harvard Medical School, Boston, MA, USA; <sup>2</sup>Thomson Healthcare, Ann Arbor, MI, USA; <sup>3</sup>Managed Markets Division, GlaxoSmithKline, Research Triangle Park, NC, USA; <sup>4</sup>Managed Markets Division, GlaxoSmithKline, Montvale, NJ, USA; <sup>5</sup>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



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

- Sets consumer costsharing on clinical benefit – not price
- Little or no out-ofpocket cost for high value care; high cost share for low value care
- Successfully implemented by hundreds of public and private payers





### V-BID in Cardiology - MI-FREEE: Better Quality and Reduced Disparities, Without Increasing Costs

### Free access to preventive medications for **Aetna members with history of MI:**

- Reduced rates of major vascular events without increasing overall health costs
- Reduced total health care spending by 70 percent among patients who selfidentified as being non-white

The NEW ENGLAND JOURNAL of MEDICIN

### Full Coverage for Preventive Medi after Myocardial Infarction

Niteesh K. Choudhry, M.D., Ph.D., Jerry Avorn, M.D. Robert J. Glynn, Sc.D., Ph.D., Elliott M. Antman, M.C. William H. Shrank, M.D., M.S.H.S., for the Post-Myor Infarction Free Rx Event and Economic Evaluation (MI FREE

### ABSTRACT

IA RIG. SS. JII. RI. WHIS I and Presentise Medicine (R.J.G.) and the Carat Brigham and Women's Hospital, 1620 Tramont St., Suite 3030, Boston, MA 00120, or at nchoudbry@partners.org.

This article (10.1056/NEJMan1107913)

N Engl J Med 2001;365:2088-97.

Adherence to medications that are prescribed after myocardial infanction inating out-of-pocket costs may increase adherence and improve outce

We enrolled patients discharged after myocardial infarction and rando their insurance-plan sponsors to full prescription coverage (1494 plan sp 2845 patients) or usual prescription coverage (1486 plan sponsors with 30 for all statins, beta-blockers, angiotensin-converting-enzyme inhibitors, sin-receptor blockers. The primary outcome was the first major vascular excularization. Secondary outcomes were rates of medication adherence, vascular events or revascularization, the first major vascular event, and

Rates of adherence ranged from 35.9 to 49.0% in the usual-coverage group 4 to 6 percentage points higher in the full-coverage group (Pc0.001 for parisons). There was no significant between-group difference in the pris come (17.6 per 100 person-years in the full-coverage group vs. 18.8 in t coverage group; hazard ratio, 0.93; 95% confidence interval [CI], 0.82 P=0.21). The rates of total major vascular events or revascularization wen cantly reduced in the full-coverage group (21.5 vs. 23.3; hazard ratio, 0.89; 0.90 to 0.99, P=0.03), as was the rate of the first major vascular event (11.0 0.50 to 0.59; F=0.031, as was the tale of the first major vascular event (11.0 hazard ratio, 0.86; 95% CI, 0.74 to 0.99; P=0.03). The elimination of copdid not increase total spending (\$66,008 for the full-coverage group and \$71 the usual-coverage group; relative spending, 0.89; 95% CI, 0.50 to 1.56; P Patient costs were reduced for drugs and other services (relative spending

The elimination of copayments for drugs prescribed after myocardial infarction significantly reduce rates of the trial's primary outcome. Enhanced prescription age improved medication adherence and rates of first major vascular events at creased patient spending without increasing overall health costs. (Funded by

Choudhry NK, Avorn J, Glynn RJ, Antman EM, Schneeweiss S, Toscano M, et al. Full coverage for preventive medications after myocardial infarction. N Engl J Med. 2011 Dec 1;365(22):2088–97.





- ACA: selected preventive services be provided without cost-sharing
- Medicare Advantage: reduced cost-sharing for high-value services and providers, additional supplemental benefits such as transportation, nutrition
- TRICARE: lower cost sharing for high value drugs
- High-Deductible Health Plans: expanded coverage of chronic disease services



## 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

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<b>Preventive Care for Specified Conditions</b>	For Individuals Diagnosed with
Angiotensin Converting Enzyme (ACE) inhibitors	Congestive heart failure, diabetes, and/or

"Under this policy, no American should ever have to pay full list price for essential drugs like insulin ever again."

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

Raise Premiums



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- Raise Premiums
- Increase Deductibles, Copayments and Coinsurance



## 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



## 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+



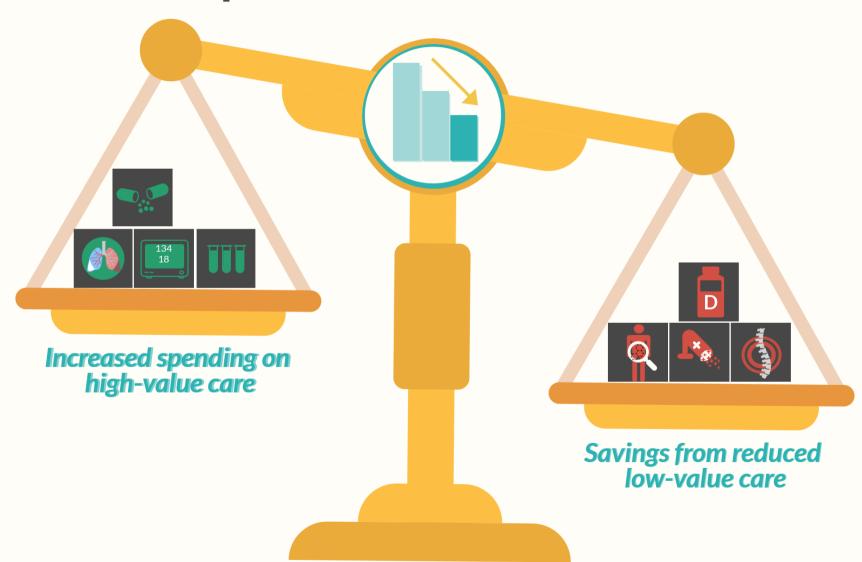
4. Imaging in First 6 Weeks of Acute Low Back Pain



5. Branded Drugs When Identical Generics Are Available



# 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



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The alignment of clinically driven

The alignment of clinically driven, provider-facing and consumer engagement initiatives is critical







### 2020 Policy 'Asks': Benefit Design Reform Goals

- Expand pre-deductible coverage/reduce cost sharing on high value clinical services
- Identify, measure and reduce low value care to pay for increase spend on high value care without the need to increase plan premium or deductible
- Better align payment reforms with consumer-facing programs



