Improving Consumers' Access to High-Value Health Care:
Value-Based Insurance Design and alignment with delivery system reform

SmarterHealthCareCoalition

Panelists

Gary Bacher, Co-Director Smarter Health Care Coalition

Tom Koutsoumpas, Co-Director Smarter Health Care Coalition

Dr. Mark Fendrick, Director, University of Michigan Center for Value Based Insurance Design

Lydia Mitts, Senior Policy Analyst, Families USA

Katy Spangler, Senior Vice President, Health Policy, American Benefits Council

Tony Brice, Managing Director, Evolent Health

Smarter Health Care Coalition

The Smarter Health Care Coalition's mission is to enhance the patient experience – encompassing access, convenience, affordability, and quality – by working together towards achieving smarter health care, with a focus on integrating benefit design innovations and consumer/patient engagement within broader delivery system reform in order to better align coverage, quality, and value-based payment goals.

Aetna ♦ American Benefits Council ♦ America's Health Insurance Plans ♦ Blue Shield of California ♦ Evolent Health ♦ Families USA ♦ Merck ♦ National Coalition on Health Care ♦ Pfizer ♦ Pharmaceutical Research and Manufacturers of America ♦ U.S. Chamber of Commerce ♦ University of Michigan Center for Value Based Insurance Design

Aligning provider-facing efforts with consumer/patient-facing reforms and engagement

Provider-facing efforts in payment and delivery reform

- Payment system and value-based incentive reforms e.g., pay-for-performance
- Clinical guidelines
- Quality metrics
- Targeted outcome measures
- Practice and care transformation
- Shared decision-making

Connect to align and drive progress in the same direction

V-BID as an organizing concept for alignment

Consumer-facing efforts in benefit and coverage design

- Benefit design to promote high-value evidence-based choices
- Consumer tools and transparency on cost and quality
- Wellness and similar health promotion programs
- Literacy programs
- Shared decision-making

What is Value-Based Insurance Design ?

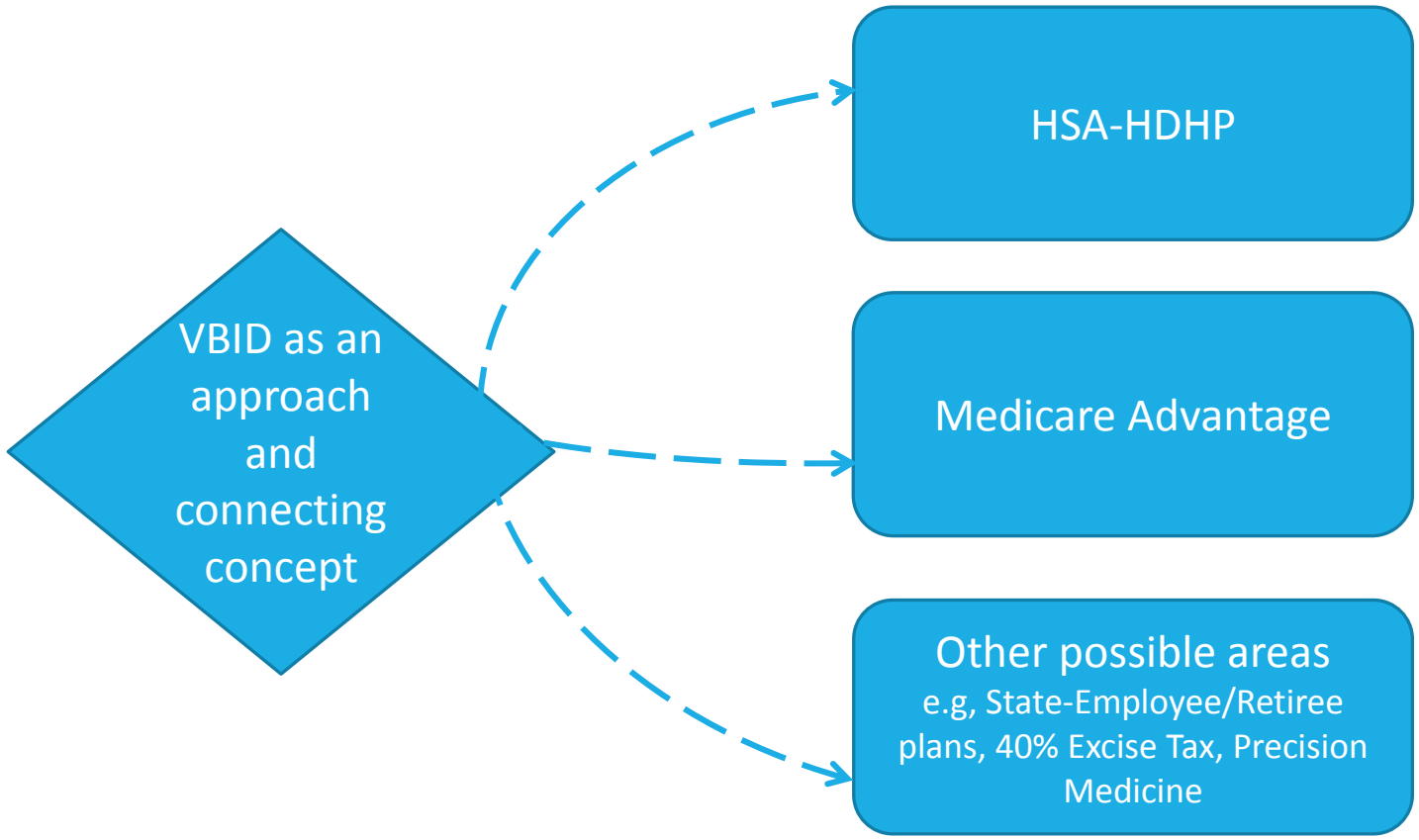
Concept to engage consumers in care decisions by aligning out-of-pocket costs (e.g., deductibles, copayments) with the *value* of care. Furthers consumer access to high-value clinical services while recognizing the importance of maintaining and promoting affordability.

Areas of Application and Impact

V-BID and a focus on both connecting and aligning benefit design and payment/delivery system reform can be applied in numerous areas to create smarter healthcare.

Ability to utilize V-BID to encourage management of chronic conditions

Importance of aligning health care delivery and coverage design approaches consistently across the continuum of care pre- and during Medicare eligibility



Opportunity to apply V-BID to Medicare Advantage Plans

- Treatment of chronic illnesses now estimated to account for nearly 93% of Medicare spending
- MA plans as of 2015 cover 31% of Medicare Beneficiaries, amounting to roughly 16.8 million people
- Importance of allowing incorporation of V-BID principles and encouraging the use of high-quality providers is becoming widely recognized, although barriers remain
- Congressional support in both the House and Senate has been instrumental, and this bipartisan support has already substantially helped advance efforts toward a V-BID demonstration in Medicare Advantage by CMS

V-BID and rules for HSA-HDHPs

BASIC REQUIREMENTS FOR HSA-HDHPS

HDHP must have a minimum deductible
- At least $1,300 for 2015 self-only coverage

The HDHP cannot provide benefits prior to this deductible being met, with limited exceptions*

Includes rules regarding maximum out-of-pocket (OOP) limit on spending and related requirements

*EXCEPTION: THE IRS "PREVENTIVE CARE SAFE HARBOR" PROVISION

Allows plans to cover certain preventive care services prior to the deductible being met
- IRS has clarified that preventive services required to be provided by the ACA fall under this safe harbor

IRS guidance excludes benefits to treat "an existing illness, injury, or condition" which excludes treatment of chronic illnesses

Improving Consumers' Access to High-Value Health Care
Shifting the discussion from "How much" to "How well"

- **Innovations to prevent and treat disease have led to impressive reductions in morbidity and mortality**
- **Regardless of these advances, cost growth is the principle focus of health care reform discussions**
- **Despite unequivocal evidence of clinical benefit, substantial underutilization of high-value services persists across the entire spectrum of clinical care**

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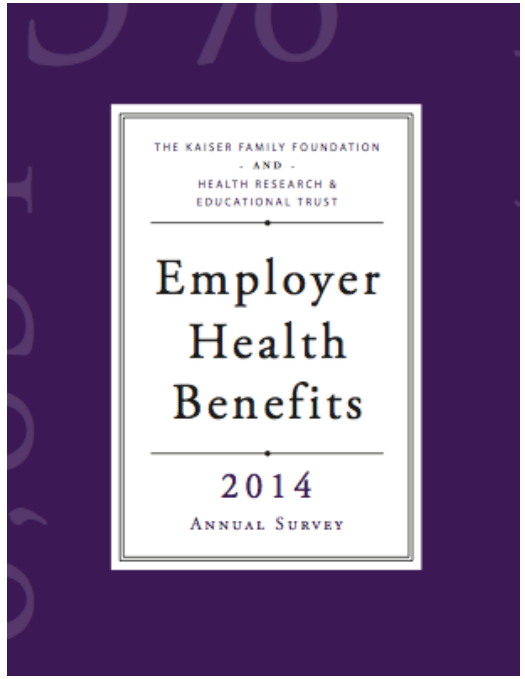
Improving Consumers' Access to High-Value Health Care
Role of Consumer Cost-Sharing in Clinical Decisions

- **For today's discussion, our focus is on costs paid by the consumer, not the employer or third party administrator**
- **Ideally consumer cost-sharing levels would be set to encourage the clinically appropriate use of health care services**
- **Instead, archaic "one-size-fits-all" cost-sharing fails to acknowledge the differences in clinical value among medical interventions**
- **Consumer cost-sharing is rising rapidly**



Health Affairs 2014. doi: 10.1377/hlthaff.2014.0792

V-BID

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 Increases in Consumer Cost-Sharing on Health Care Utilization

A growing body of evidence concludes that increases in consumer cost-sharing leads to a reduction in the use of essential services, worsens health disparities, and in some cases leads to greater overall costs

The New York Times

Business Day

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ECONOMIC VIEW

When a Co-Pay Gets in the Way of Health

By SENDHIL MULLAINATHAN
Published: August 10, 2013

ECONOMISTS specialize in pointing out unpleasant trade-offs — a skill that is on full display in the health care debate.

Enlarge This Image

Minh Uong/The New York Times

We want patients to receive the best care available. We also want consumers to pay less. And we don't want to bankrupt the government or private insurers. Something must give.

The debate centers on how to make these trade-offs, and who gets to make them. The stakes are high, and the choices are at times unseemly. No matter how necessary, putting human suffering into dollars and cents is not attractive work. It's no surprise, then, that the conversation is so heated.

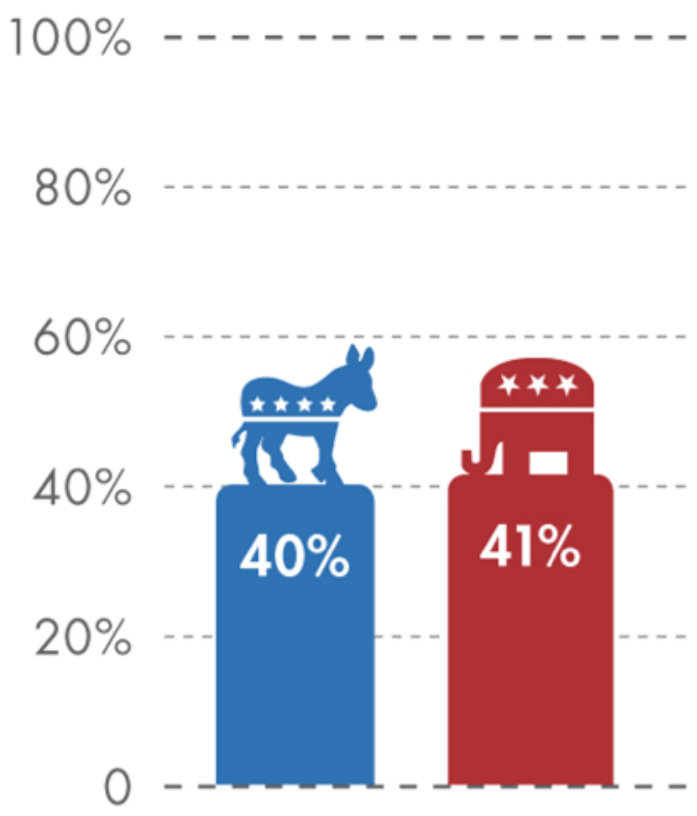
What is a surprise is that amid these complex issues, one

FACEBOOK
TWITTER
GOOGLE+
SAVE
EMAIL
SHARE
PRINT
REPRINTS

THE GRAND BUDAPEST HOTEL

Goldman D. *JAMA*. 2007;298(1):61–9. Trivedi A. *NEJM.* 2008;358:375
2010;362(4):320-8.. Chernew M. J Gen Intern Med 23(8):1131–6.

Foregoing Care Due to Cost
A Bipartisan Problem



40% of Democrats and
41% of Republicans
said cost is the number
one reason they have not
utilized preventive care

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Improving Consumers' Access to High-Value Health Care Solutions Are Needed to Enhance Efficiency

- **Consumers currently do not have the necessary information to make informed health care decisions**
- **While important, clinician incentives and providing accurate price and quality data does not ensure appropriate care delivery**
- **Additional consumer engagement solutions are necessary to better allocate health expenditures on the clinical benefit – not only the price or profitability – of services**

Potential Solution:

Clinically Nuanced Cost-Sharing

What is clinical nuance?

Services differ in clinical benefit produced

Clinical benefits from a specific service depend on:

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Implementing Clinical Nuance: Value-Based Insurance Design

- **Sets consumer cost-sharing level on clinical benefit – not acquisition price – of the service**
  - **Reduce or eliminate financial barriers to high-value clinical services and providers**

- **Successfully implemented by hundreds of public and private payers**

WSJ.com THE WALL STREET JOURNAL. ONLINE

June 16, 2004

FOLLOW THE MONEY

From 'One Size Fits All' To Tailored Co-Payments

June 16, 2004

University of Michigan researchers say a patient's payment for a drug should depend on how much he or she will benefit from the a move that would likely lower co-payments for

Value Based Insurance Design
More than High-Value Prescription Drugs

- **Prevention/Screening**
- **Diagnostic tests/Monitoring**
- **Treatments**
- **Clinician visits**
- **High performing networks**
- **PCMH**
- **Hospitals**

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V-BID: Who Benefits and How?

Health Affairs. 2013;32(7):1251-1257 Health Affairs. 2014;;33(5):863-70

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Putting Innovation into Action: Create Broad Multi-Stakeholder Support

- HHS
- CBO
- SEIU
- MedPAC
- Brookings Institution
- The Commonwealth Fund
- NBCH
- PCPCC
- Partnership for Sustainable Health Care
- Families USA
- AHIP
- National Governor's Assoc.
- US Chamber of Commerce
- Bipartisan Policy Center
- Kaiser Family Foundation
- NBGH
- National Coalition on Health Care
- Urban Institute
- RWJF
- IOM
- PhRMA
- AARP

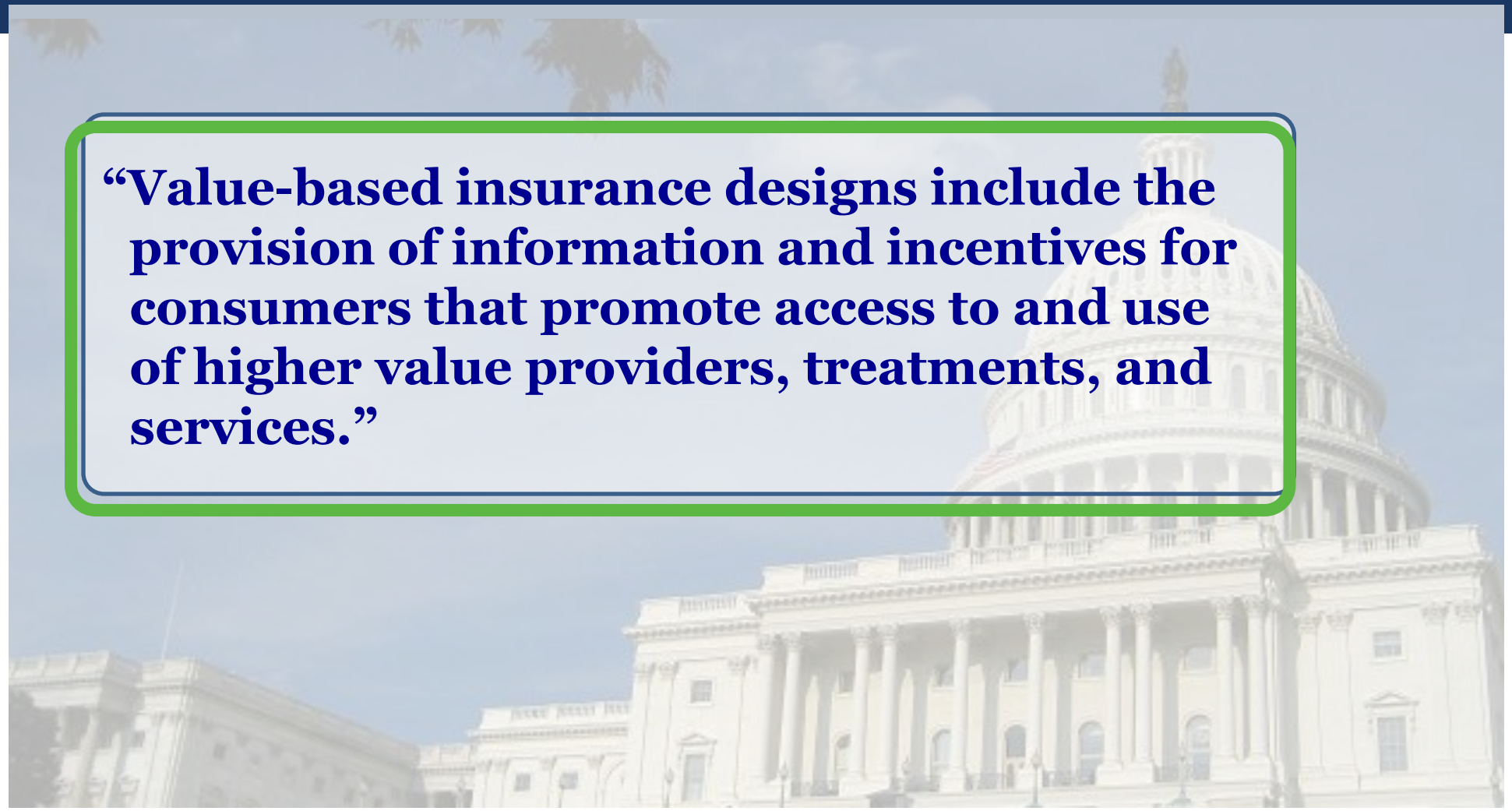
Lewin. *JAMA.* 2013;310(16):1669-1670

V-BID

Translating Research into Policy

V-BID

ACA Sec. 2713c Regulation: V-BID Definition



"Value-based insurance designs include the provision of information and incentives for consumers that promote access to and use of higher value providers, treatments, and services."

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Putting Innovation into Action
Translating Research into Policy

- **Medicare Advantage**

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Medication Affordability After Medicare Part D Implementation

- **Among elderly beneficiaries with four or more chronic conditions, the prevalence of cost-related non-adherence increased from 14% in 2009 to 17% in 2011, reversing previous downward trends**
- **The prevalence among the sickest elderly of forgoing basic needs to purchase medicines decreased from 9% in 2007 to 7% in 2009 but rose to 10% in 2011**

Health Aff August 2014 vol. 33 no. 8 1435-1443

V-BID

Effects of Increased Copayments for Ambulatory Visits for Medicare Beneficiaries

- Copays increased:
  - $7 for primary care visit
  - $10 for specialty care visit
  - remained unchanged in controls
- In the year after copayment increases:
  - 20 fewer annual outpatient visits per 100 enrollees
  - 2 additional hospital admissions per 100 enrollees
- Total cost higher for those with increased copayments

Trivedi A. *NEJM*. 2010;362(4):320-8..

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Why not lower cost-sharing on high-value services?

The anti-discrimination clause of the Social Security Act does not allow clinically nuanced consumer cost-sharing.

"providers may not deny, limit, or condition the coverage or provision of benefits"

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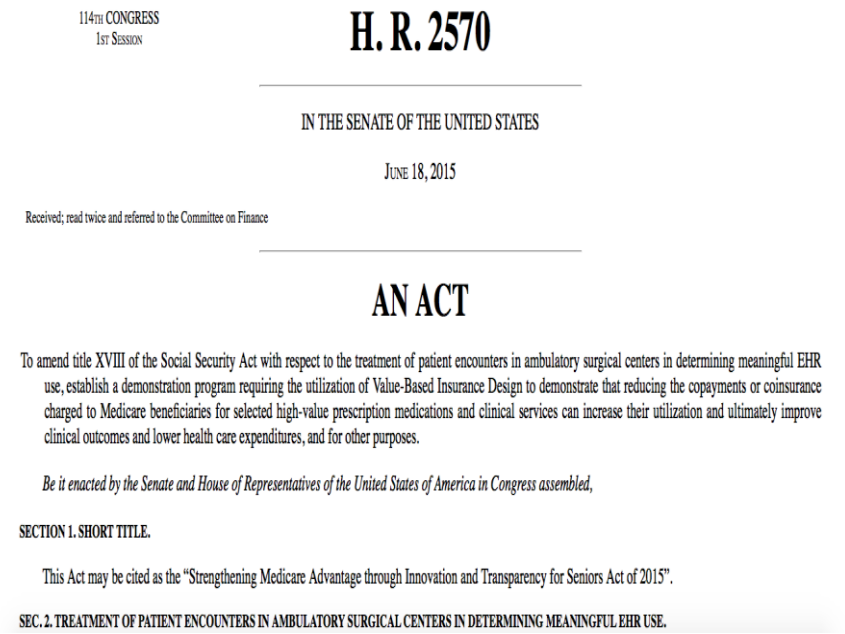
H.R.2570/S.1396: Bipartisan "Strengthening Medicare Advantage Through Innovation and Transparency"

- **Directs HHS to establish a V-BID demonstration for MA beneficiaries with chronic conditions**
- **Passed US House with strong bipartisan support in June 2015**
- **CMS issues RFI on role of V-BID in Medicare in October 2014**

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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Precision Medicine Requires Precision Benefit Design

- ✓ Mitigates cost-related non-adherence leading to enhanced clinical outcomes
- ✓ Reallocates medical spending efficiently and optimizes population health
- ✓ Aligns payment reform and consumer engagement initiatives

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Improving Consumers' Access to High-Value Health Care

Lydia Mitts, Senior Policy Analyst

Who We Are and What We Do

- Families USA is a non-profit, non-partisan organization
- Dedicated to the achievement of high-quality, affordable health care for all
- Research and produces timely reports and other informative resources.
- Collaborates with organizations across the political, business, nonprofit and health care sectors.
- Provides technical assistance at the state and community levels.

Insuring Coverage Translates to Care:

- ACA has made landmark achievements in expanding access to affordable coverage and care

- Remaining work ahead to ensure families can afford out-of-pocket costs for needed care once insured

- High deductibles/out-of-pocket costs common prior to ACA
  - Barrier to needed care, particularly for lower and middle-income families
  - Continues to pose problem across all types of coverage

Moving Forward: Need to ensure coverage facilitates access to needed care for low and middle income families

FAMILIESUSA

Families USA Report: Missed Care

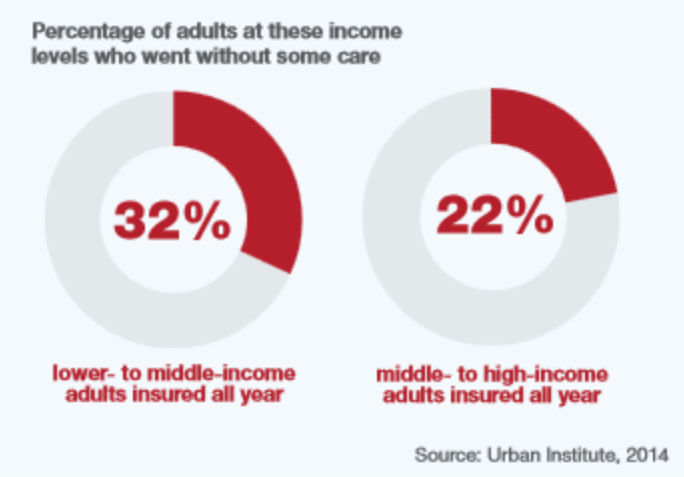
Among adults insured the full year with non-group coverage in 2014:

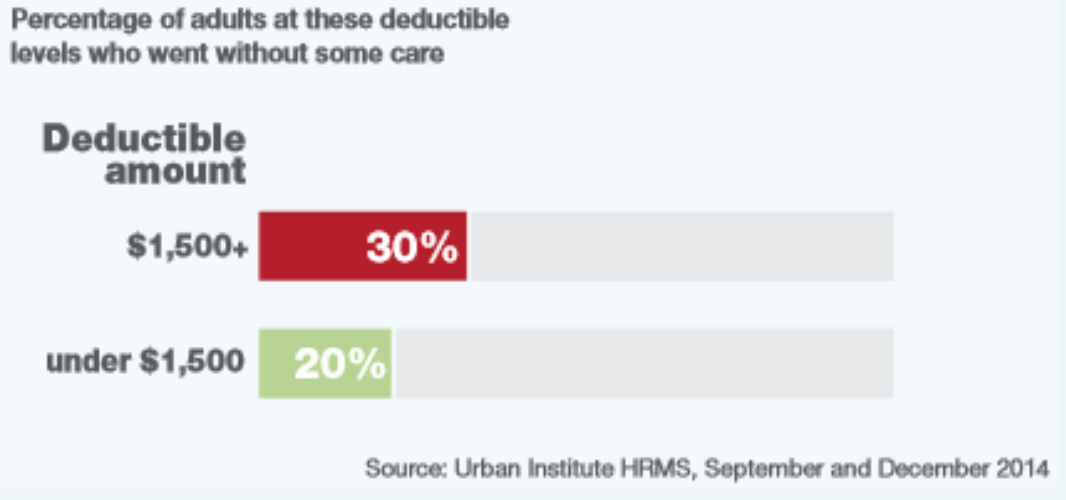
- One in four adults went without needed care due to affordability problems
- Tests, treatment, follow up care and prescription drugs most common

Report Findings: Who is struggling to afford care?

Who is more likely to skip needed care?

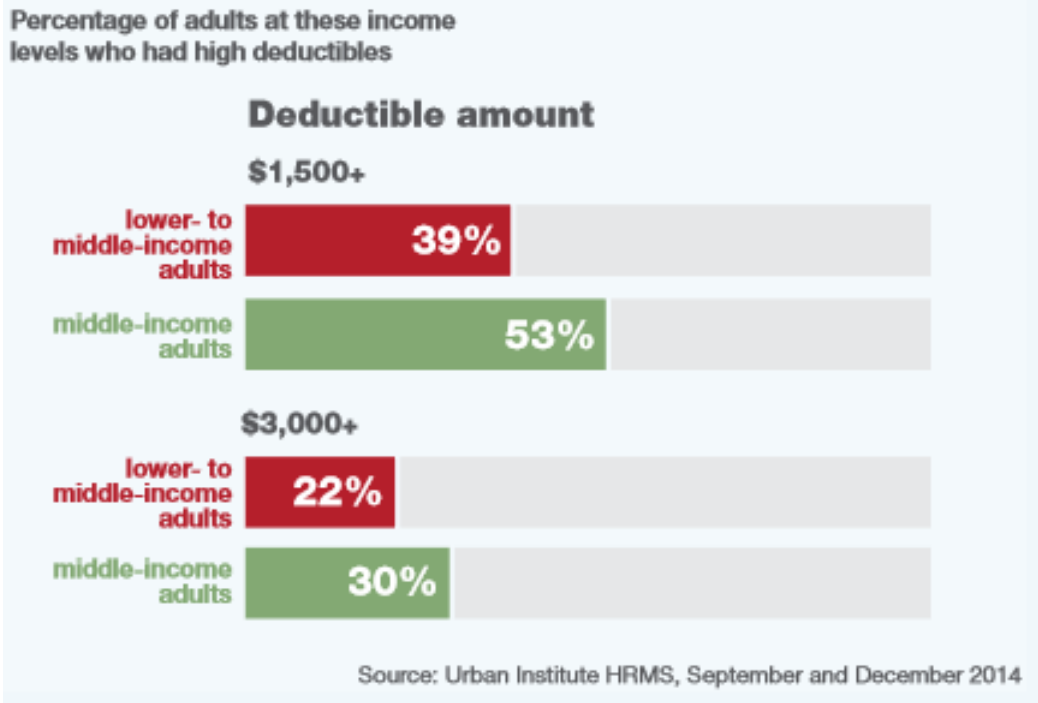
- Those with lower to middle income (under 250 percent of poverty)
- Those with high deductibles (>$1,500/person)





Report Findings: Deductibles

- High deductibles are common, even among lower to middle income adults (under 250% of poverty)
- $1,500 = 5.41 % of income for individual at 250% of poverty (making $29,200/year)



Lower to middle income:138-249 percent of poverty
Middle income: 250-400 percent of poverty

Improving Plan Offerings

Families USA Priorities:

- Increase marketplace plan offerings that cover care pre-deductible, including services to manage chronic conditions
  - Emphasis on silver plans
- HSA HDHP flexibility to cover care for chronic conditions pre-deductible
  - Common in employer-based coverage and marketplace
  - May be only affordable coverage option for some
- Expand upfront coverage for high value chronic conditions care across all types of public and private coverage

Additional Families USA Resources:

- *Non-Group Health Insurance: Many Insured Americans with High Out-of-Pocket Costs Forgo Needed Health Care: http://familiesusa.org/product/non-group-health-insurance-many-insured-americans-high-out-pocket-costs-forgo-needed-health*
- *Designing Silver Plans with Affordable Out-of-Pocket Costs for Lower– and Moderate-Income Consumers: http://familiesusa.org/product/designing-silver-health-plans-affordable-out-pocket-costs-lower-and-moderate-income*
- *Standardized Health Plans: Promoting Plans with Affordable Upfront Out-of-Pocket Costs: http://familiesusa.org/product/standardized-health-plans-promoting-plans-affordable-upfront-out-pocket-costs*

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FAMILIESUSA
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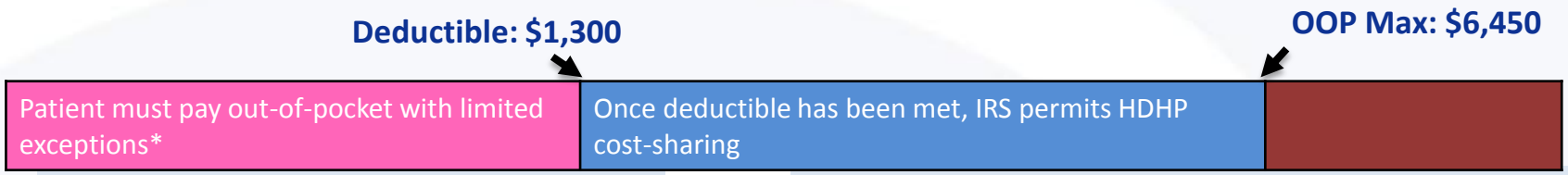
AMERICAN BENEFITS COUNCIL

Increasing Flexibility in Health Savings Accounts

Katy Spangler

July 21, 2015

IRS Rules for HSA-HDHPs



BASIC REQUIREMENTS FOR HSA-HDHPS

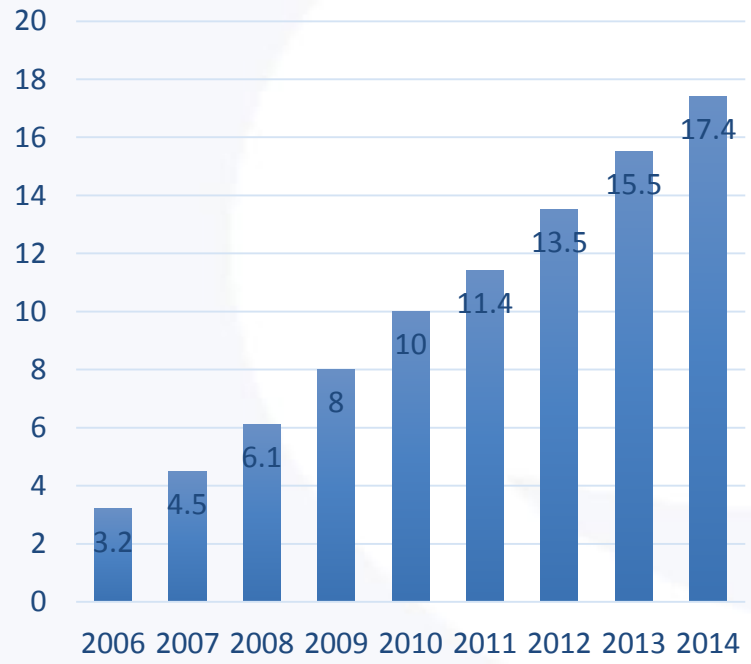
- HDHP must have a minimum deductible
  - At least $1,300 for 2015 self-only coverage
- The HDHP cannot provide benefits prior to this deductible being met, with limited exceptions*
- Includes rules regarding maximum out-of-pocket (OOP) limit on spending and related requirements

*EXCEPTION: THE IRS "PREVENTIVE CARE SAFE HARBOR" PROVISION

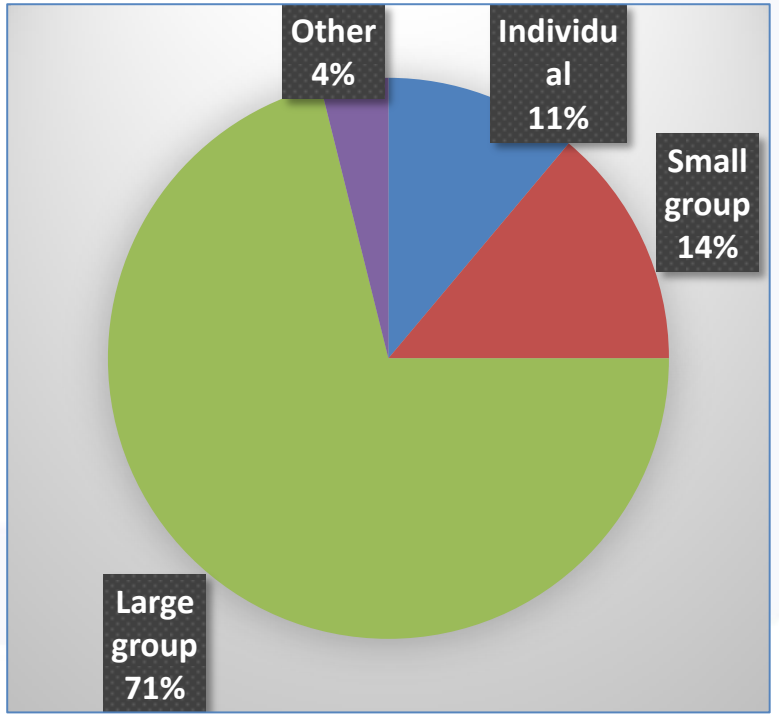
- Safe harbor allowing plans to cover certain preventive services prior to the deductible being met
  - IRS has clarified that preventive services required to be provided by the ACA fall under this safe harbor
- IRS guidance excludes benefits to treat "an existing illness, injury, or condition" which excludes treatment of chronic illnesses

Prevalence of HSA-HDHPs Increasing

HDHP ENROLLMENT (MILLIONS)



2014 DISTRIBUTION OF HDHP ENROLLEES BY MARKET TYPE



Sources: AHIP Center for Policy and Research, 2005 - 2014 HSA/HDHP Census

Why Change the Current Definition?

- According to the CDC, spending on chronic disease encompasses more than 86 percent of total U.S. health expenditures
- Yet, the "Cadillac" tax and other factors are forcing employers to move to HSA-HDHPs that limit (pre-deductible) coverage of services to treat chronic conditions
- Employers would love more flexibility to offer (currently excluded) high value services (like insulin, test strips, and eye exams for patients with diabetes) before employees meet deductibles

American Benefits Council 2020 Vision Recommendation

- **Clarify that certain prescription drugs are preventive care that will not be subject to a HSA-eligible plan deductible. Current law includes a safe harbor allowing HSA eligible high deductible plans to cover certain preventive services before the deductible is met. The IRS has too narrowly defined "prevention" to consist of primary preventive services, including some prescription drugs when used in certain instances. <u>This definition should be updated to give employers greater flexibility regarding prescription drugs that may be covered before the deductible.</u>**

Next Steps?

- IRS could utilize their existing authority under Internal Revenue Code section 223 and expand the definition of preventive services
- Congress could advance legislation expanding the definition of prevention

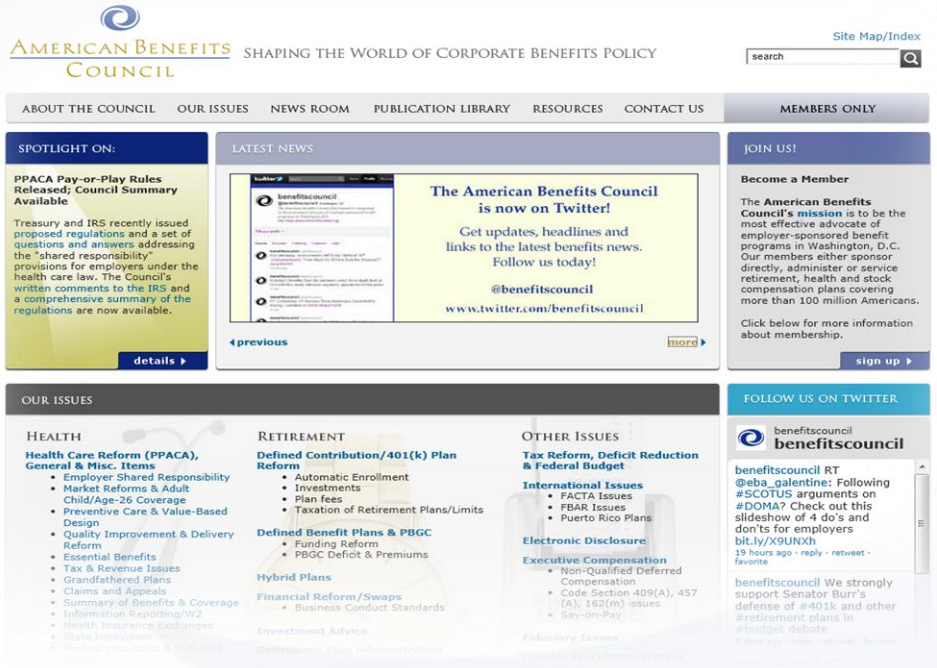
Hatch language pulled from S.1031:

SEC. 110. PREVENTIVE CARE PRESCRIPTION DRUG CLARIFICATION.

- **(a) CLARIFY USE OF DRUGS IN PREVENTIVE CARE.—Subparagraph (C) of section 223(c)(2) is amended by adding at the end the following: "Preventive care shall include prescription and over-the-counter drugs and medicines which have the primary purpose of preventing the onset of, further deterioration from, or complications associated with chronic conditions, illnesses, or diseases.".**
- **(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2003.**

For more information:

www.americanbenefitscouncil.org



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Putting Innovation into Action: Translating Research into Policy

- **HSA-qualified HDHPs**

HSA-HDHP enrollment and out-of-pocket expenses continue to grow

http://www.ahipcoverage.com/wp-content/uploads/2013/06/HSAinfographic_V9_FV.jpg

Maximum Out-of-pocket expense 2006 to 2014

individual: $5,000 to $6,350

family: $10,000 to $12,700

http://kff.org/report-section/ehbs-2014-section-eight-high-deductible-health-plans-with-savings-option/

http://www.irs.gov/pub/irs-drop/n-04-2.pdf

V-BID

HSA-qualified HDHPs: Expanding the Deductible-Exempt "Safe Harbor"

- More than 25% of employers offer HDHPs
- 85% of enrollees in the individual marketplace purchased either silver or bronze HDHP plans

J Gen Intern Med. 2012;27(9):1105-1111. *Health Aff*. 2011; 30(2):322-331.

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IRS Safe Harbor Guidance allows zero consumer cost-sharing for specific preventive services

INCLUDING:

- ✓ periodic health evaluations/screenings
- ✓ routine prenatal and well-child care
- ✓ child and adult immunizations
- ✓ tobacco cessation programs
- ✓ obesity weight-loss programs

www.irs.gov/pub/irs-drop/n-04-23.pdf

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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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Barriers to V-BID in HSA-qualified HDHPs
Expanding the Deductible-Exempt "Safe Harbor"

- **HDHP enrollees with chronic diseases are more likely to go without care due to cost or experienced financial hardship due to medical bills**
- **Many well-established quality metrics require the entire deductible to be met before coverage begins**
- **90% of employers support expanding deductible-exempt definition to include chronic disease care**

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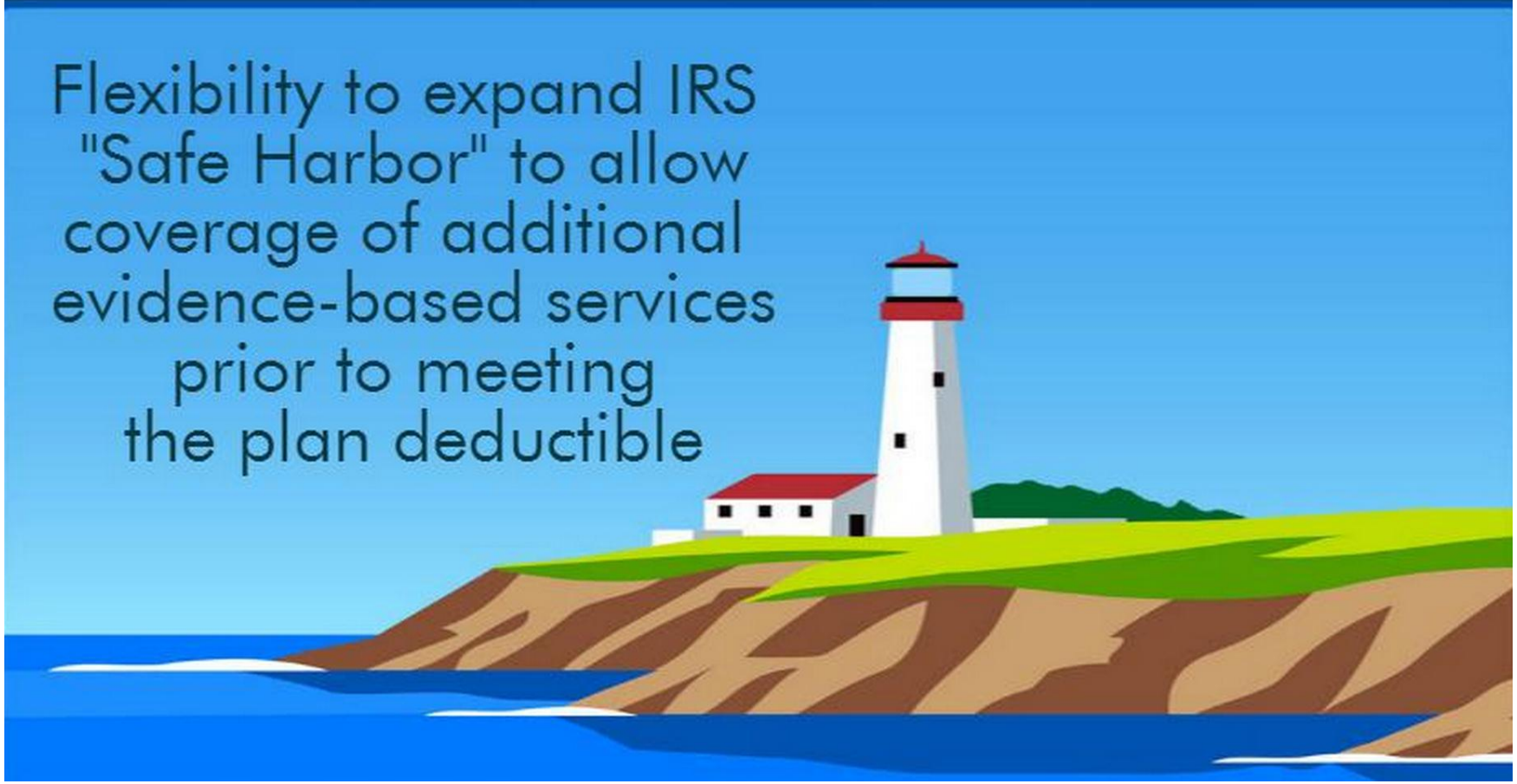
Potential Solution:

High Value Health Plan

Flexibility to expand IRS "Safe Harbor" to allow coverage of additional evidence-based services prior to meeting the plan deductible



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V-BID HDHP Hybrid with "Smarter Deductibles": High Value Health Plan

HVHP allows evidence-based, services that manage chronic disease to be deductible-exempt:

- **Lower premiums than PPOs and HMOs; slight premium increase over existing HDHPs**
- **>40 million likely enrollees**

High Value Health Plan "Smarter Deductibles, Better Value"

- HSA-HDHP with flexibility to cover additional evidence-based services prior to the deductible
- Mitigates cost-related non-adherence leading to enhanced clinical outcomes
- Aligns with provider payment reform incentives
- Lower premiums than most PPOs and HMOs, providing an alternative to health plans subject to the "Cadillac Tax"
- Substantially reduces aggregate health care expenditures

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Using Clinical Nuance to Align 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**

AJAC. 2014;2(3);10.

V-BID

Using Clinical Nuance to Align Payer and Consumer Incentives: As Easy as Peanut Butter and Jelly

- **"Supply side" initiatives are restructuring provider incentives to move from volume to value**

- **Unfortunately, "demand-side" initiatives are moving consumers in the opposite direction**

AJAC. 2014;2(3);10.

V-BID

Using Clinical Nuance to Align Payer and Consumer Incentives: As Easy as Peanut Butter and Jelly

- **"Supply side" initiatives are restructuring provider incentives to move from volume to value**

- **Unfortunately, "demand-side" initiatives are moving consumers in the opposite direction**

- **Adding clinical nuance can improve quality of care, enhance employee experience, and contain cost growth**

AJAC. 2014;2(3);10.

V-BID

Discussion

University of Michigan Center for Value-Based Insurance Design

www.vbidcenter.org

@um_vbid

vbidcenter@umich.edu

Coalition for Smarter Healthcare

www.smarterhc.org

Value-Based Insurance Design Challenges

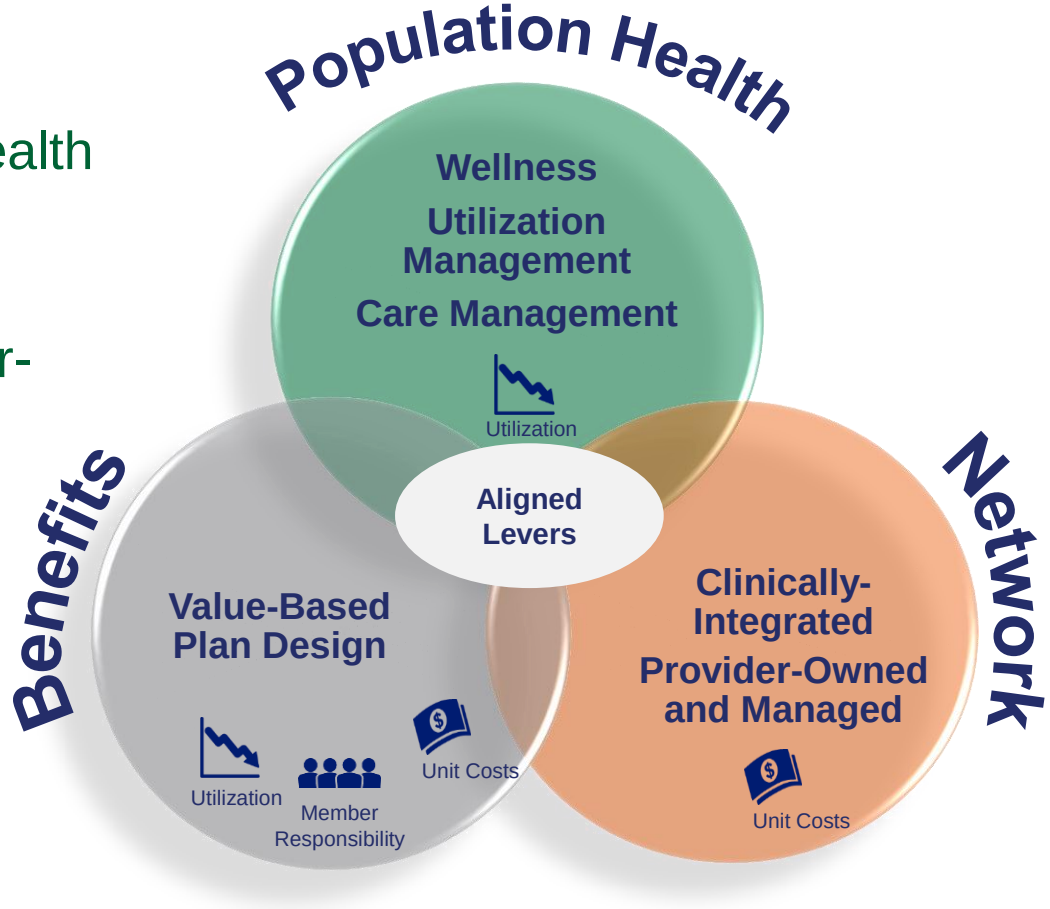
Summer 2015

Who is Evolent?

- Founded in 2011
- Operations in Arlington, VA
- Strategic investors:
  - University of Pittsburgh Medical Center (UPMC)
  - The Advisory Board Company (based in DC)
  - TPG Growth
- IPO in June 2015 – NYSE (EVH)
- Over 800 employees
- Clients include Hospital and Health Systems that are converting from Fee-For-Service delivery to value-based delivery including:
  - Launching provider-owned health plans to the commercial, Medicare Advantage, private exchange market
  - Establishing Medicare and Commercial payer-risk arrangements
  - Developing direct-to-employer population health products/services

A Successful Provider-Owned Health Plan Model Includes Value-Based Insurance Plan Designs

- Reduction in population health risk levels
- Lower per-employee-per-month costs



Integrated Population Health, Health Plan Design and Provider Network

Objectives of Value Based Insurance Designs Within Provider Owned Health Plans (POHPs)

- POHPs leverage the principles of Value Based Insurance Design (VBID) to encourage certain types of medical utilization by removing financial barriers in the plan design
- POHPs engage patients with health care providers to:
  - Close gaps in care (i.e. age appropriate screenings)
  - Improve compliance with medication therapies
  - Initiate behavior changes (i.e. exercise; nutrition)
- POHPs achieve these objectives with VBID techniques:
  - Waiving copays or coinsurance for maintenance medications
  - Waiving deductible for physician visits for chronically ill patients
  - Incenting certain personal behaviors by rewarding plan participants with cash deposits into ***accounts*** that can be used to offset medical expenses
    - i.e. participants can earn $500 for completing a health risk assessment, participating in a biometric screen, losing weight, or participating in certain disease management programs

Employer Contributions to Account-Based Plans Are Often Used as a Health Improvement Incentive

85% of large employers surveyed by the National Business Group on Health (August 2014) have a High Deductible Health Plan (HDHP) with a Health Saving Account (HSA), while 18% have an HDHP with a Health Reimbursement Account (HRA)

HSA-Qualified HDHPs

- Require that all expenses including pharmacy (but ***excluding preventive care***) be subject to the high deductible
- Employer and Employee contributions to an HSA count toward the ACA excise “Cadillac” tax
- Contributions are immediately vested and portable
- HSA contributions are triple-tax advantaged to participants

HDHPs with HRAs

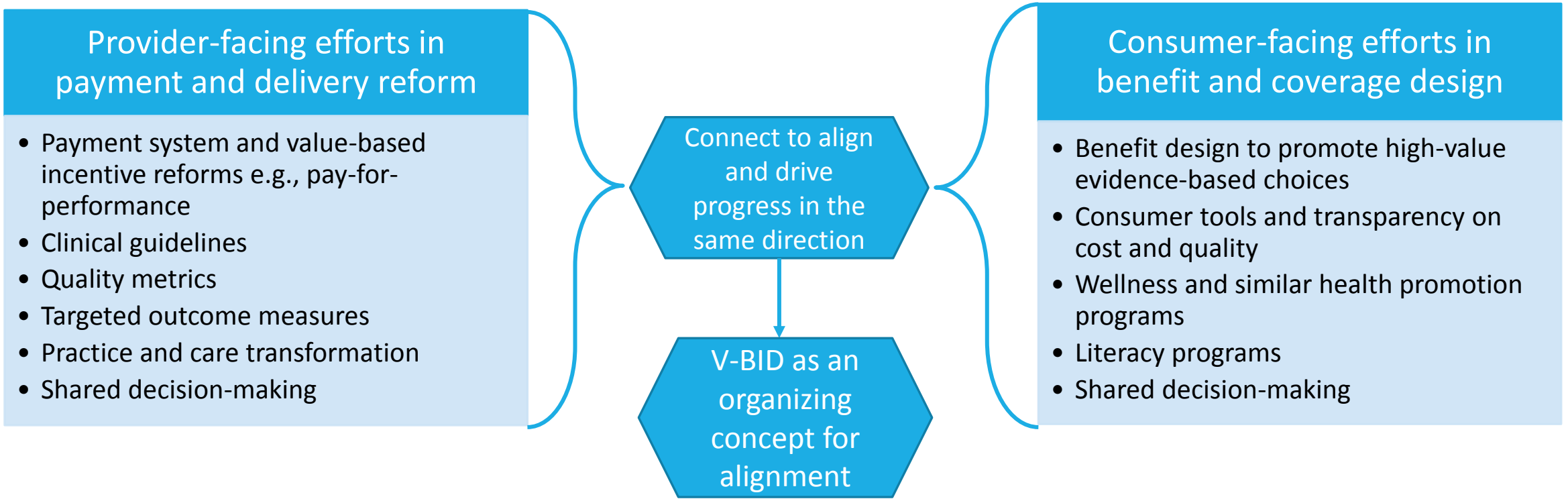
- No vesting requirements, not portable
- Only employer funded
- Contributions count towards the excise tax
- Accumulated balances can be capped or forfeited if not used
- HRA funds not considered a plan expense until used – similar to traditional insurance expense

Reform the HSA-/HDHP *Preventive-Service Safe Harbor Definition* to Include VBID Principles

- Reform of the HSA/HDHP Preventive Service Safe Harbor to include unique VBID principles (like waiving deductibles) will:
  - Provide plan participants with access to *evidence-based preventive services prior to s*atisfaction of the high deductible
  - Allow greater use of “employer-funded” HSA accounts among POHPs who are transitioning to value-based care and using account based plans as an incentive
  - Encourage more participants to join the plan
    - According to the 2014 Kaiser Family Foundation Survey:
      - 31% of covered workers enrolled in an HSA-qualified plan (where the employer makes no contribution)
      - 34% of covered workers are enrolled in an HSA-qualified plan when the employer contributes less than $462
      - 24% of covered workers are enrolled in an HSA-qualified plan when the employer contributes $1,077 or more
      - Comparatively, 44% of covered workers are enrolled in a plan with an employer funded HRA/HDHP of less than $834

Overview: Need and Opportunity

Align provider-facing efforts with consumer/patient-facing reforms and engagement to increase consumers' access to high value health care



Key Takeaways

Encouraging application of V-BID principles aligned with payment reform

Advance specific proposals in the areas of:

- Medicare Advantage
- HSA-HDHP plans
- Other growing areas such as State-Employee and Retiree Plans and Precision Medicine

Work with us on these issues and to create smarter health care:

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Questions? Comments?

FOR MORE INFORMATION:

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