



SCHOOL OF PUBLIC HEALTH

CENTER FOR VALUE-BASED INSURANCE DESIGN

UNIVERSITY OF MICHIGAN

**Value-Based Insurance Design:  
Using “Smarter” Cost-sharing to Align Consumer  
Incentives with Alternative Payment Models**

**A. Mark Fendrick, MD**

**University of Michigan Center for  
Value-Based Insurance Design**

**[www.vbidcenter.org](http://www.vbidcenter.org)**



**@um\_vbid  
#CAHPVBID**



**Table 1: Risk factors for nodding off at lectures**

| Factor                           | Odds ratio<br>(and 95% CI) |
|----------------------------------|----------------------------|
| <b>Environmental</b>             |                            |
| 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)              |
| <b>Audiovisual</b>               |                            |
| Poor slides                      | 1.8 (1.3–2.0)              |
| Failure to speak into microphone | 1.7 (1.3–2.1)              |
| <b>Circadian</b>                 |                            |
| Early morning                    | 1.3 (0.9–1.8)              |
| Post prandial                    | 1.7 (0.9–2.3)              |
| <b>Speaker-related</b>           |                            |
| 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.

# Shifting the Discussion from “How much” to “How well”

## Overview

- **Impact of Consumer Cost-sharing**
- **New Approach: “Clinically Nuanced” Cost-sharing**
- **Value-Based Insurance Design**
- **Putting Innovation into Action**
- **Identifying and Removing Waste**
- **Synergies with Alternative Payment Models**

# Getting to Health Care Value

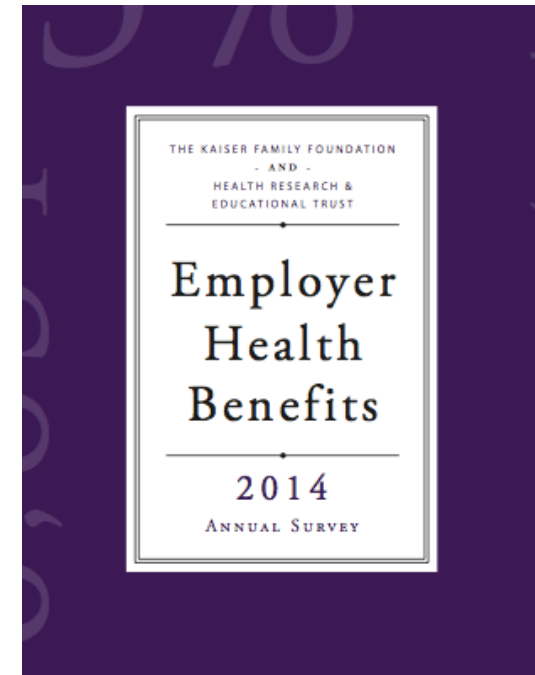
## Shifting the discussion from “How much” to “How well”

- **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**
- **Attention should turn from *how much* to *how well* we spend our health care dollars**

# Getting to Health Care Value

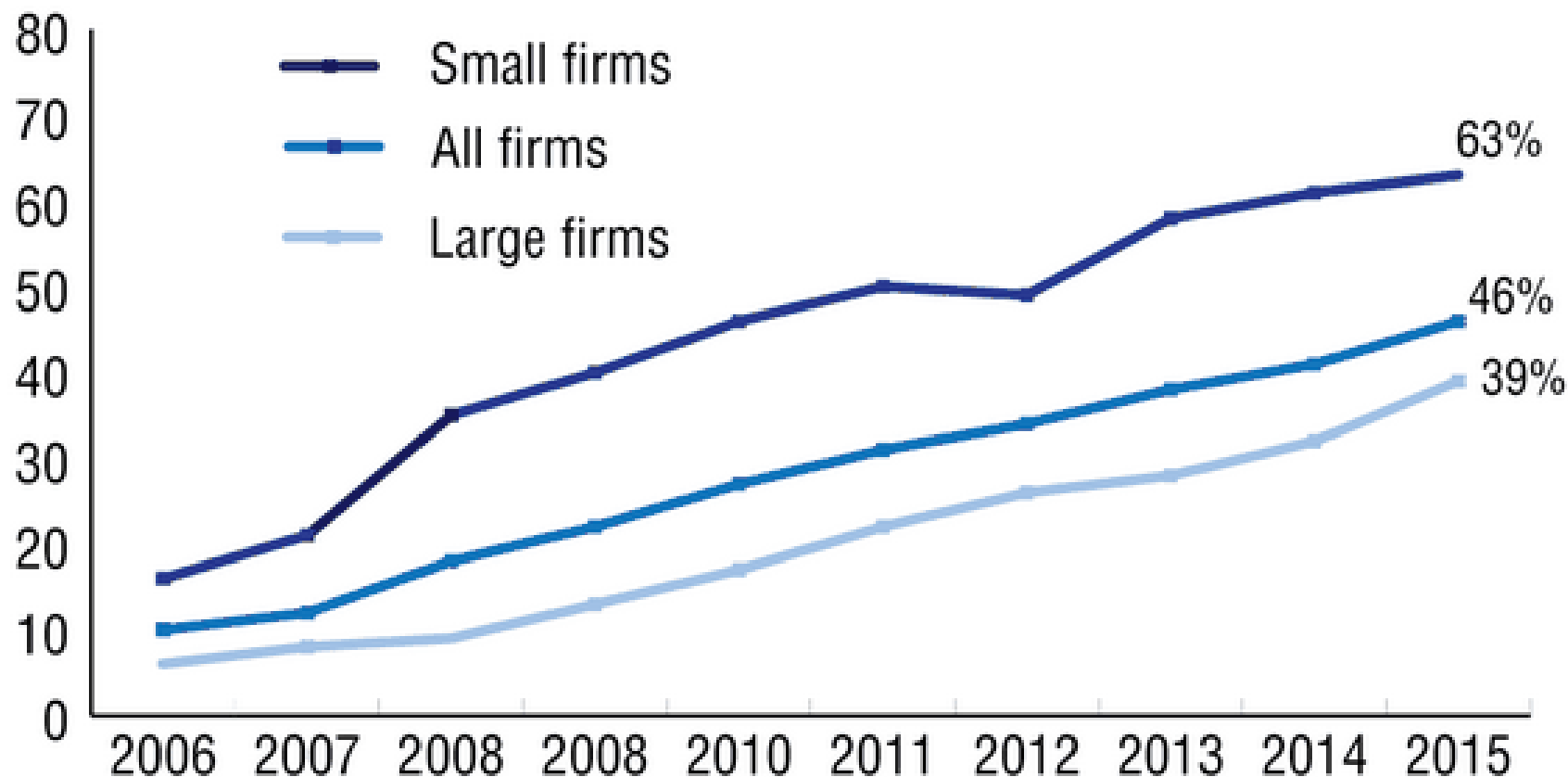
## Role of Consumer Cost-Sharing in Clinical Decisions

- For today's discussion, the focus is on costs paid **by the consumer**, not the employer or third party administrator
- Archaic “one-size-fits-all” cost-sharing fails to acknowledge the differences in clinical value among medical interventions
- Consumer cost-sharing is rising rapidly



# Deductibles on the rise

Percentage of covered workers with an annual deductible of \$1,000 or more for single coverage



Source: Kaiser Family Foundation and Health Research and Educational Trust

# **Pathway to Better Health and Lower Costs 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.**

Goldman D. *JAMA*. 2007;298(1):61–9. Trivedi A. *NEJM*. 2008;358:375-383. Trivedi A. *NEJM*. 2010;362(4):320-8.. Chernew M. *J Gen Intern Med* 23(8):1131–6.

*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](#)



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 policy sidesteps these trade-offs.

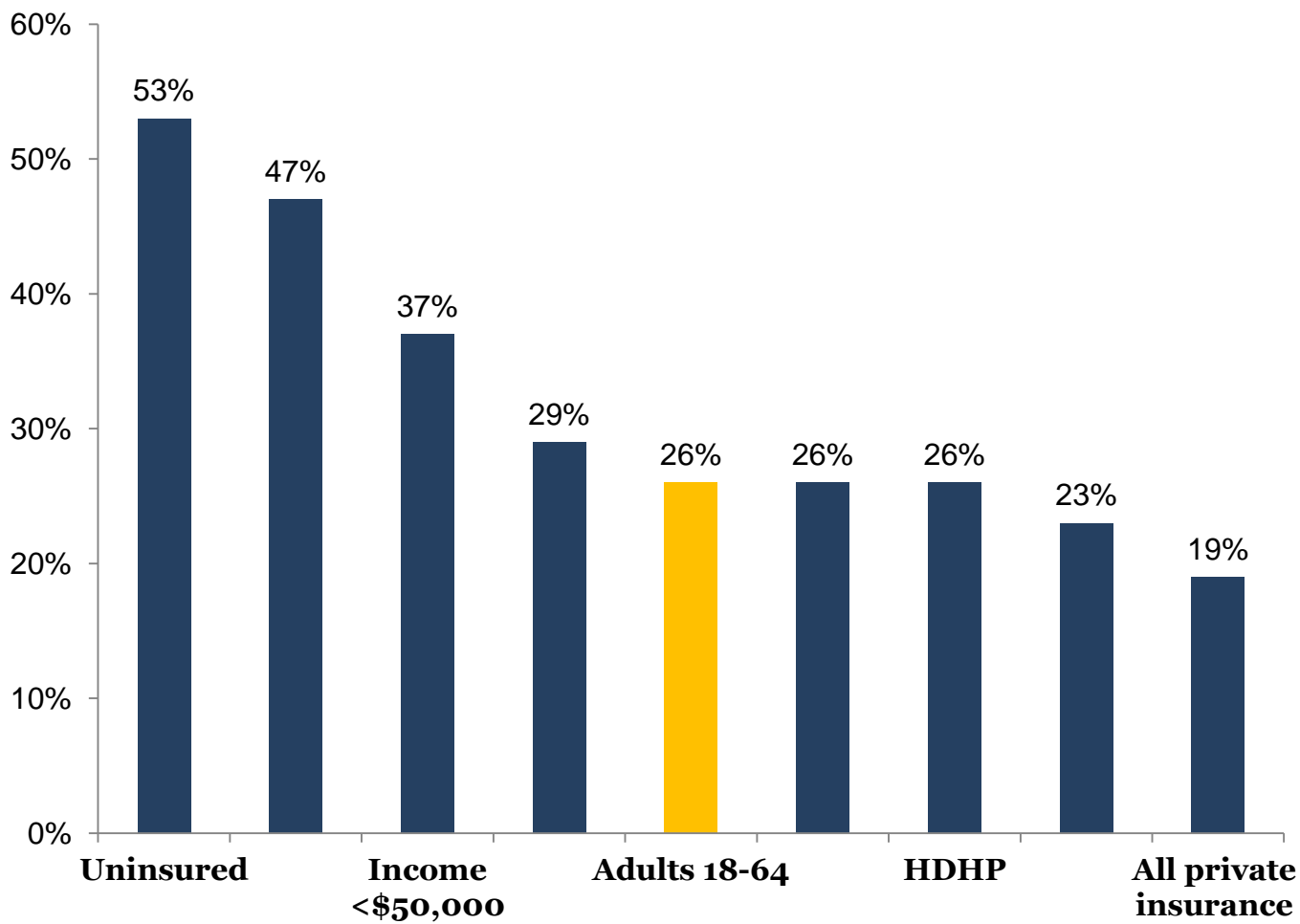
Minh Uong/The New York Times

FACEBOOK  
TWITTER  
GOOGLE+  
SAVE  
EMAIL  
SHARE  
PRINT  
REPRINTS

THE GRAND BUDAPEST HOTEL



# Americans Reporting Problems Paying Medical Bills in Past Year



Source: Kaiser Family Foundation/New York Times Medical Bills Survey



# **Getting to Health Care Value**

## **Consumer Solutions Needed to Enhance Efficiency**

- **While important, the provision of accurate price and quality data does not address appropriateness of care nor substantially impact consumer behavior**
- **Additional solutions are necessary to better allocate health expenditures on the clinical benefit – not only the price or profitability – of services**

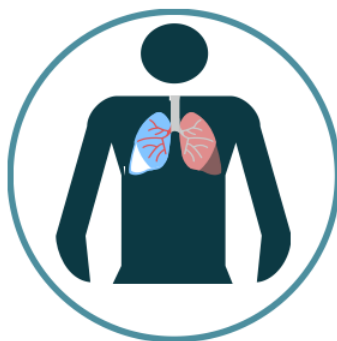
# Understanding CLINICAL NUANCE

#1

Clinical Services Differ  
in the Benefit Produced



Office  
Visits



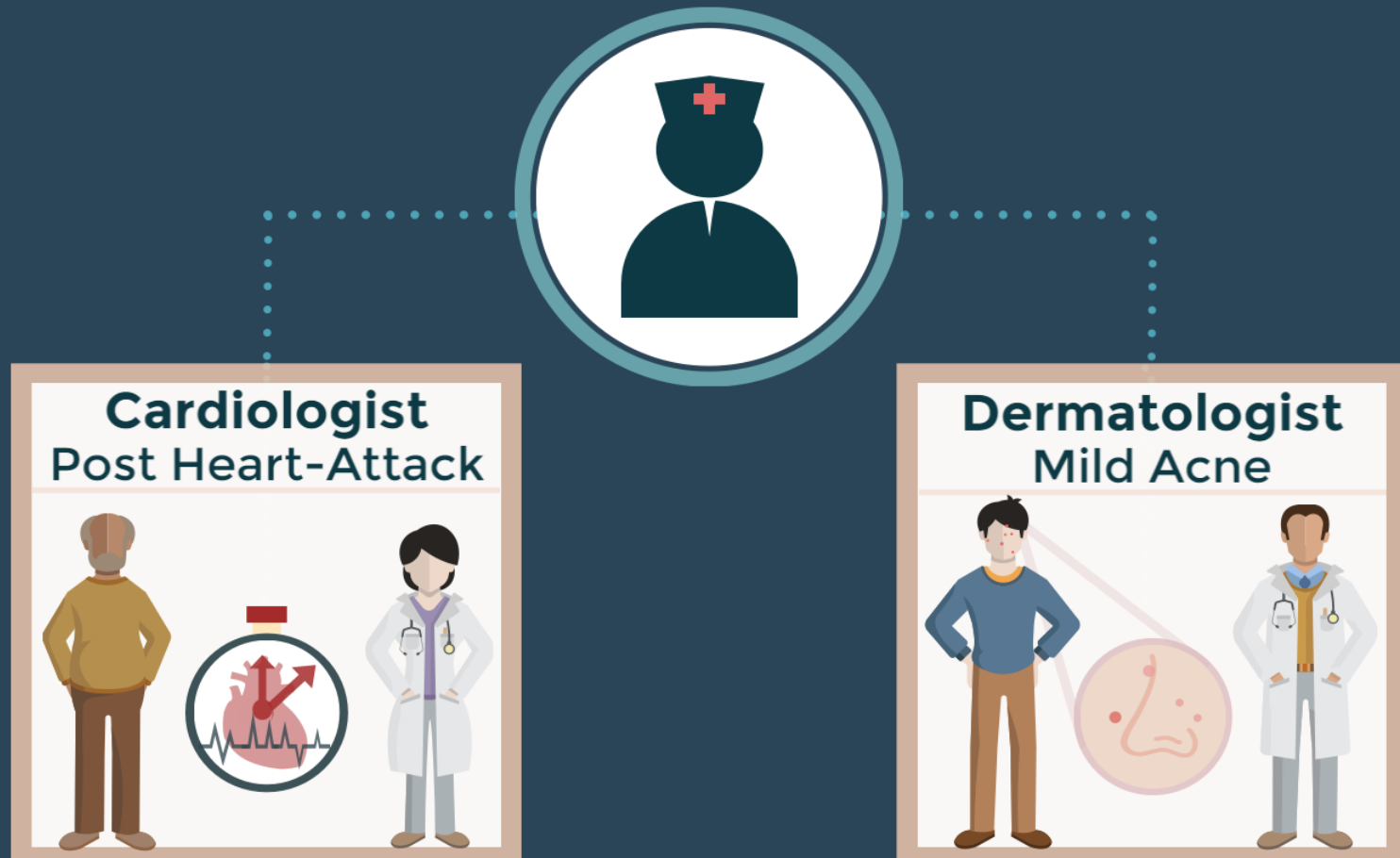
Diagnostic  
Tests



Prescription  
Drugs

Despite these differences in clinical value,  
consumer out-of-pocket costs are the same  
for every clinician visit within a network...

.....



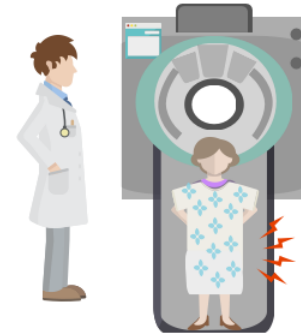
...for all diagnostic tests...



### Blood Sugar Monitoring



### CT Imaging for Back Pain



# Consumer out-of-pocket costs are the same for all drugs within a formulary tier



## Statins



## Anti-Depressants



## Toenail Fungus Rx



## Heartburn Treatment



#2

## The Clinical Benefit Derived From a Service Depends On...



**Who**  
receives it



**Who**  
provides it



**Where**  
it's provided

# Clinical benefit depends on **who** receives it

## Screening for Colorectal Cancer



### Screening Recipients

First-degree  
relative of colon  
cancer sufferer



**Exceptional  
Value**

Average risk  
50 year old



**High  
Value**

30 year old with  
no family history  
of colon cancer



**Low  
Value**



who provides it...



**High  
Performance**



**Poor  
Performance**



# Clinical benefit depends on **where** care is provided



## Ambulatory Care Center



\$

## Hospital



\$\$\$

# Implementing Clinical Nuance

## *Value-Based Insurance Design*

Sets cost-sharing to encourage greater utilization of high-value services and providers and discourage use of low-value care

# Implementing Clinical Nuance

## *Value-Based Insurance Design*

Sets cost-sharing to encourage greater utilization of high-value services and providers and discourage use of low-value care

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



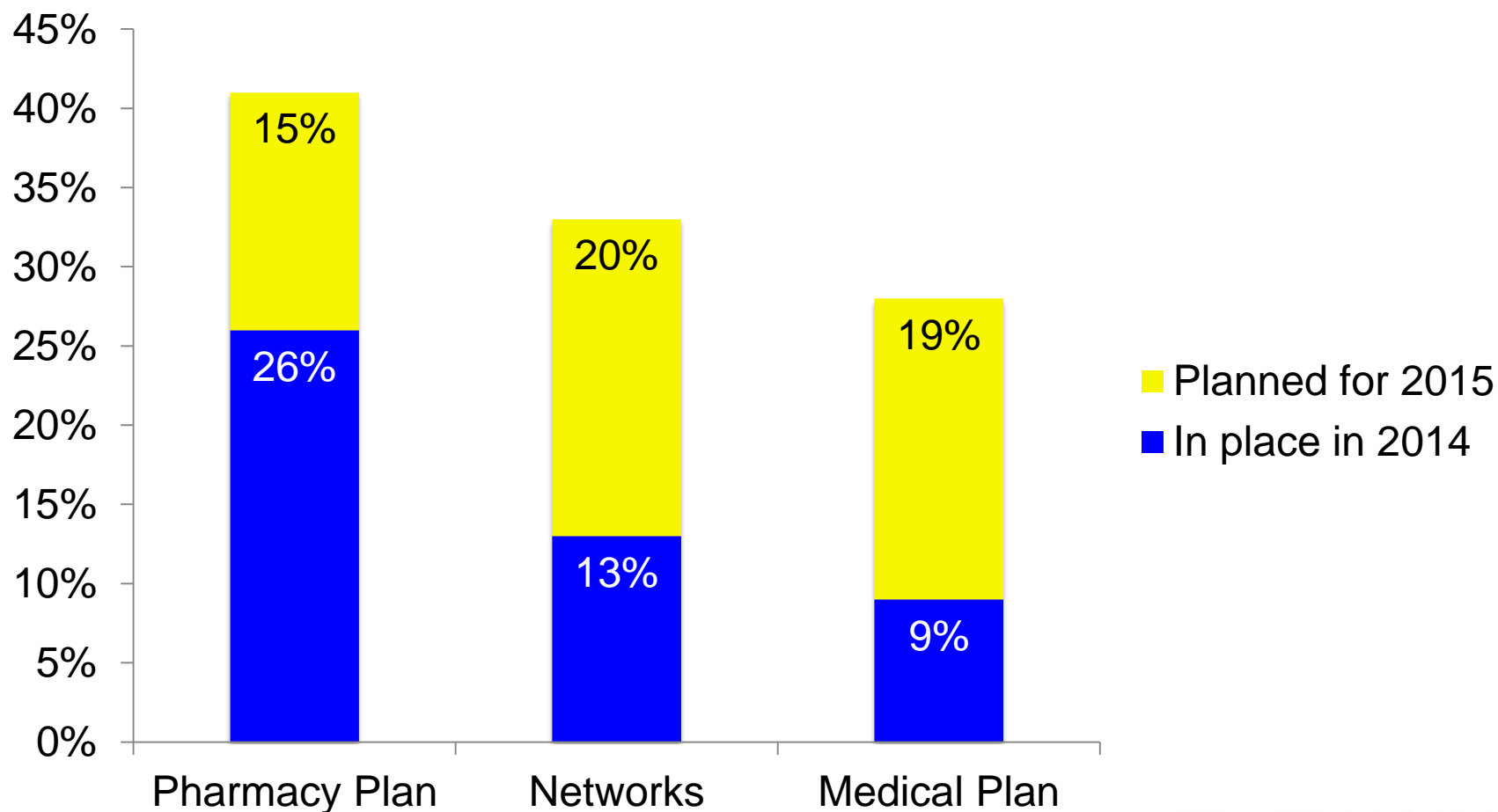
**FOLLOW THE MONEY**

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

June 16, 2004

University of Michigan researchers say a patient drug should depend on how much he or she will a move that would likely lower c

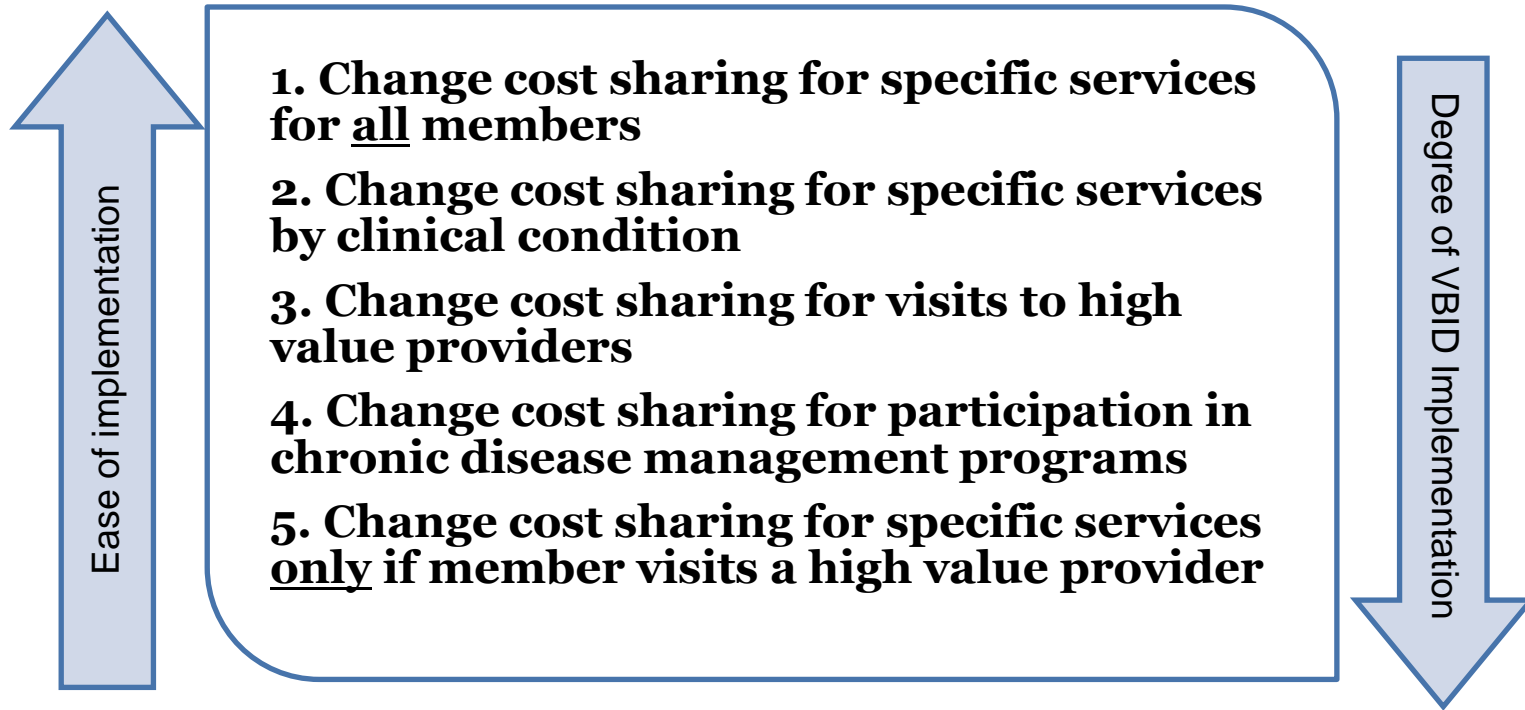
# V-BID Momentum Continues



Source: 19th Annual Towers Watson/National Business Group on Health Employer Survey



# V-BID Intervention Types



## Other Intervention Options

Enhanced coverage of supplemental benefits

Increased cost-sharing for low-value services



# V-BID: Who Benefits and How?



## CONSUMERS



Improves access

Lowers out-of-pocket costs



## PAYERS



Promotes efficient expenditures

Reduces wasteful spending



## PROVIDERS



Enhances patient-centered outcomes

Aligns with provider initiatives



# Putting Innovation into Action

## Broad Multi-Stakeholder Support

- **HHS**
- **CBO**
- **SEIU**
- **MedPAC**
- **Brookings Institution**
- **The Commonwealth Fund**
- **NBCH**
- **PCPCC**
- **Families USA**
- **AHIP**
- **AARP**
- **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**



# Putting Innovation into Action: Translating Research into Policy

- **Patient Protection and Affordable Care Act**
- Medicare
- HSA-qualified HDHPs
- State Health Reform



# 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; over 76 million have accessed preventive services without cost-sharing**

# Putting Innovation into Action: Translating Research into Policy

- Patient Protection and Affordable Care Act
- **Medicare**
- HSA-qualified HDHPs
- State Health Reform



# Translating Research into Policy: Implementing V-BID in Medicare

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"**



# 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

114<sup>TH</sup> CONGRESS  
1<sup>ST</sup> 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

# CMS Announces Medicare Advantage Value-Based Insurance Design Model Test

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\*Red denotes states included in V-BID model test

**March 8<sup>th</sup>: CMS Proposed a Rule for Part B Drugs includes V-BID principles including indication-specific pricing and consumer cost-sharing**





# Putting Innovation into Action: Translating Research into Policy

- Patient Protection and Affordable Care Act
- Medicare
- **HSA-qualified HDHPs**
- State Health Reform



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



**Maximum  
Out-of-pocket  
expense 2006 to 2014**

individual: \$5,000 to \$6,350

family: \$10,000 to \$12,700

[http://www.ahipcoverage.com/wp-content/uploads/2013/06/HSAinfographic\\_V9\\_FV.jpg](http://www.ahipcoverage.com/wp-content/uploads/2013/06/HSAinfographic_V9_FV.jpg)

<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>

***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](http://www.irs.gov/pub/irs-drop/n-04-23.pdf)



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

# **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



# Putting Innovation into Action: Translating Research into Policy

- Patient Protection and Affordable Care Act
- Medicare
- HSA-qualified HDHPs
- **State Health Reform**



# **Getting to Health Care Value - What's Your State's Path?**

## **V-BID Role in State Health Reform**

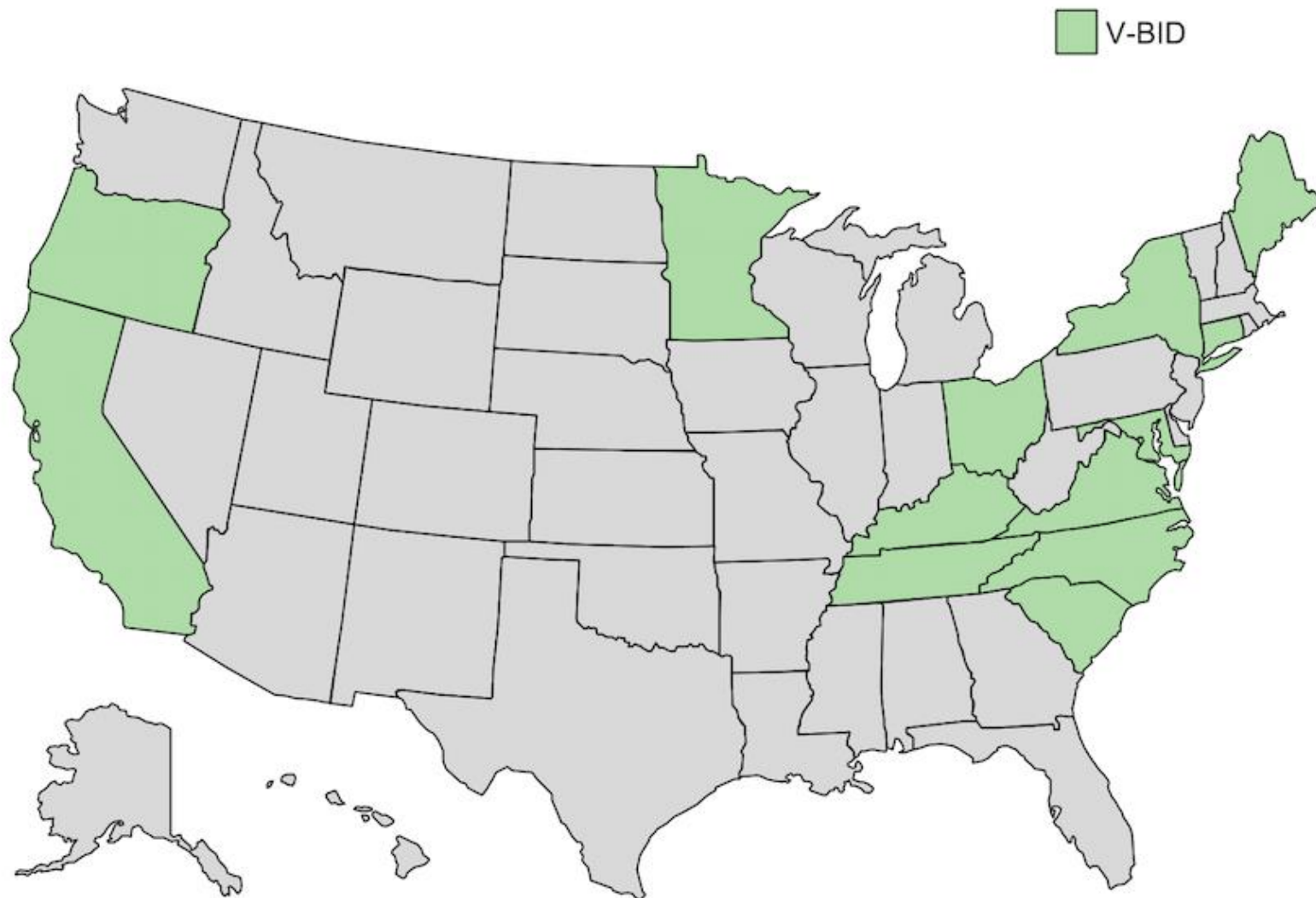
- **State Exchanges – Encourage V-BID (CA, MD)**
- **Medicaid – Michigan**
- **State Innovation Models – NY, PA, CT, VA**
- **State Employee Benefit Plans**





# Value-Based Insurance Design

## Growing Role in State Employee Plans



ENGAGING PATIENTS ON PRICE & QUALITY

By Richard A. Hirth, Elizabeth Q. Cliff, Teresa B. Gibson, M. Richard McKellar, and A. Mark Fendrick

# **Connecticut's Value-Based Insurance Plan Increased The Use Of Targeted Services And Medication Adherence**





# Value-Based Insurance Design

.....

V-BID sets cost-sharing to encourage use of high-value services and providers and discourage use of low-value care

## Current Plans

VS

## V-BID Plans

Increase out-of-pocket costs

.....

Offer one-size-fits-all  
cost-sharing

.....

Misalign consumer and  
provider incentives

Lower cost-sharing for high-  
value services and providers

.....

Enhance patient-centered  
outcomes

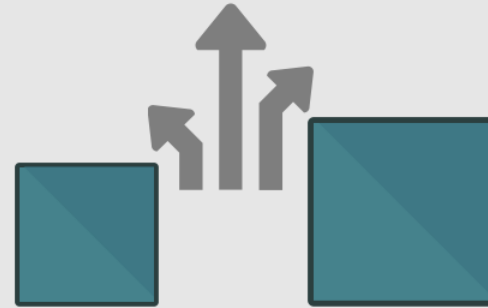
.....

Align with provider  
initiatives

# Motivation for Benefit Design Change



Address state  
budget deficits



Reduce disparities  
and quality gaps



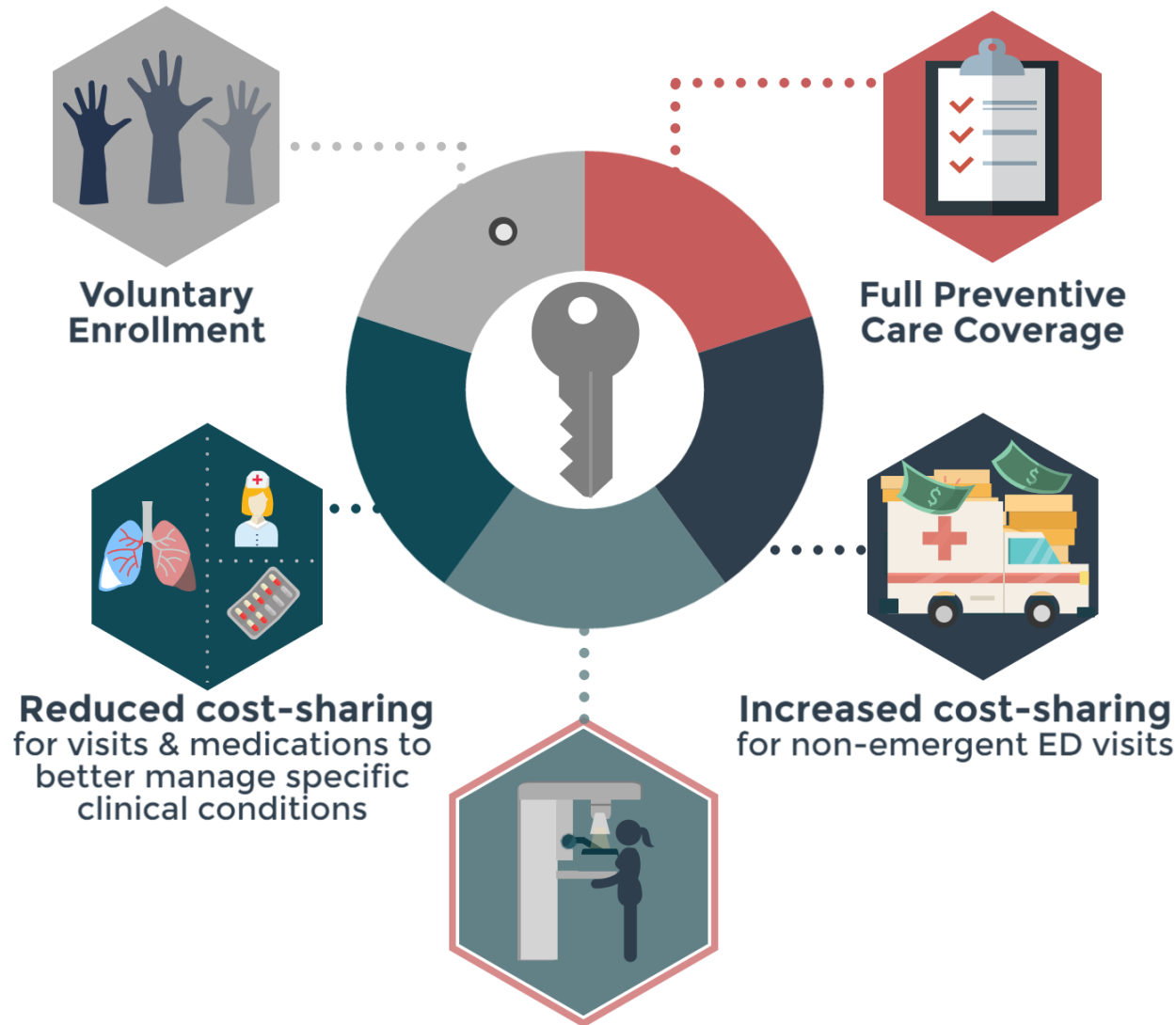
Encourage employee  
engagement



Improve individual and  
population health

# Key Features of the HEP

Align out-of-pocket costs with healthy behaviors

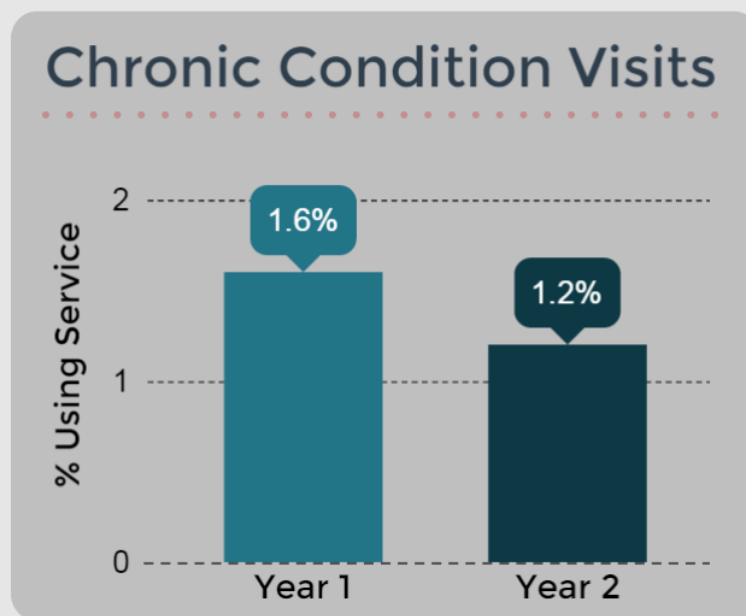
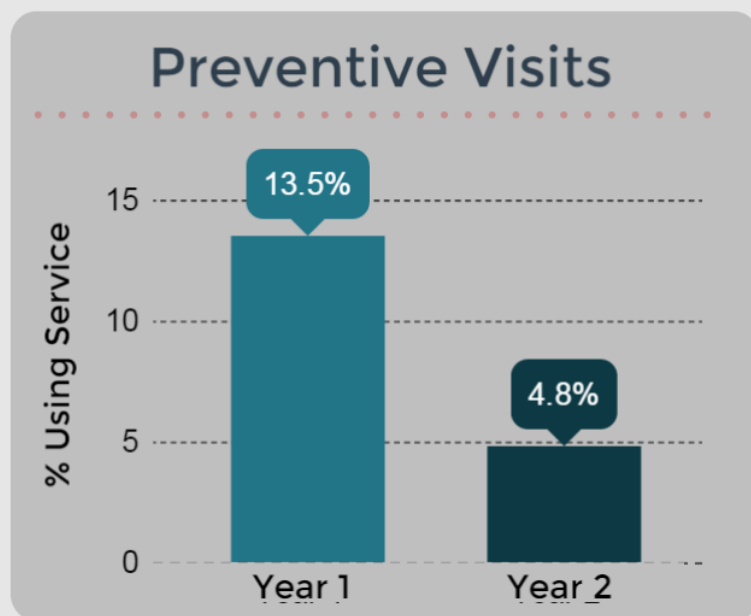


## **Participatory Requirement:**

to maintain enrollment, members must complete age-appropriate preventive care & recommended chronic disease services

# HEP Impact: 2 Year Results

## [1] Office Visit Increases

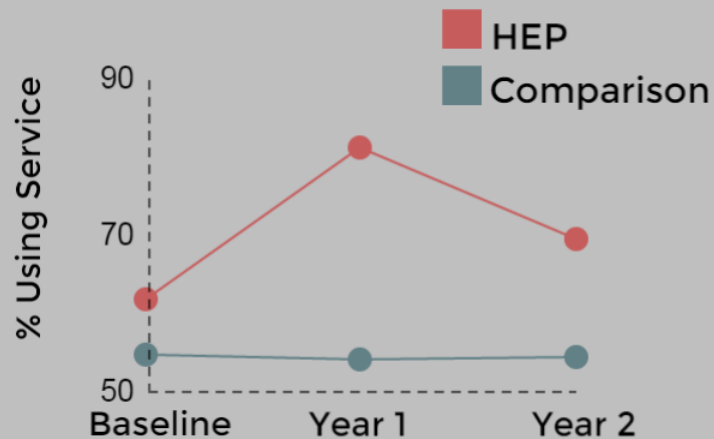


Relative change for HEP members compared to enrollees in control states

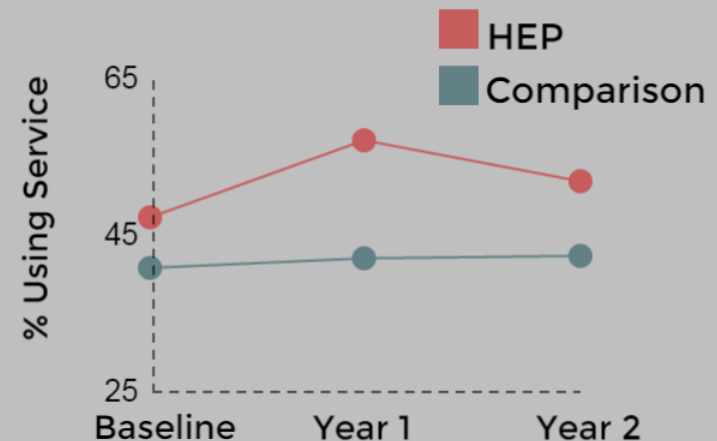
# HEP Impact: 2 Year Results

## [2] Preventive Care Utilization

### Lipid Screening

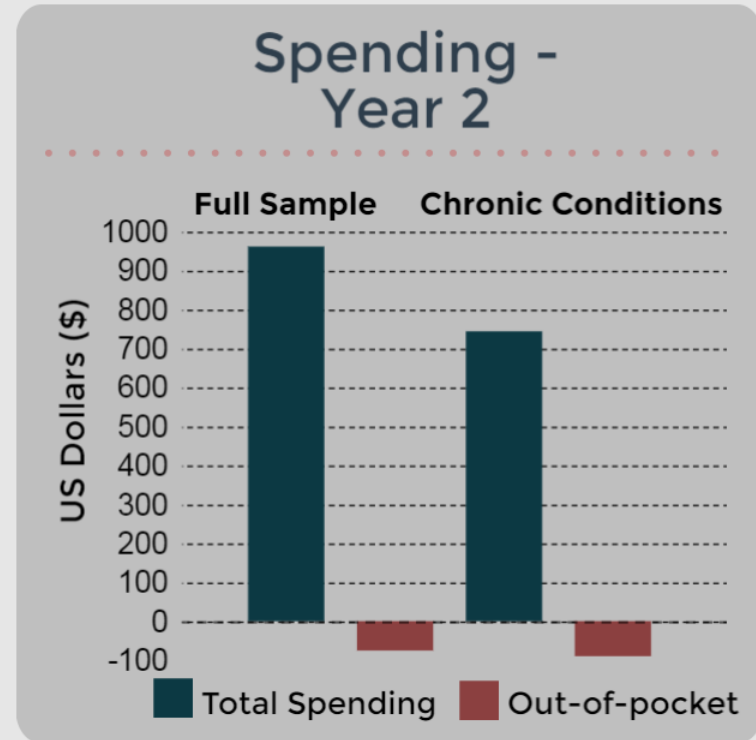
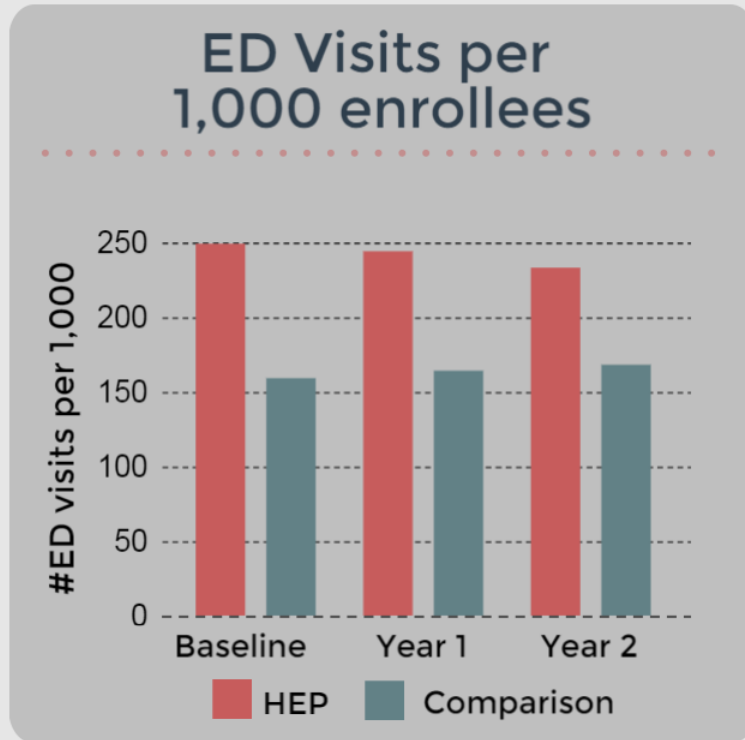


### Mammography



# HEP Impact: 2 Year Results

## [3] Resource Use



Health Affairs. 2016;35(4):637-46.

# Combining ‘Carrots’ and ‘Sticks’ to Enhance the Financial Impact of V-BID Programs: Identify Waste

| Category                                | Sources  | Estimate of Excess Costs | % of Waste | % of Total    |
|---|--|--------------------------|------------|---------------|
| <b>Unnecessary Services</b>             | <ul style="list-style-type: none"> <li>• Overuse beyond evidence-established levels</li> <li>• Discretionary use beyond benchmarks</li> <li>• Unnecessary choice of higher-cost services</li> </ul>  | \$210 billion            | 27%        | 9.15%         |
| <b>Inefficiently Delivered Services</b> | <ul style="list-style-type: none"> <li>• Mistakes, errors, preventable complications</li> <li>• Care fragmentation</li> <li>• Unnecessary use of higher-cost providers</li> <li>• Operational inefficiencies at care delivery sites</li> </ul> | \$130 billion            | 17%        | 5.66%         |
| <b>Excess Admin Costs</b>               | <ul style="list-style-type: none"> <li>• Insurance paperwork costs beyond benchmarks</li> <li>• Insurers’ administrative inefficiencies</li> <li>• Inefficiencies due to care documentation requirements</li> </ul>                            | \$190 billion            | 25%        | 8.28%         |
| <b>Prices that are too high</b>         | <ul style="list-style-type: none"> <li>• Service prices beyond competitive benchmarks</li> <li>• Product prices beyond competitive benchmarks</li> </ul>   | \$105 billion            | 14%        | 4.58%         |
| <b>Missed Prevention Opportunities</b>  | <ul style="list-style-type: none"> <li>• Primary prevention</li> <li>• Secondary prevention</li> <li>• Tertiary prevention</li> </ul>  | \$55 billion             | 7%         | 2.40%         |
| <b>Fraud</b>                            | <ul style="list-style-type: none"> <li>• All sources – payers, clinicians, patients</li> </ul>   | \$75 billion             | 10%        | 3.27%         |
| <b>Total</b>                            |  | <b>\$765 billion</b>     |            | <b>33.33%</b> |



# Identifying and Removing Waste

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# Removing Waste

## Health Waste Calculator

**Software tool designed to identify wasteful medical spending:**

- **U.S. Preventive Services Task Force**
- **Choosing Wisely**

**Underlying algorithms process claims, billing or EMR data to identify waste**

**Defines services with a degree of appropriateness of care**

- **Necessary**
- **Likely to be wasteful**
- **Wasteful**

# Removing Waste

## Health Waste Calculator – Sample Results Large Payer

**20%**

of members exposed  
to 1+ wasteful  
service

**36%**

of services were  
wasteful

**2.4%**

or \$11.94 PMPM in  
claims wasted

# Health Waste Calculator (HWC)

## Top 5 Measures by Cost

| Waste Measure   | Wasteful Services (#) | Waste Index (%) | Wasteful Spending (\$) |
|---|-----------------------|-----------------|------------------------|
| Baseline laboratory studies in patients without systemic disease undergoing low-risk surgery        | 938,814               | 79%             | \$365,847,701          |
| Stress cardiac or advanced non-invasive imaging in the initial evaluation of patients w/o symptoms  | 54,702                | 12%             | \$185,997,938          |
| Annual electrocardiograms (EKGs) or other cardiac screening for low-risk patients without symptoms. | 276,698               | 6%              | \$113,615,026          |
| Routine annual cervical cytology screening (Pap tests) in women 21–65 years of age                  | 334,184               | 80%             | \$73,369,640           |
| PSA-based screening for prostate cancer in all men regardless of age.                               | 272,015               | 41%             | \$63,137,698           |

# Identifying and Removing Waste Levers to Create Change

- **Education & Promotion**
- **Analytics & Reporting**
- **Provider Networks**
- **Pay for Performance Programs**
- **Medical Management**
- **Purchasing Criteria**
- **Benefit Design**

# 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**
- **Accountable Care**
- **Bundled Payments**
- **Reference Pricing**
- **Global Budgets**
- **High Performing Networks**
- **Health Information Technology**



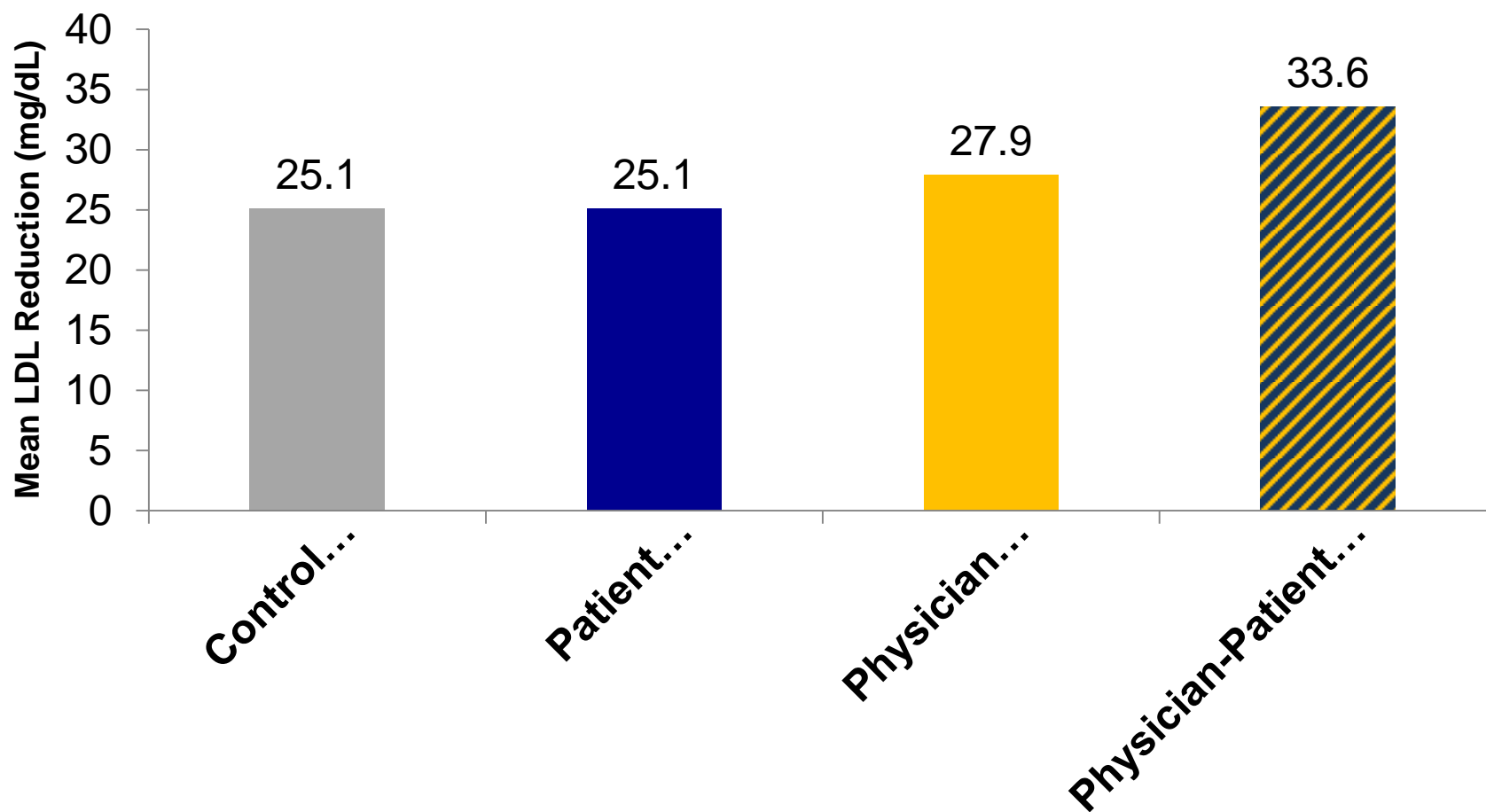


# Aligning Payer and Consumer Incentives: As Easy as Peanut Butter and Jelly

**Unfortunately, some “demand-side” initiatives – including consumer cost sharing and a lack of incentives to stay within an ACO - discourage consumers from pursuing the “Triple Aim”**



# Impact of Aligning Physicians and Patients: Financial Incentives to Lower Cholesterol



Source: *JAMA*. 2015;314(18):1926-1935



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## Beyond SGR: Aligning The Peanut Butter Of Payment Reform With The Jelly Of Consumer Engagement

Gary Bacher, Arielle Zina, and A. Mark Fendrick

April 22, 2015

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# Toward Lower Costs and Better Care — Averting a Collision between Consumer- and Provider-Focused Reforms

Elliott S. Fisher, M.D., M.P.H., and Peter V. Lee, J.D.



Over the past 20 years, two major approaches to slowing the growth of health care costs have emerged. One focuses on the delivery system, encouraging physicians, hospitals, and others to improve the way they deliver care. The other targets consumers, hoping to turn patients into more price-sensitive

shoppers. Although both have had some success, it's increasingly clear that these approaches are on a collision course: poorly structured benefit designs will sharply limit the effectiveness of efforts to promote higher-value care through payment and delivery-system reform. But a crash is not inevitable.

Interest in reforming care delivery grew out of observations regarding the relative efficiency of integrated medical group practices, growing concern about variation in quality of care, and evidence that the greater use of specialist and hospital-based care in high-cost U.S. regions and health systems did not translate

N ENGL J MED 374;10 NEJM.ORG MARCH 10, 2016

903

The New England Journal of Medicine

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

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



# Discussion

[www.vbidcenter.org](http://www.vbidcenter.org)



@UM\_VBID