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Health Care Costs Are a Top Issue For Voters: Policy solutions must protect consumers 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

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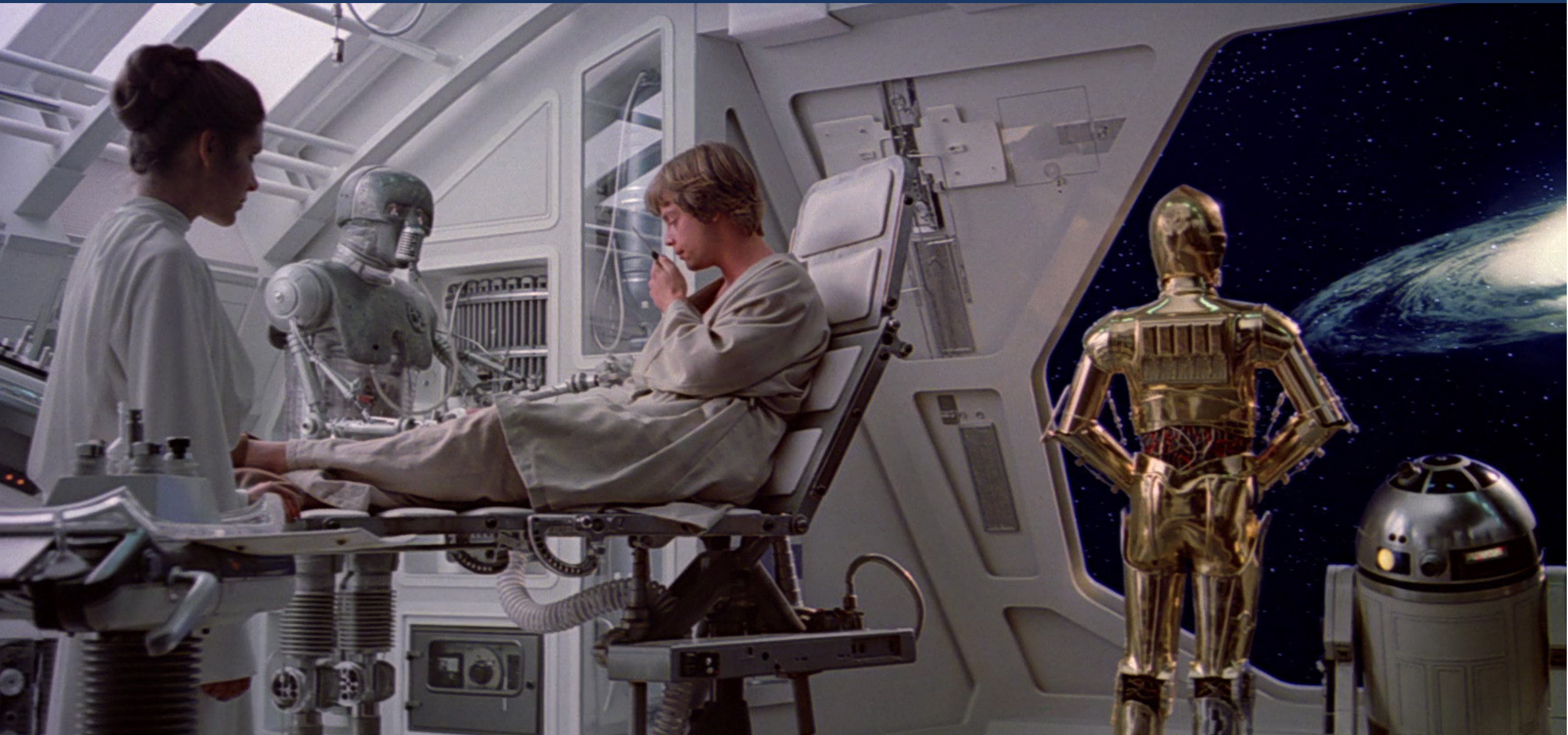
Star Wars Science



Flintstones Delivery

Americans do not care about the cost of health care; they care about what it costs them

- Consumer Cost-sharing
- Translating Research into Policy
- Low-Value Care
- V-BID
- Drug Prices

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Changing the discussion from “How much” to “How well” we spend our health care dollars

- Everyone (almost) agrees there is enough money in the system
- Three-quarters of Americans say that our country doesn’t get good value for what it spends on healthcare
- Policy deliberations focus primarily on alternative payment and pricing models
- Americans are paying more for ALL care regardless of value
- “One size fits all” increases in consumer cost-sharing are ‘blunt’ instruments that reduce the use of high value care and adversely affect health, particularly among economically vulnerable individuals and those with chronic conditions

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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)"

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Alternative to 'Blunt' 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
- Successfully implemented by hundreds of public and private payers

The Upshot

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
- ASCO
- AMA

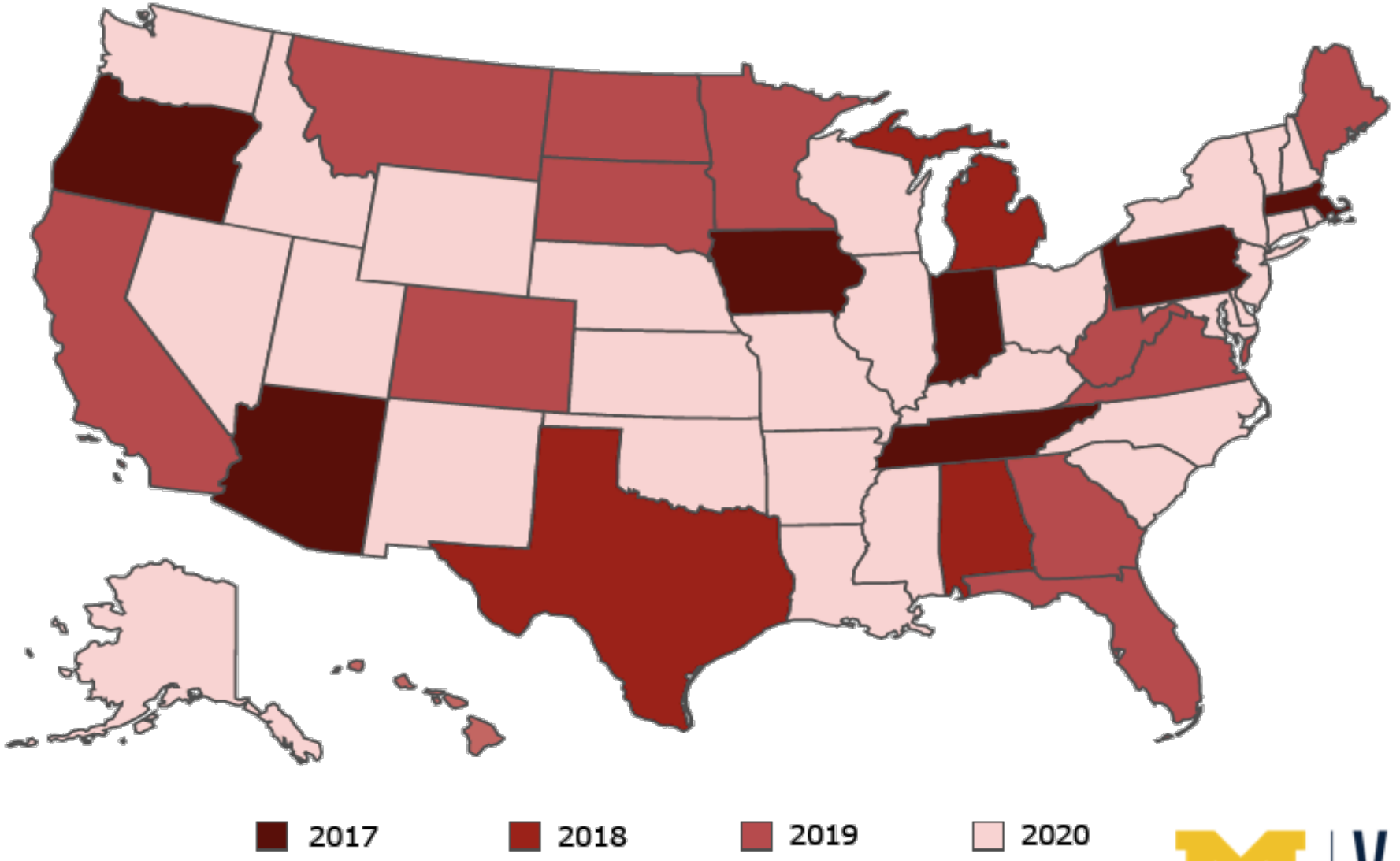
ACA Sec 2713: Selected Preventive Services be Provided without Cost-Sharing

- 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 154 million Americans have received expanded coverage of preventive services as a result of this provision

MA V-BID Model Test – 1st CMS Demonstration Allowing Cost-Sharing Reductions for Individuals with Specific Clinical Conditions

MA V-BID Model Test expanded to all 50 States by 2020



V-BID

Medicare Allows More Benefits for Chronically Ill, Aiming to Improve Care for Millions

By Robert Pear

June 24, 2018

WASHINGTON — Congress and the Trump administration are revamping Medicare to provide extra benefits to people with multiple chronic illnesses, a significant departure from the program's traditional focus that aims to create a new model of care for millions of older Americans.

Value-based insurance coming to millions of people in Tricare

- 2017 NDAA: Obama Administration - reduce or eliminate co-pays and other cost sharing for certain high services and providers

- 2018 NDAA: Trump Administration – reduce cost sharing for high value drugs on the uniform formulary

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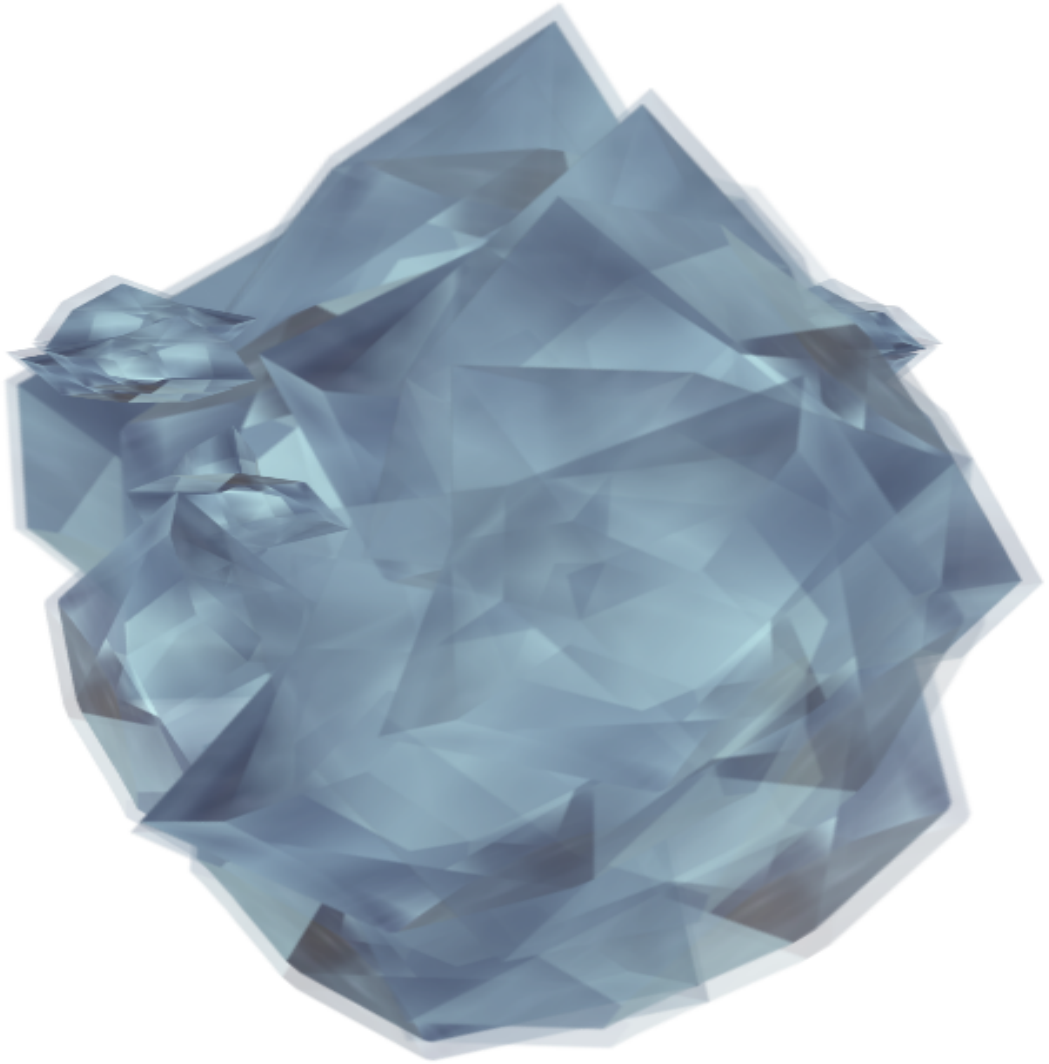
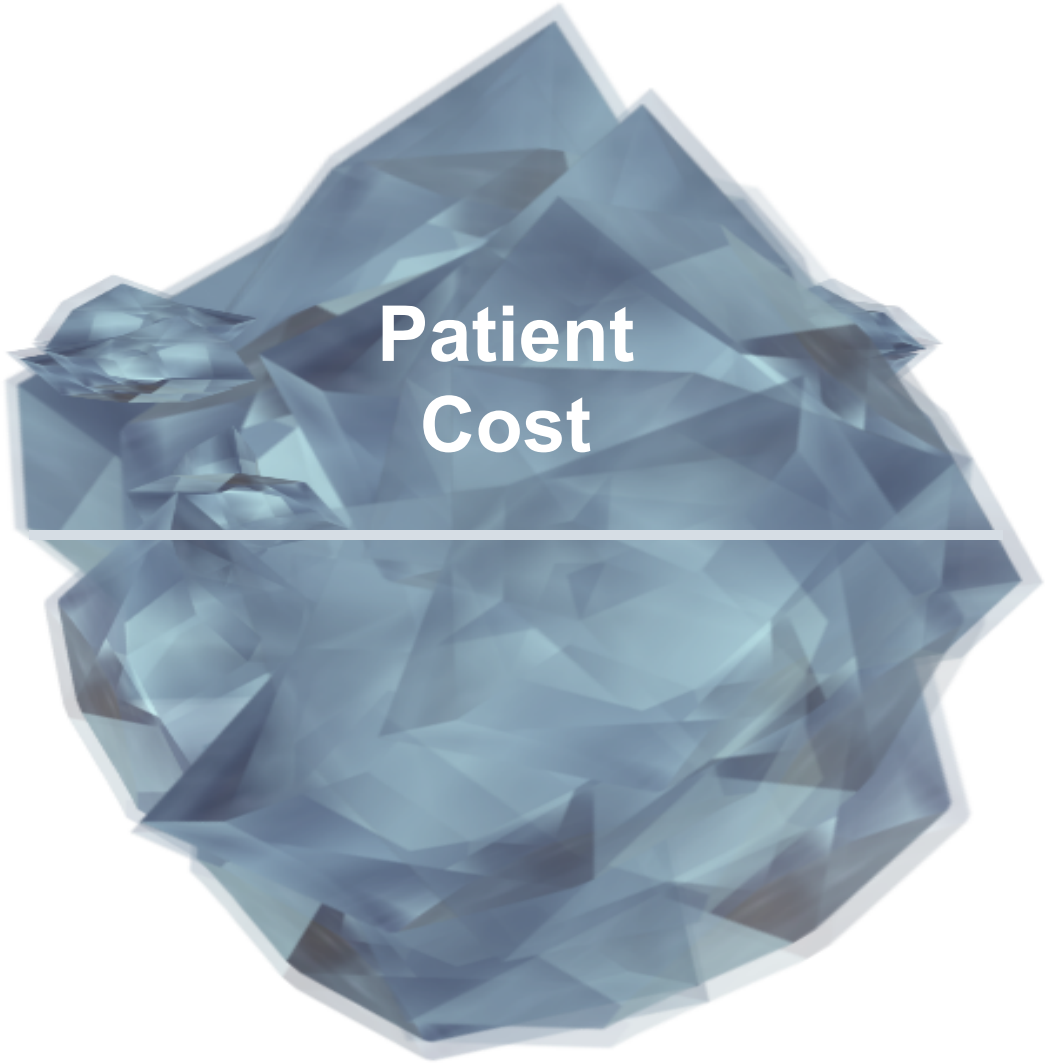
Drugs

- Nearly 3 in 5 American adults take at least 1 prescription drug
- Percentage of American adults taking 5 or more prescription drugs nearly doubled between 2000 and 2012, from 8% to 15%
- Certain expensive drugs are of extremely high clinical value, whereas some commonly used diagnostic tests, procedures, and inexpensive drugs are of no value, and are sometimes harmful
- Drug prices change over time in a way unlike prices of other clinical services

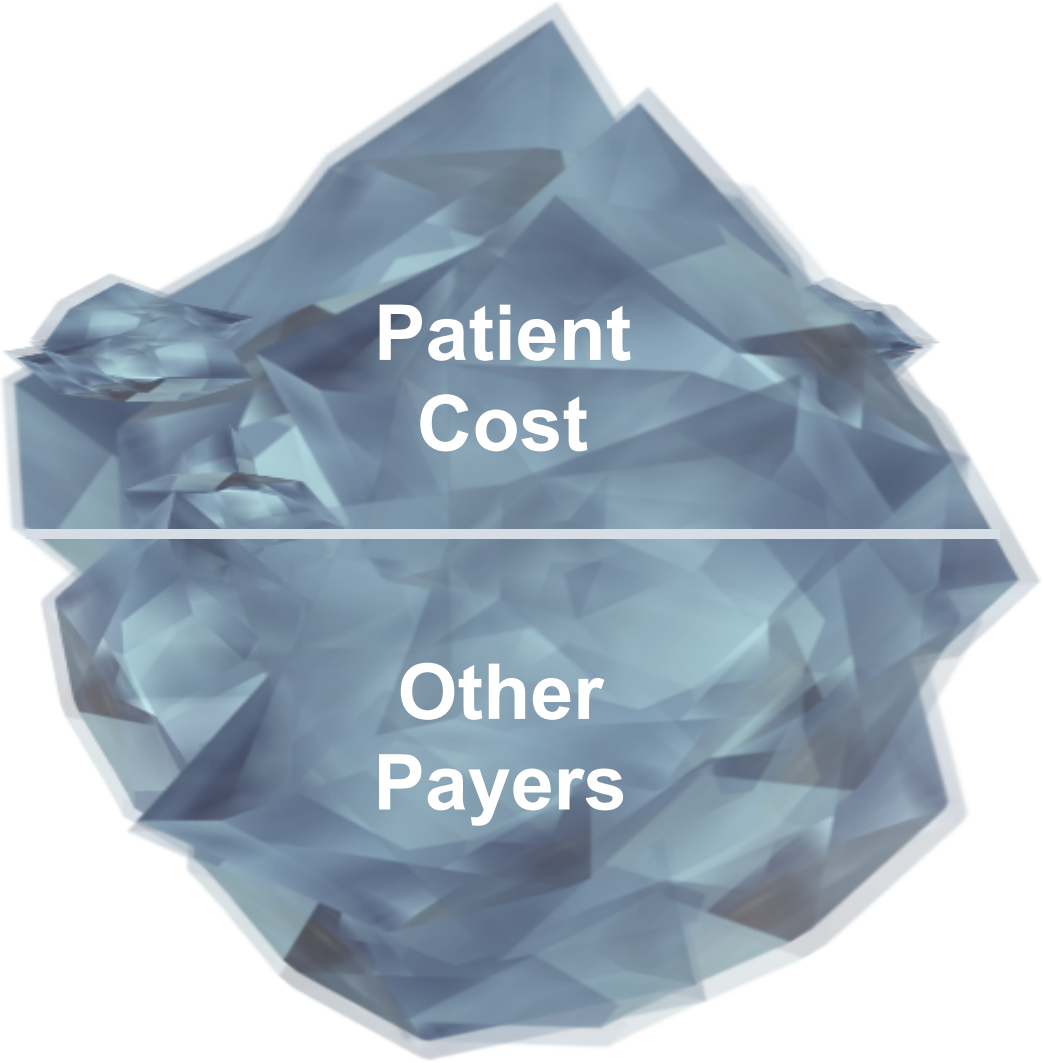
Drug price Iceberg



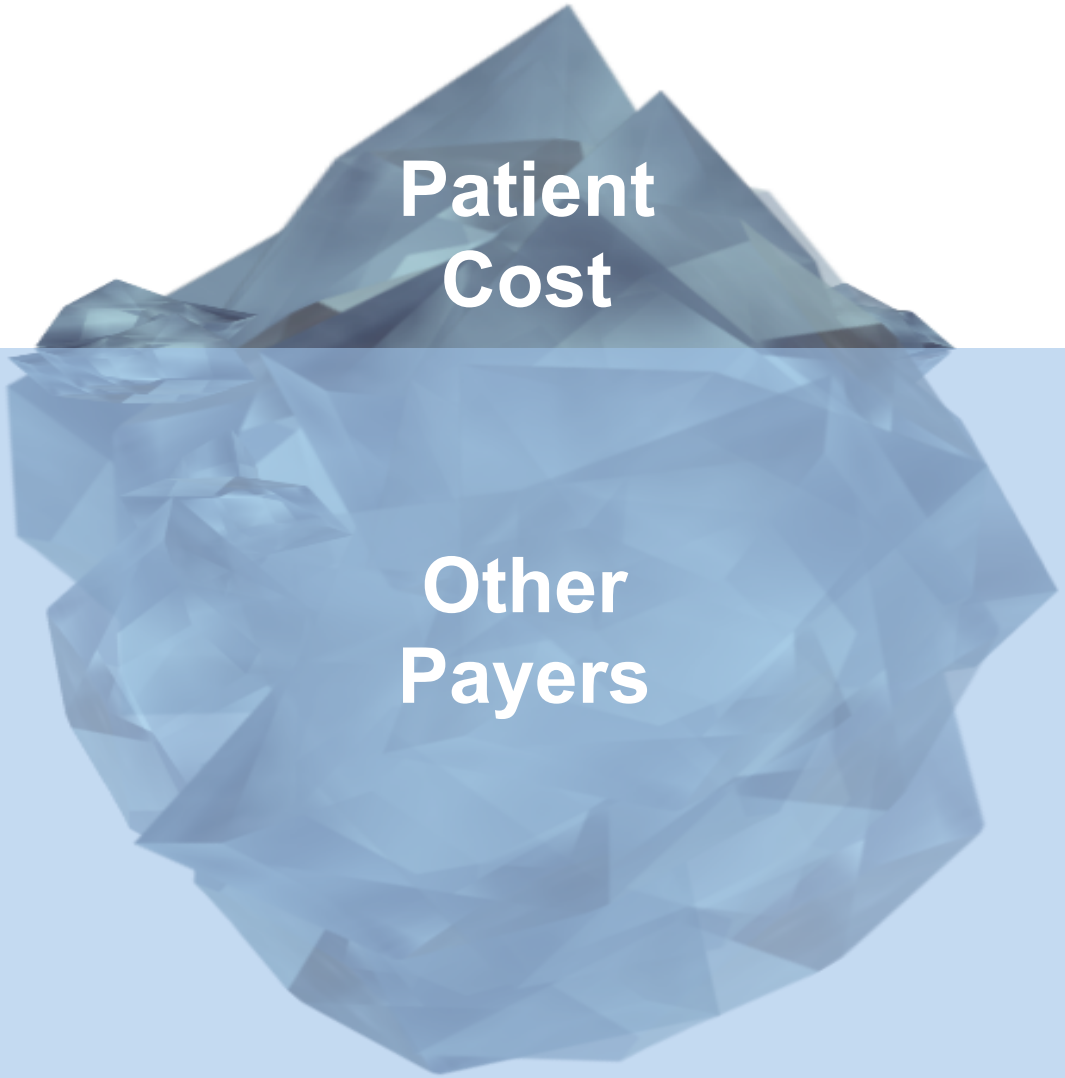
Drug prices are paid by different stakeholders



Drug prices are typically paid in two portions



The amount a patient pays for drugs is determined by their insurance coverage



Insurance
Coverage

If coverage is generous; patients pay little

Patient Cost

Generous
Insurance
Coverage

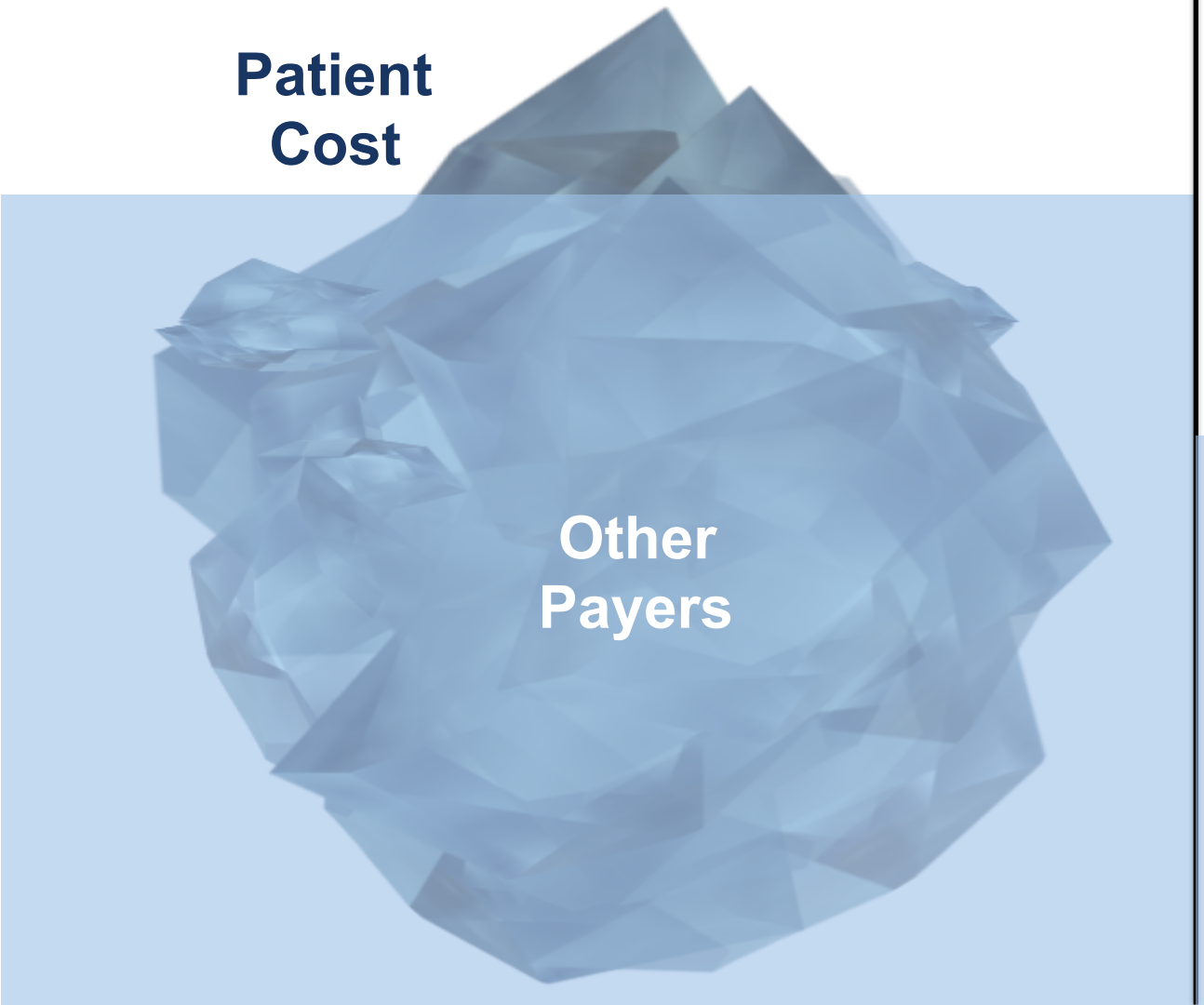
If coverage is not generous; patients can pay the entire drug price

This scenario is typical for individuals who are enrolled in a health plan that includes a deductible

Skimpy Insurance Coverage

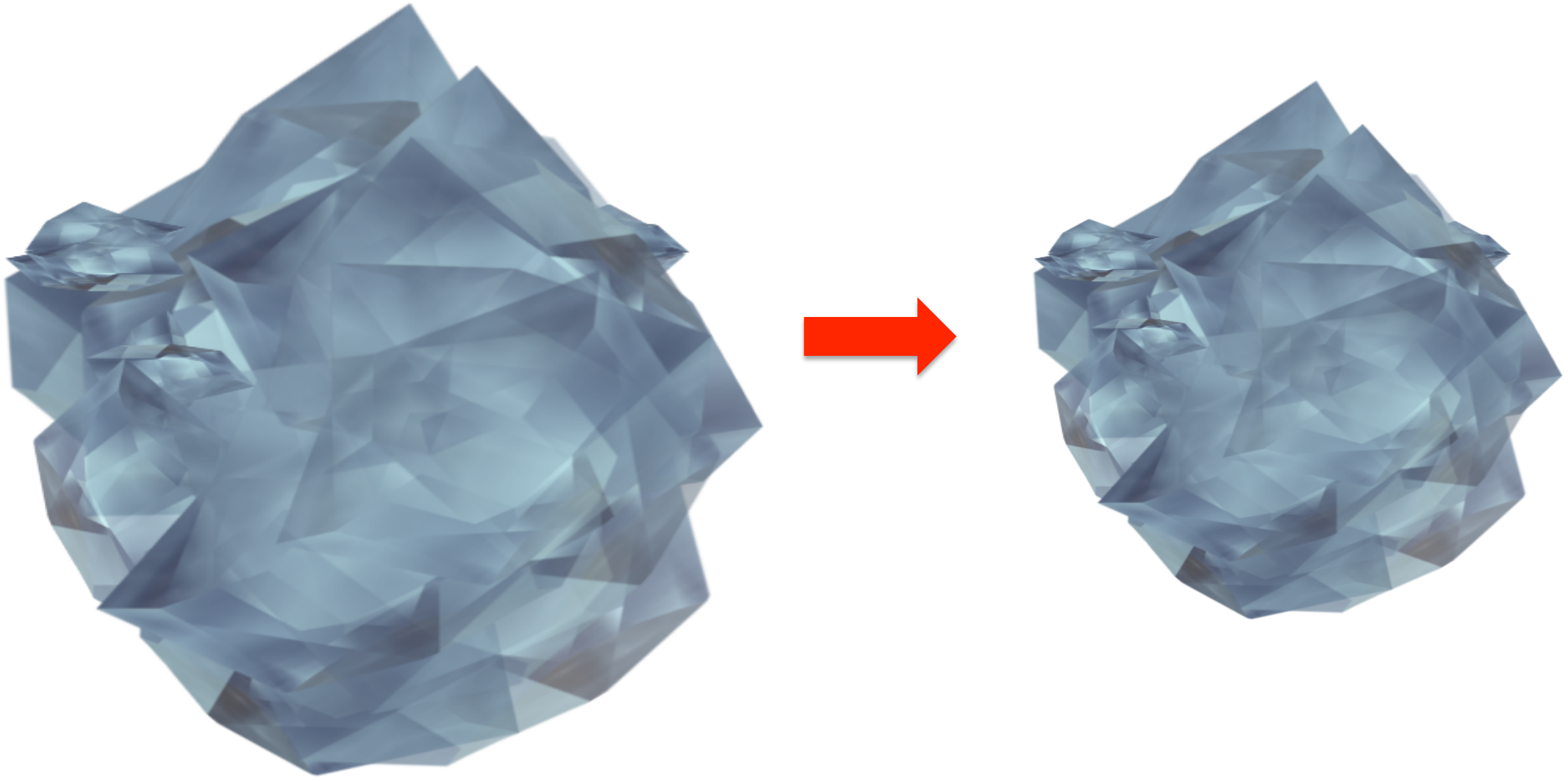
Two ways to lower patient out-of-pocket drug costs: Both approaches can be tried simultaneously

Enhance coverage (Raise the water line)

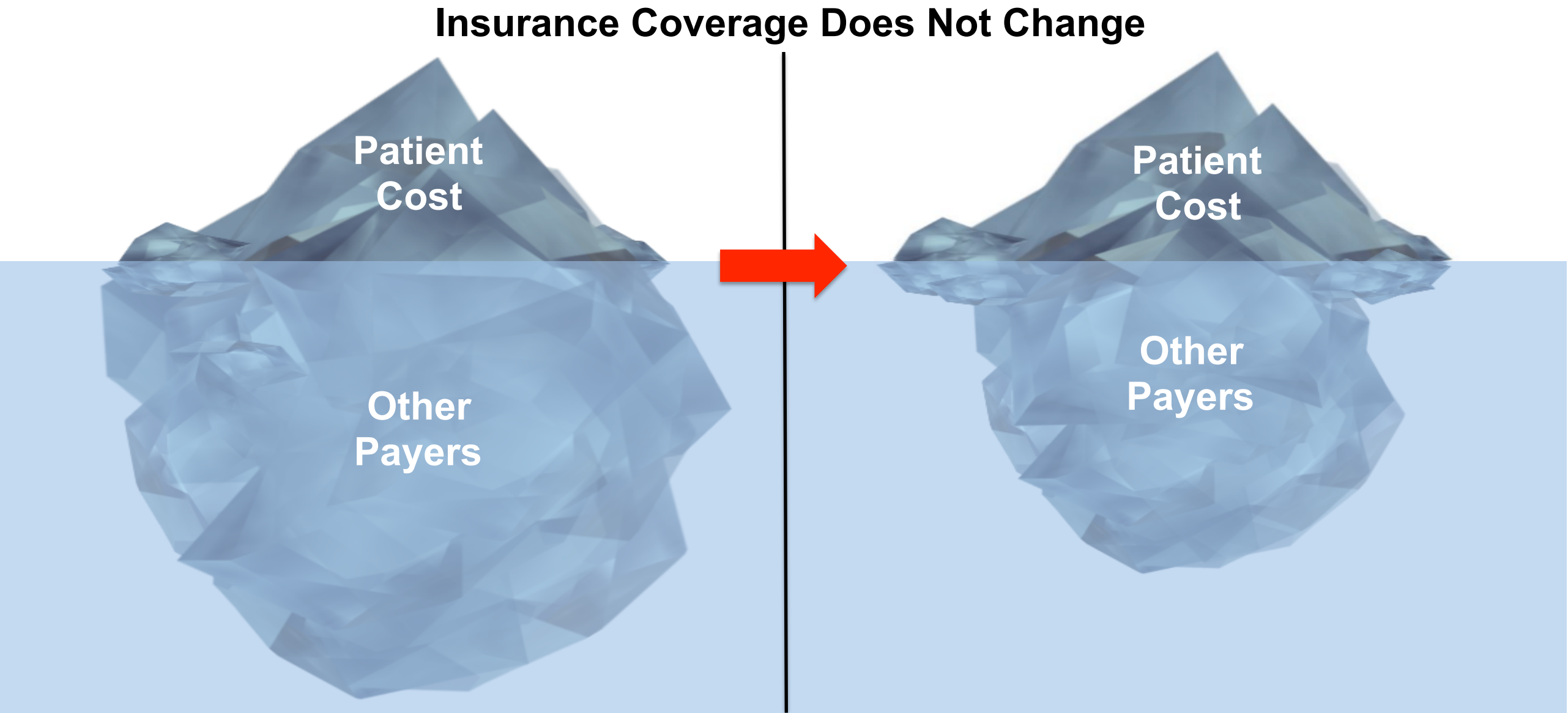


Lower drug price (Melt the iceberg)

Most policies under consideration aim to lower net price, ‘melt the iceberg’



Bad outcome – total price falls, but benefit design stays the same and patient don't pay less



Best Outcome - “Value-Based Pricing”

- The total ‘value based’ net drug price is determined by the clinical benefit to patients, as compared to available alternatives
- Under this scenario, the patient pays close to zero

Policies that reduce prices - but do not lower out-of-pocket costs - do not address the main challenge facing most Americans

Simultaneously consider popular, easy to implement, policies that would quickly lower out-of-pocket drug costs for tens of millions of Americans with chronic conditions

- **Value-Based Insurance Design (V-BID)**
- **Allow HSA-HDHPs the flexibility to cover medications that treat chronic diseases on a pre-deductible basis (HR 4978, S 2410)**

Creating ‘Headroom” to Pay for High-Value Care
Identifying /Removing Unnecessary Services

- Discouraging the use of specific low-value services must be part of the strategy to pay for high-value care
- Unlike delayed cost offsets that result from improved quality, savings from waste elimination are immediate and substantial
- Identification, measurement, and removal of unnecessary care has proven challenging

V-BID

ACA Sec 4105:
Selected No-Value Preventive Services Shall Not Be Paid For

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 not pay for USPSTF 'D' Rated Services in Medicare

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Reducing Low Value Care: Where to Start?

- Although much of the low-value care discussion has focused on high-cost services, low-cost items are less likely to draw attention by particular clinicians or patient advocacy groups
- Choose services:
  - Easily identified in administrative systems
  - Almost always low value
  - Reduction in their use would be barely noticed

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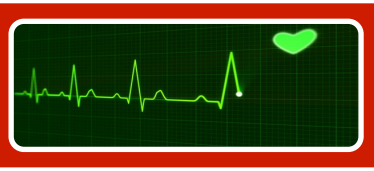
Multi-Stakeholder Task Force on Low Value Care Identifies 5 Commonly Overused Services Ready for Action



1. Laboratory Testing Prior to Low Risk Surgery ($1.1B)

2. Vitamin D Screening ($45M)

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

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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**

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

Unfortunately, some "demand-side" initiatives – including blunt consumer cost sharing – undermine a transformation to patient centered, value-driven system

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

"We believe that relying on clinically informed financial incentives – for patients and providers – will be useful in achieving improved health outcomes for any level of health care expenditures."

Fendrick and Chernew. *JGIM*. 2007.

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