Value-Based Insurance Design: Enhancing Access and Affordability to Essential Clinical Services

A. Mark Fendrick, MD

University of Michigan Center for Value-Based Insurance Design

www.vbidcenter.org

@um_vbid

Hail to the Frontline

So many selfless people are doing truly wonderful things to successfully defeat this pandemic. Thank you.

Health Care Costs Are a Top Issue For Purchasers and Policymakers: Solutions must protect consumers, 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

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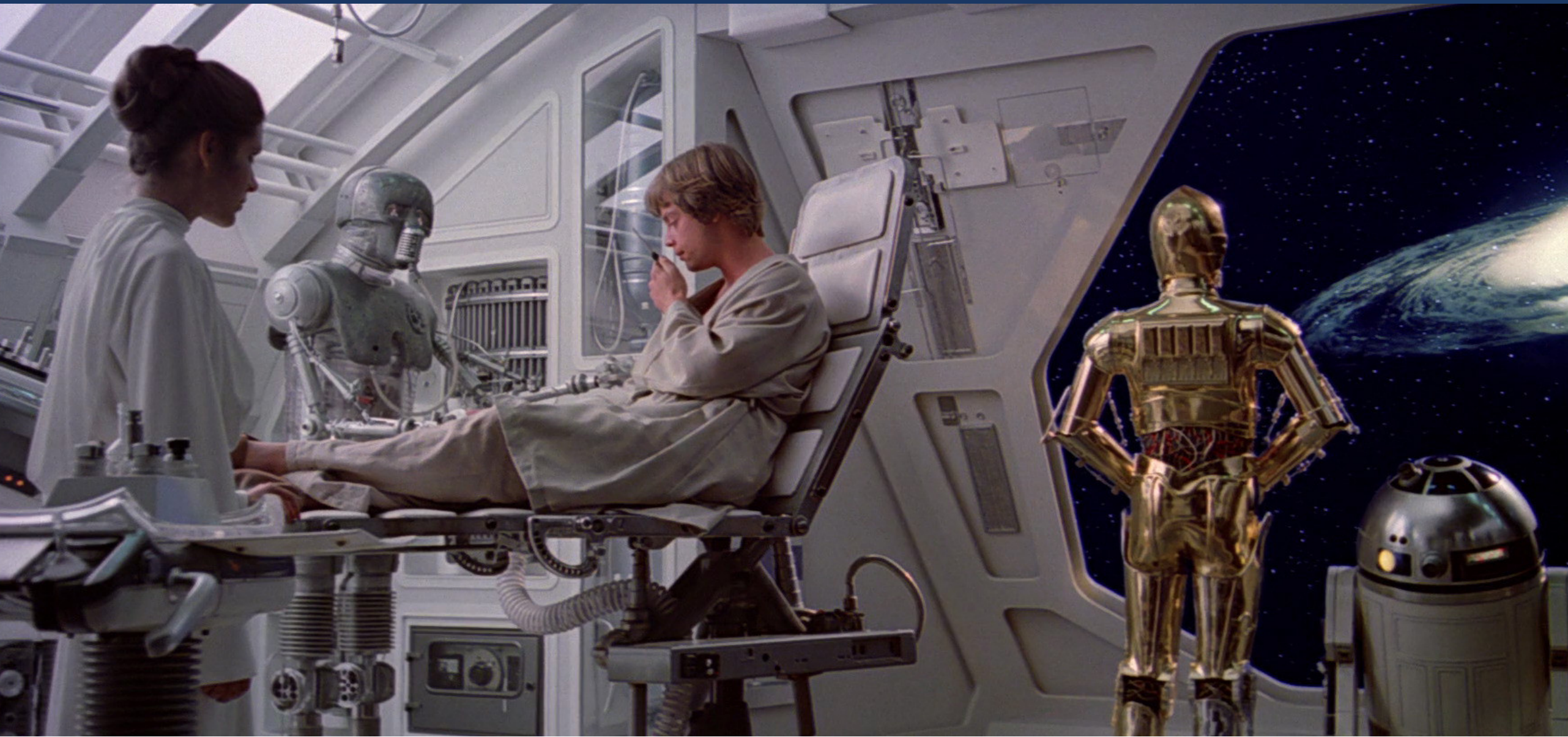
Star Wars Science



Flintstones Delivery

Health Care Costs Are a Top Issue For Purchasers and Policymakers: Solutions must protect consumers, reward providers and preserve innovation

- Everyone (almost) agrees there is enough money in the US health care system; we just spend it on the wrong services and in the wrong places
- 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
- The most common patient-facing strategy - consumer cost-sharing – is a 'blunt' instrument, in that patients pay more out of pocket for ALL care regardless of clinical value

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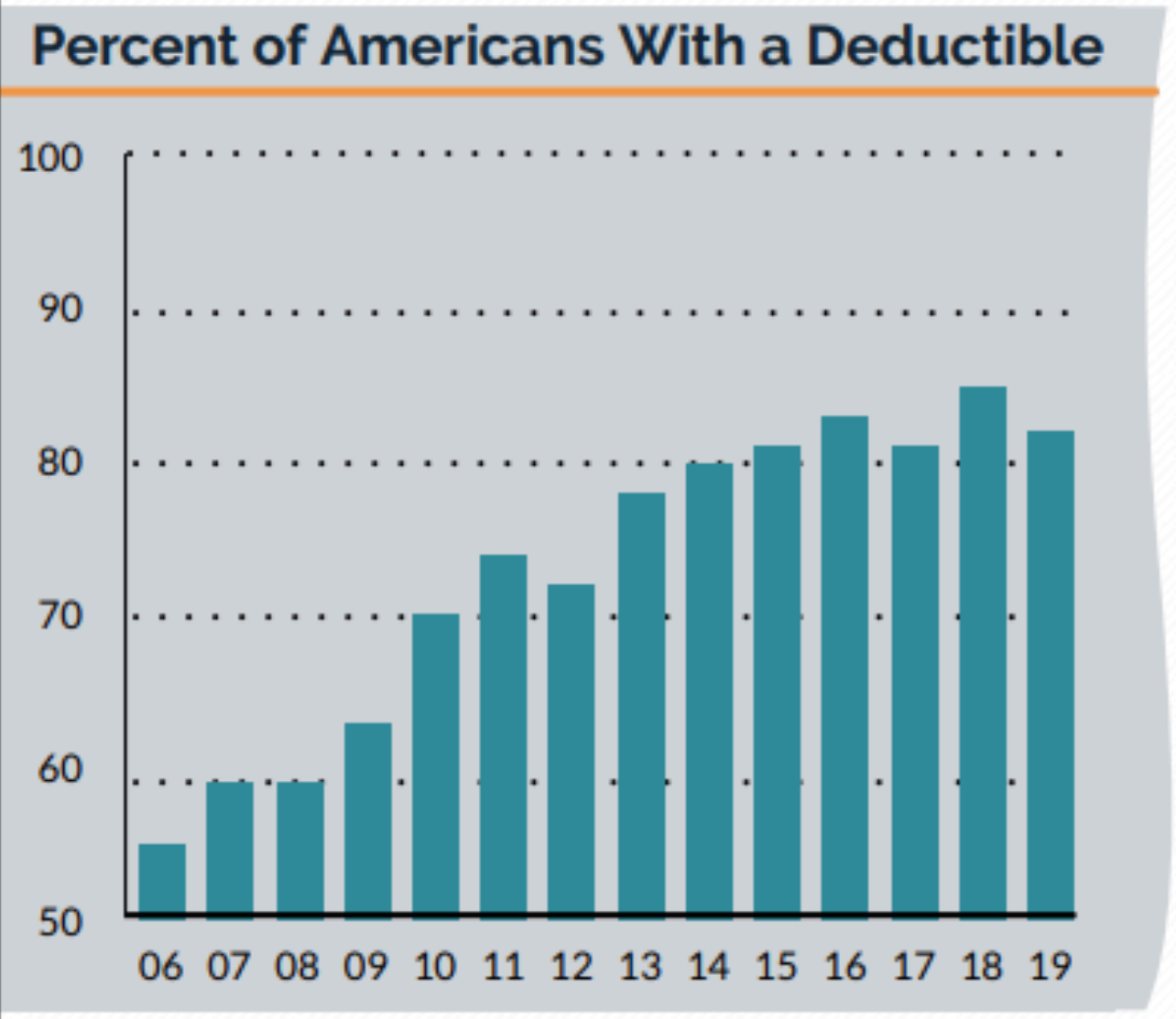
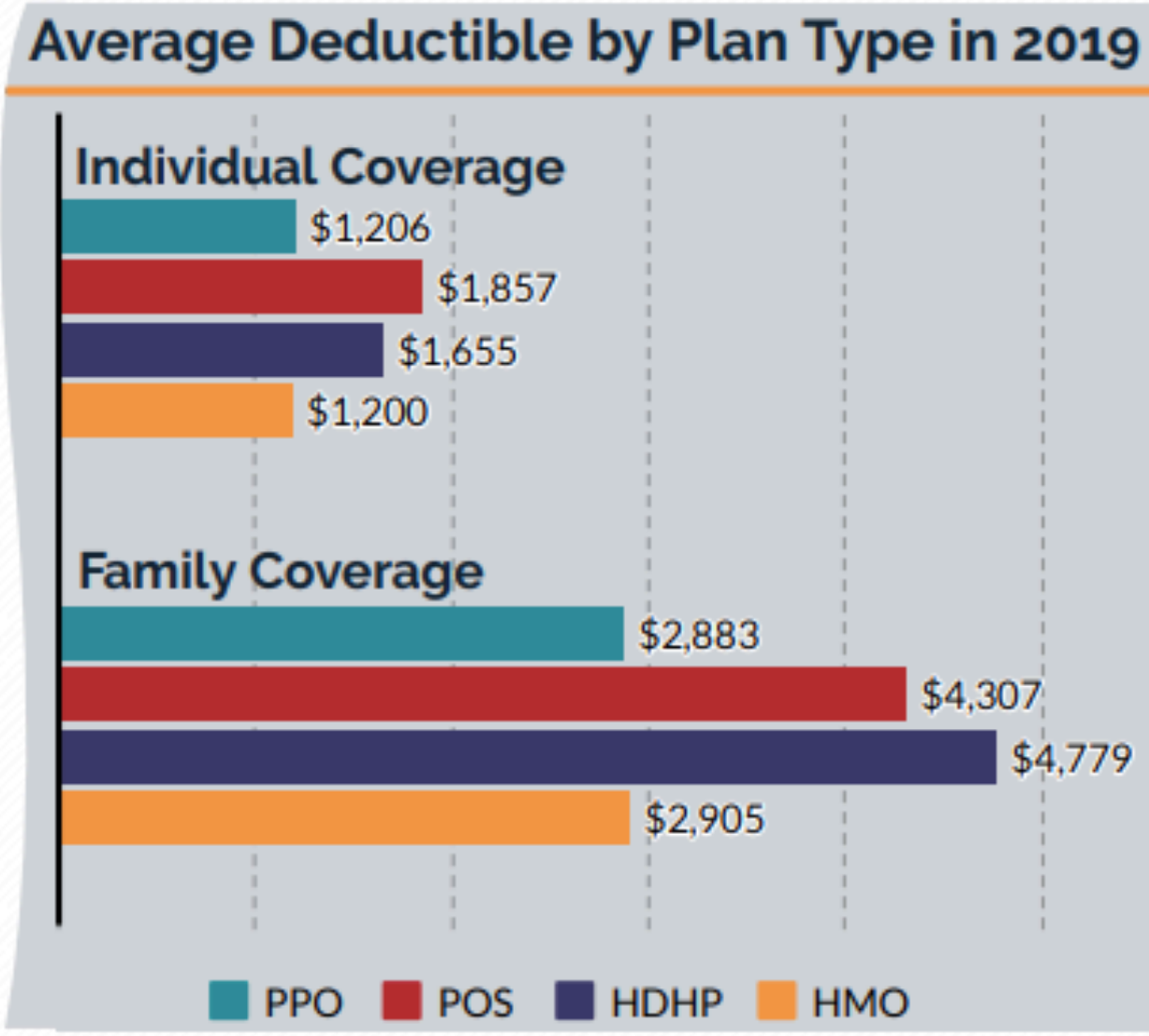
Health Plan Deductibles have grown more than ten times faster than inflation over the last decade

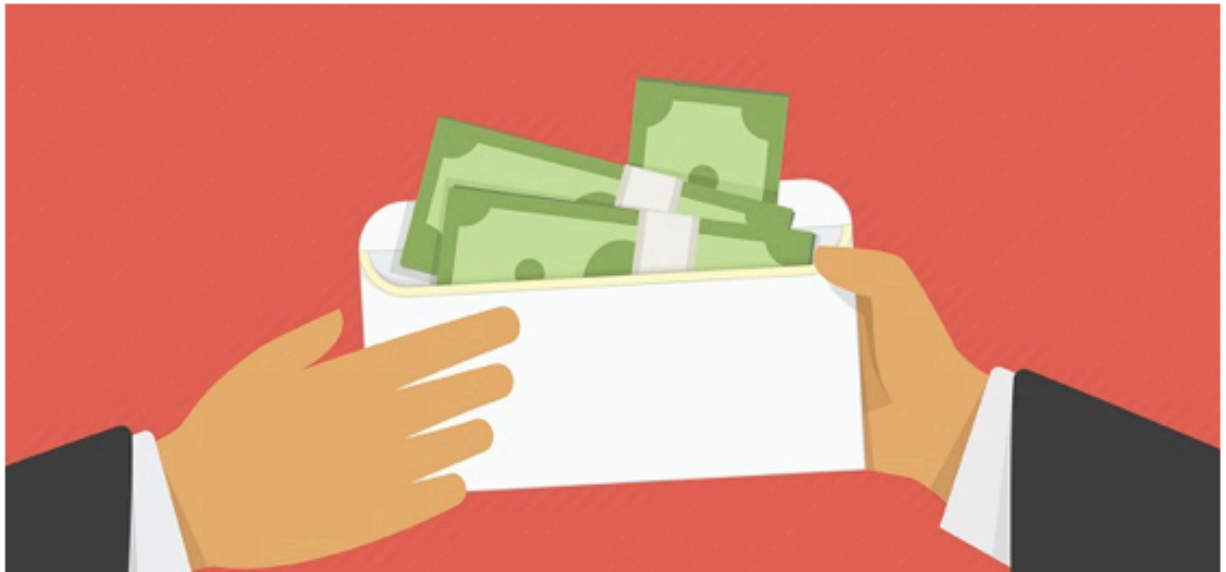




Americans Do Not Care About Health Care Costs; They Care About What It Costs Them

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.



International Journal of Technology Assessment in Health Care

Article Metrics

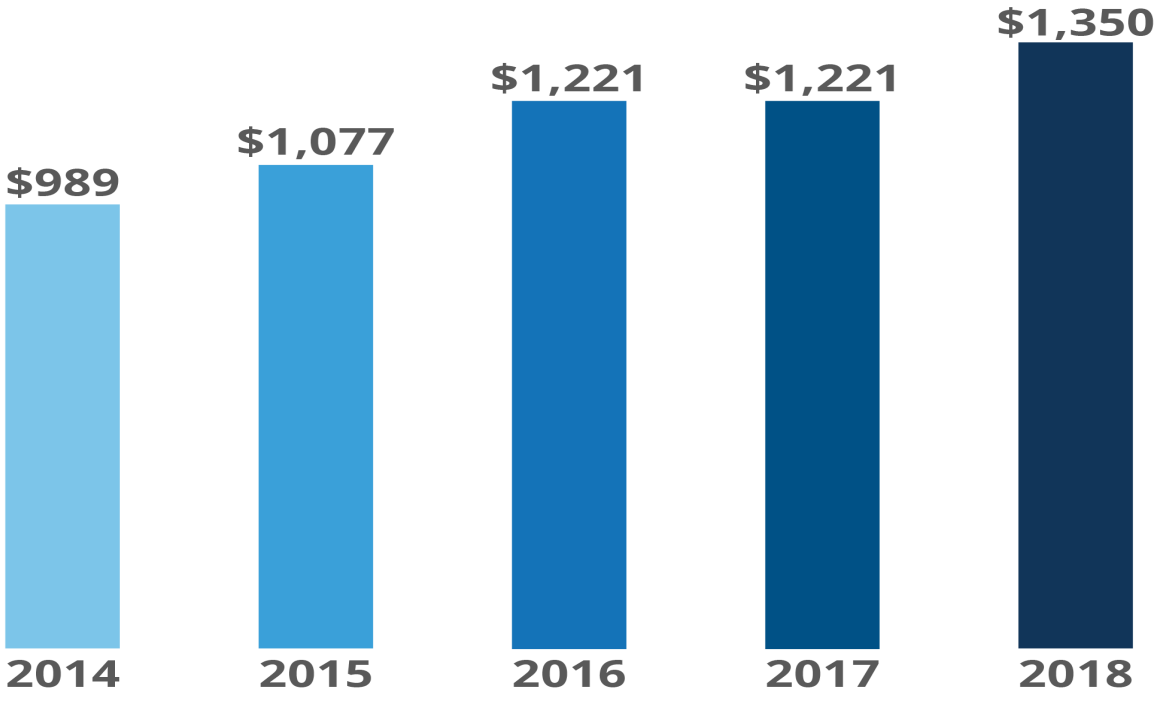
Volume 12, Issue 1 January 1996, pp. 1-8

The Tension Between Cost Containment and the Underutilization of Effective Health Services

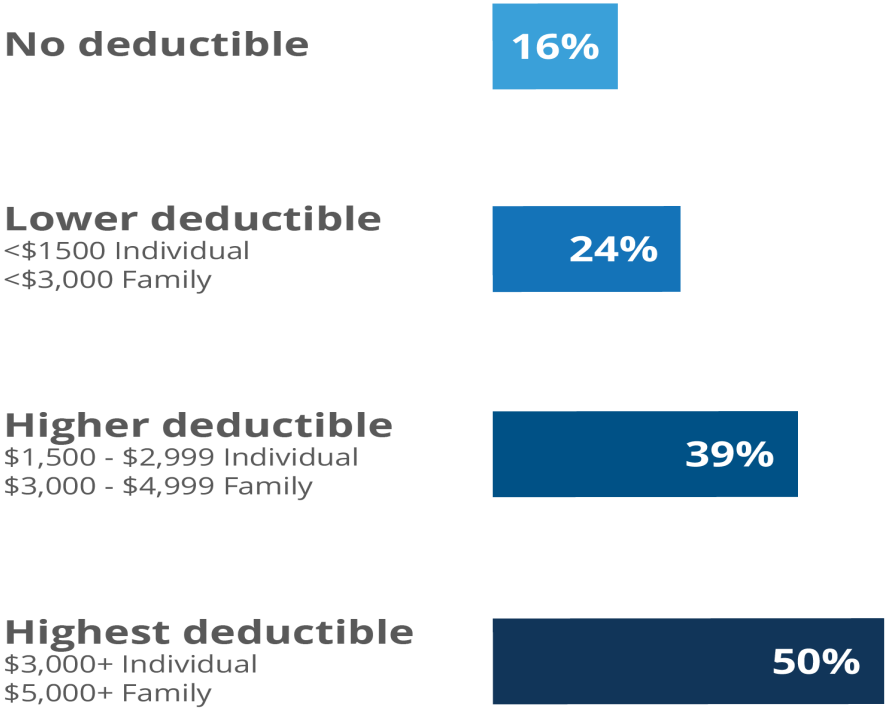
Bernard S. Bloom [a1] and A. Mark Fendrick [a2]

Dissatisfaction With Employer Coverage Rises As Deductibles Climb

Average deductible among large employer plans, including those with $0 deductibles



Percent who say their health insurance has gotten worse over the past 5 years



SOURCE: KFF analysis of data from KFF Employer Health Benefits Survey, 2018. KFF/LA Times Survey of Adults with Employer-Sponsored Health Insurance (Sept. 25-Oct. 9, 2018).

KFF
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Inspiration (Still)

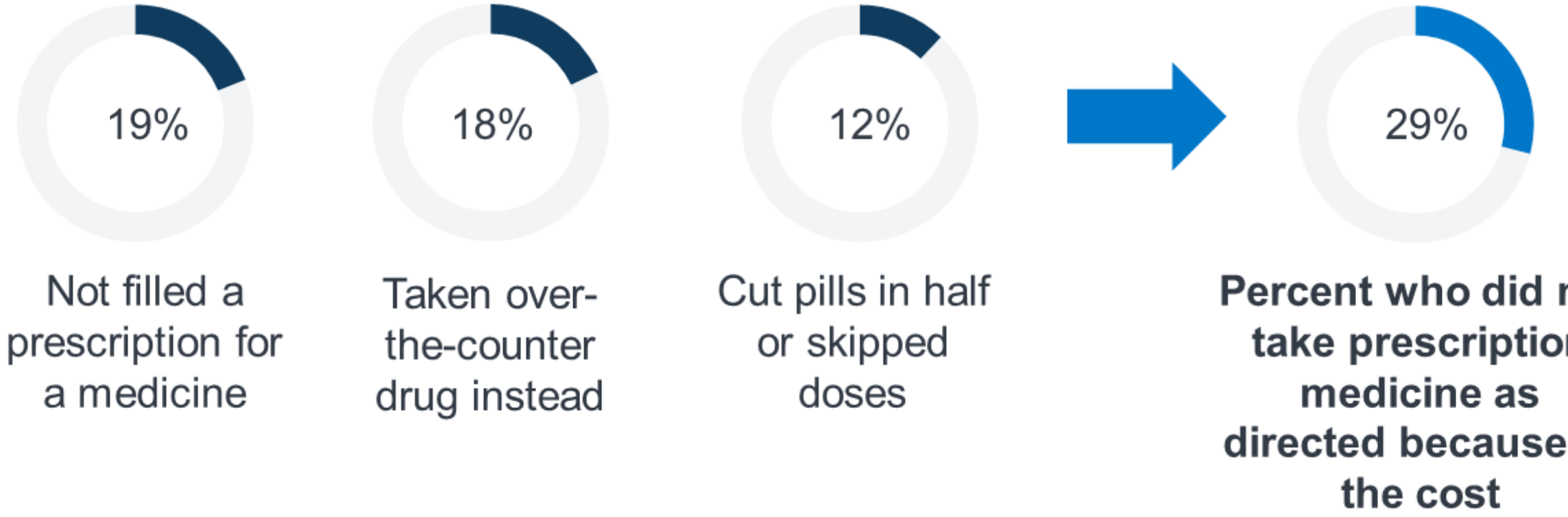
“I can’t believe you had to spend a million dollars to show that if you make people pay more for something, they will buy less of it.”

- Barbara Fendrick (my mother)

Figure 10

Three In Ten Say They Haven't Taken Their Medicine As Prescribed Due To Costs

Percent who say they have done the following in the past 12 months because of the cost:



SOURCE: KFF Health Tracking Poll (conducted February 14-24, 2019). See topline for full question wording and response options.

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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.

Next Generation Plan Option: “ 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: 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

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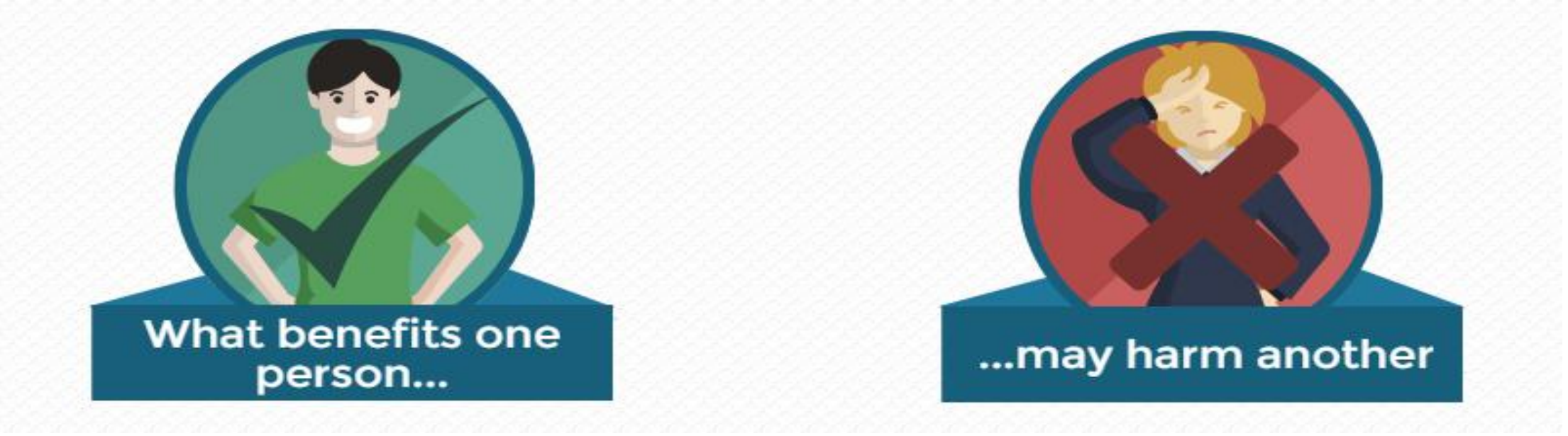
Clinical Nuance: Key Takeaway



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**

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
- EBRI
- AMA

Putting Innovation into Action: Translating Research into Policy

Translating Research into Policy

THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

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.

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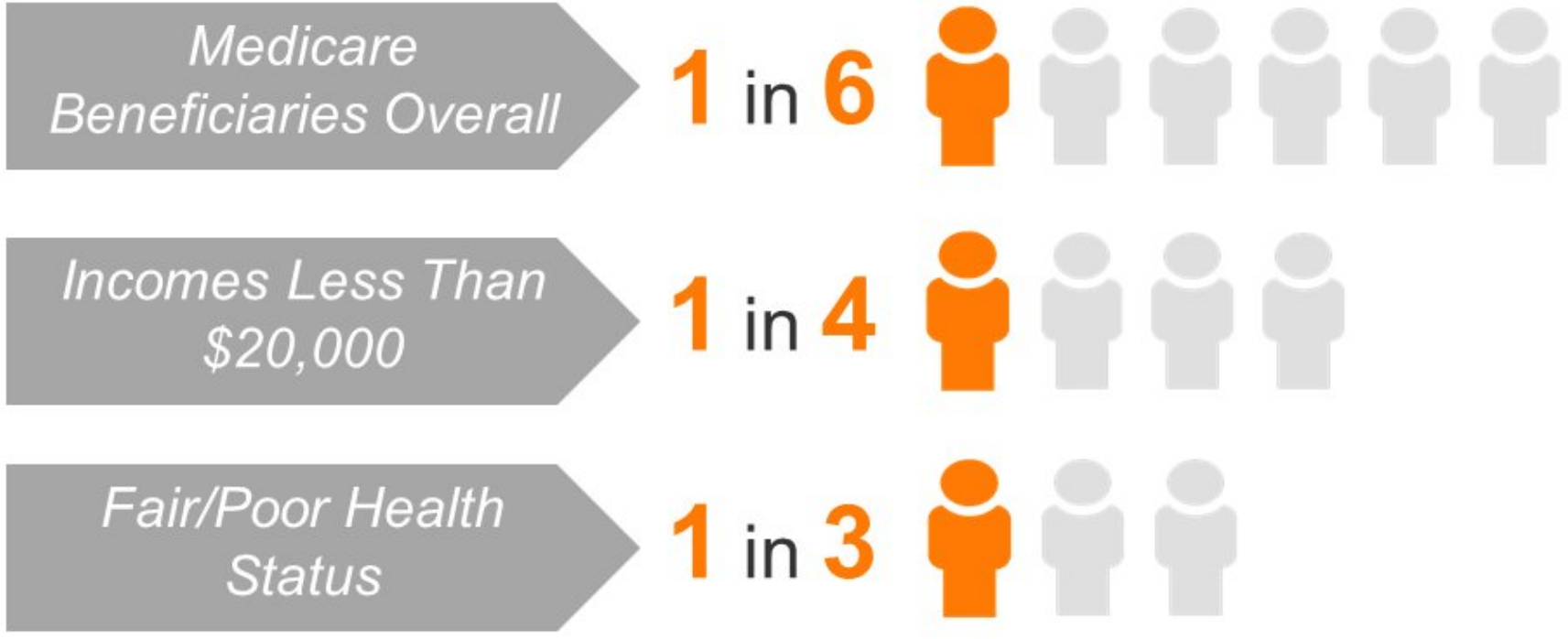
Putting Innovation into Action: Translating Research into Policy

Medicare

One in Six Medicare Beneficiaries Had Problems Getting Care Due to Cost or Paying Medical Bills in 2017; the Share is Higher Among Beneficiaries with Low Incomes and in Fair or Poor Health



*Number of Medicare Beneficiaries, 2017: 48.3 million**

NOTE: *Excludes institutionalized beneficiaries and those with Part A or Part B only and Medicare as a Secondary Payer for most months of the year.
SOURCE: KFF analysis of the Centers for Medicare & Medicaid Services Medicare Current Beneficiary Survey, 2017 Survey File.

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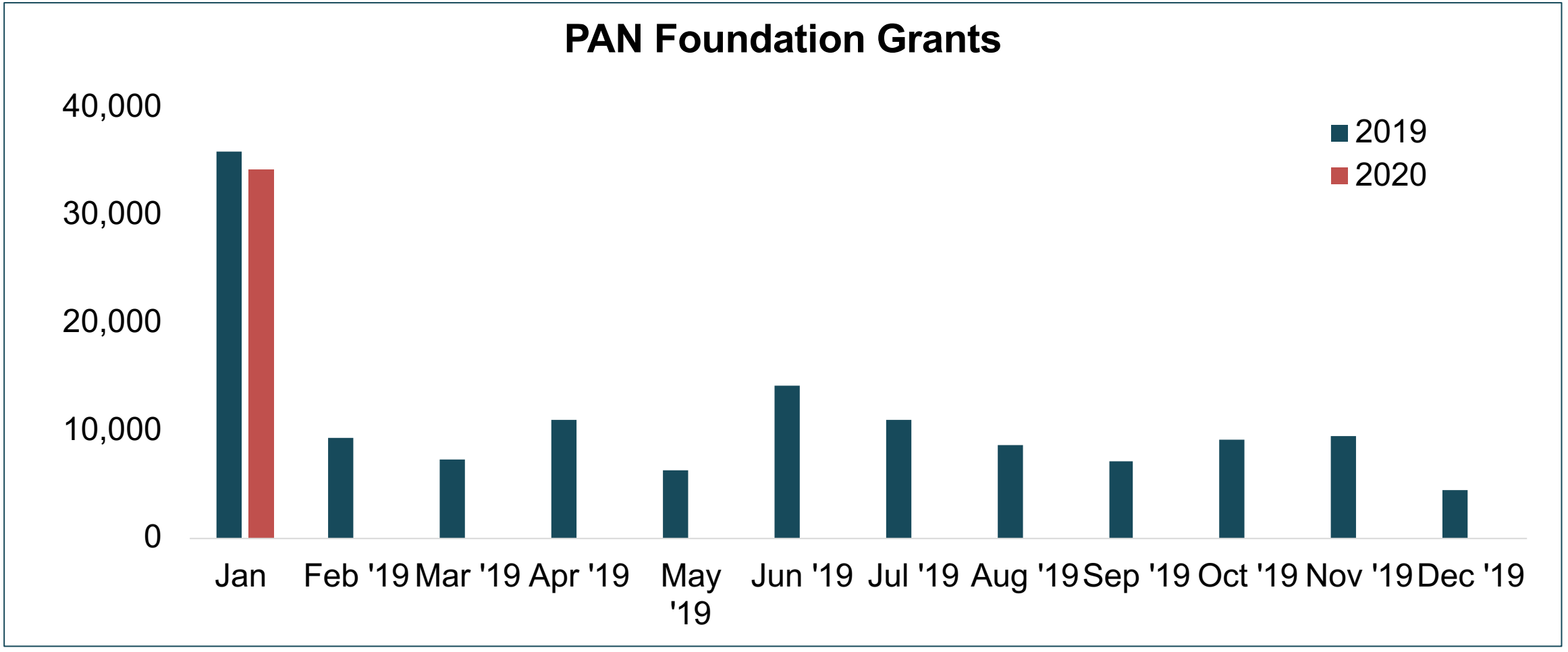
The ‘January Effect’ for Medicare Part D Beneficiaries



Klein and Fendrick, *Morning Consult,* 2020

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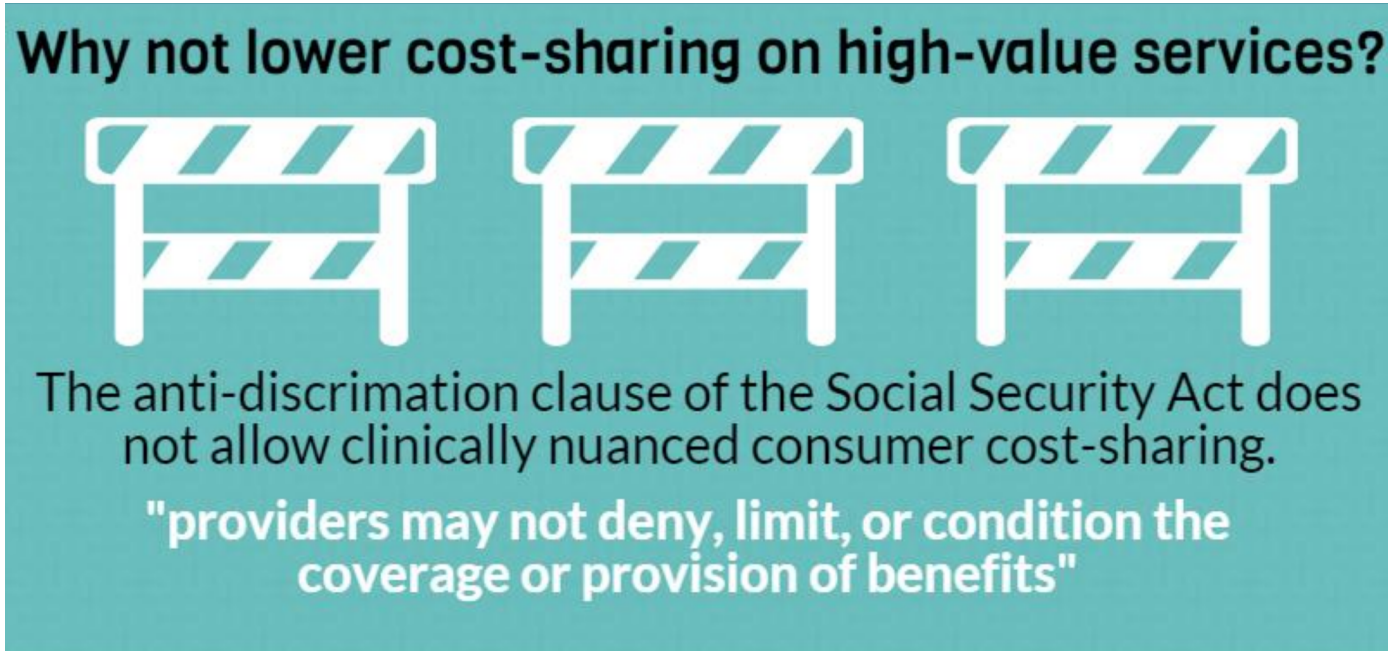
Implementing V-BID in Medicare

Implementing V-BID in Medicare



“Implementing V-BID in Medicare will take an act of Congress”

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.

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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

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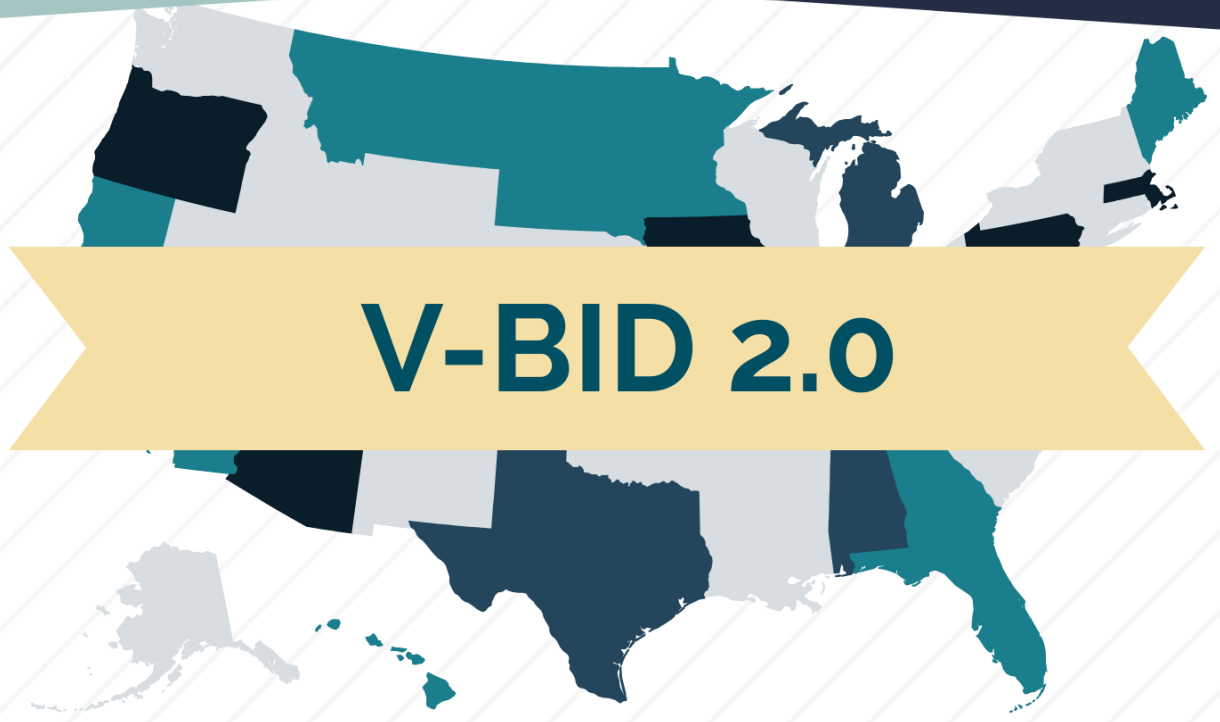
THE EXPANDED ROLE OF V-BID IN MEDICARE ADVANTAGE



CMS announced transformative updates to the **Medicare Advantage Value-Based Insurance Design model**, including its expansion to all 50 states

Medicare Advantage V-BID Model Test: Expanded Opportunities

Reduced cost-sharing permissible for:

- **High-value services**
- **High-value providers**
- **Participation 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
Transportation, nutrition support

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

Telehealth
Service delivery innovations
Augment existing provider networks

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Press release

CMS Launches Groundbreaking Model to Lower Out of Pocket Expenses for Insulin

Mar 11, 2020 | Coverage, Innovation models, Medicare Part D, Prescription drugs, Quality

Share

Putting Innovation into Action: Translating Research into Policy

TRICARE®

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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HSA-HDHP Reform

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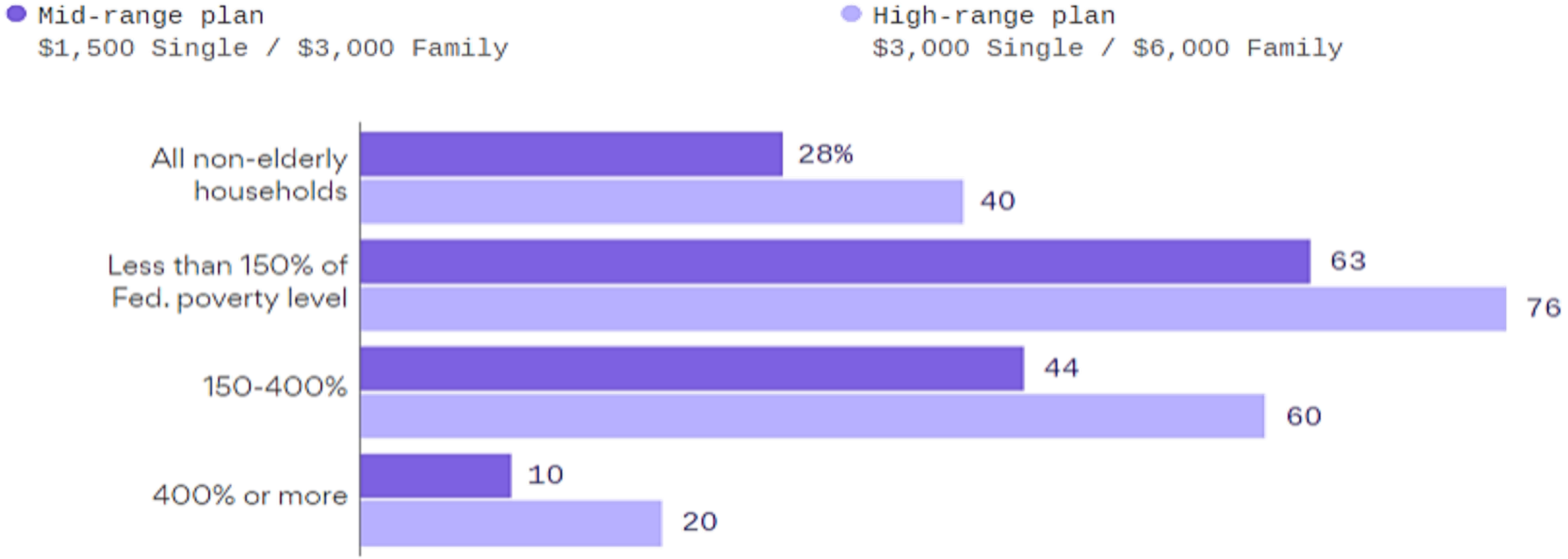
A Significant Number of Households Do NOT Have Liquid Assets to Cover Their Plan Deductible

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

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

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

U.S. DEPARTMENT OF THE TREASURY

Additional Preventive Care Benefits Permitted to be Provided by a High Deductible Health Plan Under § 223

NOTICE 2019-45

PURPOSE

This notice expands the list of preventive care benefits permitted to be provided by a high deductible health plan (HDHP) under section 223(c)(2) of the Internal Revenue Code (Code) without a deductible, or with a deductible below the applicable minimum deductible (self-only or family) for an HDHP.

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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

Chronic Disease Management of 2020

116th Congress
2D Session

2020

S.3200

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.

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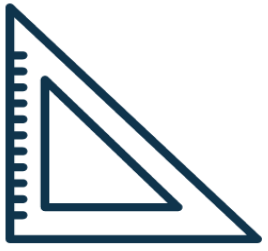
REDUCING
LOW-VALUE CARE

IDENTIFY.



MEASURE.

REPORT.

REDUCE.

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

Choose services:

- Easily identified in administrative systems
- Mostly low value
- Reduction in their use would be barely noticed

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Reducing Low Value Care: Measure

Health Waste Calculator

- Collaboration between Milliman and V-BIDHealth
- Measures potentially unnecessary services
- Analyze cost savings potential
- Generate actionable reports and summaries

Milliman

MedInsight

COSTS & SPENDING

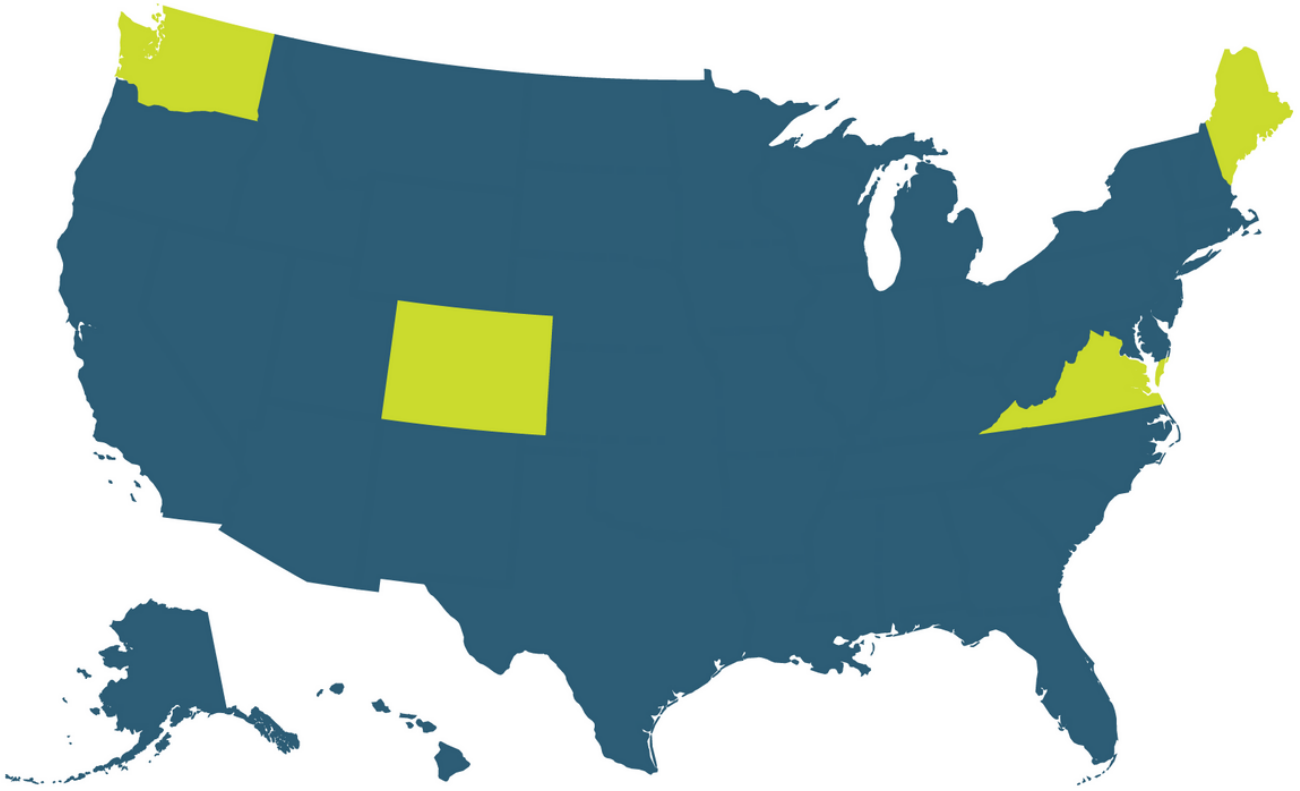
By John N. Mafi, Kyle Russell, Beth A. Bortz, Marcos Dachary, William A. Hazel Jr., and A. Mark Fendrick

DATAWATCH

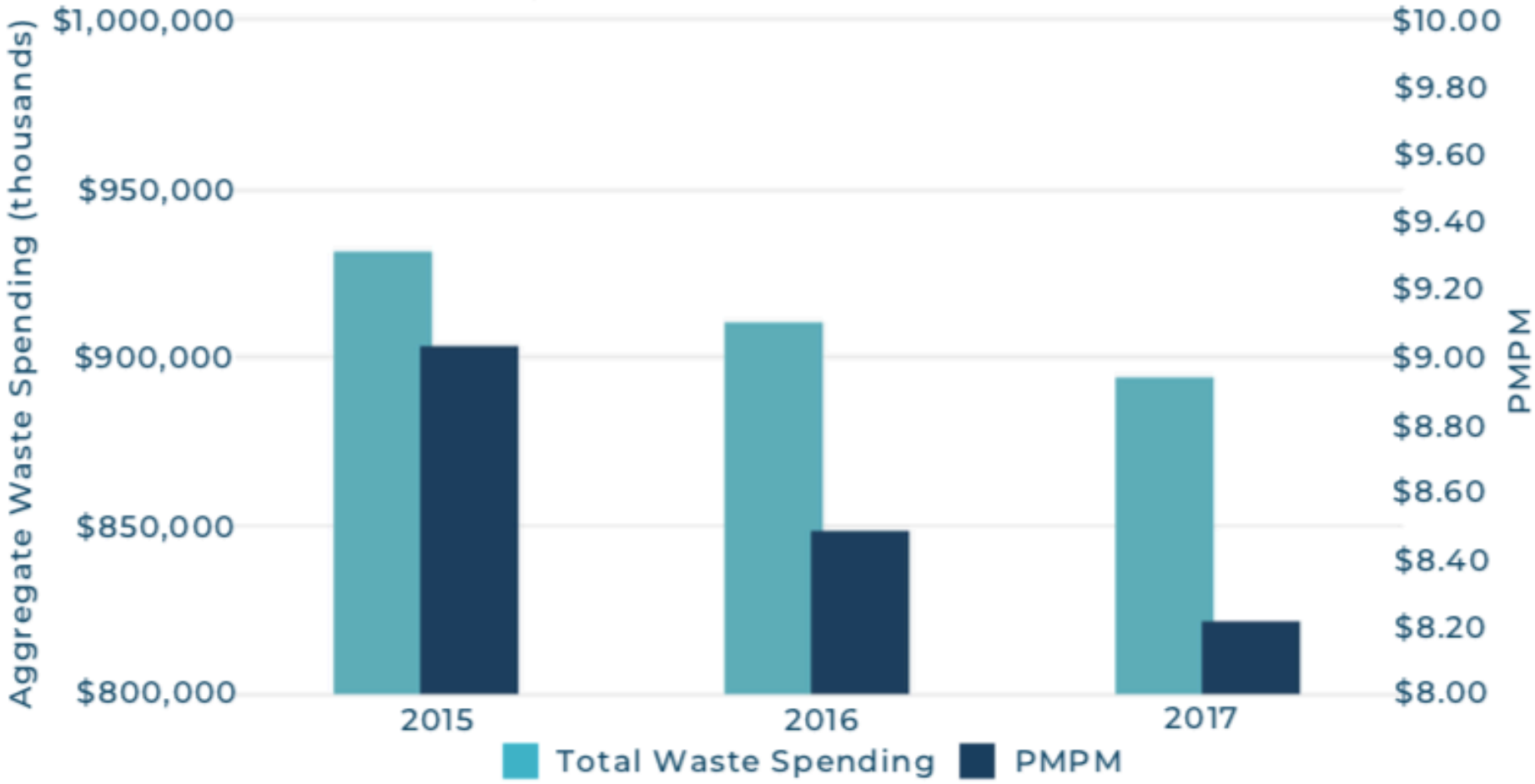
Low-Cost, High-Volume Health Services Contribute The Most To Unnecessary Health Spending

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).

State APCD Low-Value Care Report



Total Spending on 47 Low-Value Services by Four States in Medicaid and Commercial Plans, 2015-2017



Notes: this figure shows total spending (sum of plan and patient spending) on the 47 low-value services for commercial and Medicaid only, across three years for all four states: Colorado, Maine, Virginia, Washington.

Spending on 47 Low-Value Services in Medicaid and Commercial Plans in 2017 by Patients and Plans

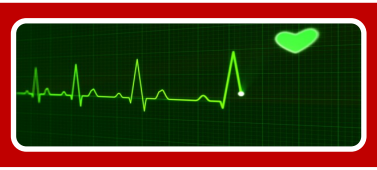
Notes: spending in thousands $. These figures only represent Maine, Colorado, and Virginia. Washington did not separately report patient and plan spending, estimated allowed spending based on standard pricing for Medicaid and commercial plans

Spending on "Top 10" Commercial and Medicaid Low-Value Services by Volume in 2017

2017	Total Spend on "Top 10" LVC Services	PMPM	% Total Medicaid and Commercial Waste Spending
Maine	$49,659	$6.67	78%
Washington*	$278,236	$8.69	80%
Colorado	$160,125	$5.65	73%
Virginia	$179,322	$4.37	68%
Total	$667,343	$6.13	70%

*Notes: total spending in thousands $. PMPM = total spending on the top 10 services divided by total member months (Appendix 3) provided by the states for 2017. These data only include Medicaid and commercial spending. *Washington does not report plan and patient spending separately.*

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. 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

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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.

HHS granted authority to not pay for USPSTF 'D' Rated Services

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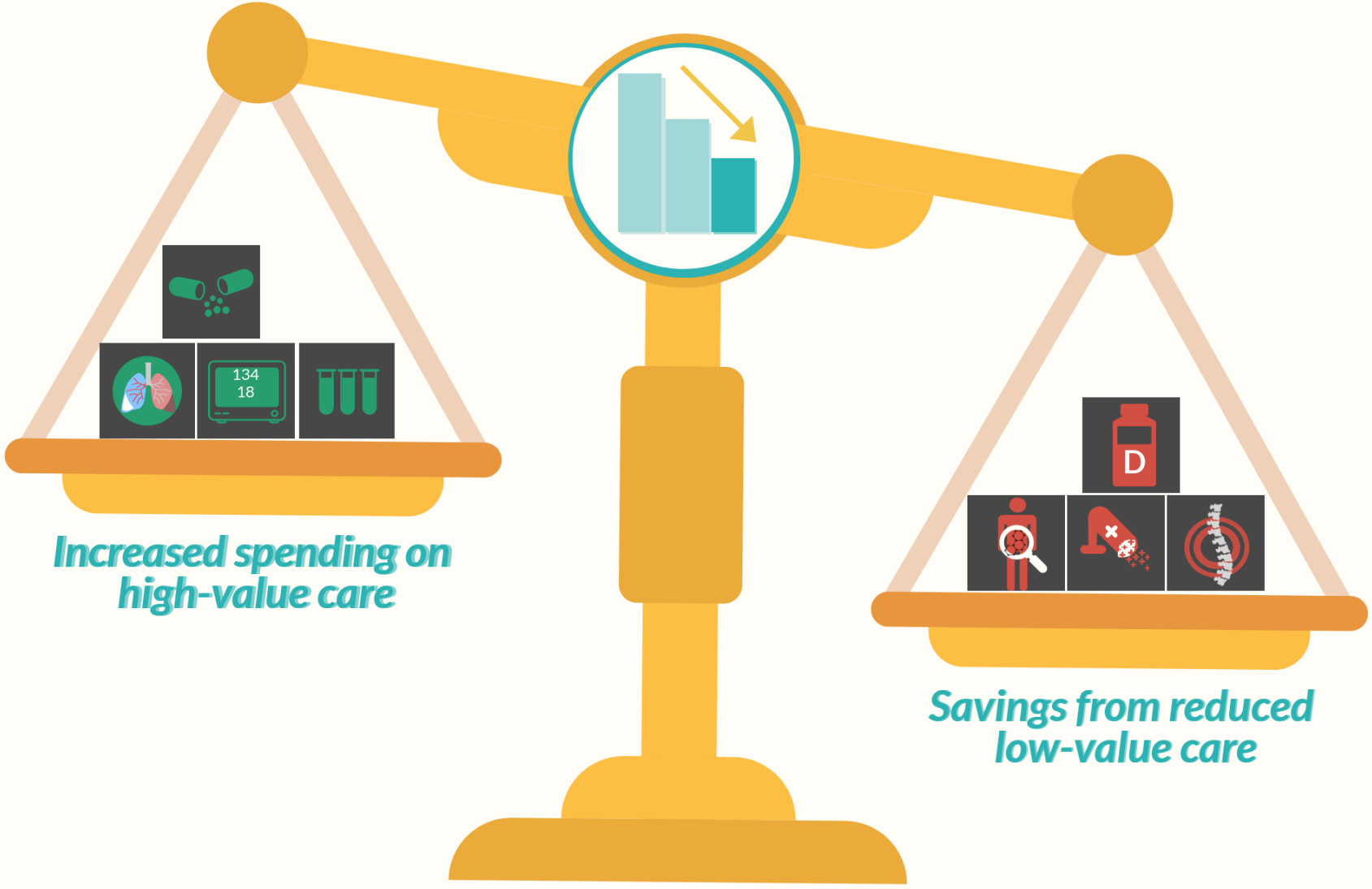
V-BID X aims to reduce consumer cost-sharing for targeted high-value services and increase cost-sharing for specific low-value services while avoiding increases in premiums and deductibles.

When savings from reduced use of low-value care exceed extra spending on high-value services, **premiums will decrease**



HEALTH AFFAIRS BLOG

RELATED TOPICS:
COST SHARING | DEDUCTIBLES | COSTS AND SPENDING | PHARMACEUTICALS | PREMIUMS | AFFORDABLE CARE ACT | MEDICARE ADVANTAGE

V-BID X: Creating A Value-Based Insurance Design Plan For The Exchange Market

Haley Richardson, Michael Budros, Michael E. Chernew, A. Mark Fendrick

JULY 15, 2019

10.1377/hblog20190714.

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V-BID X: Expanding Coverage of Essential Clinical Care Without Increasing Premiums or Deductibles

Clinically driven plan designs, like *V-BID X*, reduce spending on low-value care

...creating headroom to reallocate spending to high-value services without increasing premiums or deductibles

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High-Value Services and Drugs with Highly Reduced or Eliminated Cost-Sharing	
Glucometers and testing strips	Anti-thrombotic/anticoagulants
LDL testing (hyperlipidemia)	Anti-depressants
Hemoglobin A1C testing (diabetes)	Statins
Cardiac rehabilitation	Antipsychotics
INR testing (hypercoagulability)	ACE inhibitors and ARBs
Pulmonary rehabilitation	Beta blockers
Peak flow meters (asthma)	Buprenorphine-naloxone
Blood pressure monitors (hypertension)	Anti-resorptive therapy
Glucose lowering agents	Tobacco cessation treatments
Rheumatoid arthritis medications	Naloxone
Inhaled Corticosteroids	Thyroid-related
Antiretrovirals	

High-Value Branded Drug Classes with Reduced Cost-Sharing
Pre-exposure prophylaxis for HIV
Hepatitis C directing-acting combination
Anti-TNF

Low-Value Services with No Coverage
Spinal fusions
Vertebroplasty and kyphoplasty
Vitamin D testing
Proton beam therapy for prostate cancer

Commonly Used Services with Limited Value and Increased Cost-Sharing	
Outpatient specialist services	X-rays and other diagnostic imaging
Outpatient labs	Outpatient surgical procedures
High-cost imaging	Non-preferred branded drugs

V-BID X: Key Takeaways

- **Cost neutral V-BID designs are feasible. Coverage can be enhanced for targeted high-value services, without raising premiums and deductibles**

- **There are a large number of plausible combinations of services or cost-sharing changes that could fit different needs and goals, depending on the carrier and market**

V-BID Included in Biden-Sanders Unity Task Force Recommendations

- **Provide free or low-cost prescription prescription drugs proven effective in treating for chronic illness (i.e., adopt a "Value-Based Insurance Design" benefit)**
- **Redesign the Medicare V-BID benefit to provide free or low-cost Rx drugs of proven benefit for chronic illness**

Confronting the ‘New Normal’

- Less $ for everything
  - –Everyone looking to reduce spend
  - –Increased scrutiny on low value care
- Changes in care delivery patterns
  - –While popular quality and cost impact of telemedicine uncertain
  - –Shift to evidence based services

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Issues for Payers in the ‘New Normal’

- New costs
  - –COVID-19 care
  - –Copay waivers for COVID-19 care and telemedicine
  - –Out of network issues
- How much volume returns?
- Lower spend?
- Lower premiums?
- Cost of coronavirus vaccine

V-BID

Enhancing Access and Affordability to Essential Clinical Services: A Role for V-BID in the 'New Normal'

- **Expand pre-deductible coverage/reduce consumer cost-sharing on high-value clinical COVID-19 related care and other essential chronic disease services**
- **Identify, measure and reduce low-value care to pay for more generous coverage of high-value care**
- **Implement clinically-driven plan payment reform, technologies and benefit designs that increase use of high-value services and deter low value care**

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“This pandemic has uncovered a flaw in current benefit designs that do not provide affordable coverage for critical services—including care to treat COVID-19–related illness. Now that COVID-19 has exposed this problem to all Americans, the time has come for public and private health insurers to revisit their benefit designs to provide better access to essential services and deter the use of low value care.”

“If we don’t succeed then we will fail.”

Dan Quayle

Questions?