CENTER FOR VALUE-BASED INSURANCE DESIGN
UNIVERSITY OF MICHIGAN

Measuring and Eliminating Low Value Care

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FROM NUMBERS TO KNOWLEDGE
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VIRGINIA HEALTH INFORMATION

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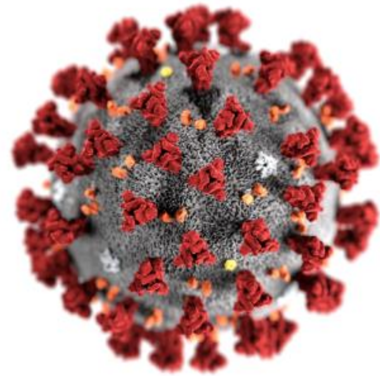
Hail to the Frontline

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

- 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

A Second Health Care Pandemic will Follow COVID-19
We Need to Plan Accordingly



A Second Health Care Pandemic will Follow COVID-19
We Need to Prepare for is What to Come

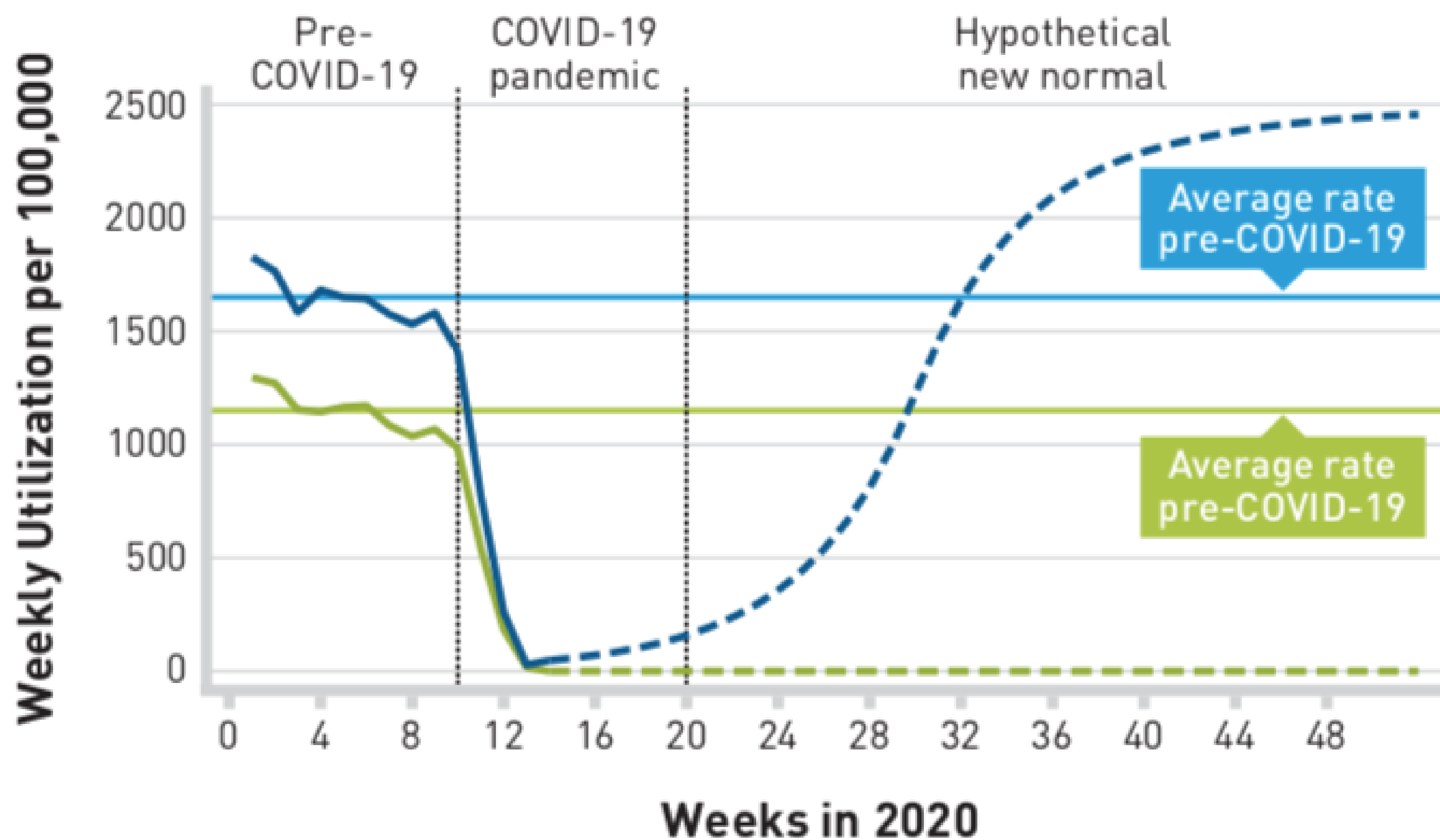
COVID-19 Projected to Drive Increased Costs for Consumers, Employers

COVID-19 costs could lead to significant increases in premiums

COVID-19 Recession to Increase Uninsurance Rates, Test Medicaid

COVID-19 will lead to increased unemployment and pose serious challenges to Medicaid and coverage for uninsured individuals.

Crisis Into Opportunity: Can COVID-19 Help Set a Path to Improved Health Care Efficiency?



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Crisis Into Opportunity: Can COVID-19 Help Set a Path to Improved Health Care Efficiency?

- Build on existing alternative payment models that base reimbursement on patient-centered outcomes. increase reimbursement for high-value services and reduce or cease payment for known low-value care

- Leverage the widespread adoption of electronic health records (EHRs) to make it easier to order high-value care with simplified processes and discourage the use of low-value care with alerts

- Align patient cost-sharing with the value of the underlying services; reduce out of pocket cost on high value services and increase patient cost on low value care

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Paying for More Generous Coverage of High Value Care: Reduce Spending on Low Value Care

LOW-VALUE CARE

A silver lining to COVID-19: Fewer low-value elective procedures

Paying for More Generous Coverage of High Value Care: Reduce Spending on Low Value Care

- Increase premiums – politically not feasible
- Raise deductibles and copayments – ‘tax on the sick’
- Reduce spending on low value care

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$345 BILLION

Examples include:

Vitamin D screening tests

Diagnostic tests before low-risk surgery

PSA screening for men 70 and older

Branded drugs when identical generics are available

Low-back pain imaging within 6 weeks of onset

Table 1. Claims Data Sources included in APCD, by State

	Commercial	Medicaid	Medicare FFS	Medicare Advantage	Patient *and* Plan Spending
Maine	X	X	X	X	X
Washington	X	X			
Colorado	X	X	X	X	X
Virginia	X	X	X		X

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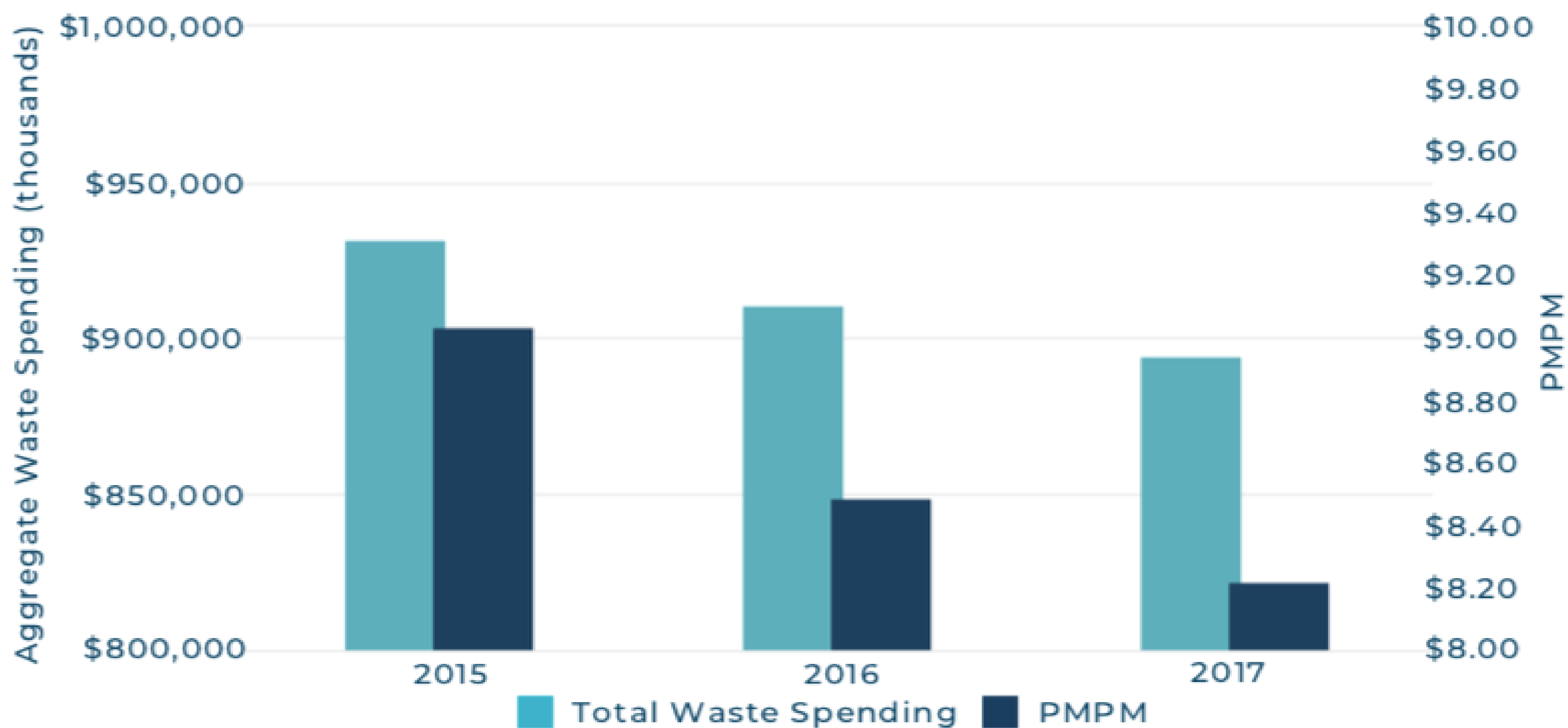
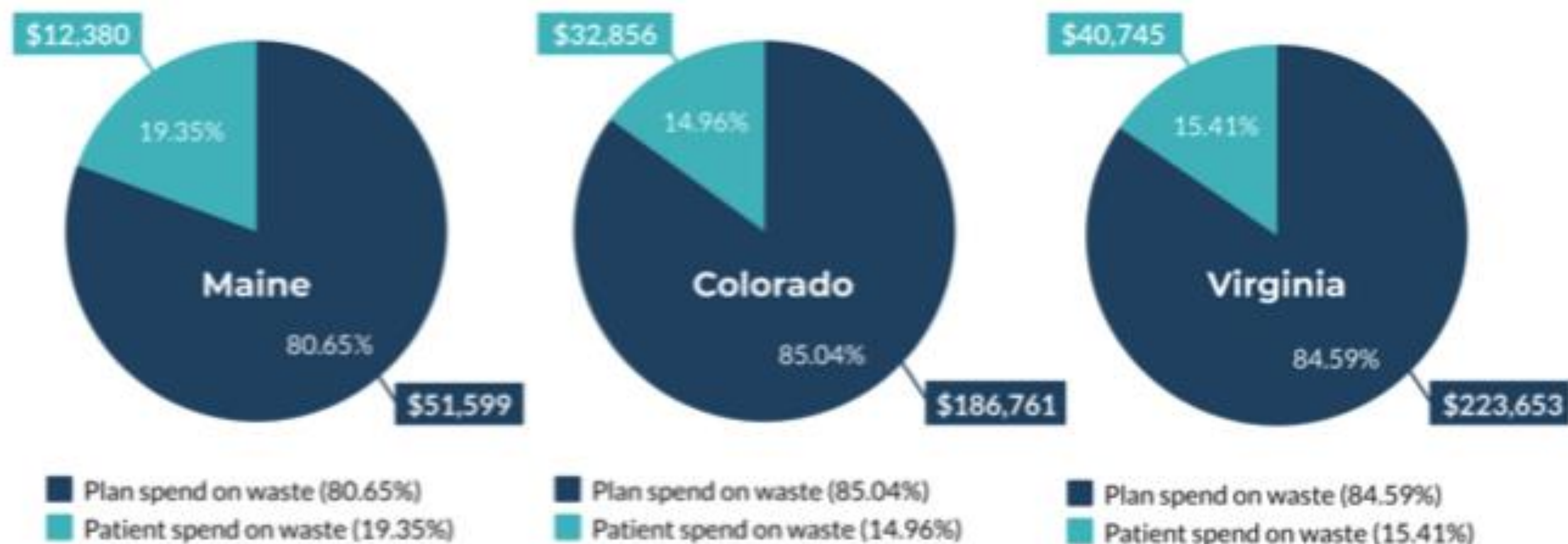
Total Spending on 47 Low-Value Services by Four States in Medicaid and Commercial Plans, 2015-2017



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.*

Total Plan and Patient LVC Spending, including Medicare, 2017

	Total LVC Spending, with Medicare	PMPM, with Medicare	% Total Health Spending, with Medicare
Maine	$146,884	$12.53	1.72%
Colorado	$358,111	$9.67	1.86%
Virginia	$627,768	$10.66	1.92%

Maine and Colorado include Medicare FFS and Medicare Advantage, Virginia Medicare FFS only

V-BID X:
Better Coverage, Same Premiums and Deductibles

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

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

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

Enhancing Access and Affordability to Essential Clinical Services: A Need to Reduce Low Value Care 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
- Implement clinically-driven plan payment reform, technologies and benefit designs that increase use of high-value services and deter low value care
- Identify, measure and reduce low-value care to pay for more generous coverage of high-value care

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Dan Quayle