

Value-Based Insurance Design: Incentivizing High Value Care While Eliminating Low Value Care

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Appreciation to the Essential Workers on the Frontline

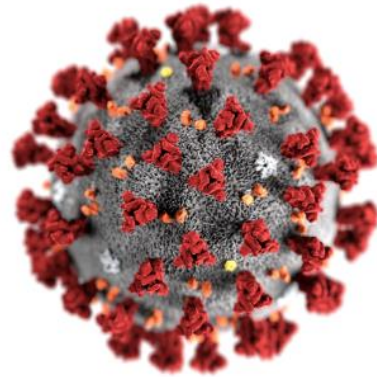
To the many people who are working selflessly to defeat this pandemic.
Thank you.



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 delivery 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

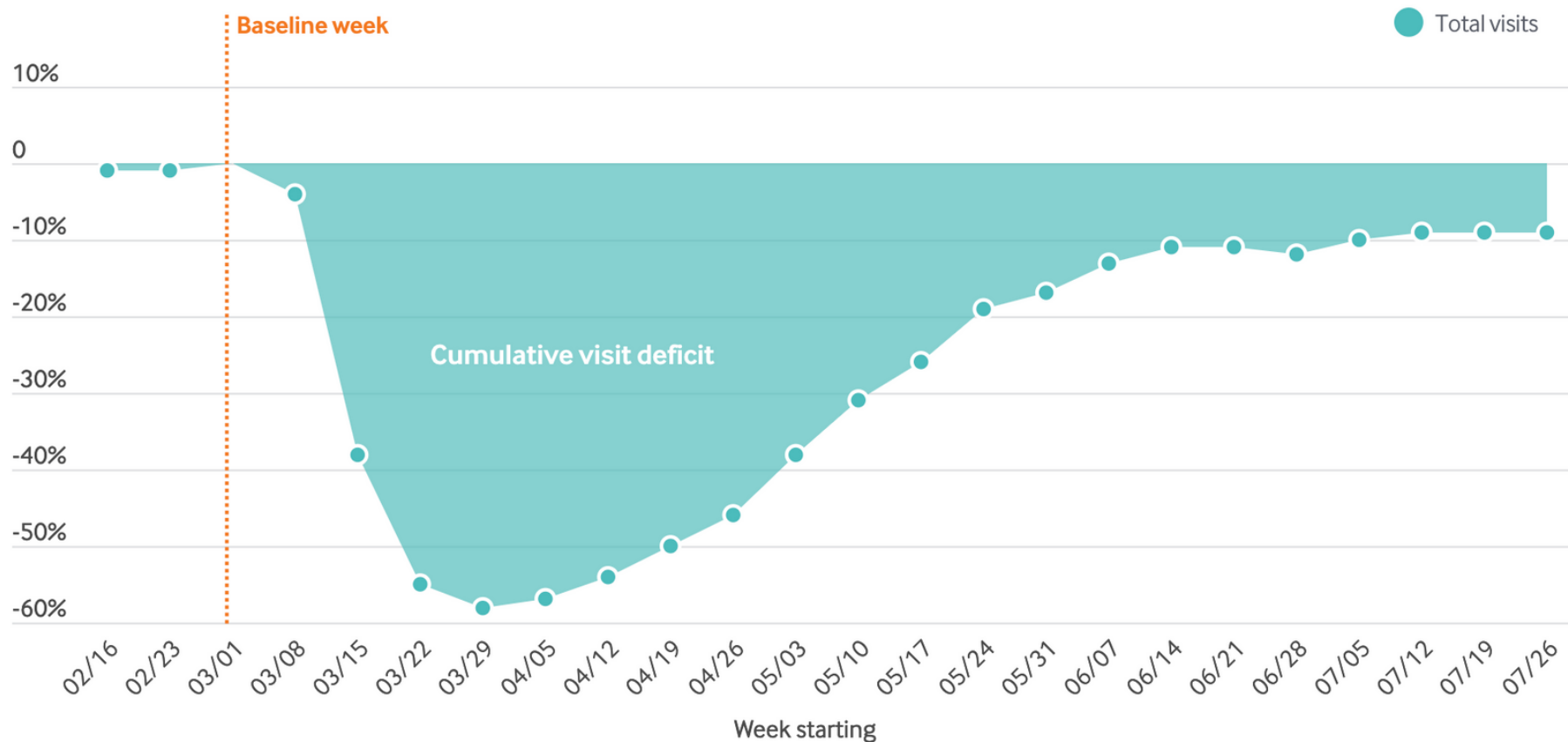
Then Came Coronavirus...



Large Drop in Physician Visits

The number of visits to ambulatory practices fell nearly 60 percent by early April before rebounding through mid-June. From then through the end of July, weekly visits plateaued at 10 percent below the pre-pandemic baseline. The cumulative number of lost visits since mid-March remains substantial and continues to grow.

Percent change in visits from baseline

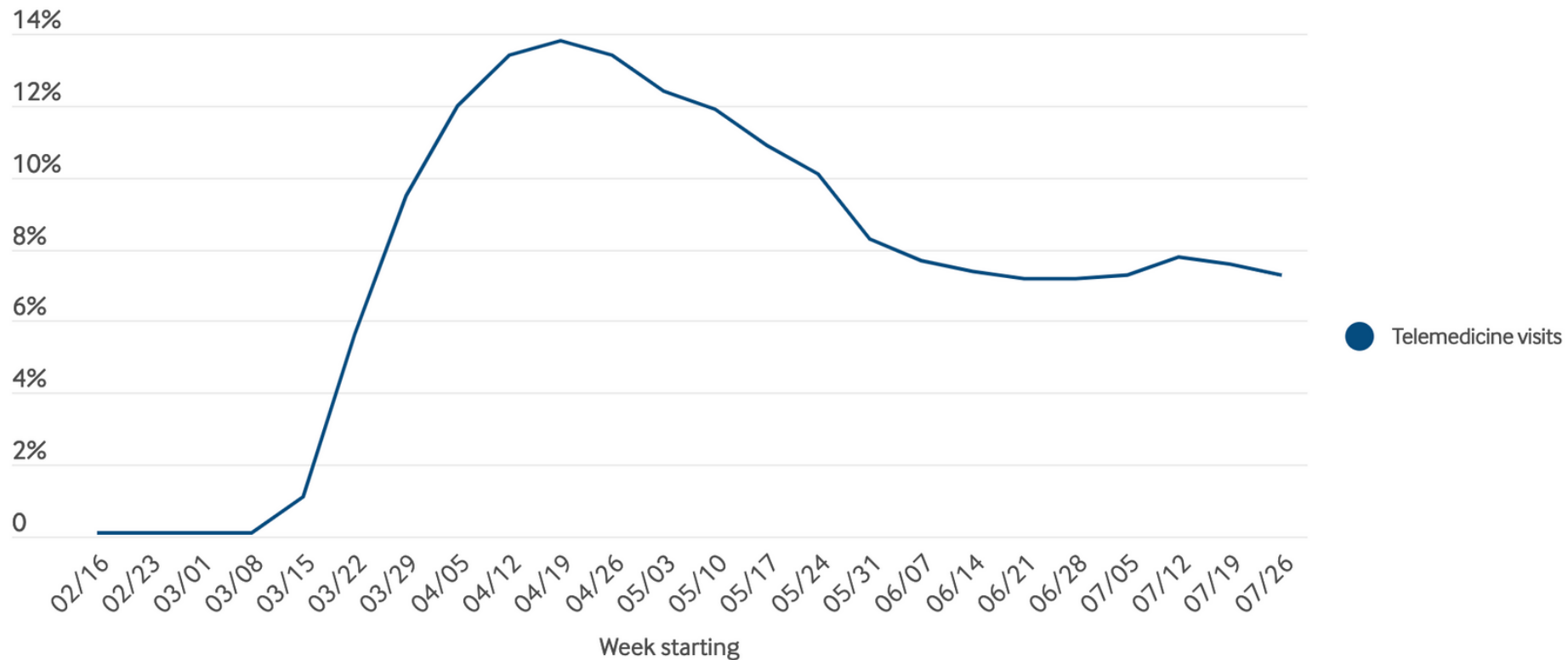


Note: Data are presented as a percentage change in the number of visits in a given week from the baseline week (March 1–7).

Source: Ateev Mehrotra et al., [The Impact of the COVID-19 Pandemic on Outpatient Visits: Changing Patterns of Care in the Newest COVID-19 Hot Spots](https://doi.org/10.26099/yaq-q550) (Commonwealth Fund, Aug. 2020). <https://doi.org/10.26099/yaq-q550>

Telehealth Visits Grew Dramatically, but have Since Declined

Number of telemedicine visits in a given week as a percent of baseline total visits



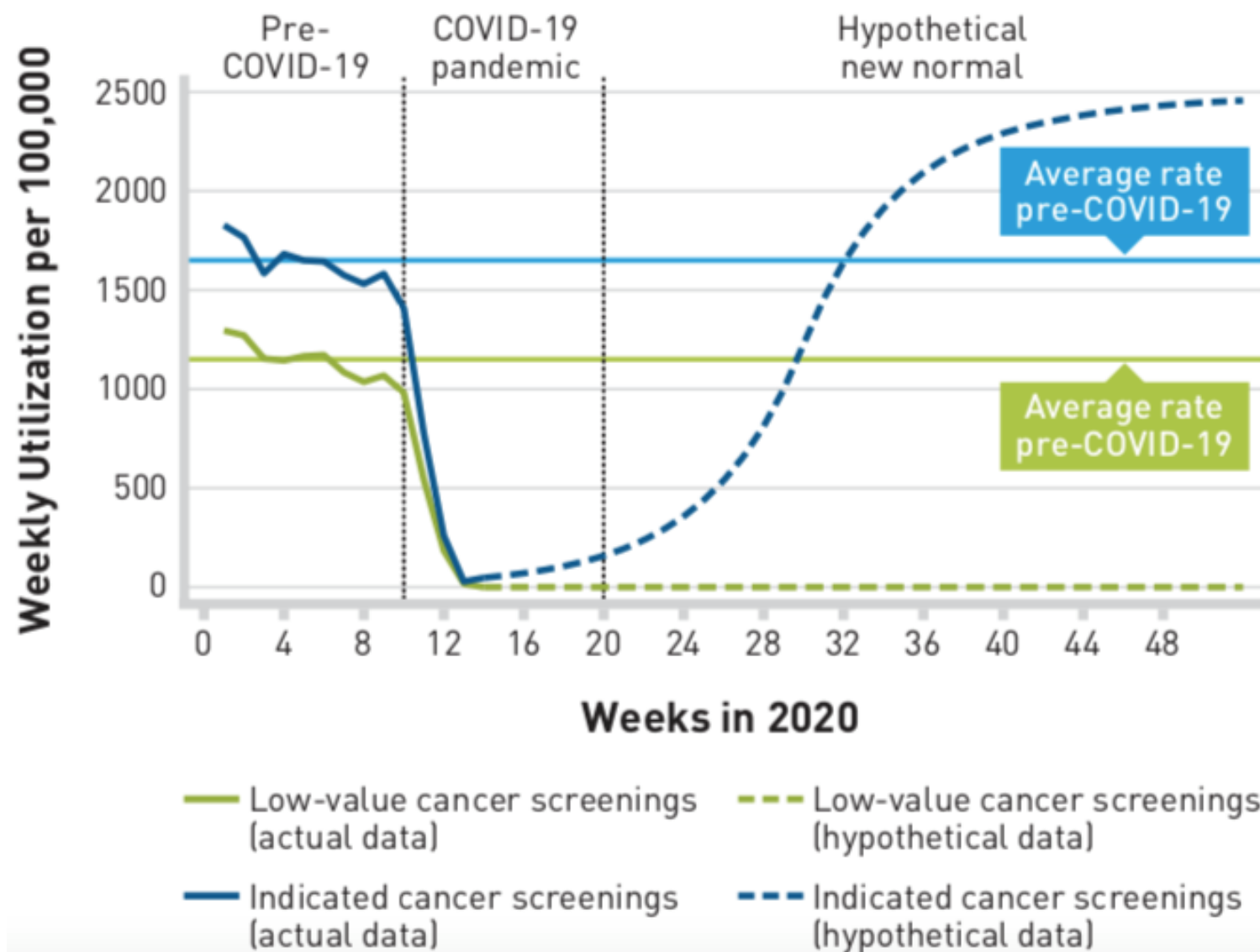
Data are presented as a percentage, with the numerator being the number of telemedicine visits in a given week and the denominator being the number of visits in the baseline week (March 1–7). Telemedicine includes both telephone and video visits.

Source: Ateev Mehrotra et al., [The Impact of the COVID-19 Pandemic on Outpatient Visits: Changing Patterns of Care in the Newest COVID-19 Hot Spots](https://doi.org/10.26099/yaqe-q550) (Commonwealth Fund, Aug. 2020). <https://doi.org/10.26099/yaqe-q550>

LOW-VALUE CARE

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

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

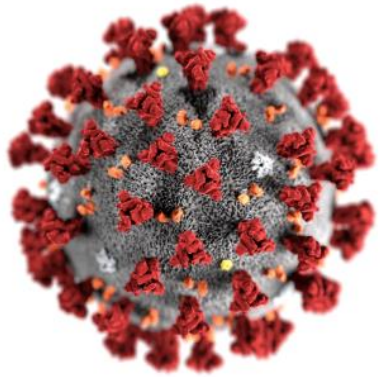


Crisis Into Opportunity: Can COVID-19 Help Set a Path to Improved Health Care Efficiency?

- 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 to make it easier to order high-value care 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

A Second Health Care Pandemic will Follow COVID-19

We Need to Plan Accordingly



**NEARLY THREE IN FOUR AMERICANS
SAY THEIR INCOMES HAVE ALREADY
TAKEN A HIT FROM THE PANDEMIC**

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.



Concerns Regarding Coronavirus: Americans Cannot Afford a COVID-19 Deductible

- About half of Americans have skipped or postponed care because of the Coronavirus outbreak
- 68% of adults report out-of-pocket costs would be very or somewhat important in their decision to get care if they had coronavirus symptoms
- Insured patients are responsible for over \$1,000 for a COVID-19 hospitalization
- 40% of Americans do not have \$400 for an expected expense

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)

Alternative to “Blunt” Health Care Financing: A Clinically-Driven Approach

A “**smarter**” payment and cost-sharing approach that encourages clinicians and consumers to use more high value services and providers, but discourages the use of low value ones

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



Putting Innovation into Action: Translating Research into Policy



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

Putting Innovation into Action: Translating Research into Policy



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

Rewards and Incentives

\$600 annual limit

Increase participation

Available for Part D

Targeting Socioeconomic Status

Low-income subsidy

Transportation, nutrition support

Telehealth

Service delivery innovations

Augment existing provider networks

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



HSA-HDHP Reform



2004 IRS Code - High deductible health plans could not cover clinical services used to treat 'existing illness, injury or conditions' until the plan deductible was met

PREVENTIVE CARE COVERED

Dollar one



CHRONIC DISEASE CARE

NOT covered until deductible is met



2019 – IRS Notice 2019-45: Specific services and drugs used to treat certain chronic conditions can be covered before the plan deductible is met



U.S. DEPARTMENT OF THE TREASURY

PRESS RELEASES

Treasury Expands Health Savings Account Benefits for Individuals Suffering from Chronic Conditions

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 – Bipartisan bill expands list of services that could be covered before the plan deductible is met

116th Congress
2D Session



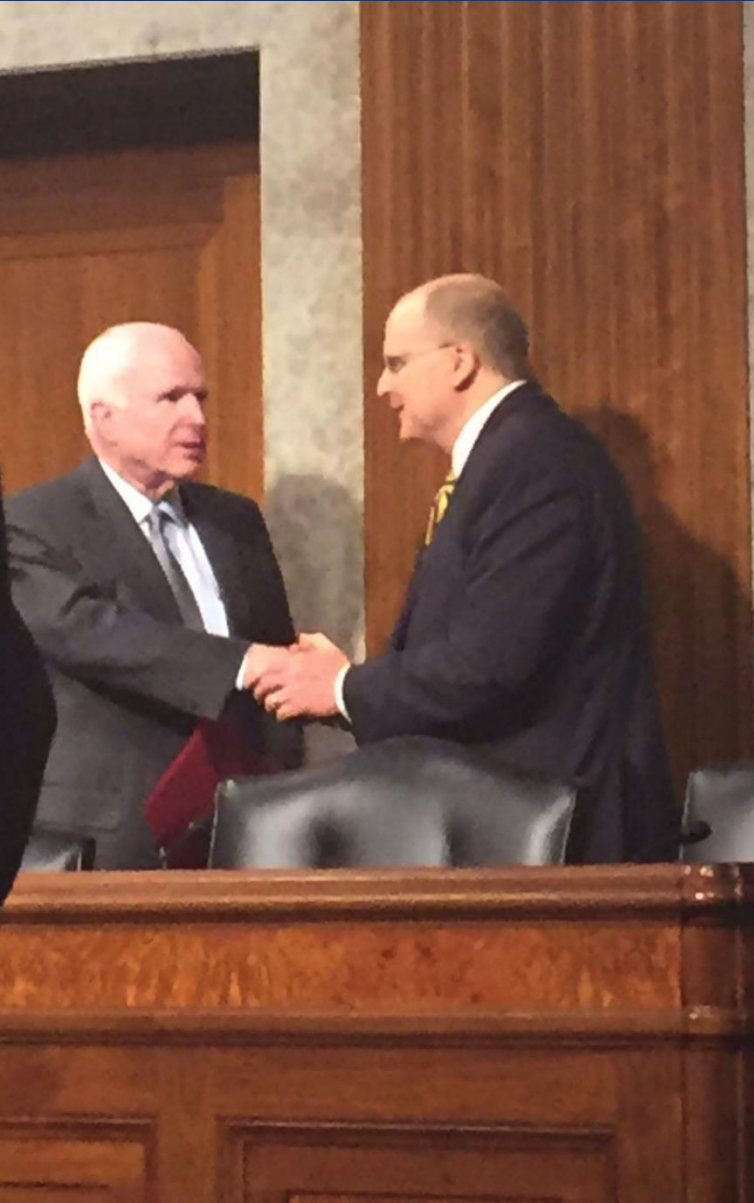
S.3200

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.

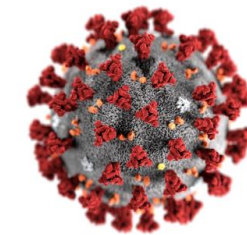
Putting Innovation into Action: Translating Research into Policy



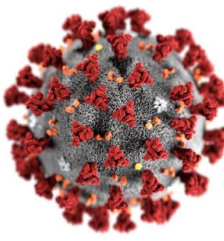
Putting Innovation into Action: V-BID Elements included in NDAA



- 2017: Obama Administration - reduce or eliminate co-pays and other cost sharing for certain high services and providers
- 2018: Trump Administration – reduce cost-sharing for high value drugs on the uniform formulary



- March 11: IRS Notice 2020-15 - extended pre-deductible coverage for medical services to test for and treat the virus
- March 18: Families First Coronavirus Response Act
 - Eliminated cost-sharing for COVID-19 testing
 - Eliminated cost-sharing for any in-person or telehealth provider visit that results in a COVID-19 test



March 27 - Coronavirus Aid, Relief, and Economic Security (CARES) Act

- Allows HDHPs to cover Telehealth (not just COVID-19 related) on a pre-deductible basis
- Mandates coverage of COVID-19 diagnostic testing without cost sharing by all plans
- Amends Public Health Service Act Section 2713, requiring all plans to cover Coronavirus vaccine without consumer cost-sharing

SEC. 4203. RAPID COVERAGE OF PREVENTIVE SERVICES AND VACCINES FOR CORONAVIRUS.

(a) **IN GENERAL.**—Notwithstanding 2713(b) of the Public Health Service Act ([42 U.S.C. 300gg-13](#)), the Secretary of Health and Human Services, the Secretary of Labor, and the Secretary of the Treasury shall require group health plans and health insurance issuers offering group or individual health insurance to cover any qualifying coronavirus preventive service, pursuant to section 2713(a) of the Public Health Service Act ([42 U.S.C. 300gg-13\(a\)](#)). The requirement described in this subsection shall take effect with respect to a qualifying coronavirus prevention service on the specified date described in subsection (b)(2).

(b) **DEFINITIONS.**—For purposes of this section:

(1) **QUALIFYING CORONAVIRUS PREVENTIVE SERVICE.**—The term “qualifying coronavirus preventive service” means an item, service, or immunization that is intended to prevent or mitigate coronavirus disease 2019 and that is—

(A) an evidence-based item or service that has in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force; or

(B) an immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.

(2) **SPECIFIED DATE.**—The term “specified date” means the date that is 15 business days after the date on which a recommendation is made relating to the immunization as described in such paragraph.

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



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**

**\$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

RESEARCH ARTICLE

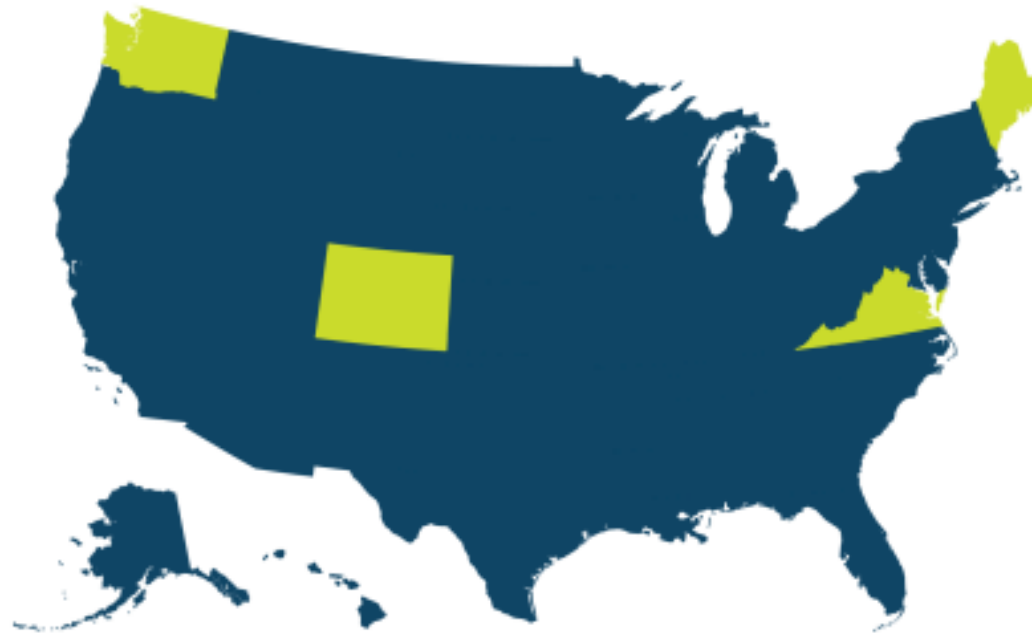
MILITARY HEALTH SYSTEM

HEALTH AFFAIRS > VOL. 38, NO. 8: MILITARY HEALTH SYSTEMS

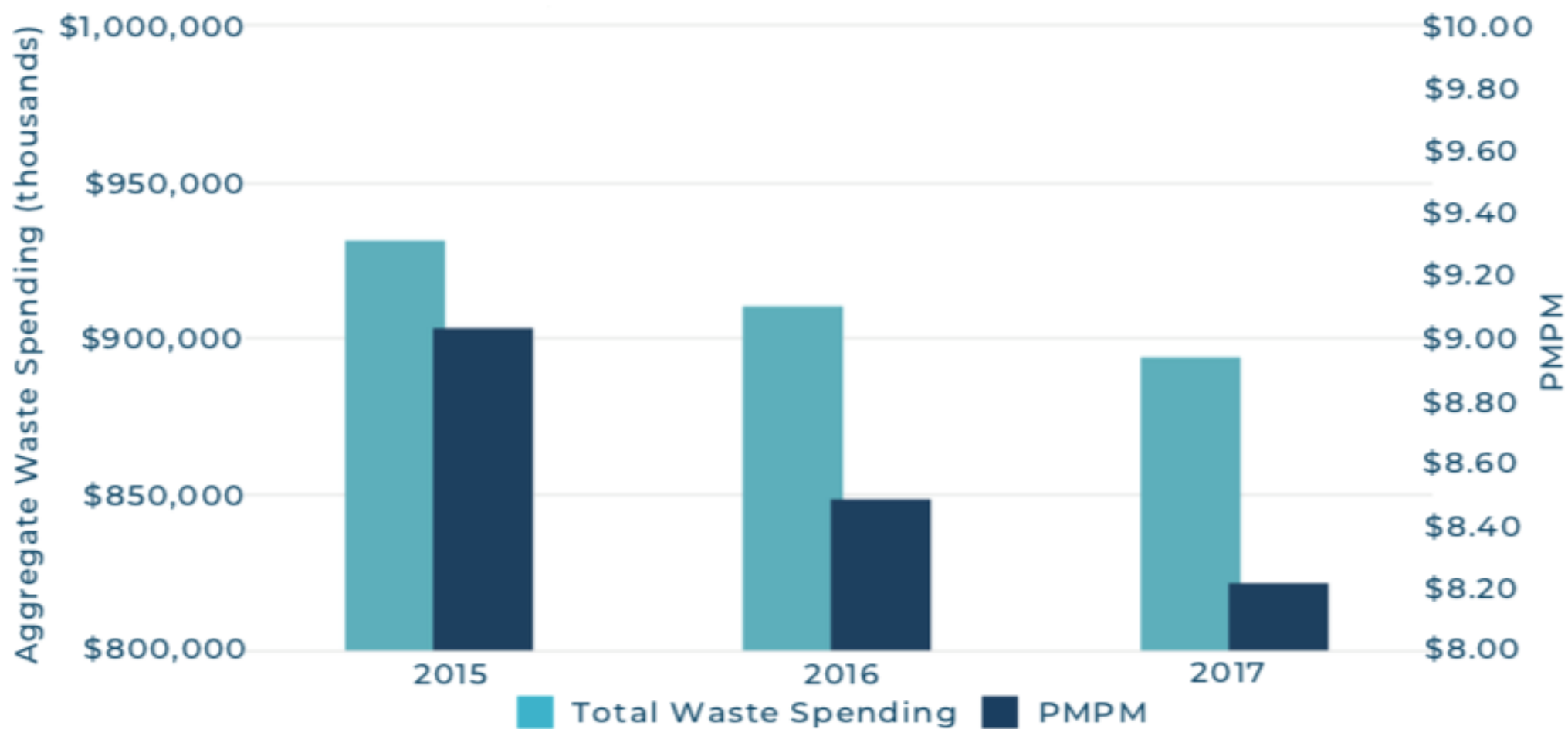
Assessing Low-Value Health Care Services In The Military Health System

“As the MHS and the United States increasingly focus on value-based care, the identification of low-value services accompanied by efforts to reduce such inefficient practices could provide greater quality of care at a lower cost.”

Utilization and Spending on Low-Value Medical Care Across Four States

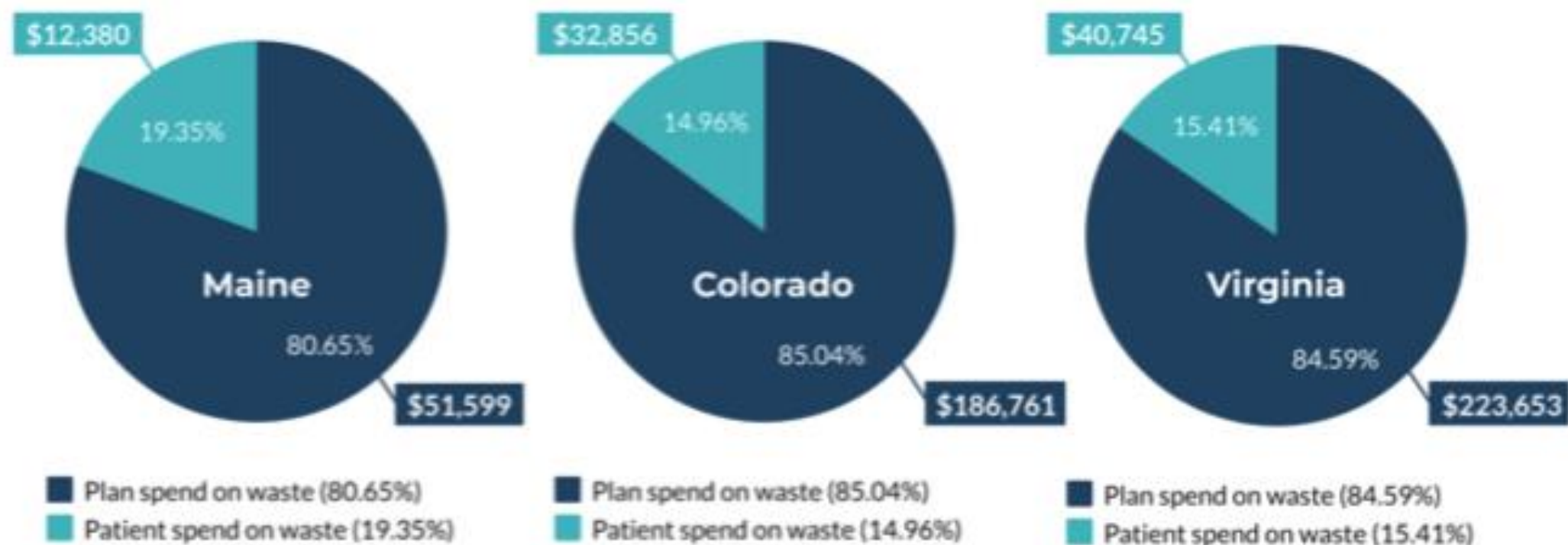


Total Spending on 47 Low-Value Services by Four States in Medicaid and Commercial Plans, 2015-2017



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 Efforts to Reduce Low Value Care: Smarter Care Virginia



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	

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**

HHS 2021 Payment Rule Strongly Endorses V-BID X

6. Promoting Value-Based Insurance Design

Borrowing from work provided by the Center for Value-based Insurance Design at the University of Michigan ¹⁵⁶ (the Center), Table 5 lists high value services and drugs that an issuer may want to consider offering with lower or zero cost sharing. Table 5 also includes a list of low value services that issuers should consider setting at higher consumer cost sharing. High value services are those

Issues for Defense Health Agency in the 'New Normal'

- Costs related to COVID-19 care
 - testing
 - treatment
 - vaccine
- How much volume returns?
- Less funding for everything
 - Increased scrutiny on low value care
- Changes in care delivery patterns
 - While popular, quality and cost impact of telemedicine uncertain

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

- Enhance access to high-value clinical COVID-19 related care and other essential services
- Identify, measure and reduce low-value care to pay for more generous coverage of high-value care
- Implement clinically-driven payment reform, technologies and benefit designs that increase use of high-value services and deter low value care

