Turning the COVID-19 Crisis into Opportunity:
Using Value-Based Insurance Design to Increase Use of High-value Care and Eliminate Low Value Services

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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

- Innovations to prevent and treat disease have led to impressive reductions in morbidity and mortality
- Irrespective of remarkable clinical advances, cutting health care spending is the main focus of reform discussions
- Underutilization of high-value care persists across the entire spectrum of clinical care leading to poor health outcomes
- Our ability to deliver high-quality health care lags behind the rapid pace of scientific innovation

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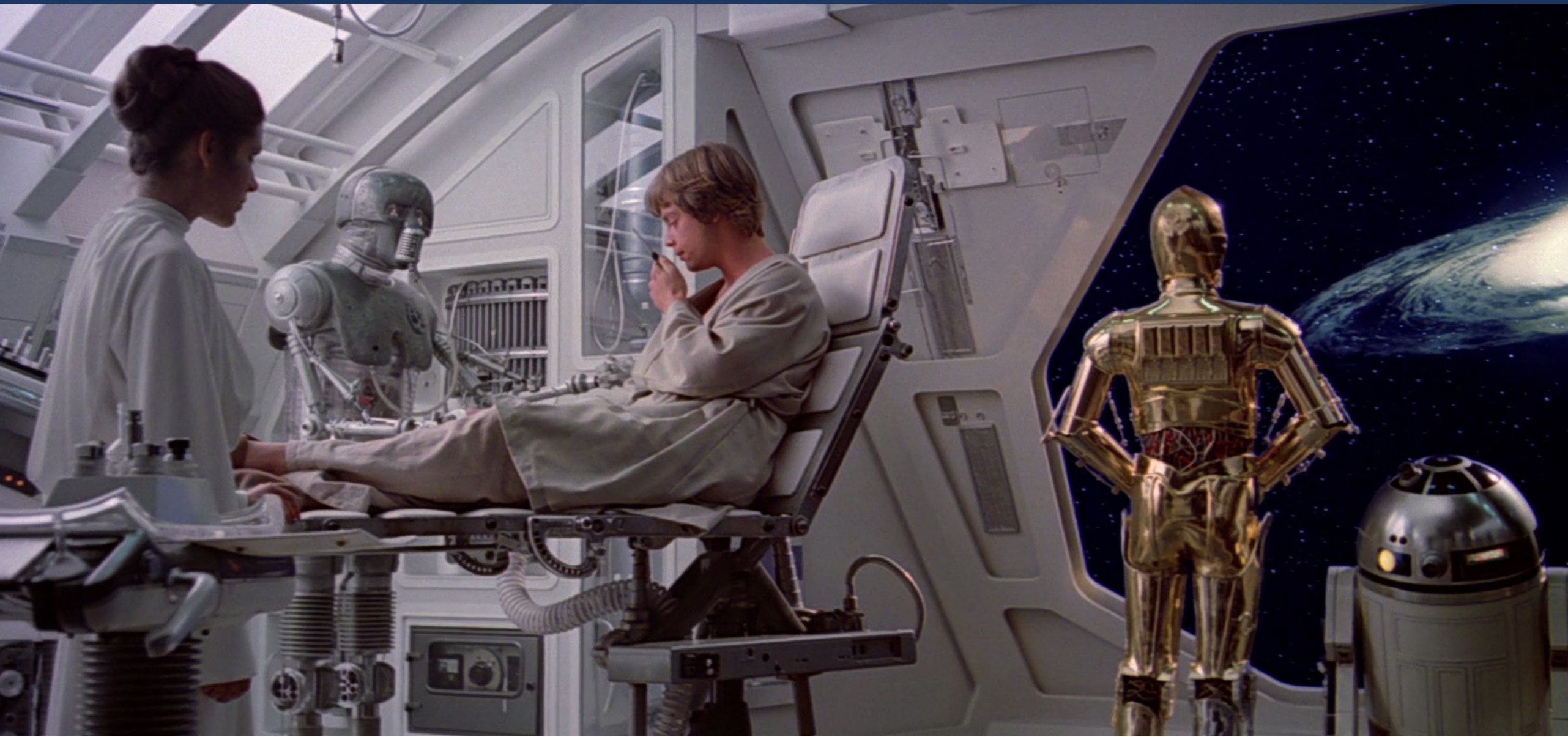
Star Wars Science



Flintstones Delivery

Change the health care cost discussion from “How much” to “How well”

- 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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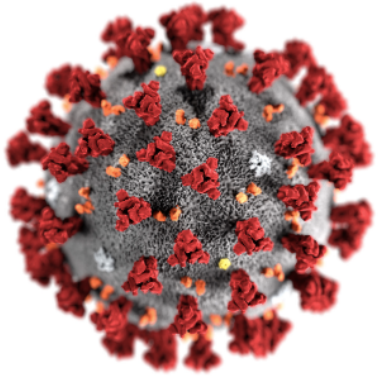
Then Came Coronavirus…



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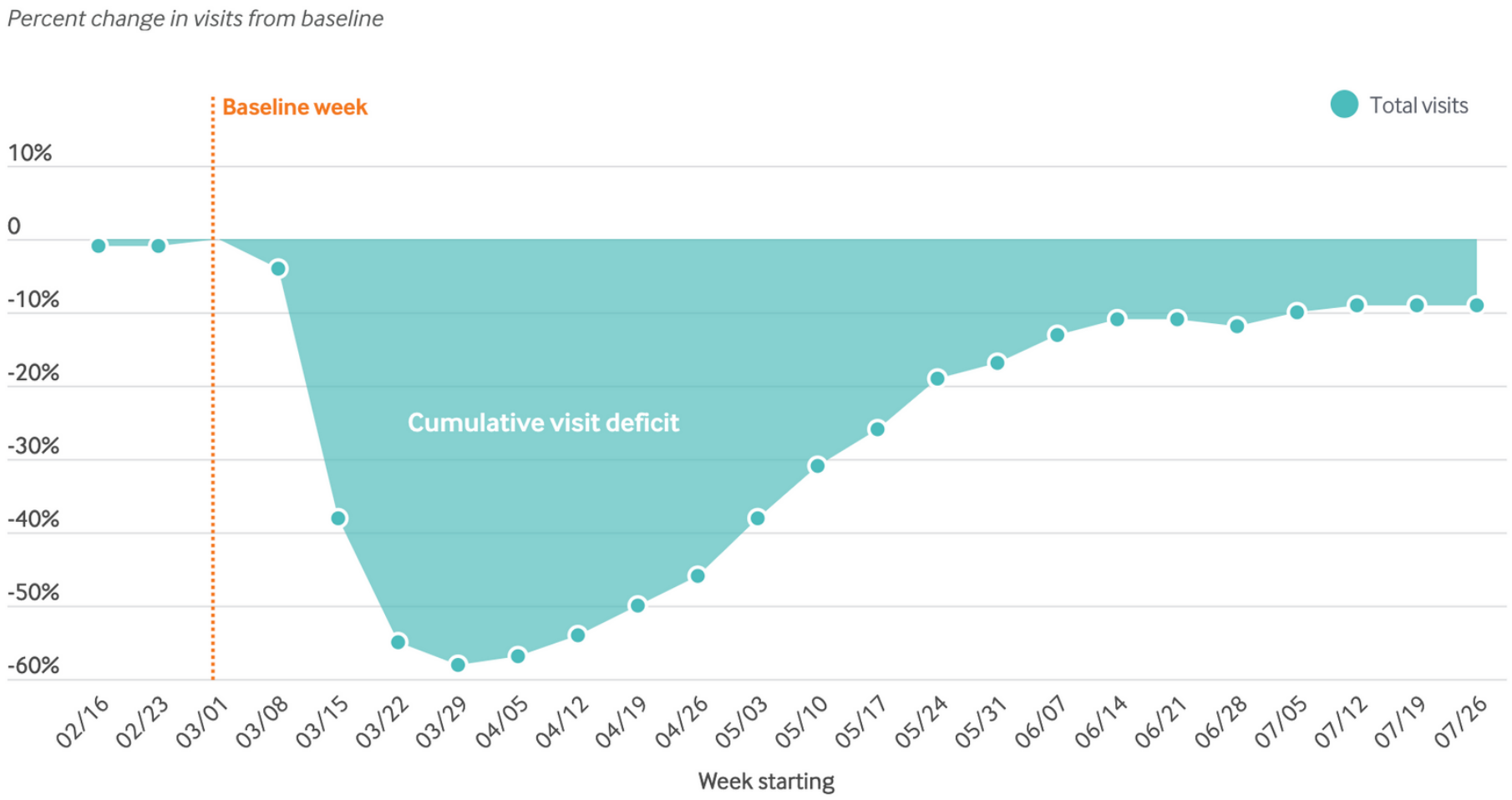
Large Drop in Physician Visits

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.

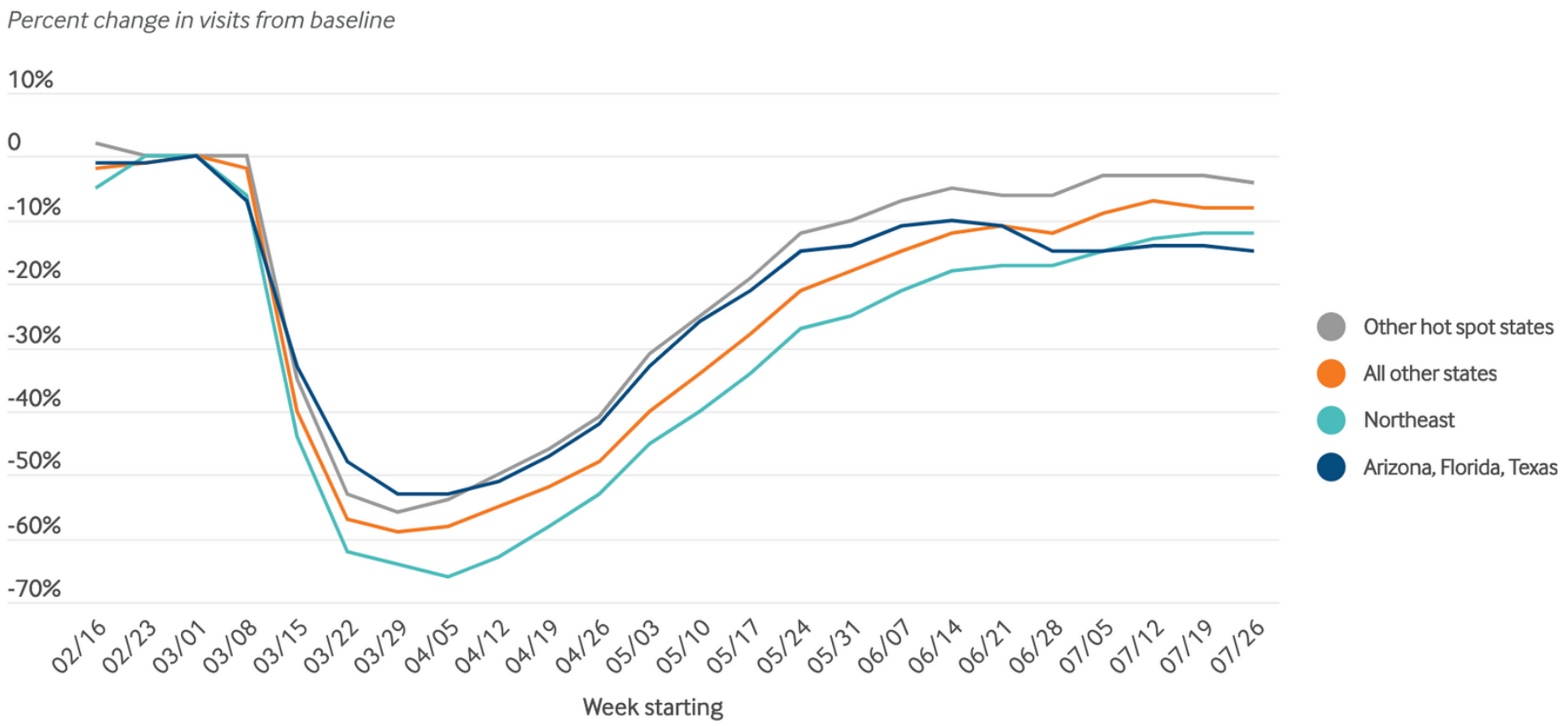


Note: Data are presented as a percentage change in the number of visits in a given week from the baseline week (March 1–7).

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 (Commonwealth Fund, Aug. 2020). https://doi.org/10.26099/yaqe-q550

All Regions are Affected

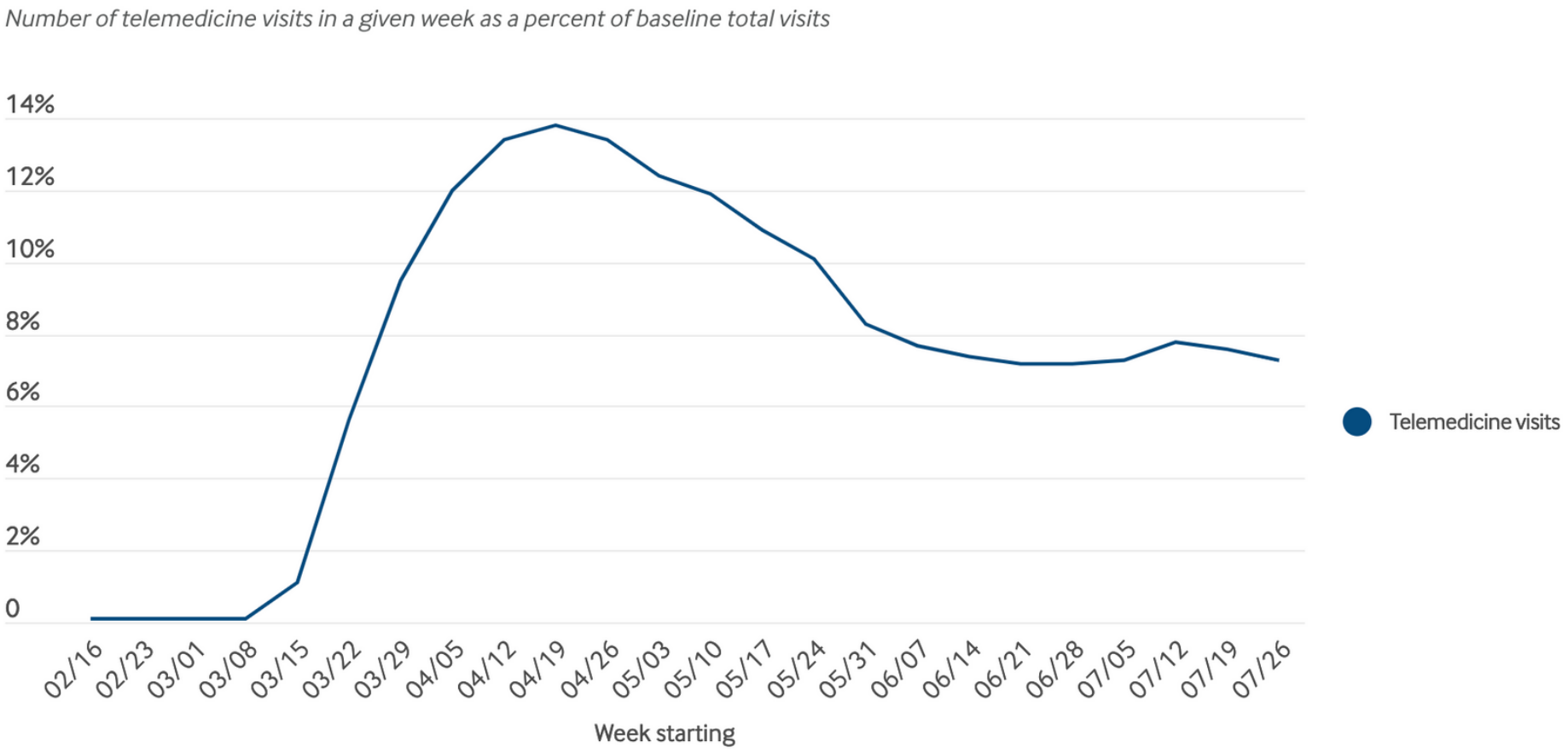
Several states with surging COVID-19 cases during June and July (Arizona, Florida, and Texas) have seen a decline in provider office visits, although it's been a small one compared to early in the pandemic. Visit volumes in other states with surging new cases have held steady. Visit rates in the Northeast continue to lag most of the nation, even with relatively low weekly new case counts.



Data are presented as a percentage change in the number of visits in a given week from the baseline week (March 1–7). Hot spot states were the top 10 states in terms of new cases per capita in the weeks of June 28th and July 4th, according to data from the New York Times. These hot spots were divided into two groups: 1) Arizona, Florida, and Texas, which clearly had a different trajectory of visits, and 2) Alabama, Georgia, Idaho, Louisiana, Nevada, and South Carolina. The Northeast includes Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont.

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 (Commonwealth Fund, Aug. 2020). https://doi.org/10.26099/yaqe-q550

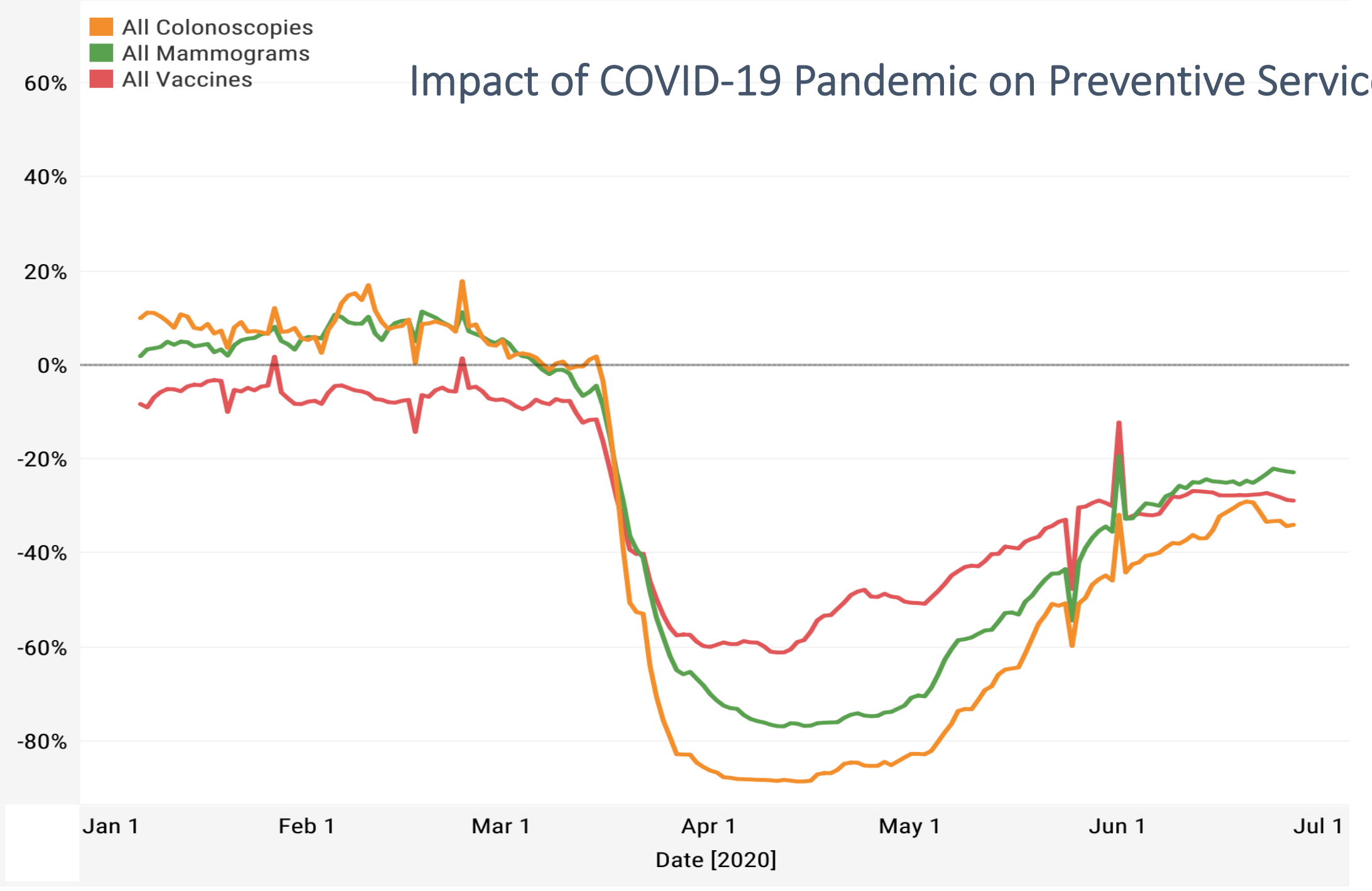
Telehealth Visits Grew Dramatically, but have Since Declined



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 (Commonwealth Fund, Aug. 2020). https://doi.org/10.26099/yaqe-q550

Impact of COVID-19 Pandemic on Preventive Services



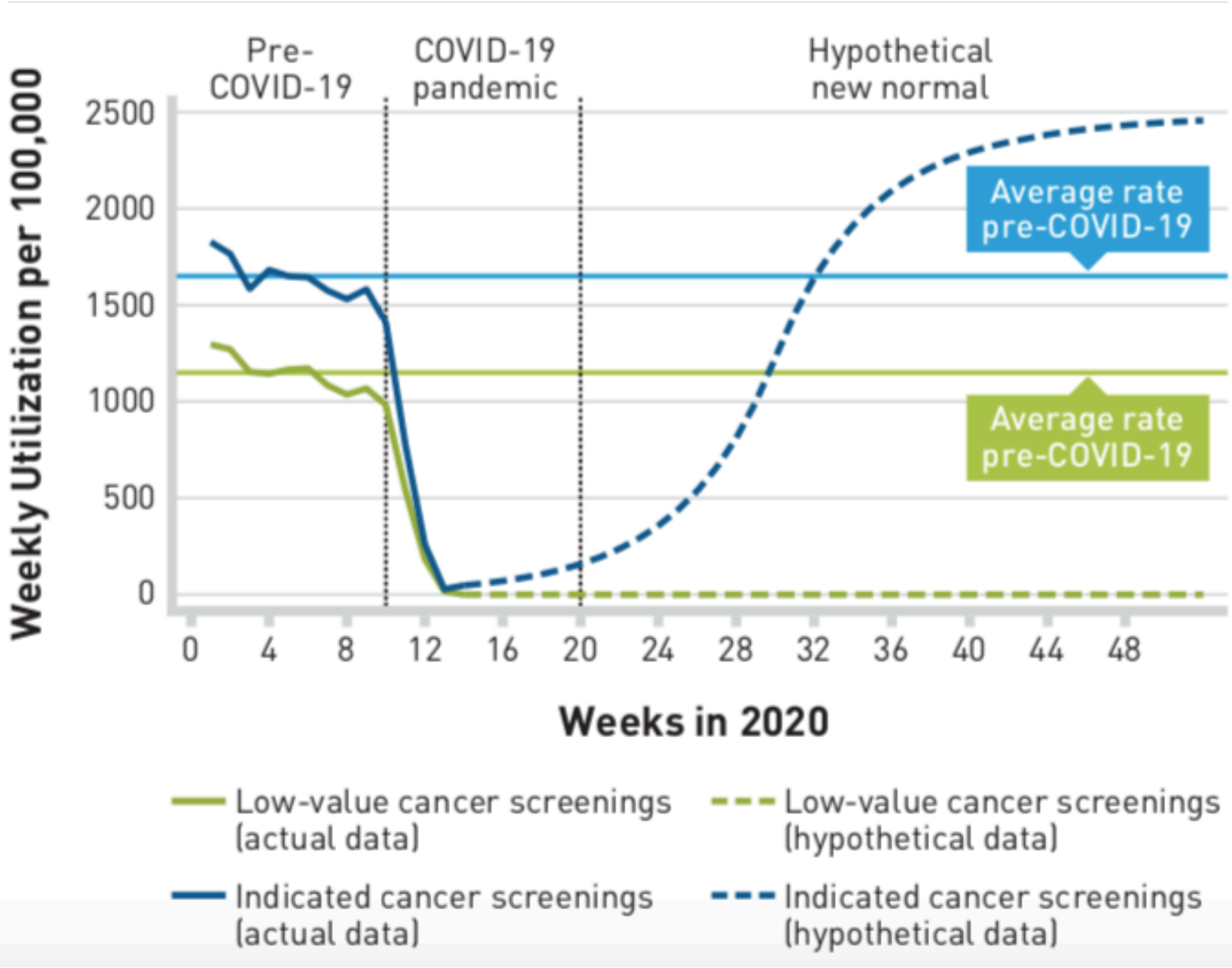
LOW-VALUE CARE

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

The Onion
@TheOnion

Patient Rushed Into Unnecessary Surgery To Save Cash-Strapped Hospital bit.ly/314r3zN

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 telemedicine and electronic health records (EHRs) to make it easier to order high-value care and discourage the use of low-value

Turning Crisis into Opportunity: Leverage the Widespread Adoption of Telemedicine

Health Affairs

TOPICS JOURNAL BLOG

Establishing A Value-Based 'New Normal' For Telehealth

Christina Cutter, Nicholas L. Berlin, A. Mark Fendrick

OCTOBER 8, 2020

10.1377/hblog20201006.638022

https://www.healthaffairs.org/do/10.1377/hblog20201006.638022/full/

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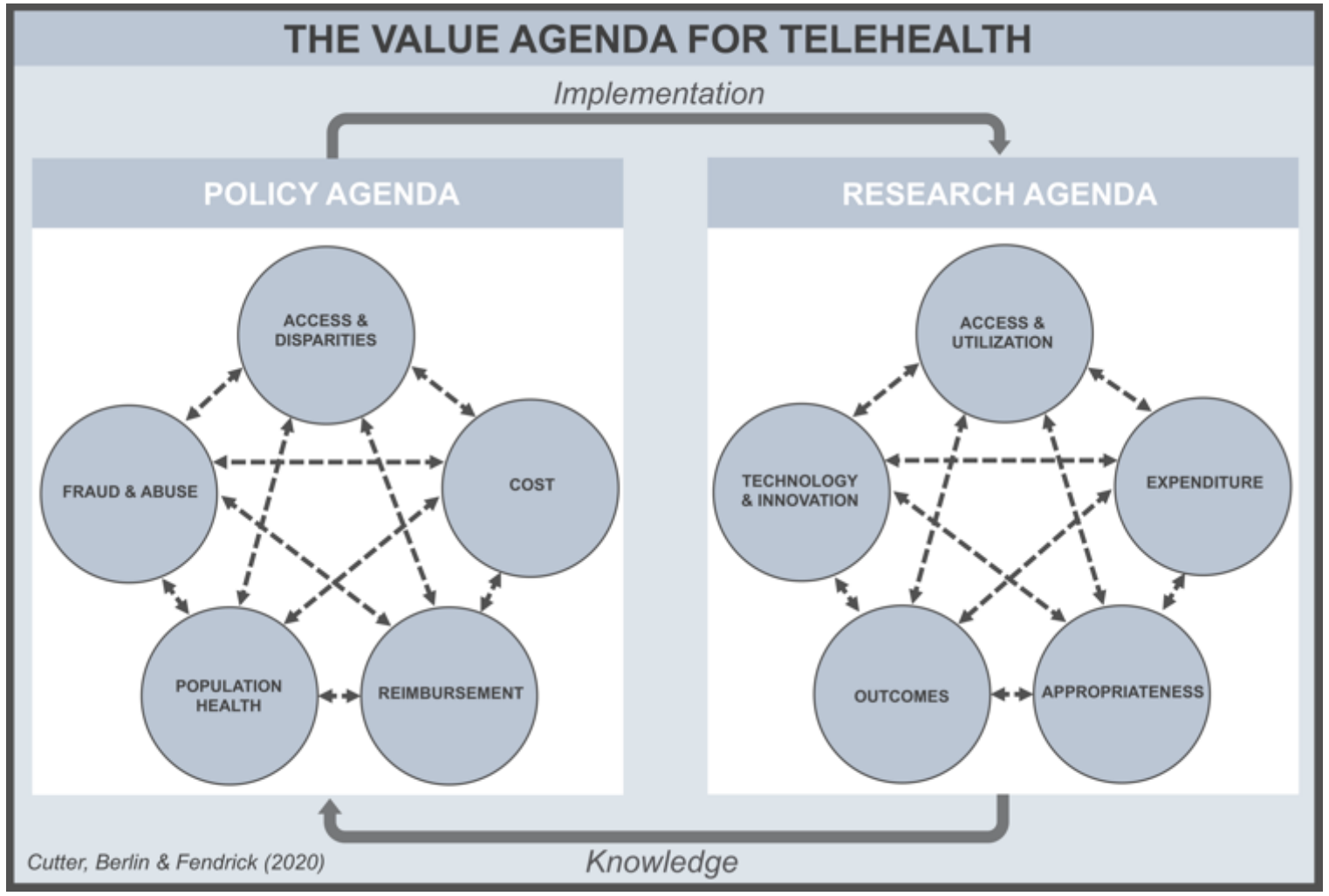
THE VALUE AGENDA FOR TELEHEALTH



I. LEARNING SYSTEM

II. POLICY AGENDA

III. RESEARCH AGENDA

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 telemedicine and electronic health records (EHRs) to make it easier to order high-value care and discourage the use of low-value
- 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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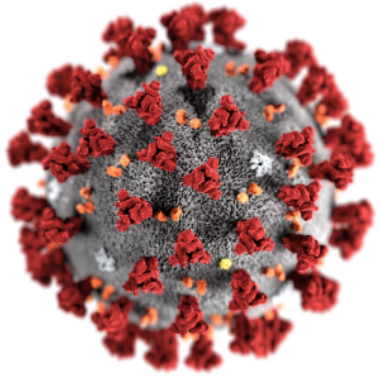
A Second Health Care Pandemic will Follow COVID-19
We Need to Plan Accordingly



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

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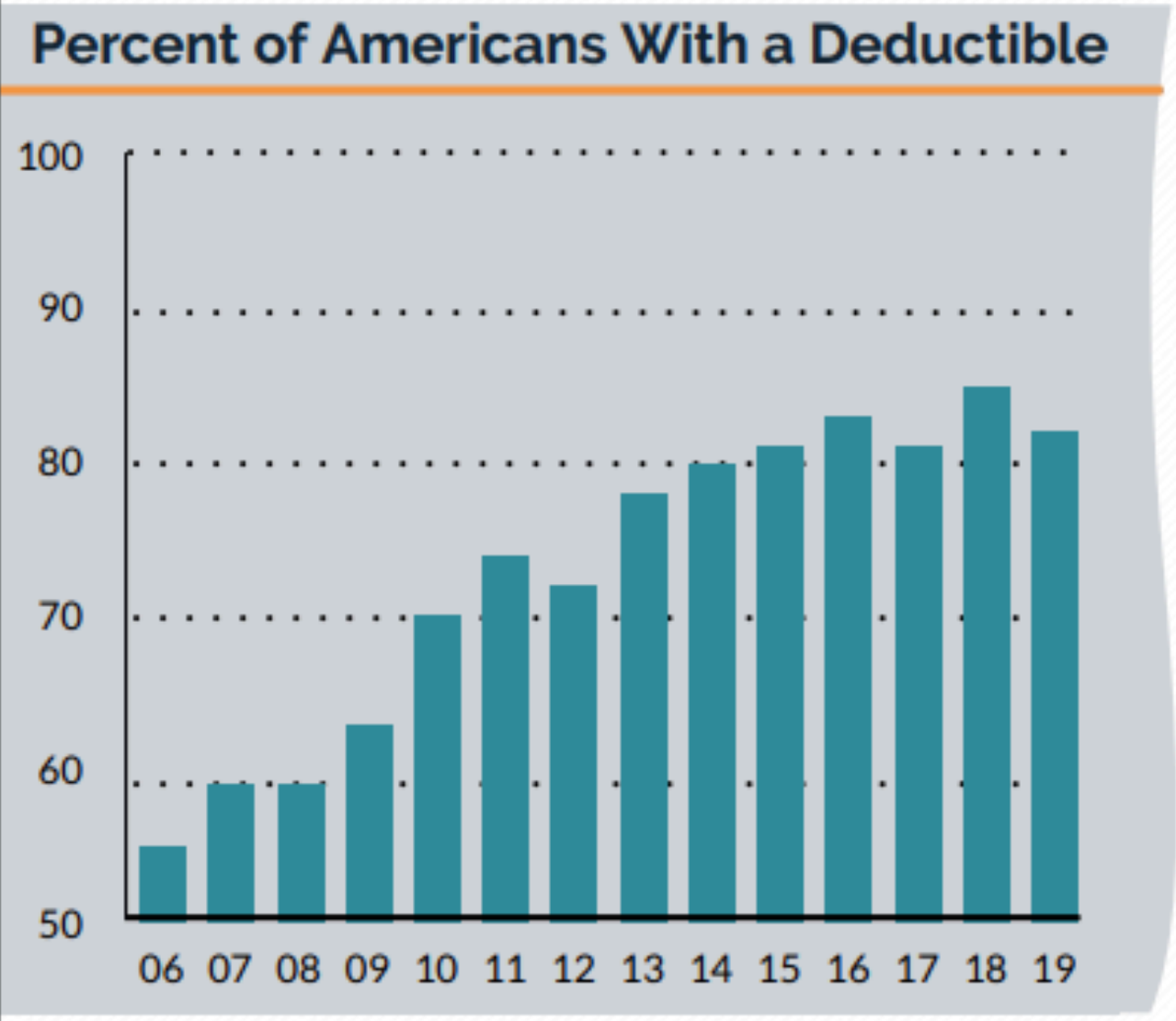
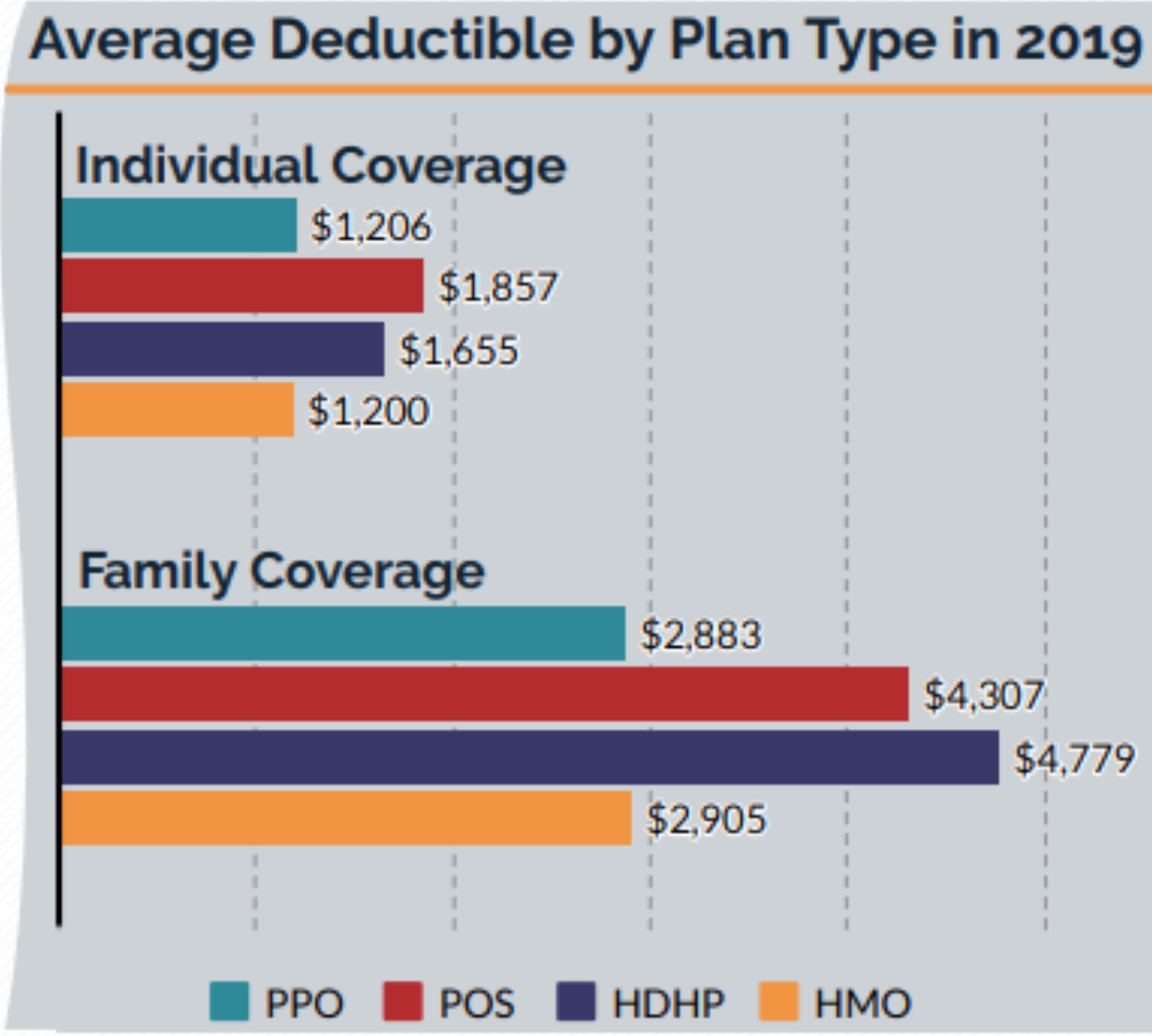
Health Plan Deductibles have grown more than ten times faster than inflation over the last decade





Concerns Regarding Coronavirus Out of Pocket Costs:
Americans Cannot Afford a COVID-19 Deductible

- About Half of the Public Says They Have Skipped or Postponed Medical Care because of the Coronovirus 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

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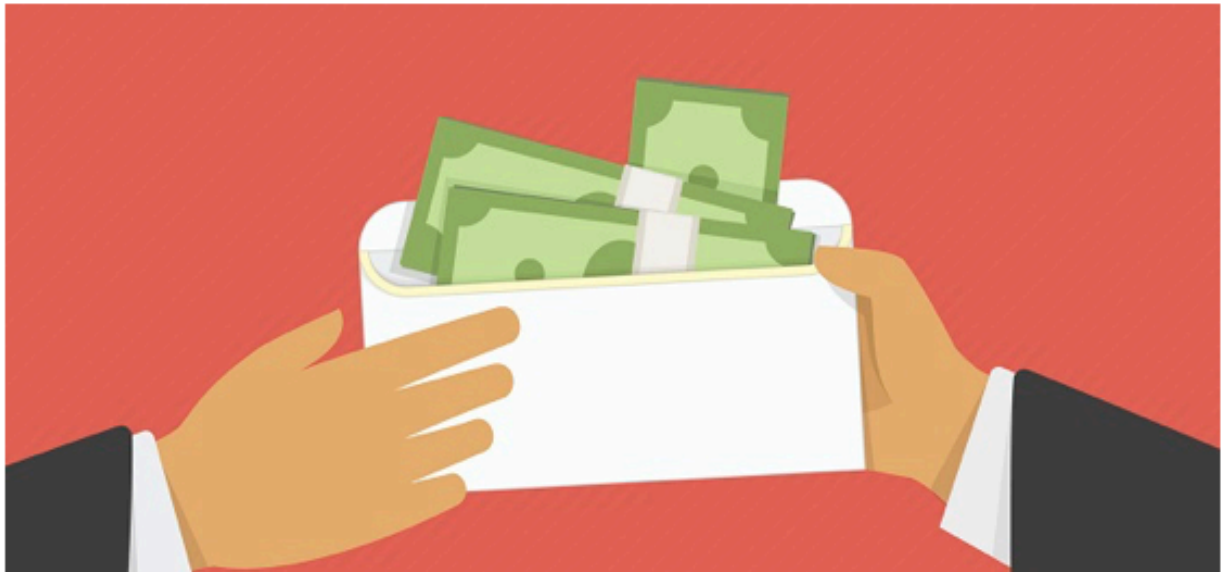
Americans Do Not Care About Health Care Costs; They Care About What It Costs Them

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.



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)

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“Blunt” Cost-Sharing Worsens 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]

- Cost-sharing worsens 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.

Alternative to "Blunt" Consumer Cost-Sharing: A Clinically Driven Approach

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

TRADE OFFS

HEALTH CARE.
POLICY.
PEOPLE.

- Listen to TRADEOFFS podcast to learn how two friends—a doctor and an economist—spent more than 20 years trying to redesign insurance around one simple but elusive goal: make the good stuff more accessible than the bad stuff.

https://tradeoffs.org/2019/12/11/season-1-ep-5/

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

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

USPSTF: Preventive Services A or B Rates Services Provided without Cost-Sharing, 2019-2020

- HIV screening for adolescents, pregnant women, and adults 15 to 65 years
- HIV pre-exposure prophylaxis
- Hepatitis B and bacteriuria screening for pregnant women
- BRCA risk assessment, and genetic counseling/testing for those with a family history
- Breast cancer preventive medication for women at increased risk
- Abdominal aortic aneurysm screening for men aged 65-75 who have ever smoked
- Hepatitis C virus infection screening for adults aged 18 to 79 years

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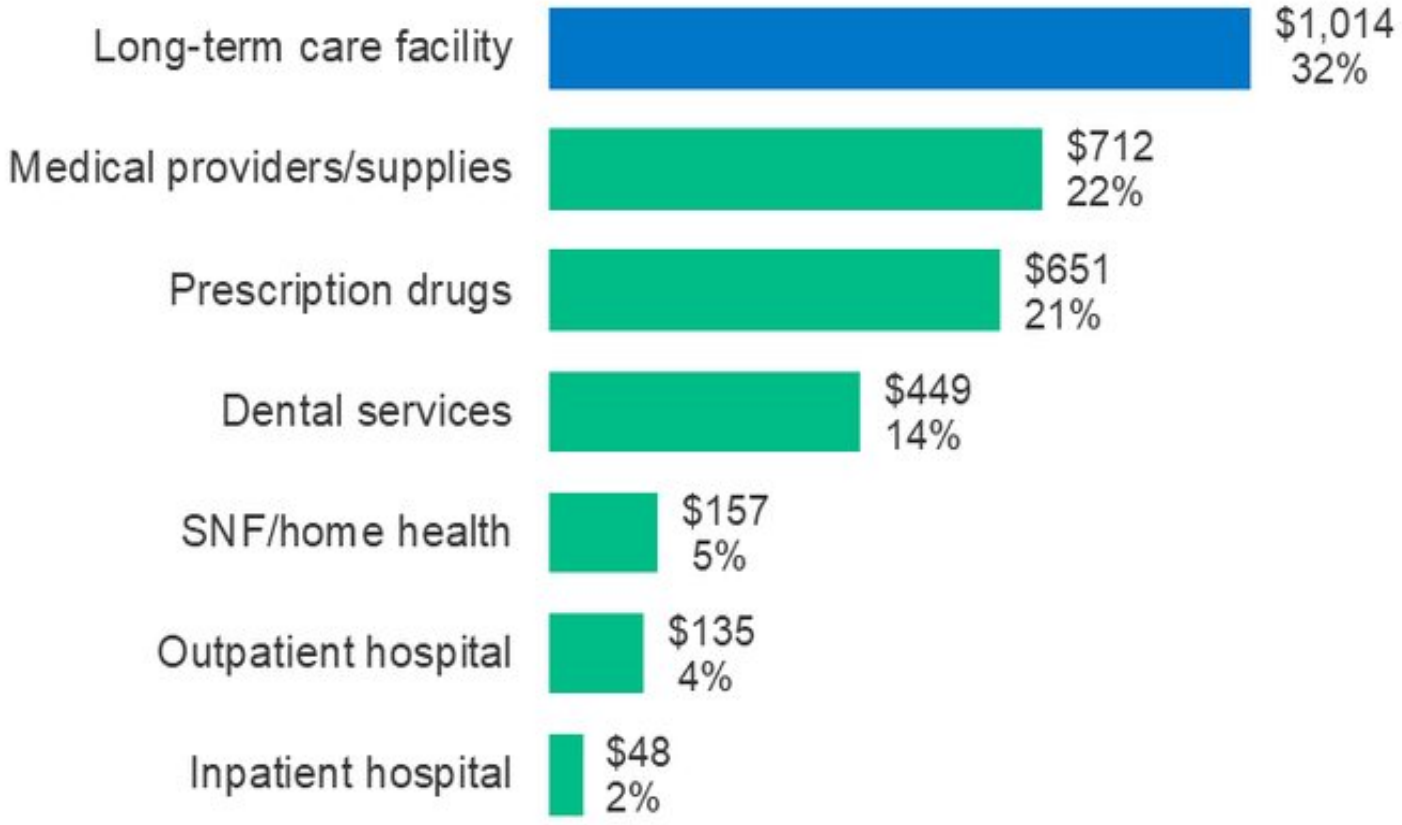
Putting Innovation into Action: Translating Research into Policy

Average annual Medicare out-of-pocket spending exceeds $5,000

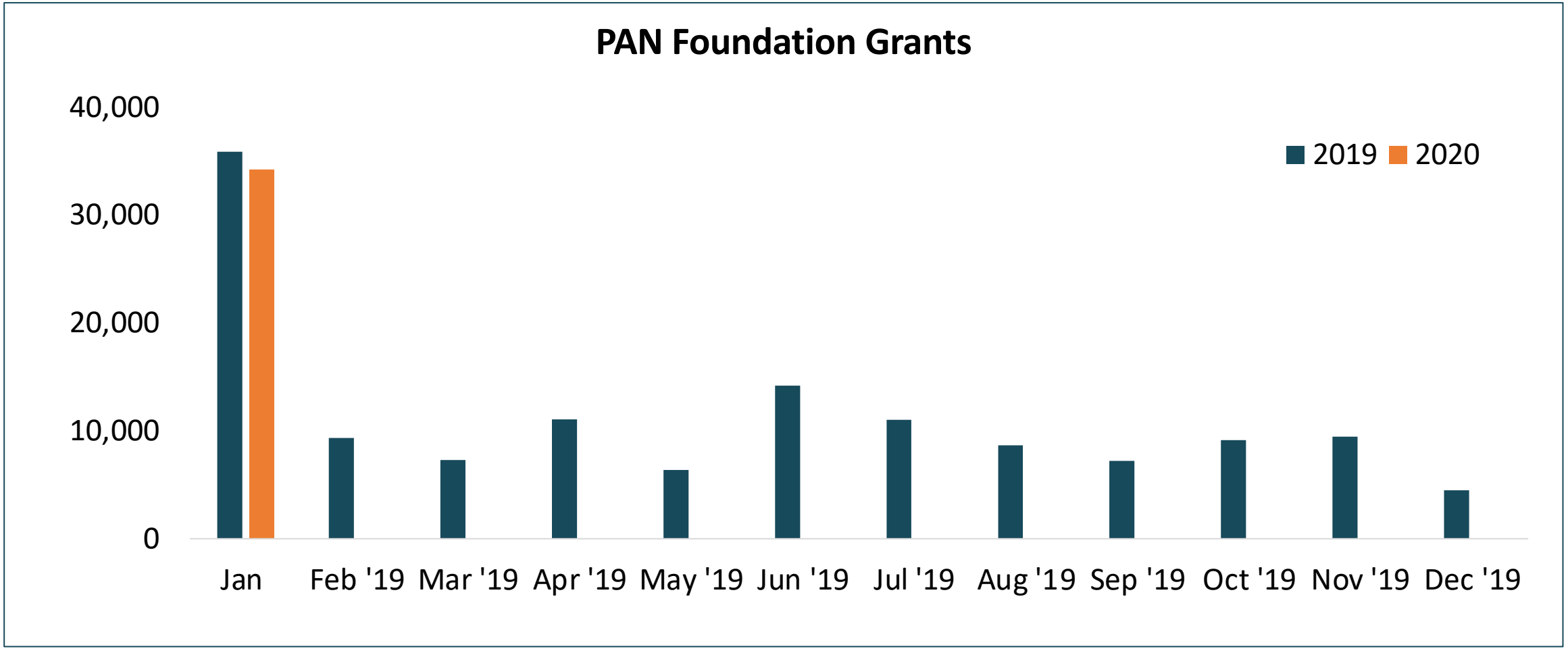
Distribution of Spending on Services by Type of Service:



NOTES: 2016 data. SNF is skilled nursing facility. Analysis excludes beneficiaries with Part A only or Part B only for most of the year or Medicare as a Secondary Payer, and beneficiaries in Medicare Advantage.
SOURCE: KFF analysis of Centers for Medicare & Medicaid Services 2016 Medicare Current Beneficiary Survey.

KFF
HENRY J KAISER FAMILY FOUNDATION

The 'January Effect' for Medicare Part D Beneficiaries



Klein and Fendrick, *Morning Consult,* 2020

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Implementing V-BID into Medicare: Legislative Barriers

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"

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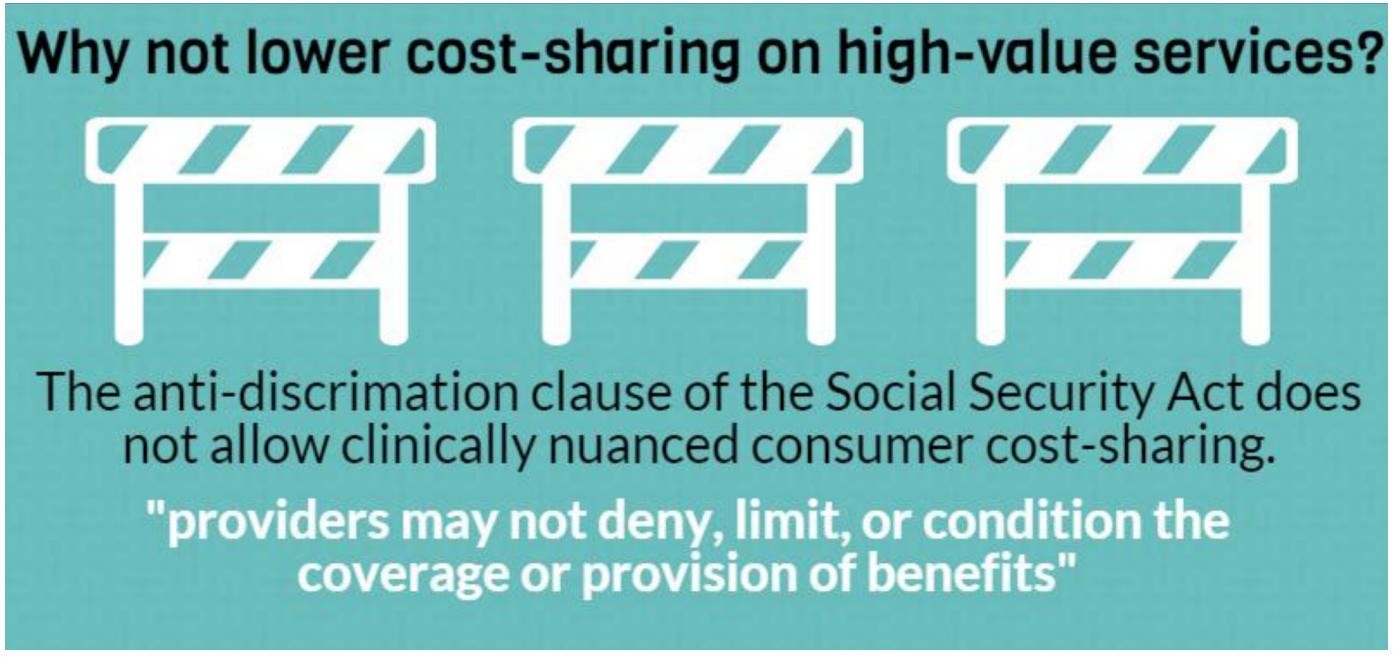
“Implementing V-BID in Medicare will take an act of Congress”



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H.R.2570/S.1396: Bipartisan "Strengthening Medicare Advantage Through Innovation and Transparency"

HR 2570: Strengthening Medicare Advantage Through Innovation and

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.

- Directs HHS to establish a V-BID demonstration for MA beneficiaries with chronic conditions
- Passed US House with strong bipartisan support in June 2015

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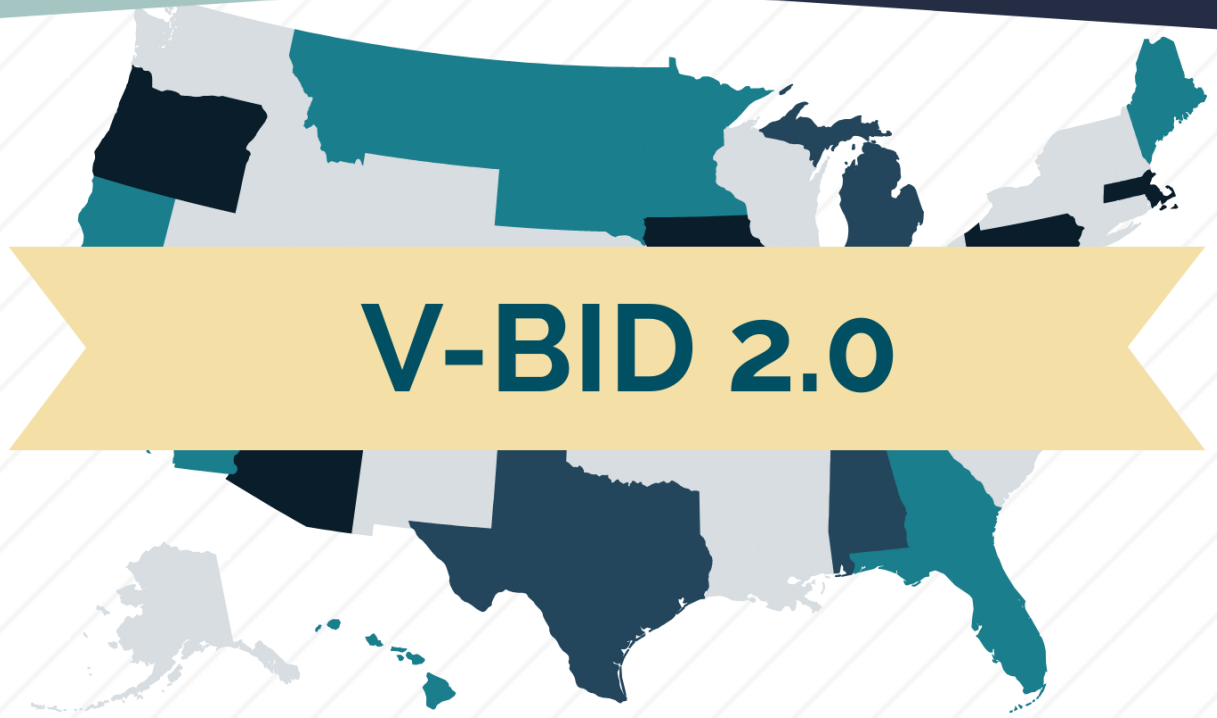
CMS Announces Medicare Advantage Value-Based Insurance Design Model Test

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

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
- enrollees participating 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
Improve quality, decrease costs

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: 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

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HSA-HDHP Reform

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PREVENTIVE CARE COVERED

Dollar one

CHRONIC DISEASE CARE

NOT covered until deductible is met

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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

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.

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HEALTH AFFAIRS BLOG

RELATED TOPICS:
COSTS AND SPENDING | HIGH-DEDUCTIBLE HEALTH PLANS | HEALTH INSURANCE BENEFIT DESIGN | DEDUCTIBLES | COST SHARING | VALUE | PHARMACEUTICALS

A Scalpel Instead Of A Sledgehammer: The Potential Of Value-Based Deductible Exemptions In High-Deductible Health Plans

Douglas Barthold, Anirban Basu

JUNE 18, 2020

10.1377/hblog20200615.238552

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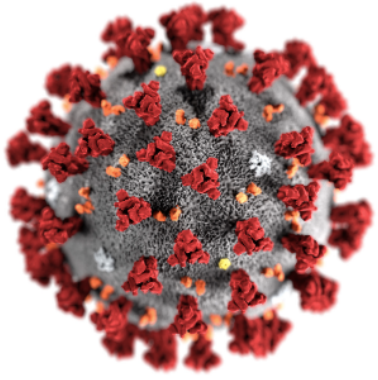
V-BID Response to COVID-19



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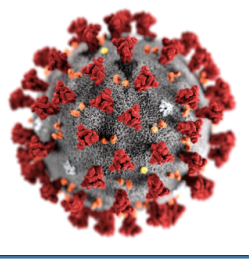
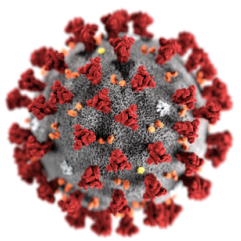
V-BID and the COVID-19 Response



- 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

V-BID and the COVID-19 Response



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

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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

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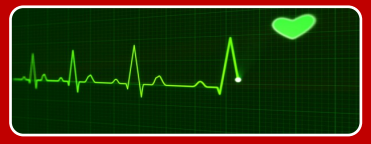
Multi-Stakeholder Task Force Identifies 5 Commonly Overused Services Ready for Action



1. Diagnostic Testing and Imaging Prior to Low Risk Surgery

2. Population Based Vitamin D Screening

3. PSA Screening in Men 70+

4. Imaging in First 6 Weeks of Uncomplicated 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:
Better Coverage, Same Premiums and Deductibles

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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	

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

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CMS promotes value-based insurance design in final payment notice for 2021

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

https://www.govinfo.gov/content/pkg/FR-2020-05-14/pdf/2020-10045.pdf

V-BID X: Enhancing Access and Affordability to Essential Clinical Services in Addition to COVID-19 Related Care

Table 5—High and Low Value Services and Drug Classes

High Value Services with Zero Cost Sharing
Blood pressure monitors (hypertension)
Cardiac rehabilitation
Glucometers and testing strips (diabetes)
Hemoglobin a1c testing (diabetes)
INR testing (hypercoagulability)
LDL testing (hyperlipidemia)
Peak flow meters (asthma)
Pulmonary rehabilitation

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Enhancing Access and Affordability to Essential Clinical Services during COVID-19 and Beyond

"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."

Enhancing Access and Affordability to Essential Clinical Services

Important Factors Influencing the Post-COVID 'New Normal'

- Costs of COVID-19 care and coronavirus vaccine
- Changes in care delivery patterns
  - Utilization, quality, and cost impact of telemedicine remains uncertain
- How much volume returns?
  - Shift to evidence based services
  - Increased scrutiny on low value care

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Enhancing Access and Affordability to Essential Clinical Services

The role of V-BID in the 'New Normal'

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

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"If we don't succeed then we will fail."

Dan Quayle

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