SCHOOL OF PUBLIC HEALTH
CENTER FOR VALUE-BASED INSURANCE DESIGN
UNIVERSITY OF MICHIGAN

Turning the COVID-19 Crisis into Opportunity: Aligning Patient and Provider Incentives to Increase Use of High Value Care and Eliminate Low Value Services

A. Mark Fendrick, MD
University of Michigan Center for Value-Based Insurance Design

www.vbidcenter.org

@um_vbid

Kansas Business Group on Health

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Employer Strategies to Increase Use of High-value Care and Eliminate Low Value Services: Outline

- Motivation for Value Based Payment and Insurance Design
- Putting Innovation into Action
- Reducing Low Value Care to Create ‘Headroom’ for more High Value Care
- Aligning Clinicians and Patient Incentives

Balancing Health Care Costs and Patient Centered Outcomes is Complicated
Solutions must protect patients, reward clinicians 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

Moving from the Stone Age to the Space Age: 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
- 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
- Employers were leading the transition from volume to value

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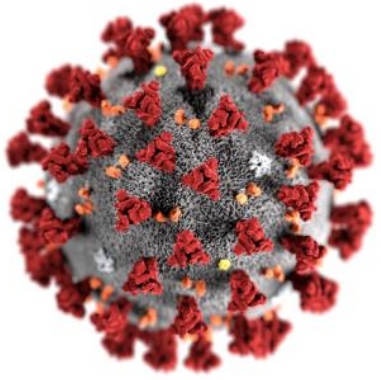
Then Came Coronavirus…



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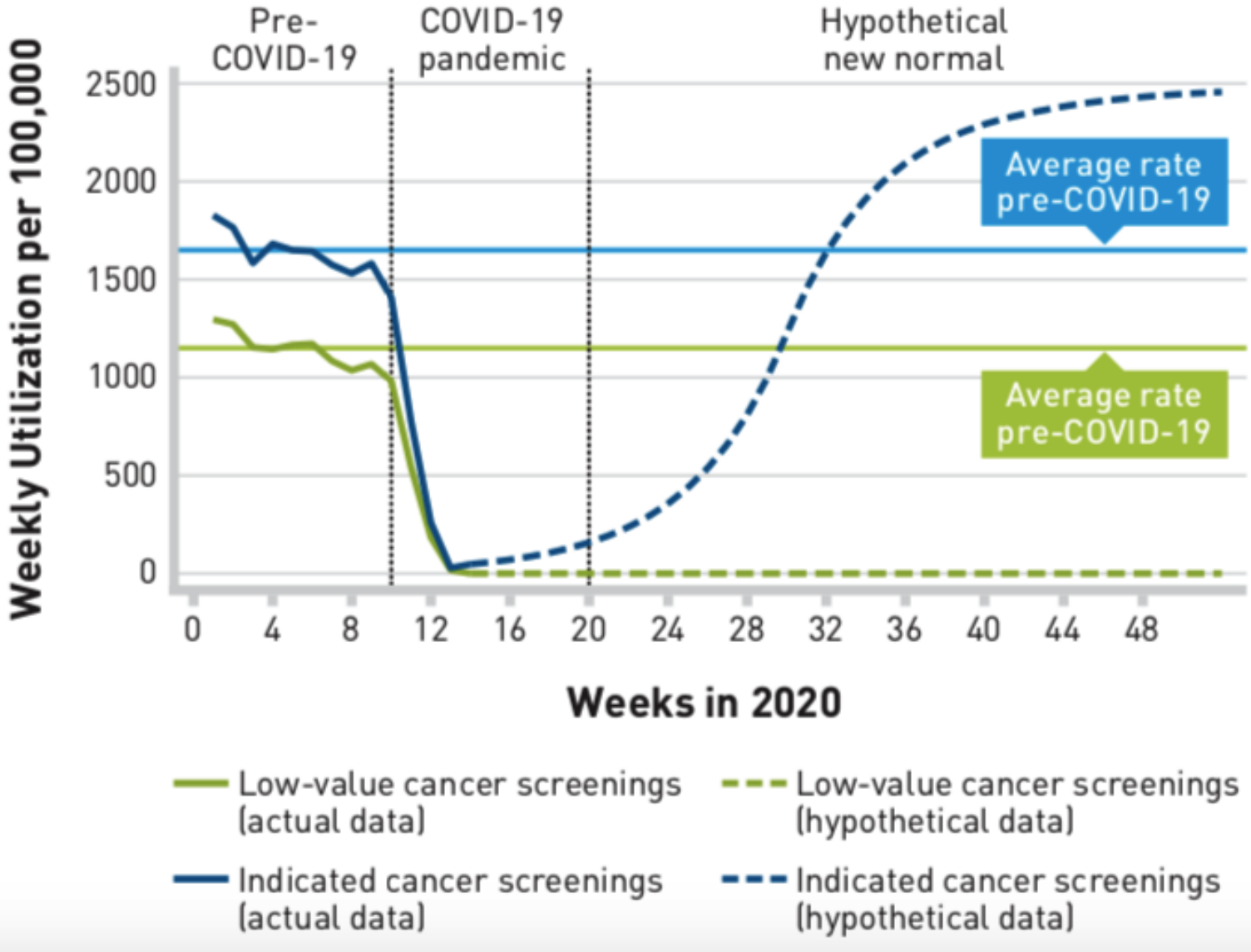
Crisis Into Opportunity: Can COVID-19 Help Set a Path to Improved Health Care Efficiency?



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

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

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

- Build on existing alternative payment models that base clinician reimbursement on patient-centered outcomes
  - increase reimbursement for high-value services
  - reduce or cease payment for known low-value care
- Technology: Leverage the widespread adoption of telemedicine, electronic health records (EHRs), wearables, and other technologies to enhance access to high-value care and discourage low-value

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

- Build on existing alternative payment models that base clinician reimbursement on patient-centered outcomes
  - increase reimbursement for high-value services
  - reduce or cease payment for known low-value care
- Leverage the widespread adoption of telemedicine, electronic health records (EHRs), and other technologies to enhance access to high-value care and discourage low-value
- Value-Based Insurance Design (V-BID): Set patient cost sharing with the value of the underlying services
  - reduce out of pocket cost on high value services
  - increase patient cost on low value care

Value-Based Solutions to Increase High-value Care and Reduce Low Value Services:

Implement “clinically nuanced” approaches that encourage and align clinicians and consumers to use more high value services, but discourage the use of low value ones

Restructuring Clinician Incentives to Encourage Value

- Primary Care
- High Performing Networks
- Accountable Care Organizations
- Bundled Payments
- Reference Pricing
- Global Budgets/Capitation

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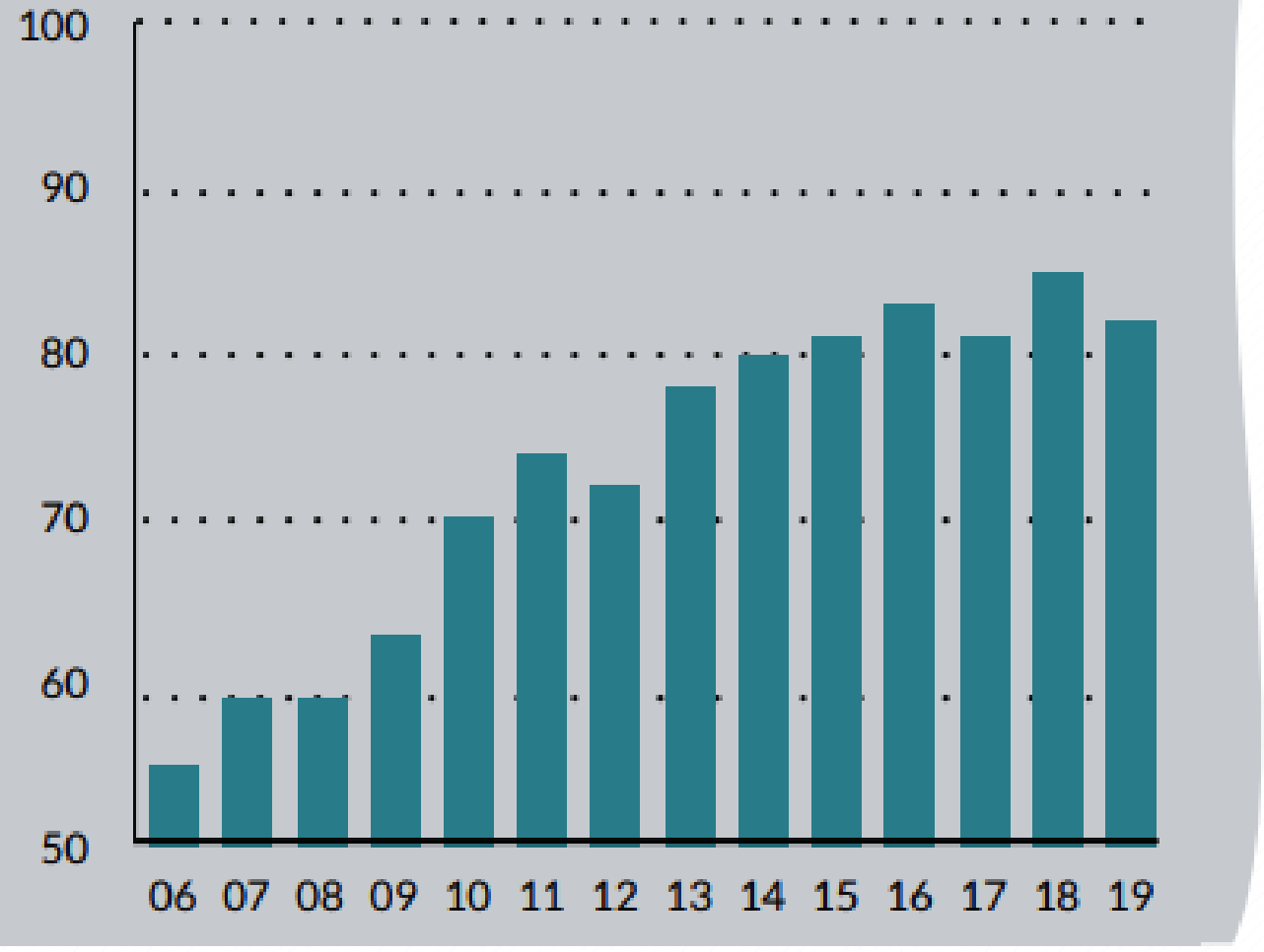
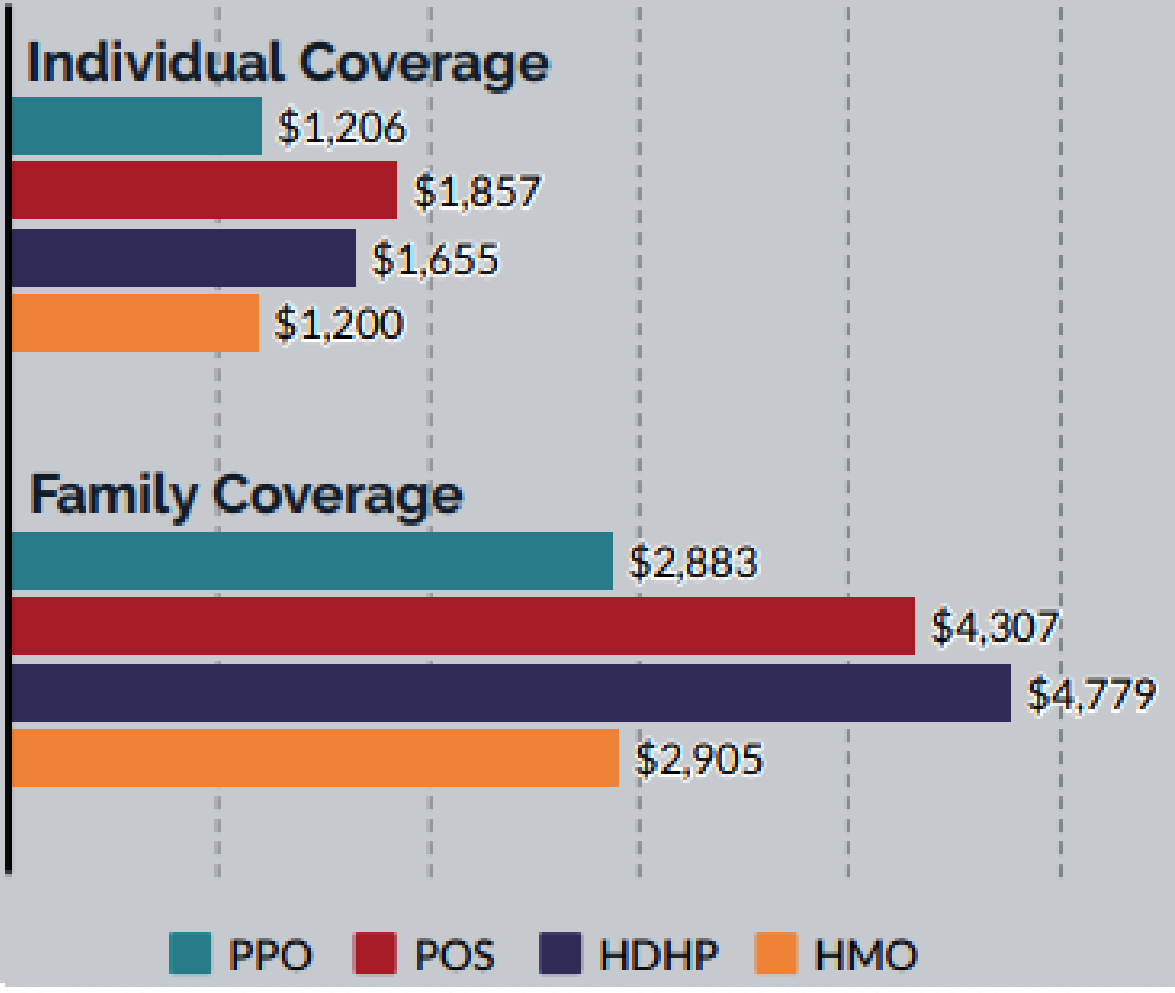
Health Plan Deductibles Deter use of High and Low Value Services

Percent of Americans With a Deductible



Average Deductible by Plan Type in 2019



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)

Concerns Regarding Out of Pocket Costs: COVID-19 made a bad problem worse

- About 50% of people have skipped or postponed care because of the Coronavirus pandemic
- 68% of US 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 unexpected expense

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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.

Restructuring Consumer Incentives to Encourage Value: 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
- Rare Bipartisan Political and Broad Multi-Stakeholder Support
- Successfully implemented by hundreds of public and private US health care payers

The Upshot

Health Plans That Nudge Patients to Do the Right Thing

Austin Frakt
THE NEW HEALTH CARE JULY 10, 2017

RELATED COVERAGE

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

COVID-19 Testing and Vaccines Provided without Cost-sharing

Putting Innovation into Action: Translating Research into Policy

Medicare

COVID-19 impacted the health and financial decisions of many seniors on Medicare

A majority of seniors on Medicare say COVID-19 impacted their healthcare decisions in the following ways:

58%

Avoided or delayed seeing their health care provider

56%

Delayed starting or did not start a treatment for a chronic condition

54%

Prioritized taking a prescription drug for one condition over another

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

High Deductible Health Plan Reform

PREVENTIVE CARE COVERED
Dollar one

CHRONIC DISEASE CARE
NOT covered until deductible is met

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U.S. DEPARTMENT OF THE TREASURY

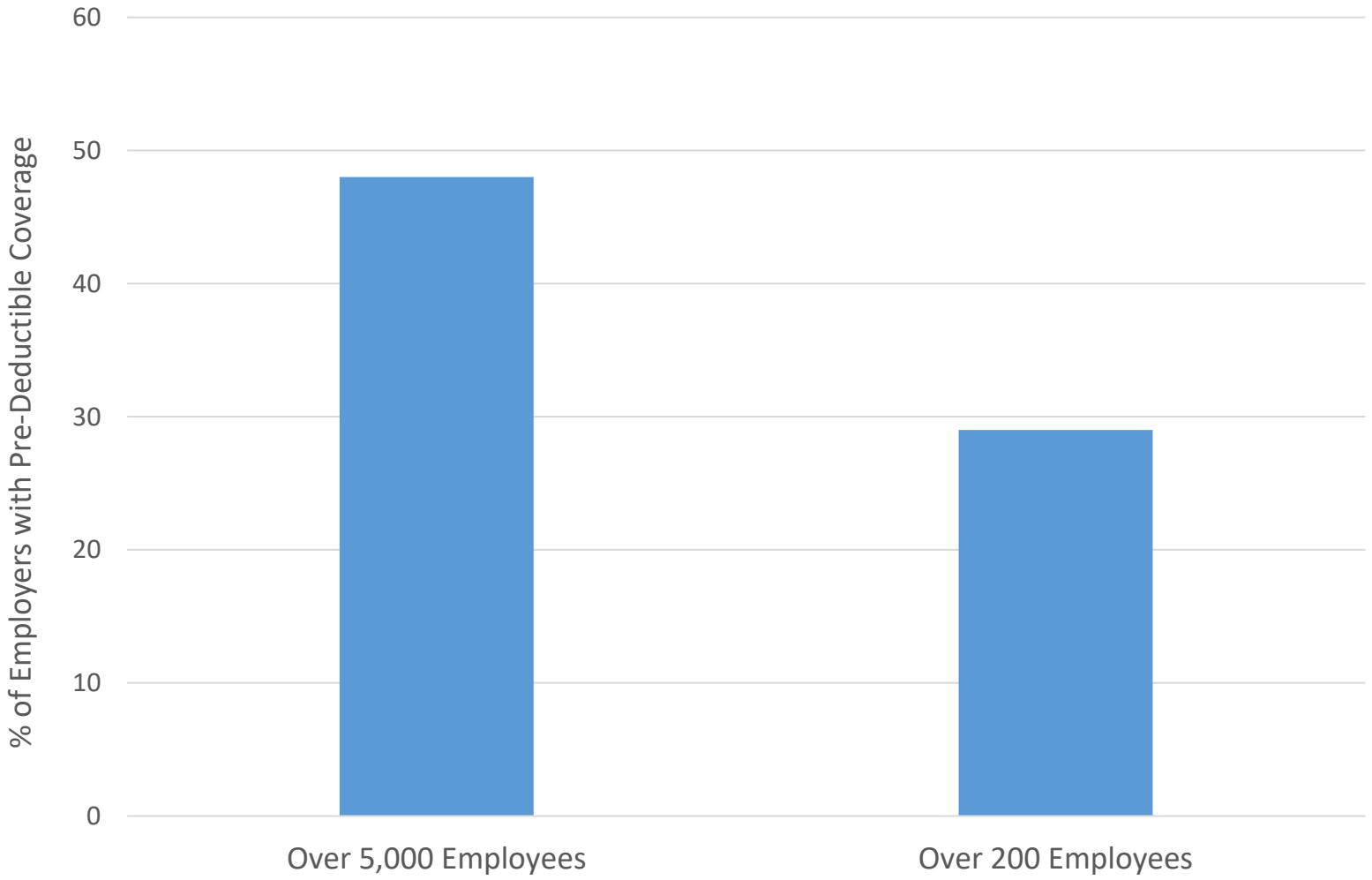
PRESS RELEASES

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

Significant Uptake of IRS Rule Expanding Pre-Deductible Coverage of Chronic Disease Services



Source: Kaiser Family Foundation 2020 Employer Health Benefits Survey. Accessed at: http://files.kff.org/attachment/Report-Employer-Health-Benefits-2020-Annual-Survey.pdf

Chronic Disease Management Act of 2021

117TH CONGRESS
1ST SESSION

S. _____

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.

Paying for More Generous Coverage of High 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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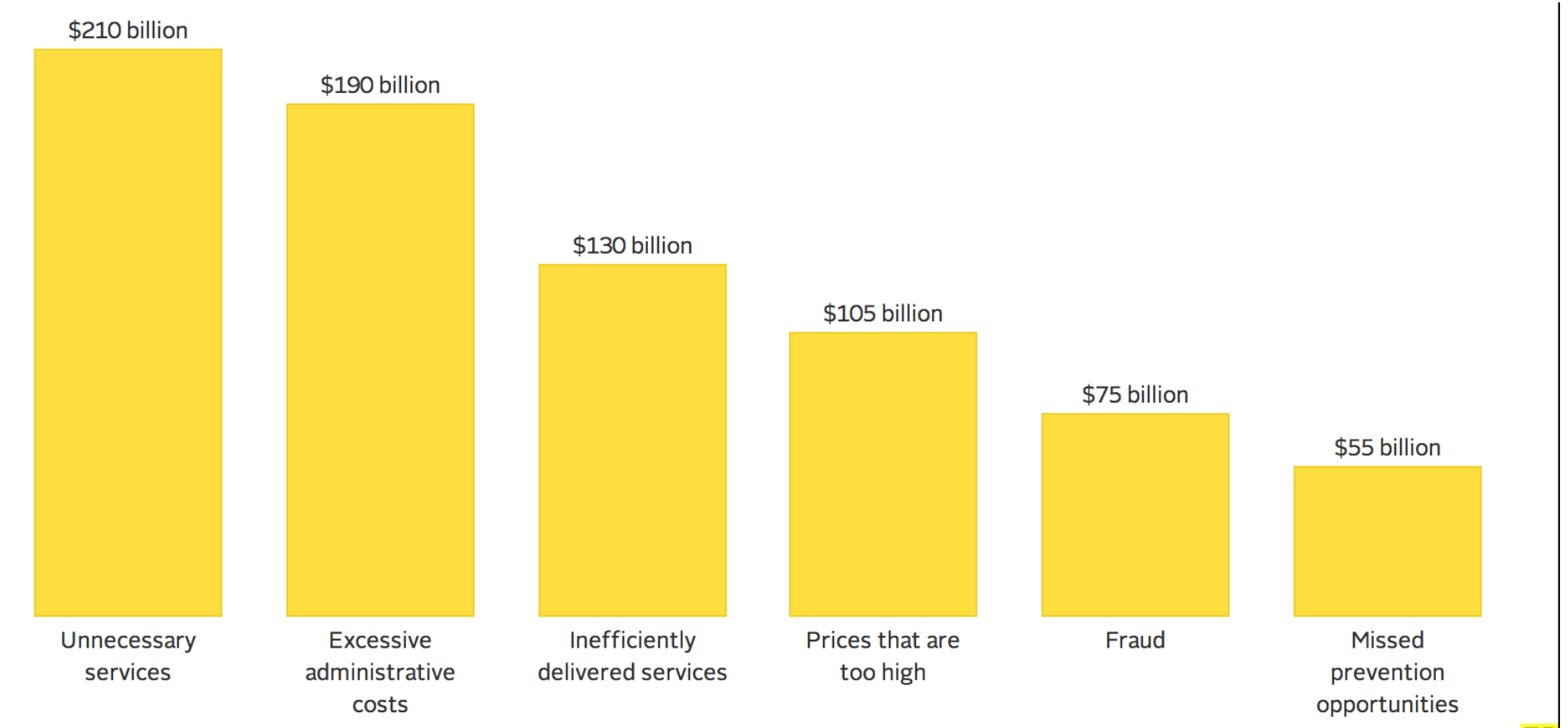
Sources of Waste in US Healthcare



Source: The Institute of Medicine

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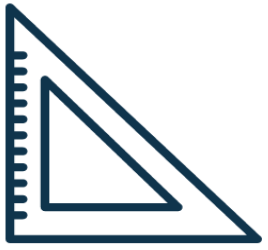
REDUCING
LOW-VALUE CARE

IDENTIFY.



MEASURE.

REPORT.

REDUCE.

Identifying and Measuring Unnecessary Care: Milliman Health Waste Calculator

- Uses claims to measure potentially unnecessary services
- Analyze cost savings potential
- Discover ways to enhance equity, improve quality and patient safety
- Generate actionable reports and summaries

Milliman
MedInsight

VBIDHEALTH

Milliman Health Waste Calculator
Commonwealth of Virginia Unnecessary Care Initiative

- Among 5.5 million Virginia beneficiaries, 1 in 5 received at least 1 low-value service in 2014
- The 44 low-value services were delivered 1.7 million times, which cost $586 million (~2% of healthcare spend – does NOT include care cascades)

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).

Milliman MedInsight

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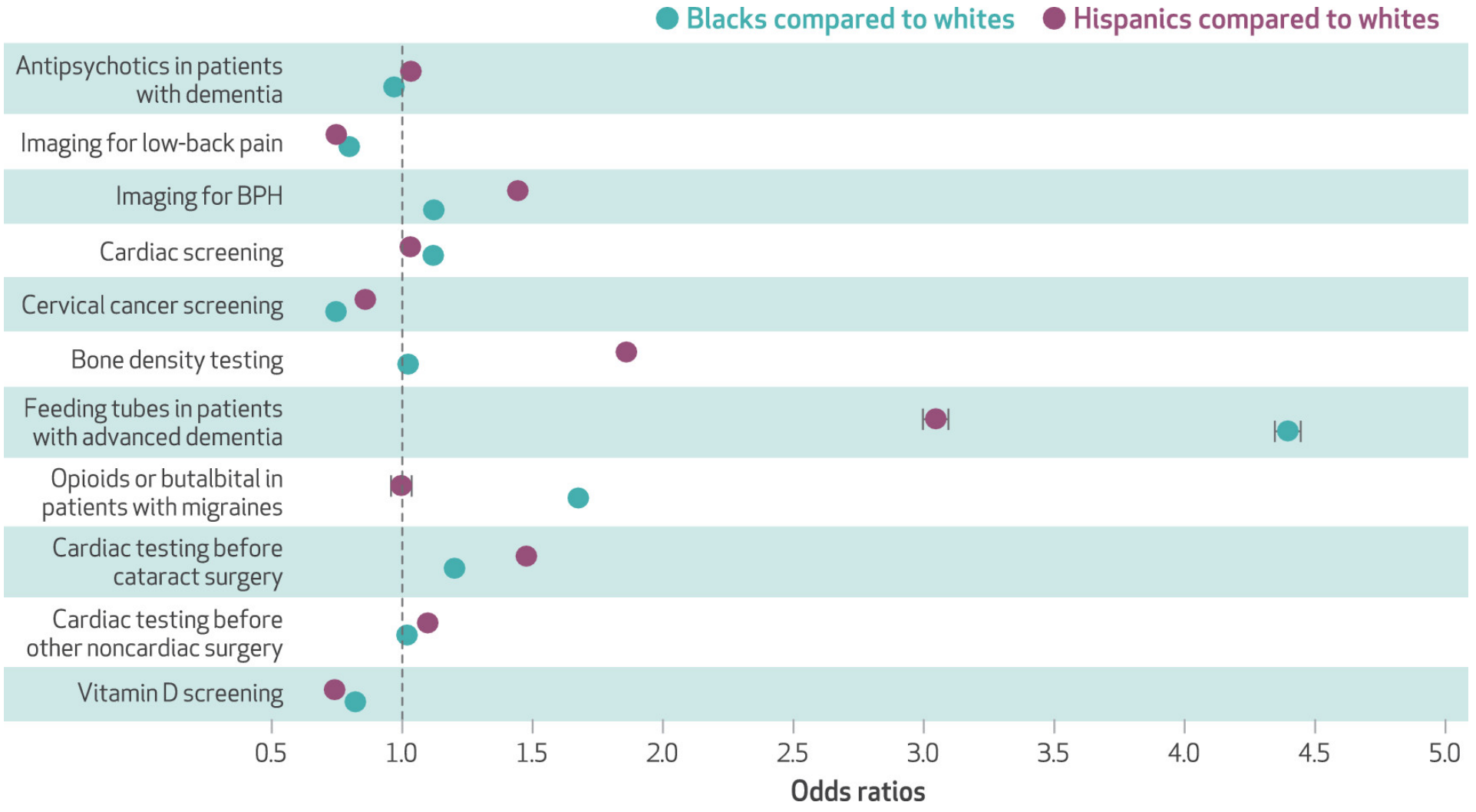
Blacks And Hispanics More Likely To Receive Low-Value Care Than Whites



Health Affairs. https://doi.org/10.1377/hlthaff.2016.1416

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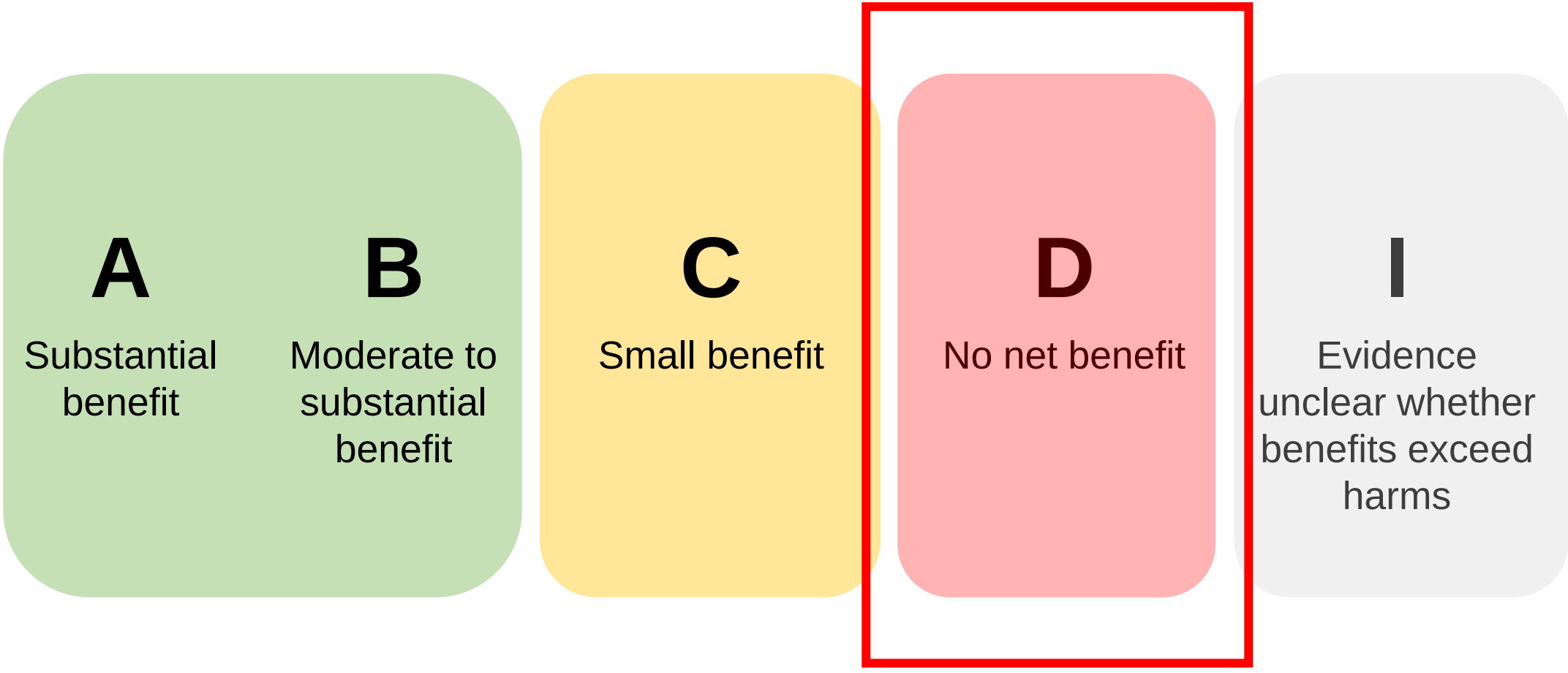
United States Preventive Services Task Force Ratings



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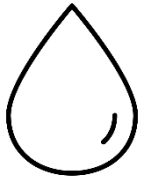
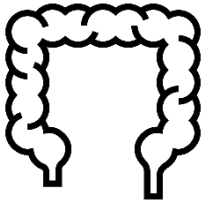
Examples of USPSTF Grade D Services



Prostate cancer screening ≥ 70 years

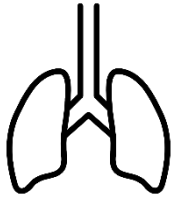
Cervical cancer screening > 65 years



Colon cancer screening >85 years

Cardiovascular screening in low risk patients

Asymptomatic bacteriuria screening



COPD screening

Vitamin D to prevent falls among older women

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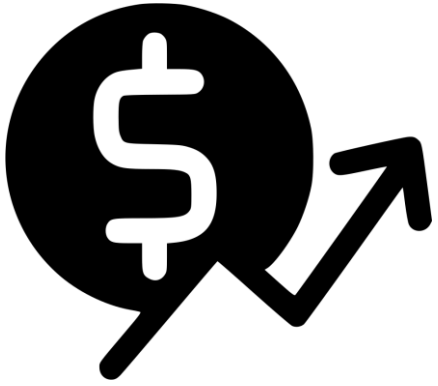
Annual Use and Cost of Seven Grade D Services Among Medicare Enrollees



Total Annual Count:

31 million

Total Annual Costs:

$478 million

Oronce CIA, Fendrick AM, Ladapo J, Sarkisian C, Mafi JN. *JGIM 2021.*

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Report:
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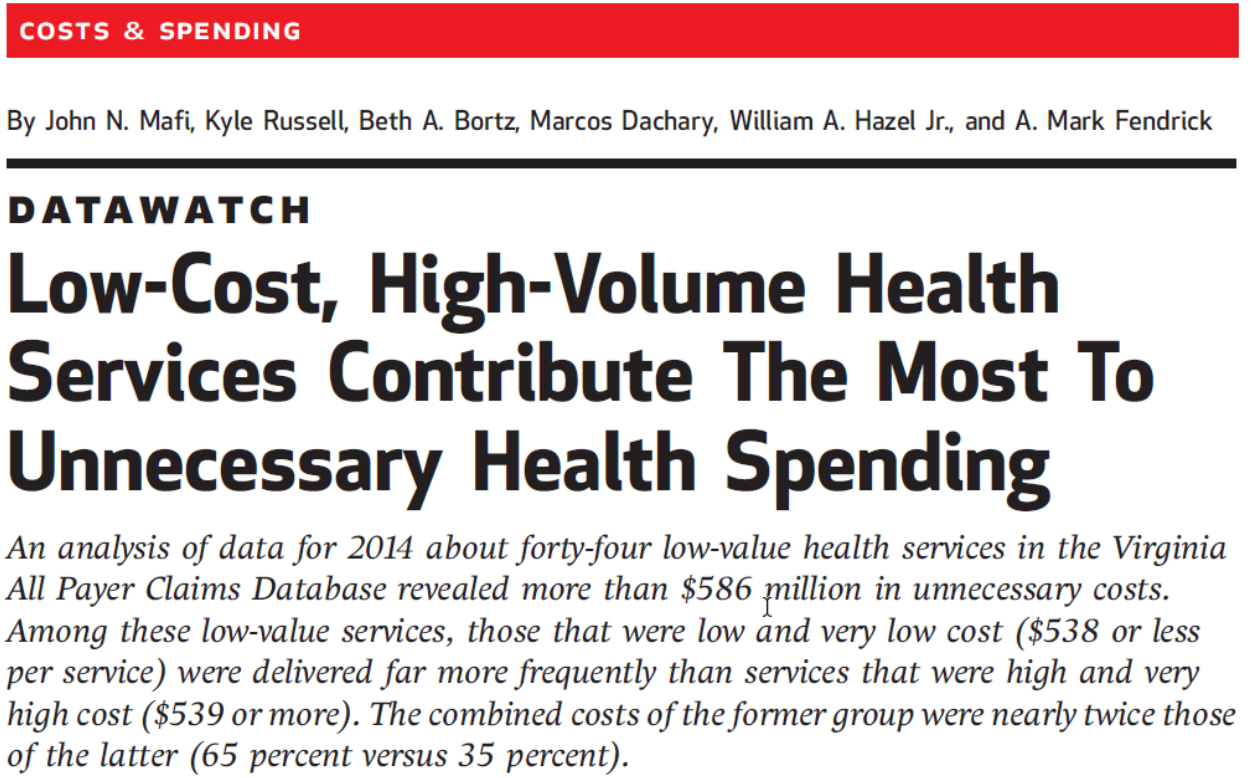

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Employers can Address Low Value Care through the RFP Process

1. Indirect mentions in RFP:

> “Please describe general coverage policies and, where applicable, use of relevant edits and/or prior authorization requirements, for commonly overused services.”

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FEHB Program Carrier Letter

All FEHB Carriers

U.S. Office of Personnel Management
Healthcare and Insurance

Letter No. 2021-03

Date: February 17, 2021

Addressing Low Value Care (USPSTF Ratings)

OPM expects FEHB Carriers to cover all preventive services recommended by the United States Preventive Services Task Force (USPSTF) with an "A" or "B" rating as a preventive service. Those with a "D" rating indicate that the USPSTF recommends against the service because there is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits and should not be covered *as a preventive service*.

As coverage of preventive services rated a "D" rating needlessly drives up costs with no associated medical benefit, FEHB Carriers are reminded that the accurate processing of claims includes review to ensure that medical services are appropriate and necessary. Therefore, OPM is instructing FEHB Carriers **not to cover as preventive benefits,** those services with a sole rating of "D" from the USPSTF. A current list will be included in the technical guidance.

Employers can Address Low Value Care through the RFP Process

2. Directly quantifiable LVC measures as part of the RFP

- Pay bonus if LVC < benchmark
- Pay bonus if LVC falls

- Charge penalty if LVC > benchmark
- Do not pay admin cost on top of LVC
- Do not pay 100% fees for LVC

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Increase Spending on 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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MAY 08, 2020 | MORE ON MEDICARE & MEDICAID

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

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Value-Based Solutions for Employers to Increase High-value Care and Reduce Low Value Services

- Access and affordability to high value care must be a priority
  - Lower cost sharing / expand pre-deductible coverage
- Identify, measure and reduce low-value care to pay for more generous coverage of high-value care
  - Incorporate specific language about low value care in RFP
  - EBC buy in?
- Align clinically-nuanced payment reform, technologies and health benefit designs (i.e., V-BID) that enhance patient access to high-value services and deter the use of low value care

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Thank you

Questions?

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