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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University of Michigan Center for
Value-Based Insurance Design

www.vbidcenter.org

@um_vbid

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

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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]

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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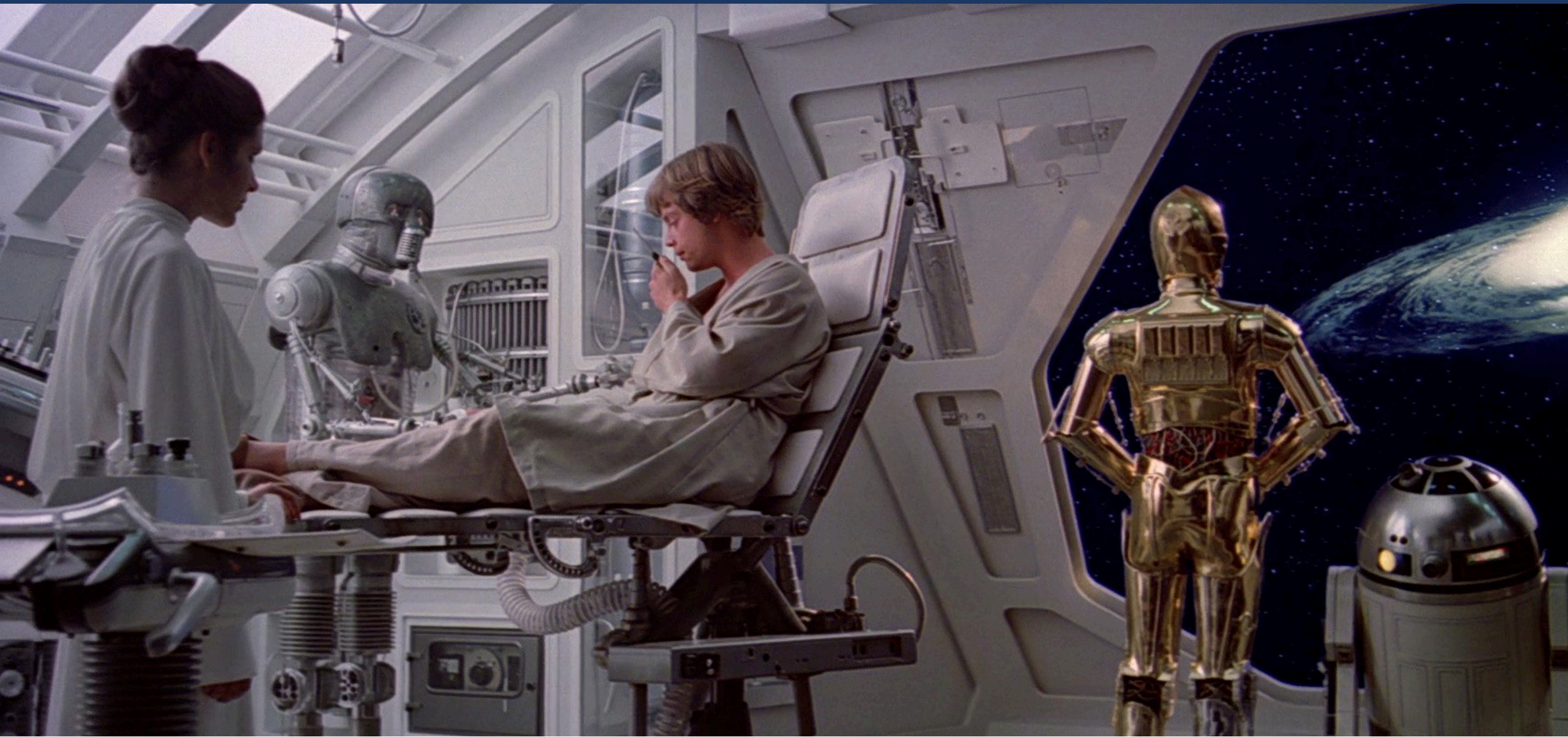
Star Wars Science



Flintstones Delivery

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

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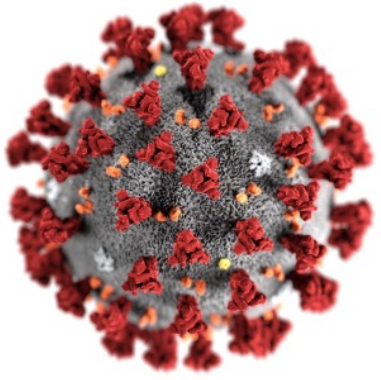
Then Came Coronavirus…



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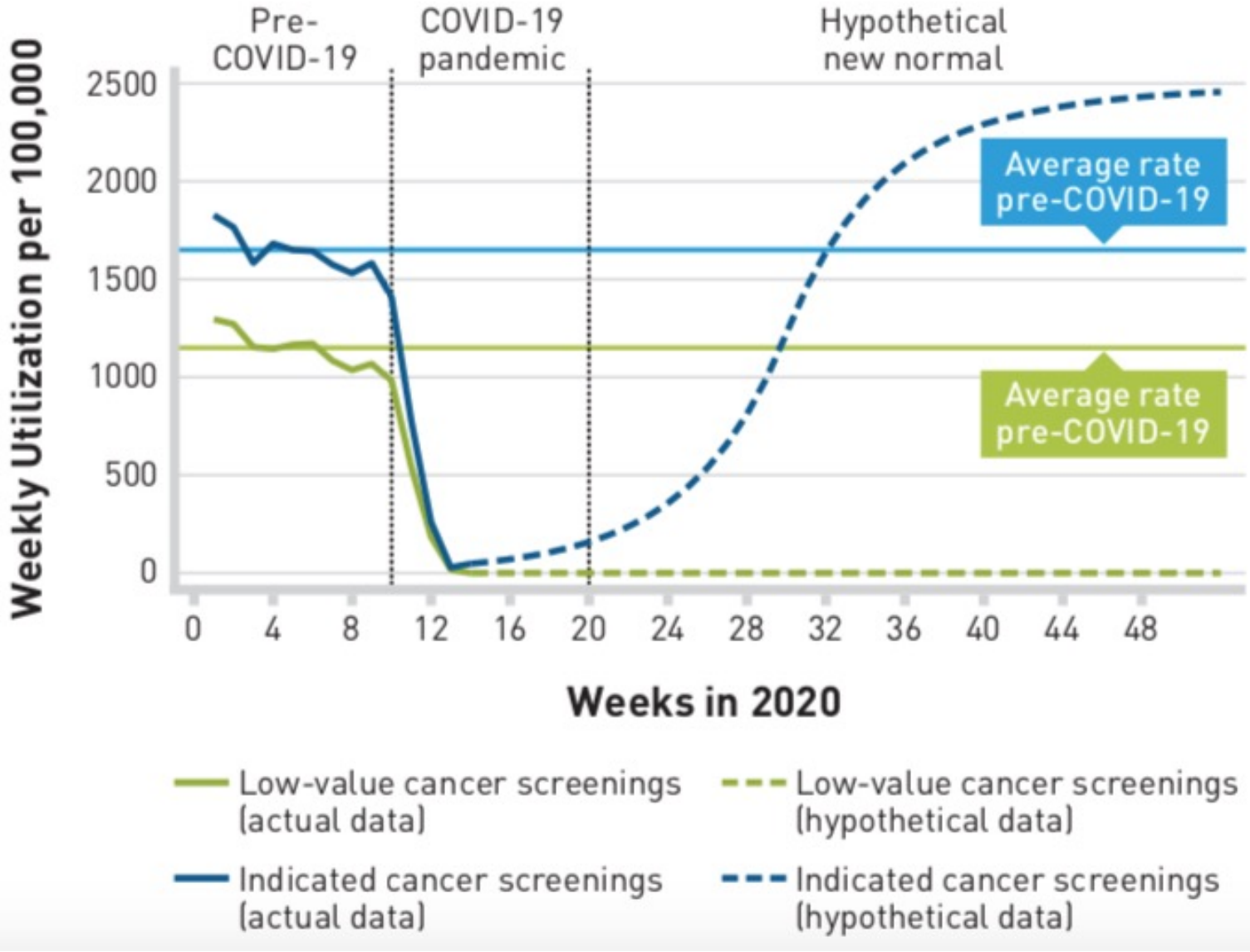
The Onion
@TheOnion

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?

- 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

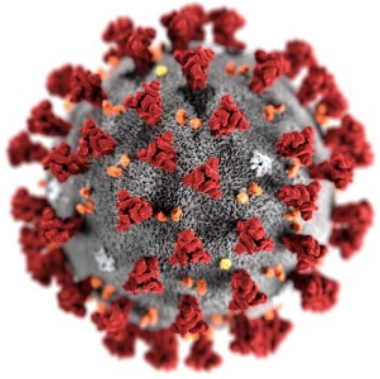
Crisis Into Opportunity: Can COVID-19 Help Set a Path to Improved Health Care Efficiency?

- 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

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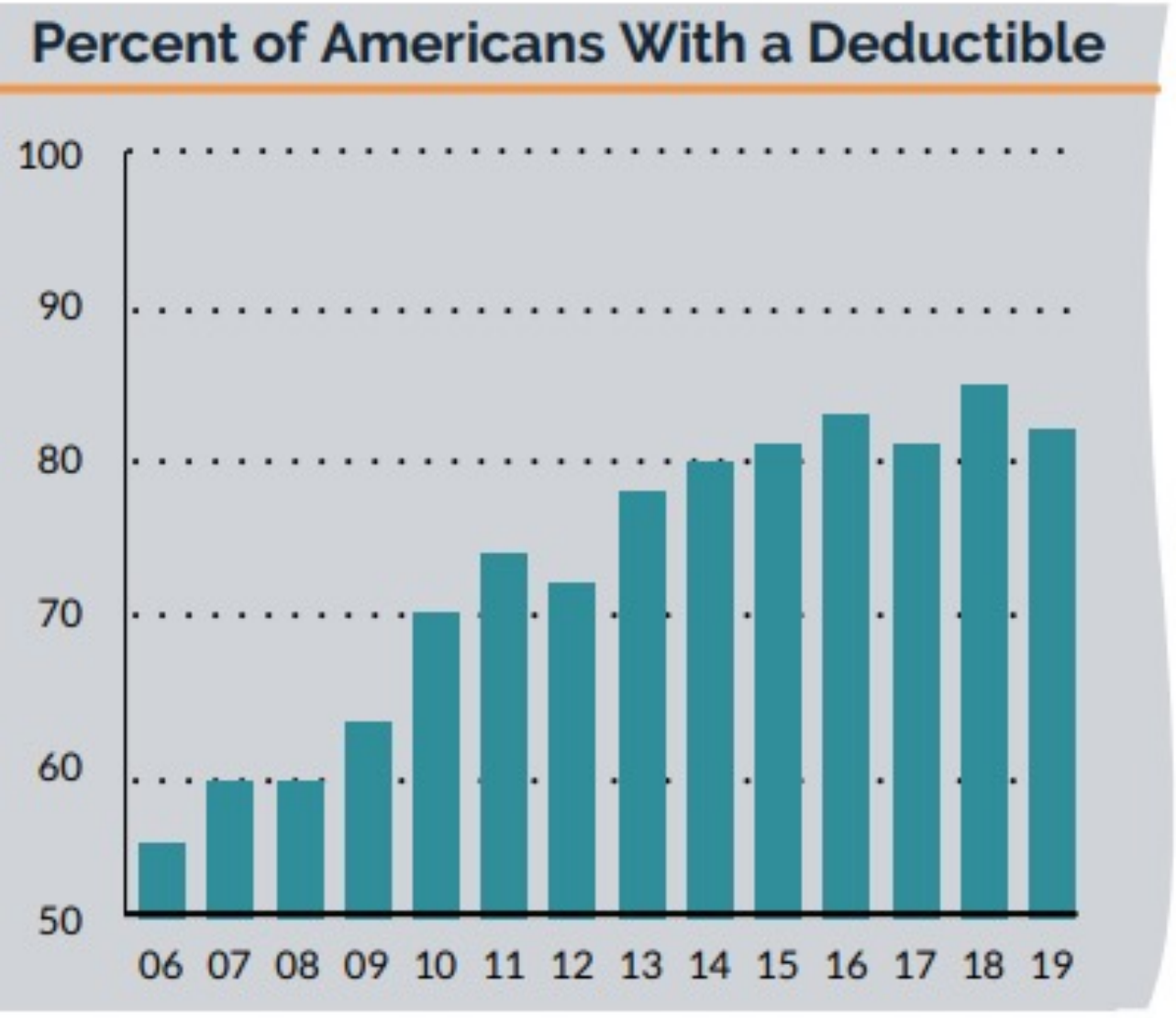
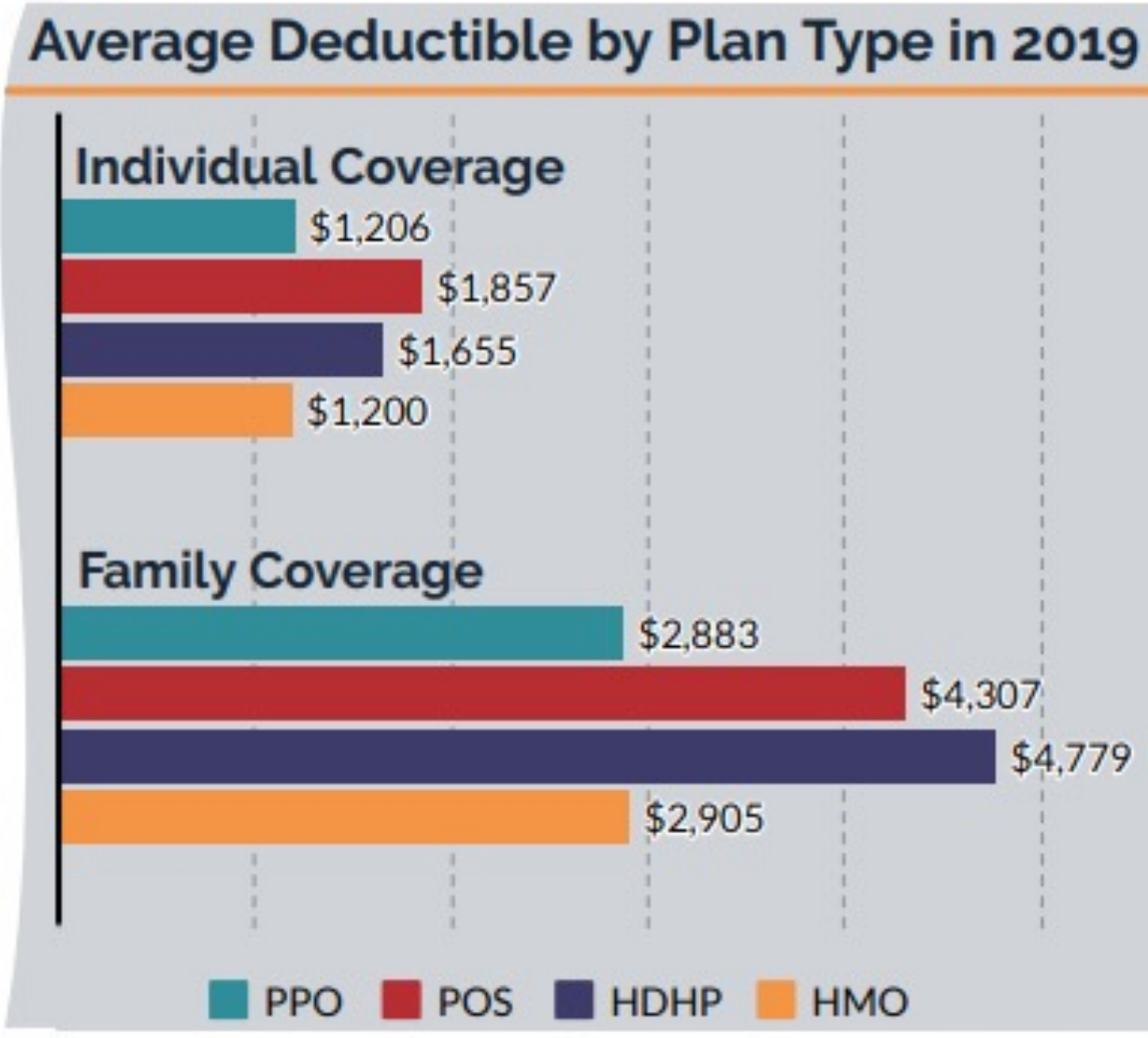
Health Plan Deductibles have grown more than ten times faster than inflation over the last decade





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.

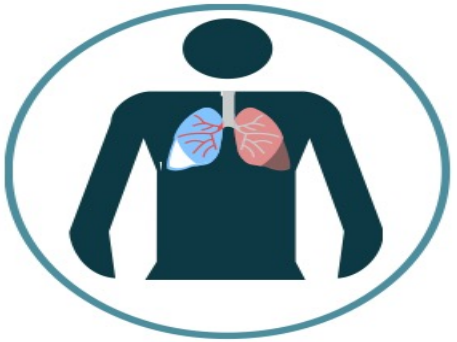
Alternative to “Blunt” Consumer Cost-Sharing: A Clinically Nuanced Approach

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

Understanding CLINICAL NUANCE

#1 Clinical Services Differ in the Benefit Produced

Office Visits

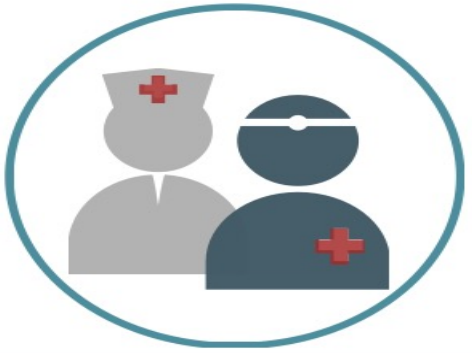


Diagnostic Tests

Prescription Drugs

#2 The Clinical Benefit Derived From a Service Depends On...

Who receives it



Who provides it

Where it's provided

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Clinical benefit depends on **who** receives it

Screening for Colorectal Cancer

Screening Recipients

First-degree relative of colon cancer sufferer	Average risk 50 year old	30 year old with no family history of colon cancer
Exceptional Value	**High Value**	**Low Value**

who provides it...

High Performance

Poor Performance

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Clinical benefit depends on **where** care is provided

Ambulatory Care Center

$

Hospital

$$$

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

Final Recommendation Statement

Colorectal Cancer: Screening

May 18, 2021

Recommendation Summary

Population	Recommendation	Grade
Adults aged 50 to 75 years	The USPSTF recommends screening for colorectal cancer in all adults aged 50 to 75 years. See the "Practice Considerations" section and Table 1 for details about screening strategies.	A
Adults aged 45 to 49 years	The USPSTF recommends screening for colorectal cancer in adults aged 45 to 49 years. See the "Practice Considerations" section and Table 1 for details about screening strategies.	B
Adults aged 76 to 85 years	The USPSTF recommends that clinicians selectively offer screening for colorectal cancer in adults aged 76 to 85 years. Evidence indicates that the net benefit of screening all persons in this age group is small. In determining whether this service is appropriate in individual cases, patients and clinicians should consider the patient's overall health, prior screening history, and preferences.	C

COVID-19 Testing and Vaccines Provided without Cost-sharing

V-BID in the 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

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

Translating Research into Policy: Implementing V-BID in Medicare

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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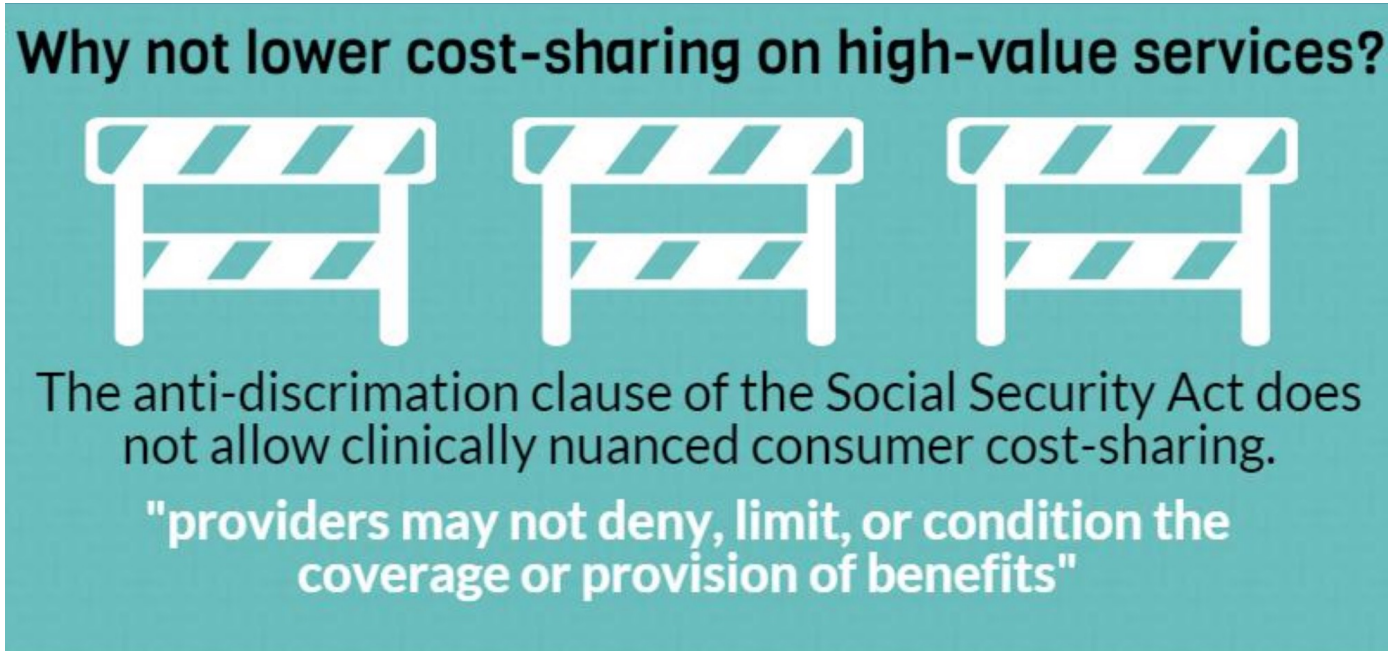
Translating Research into Policy: Implementing V-BID in Medicare



“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"

- 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

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 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

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

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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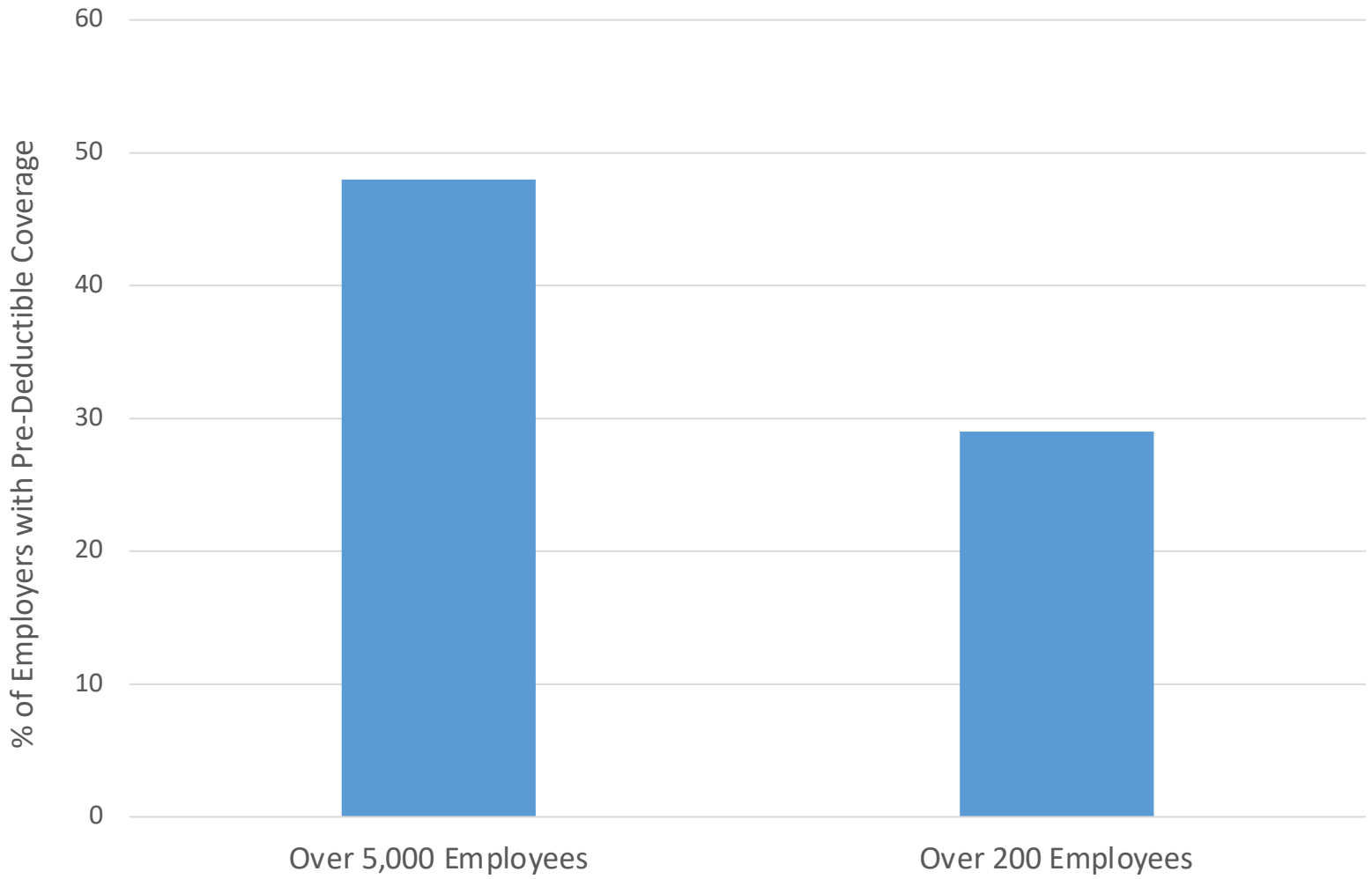
List of services and drugs for certain chronic conditions that will be classified as preventive care under Notice 2019-45

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

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: 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

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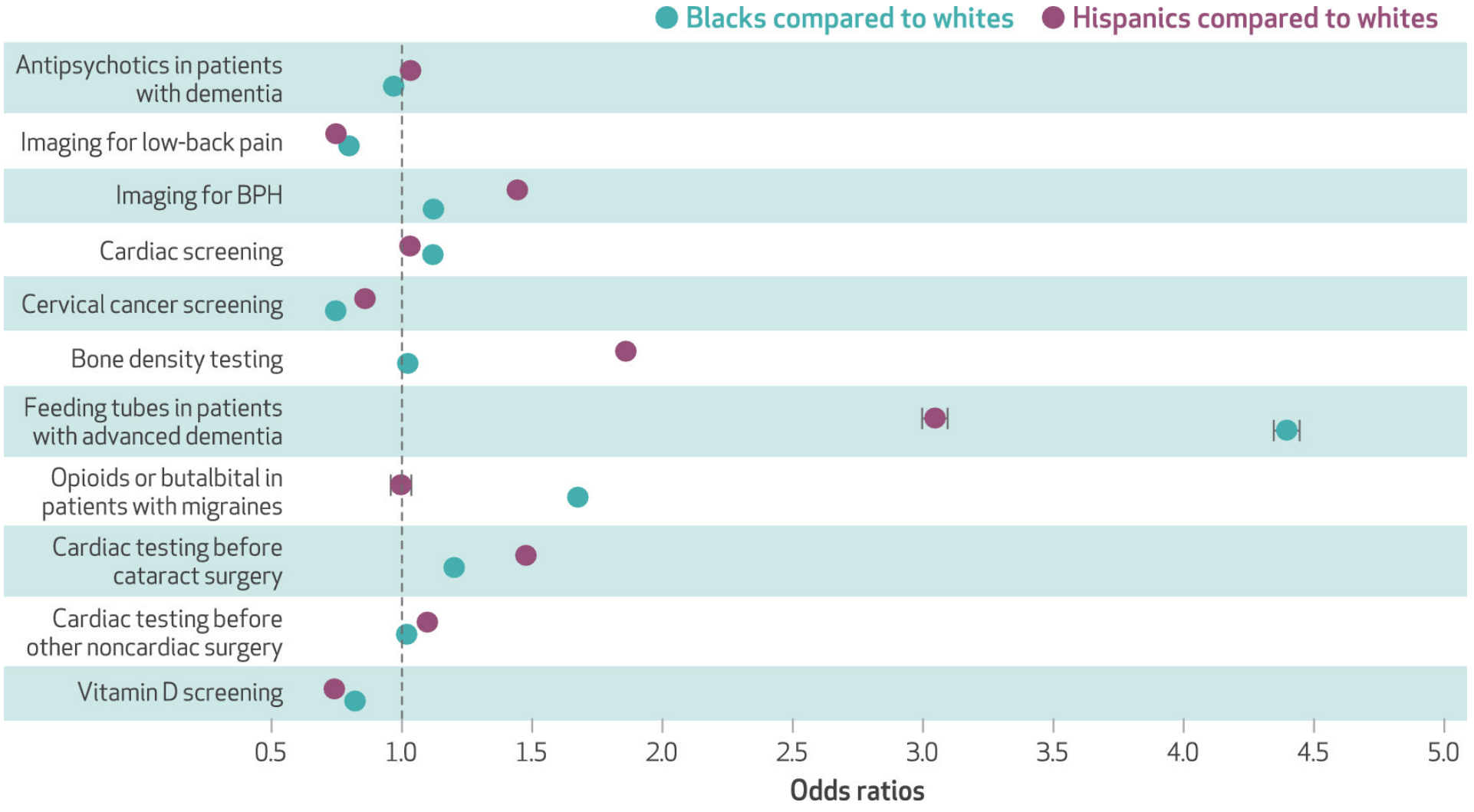
Blacks And Hispanics More Likely To Receive Low-Value Care Than Whites



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

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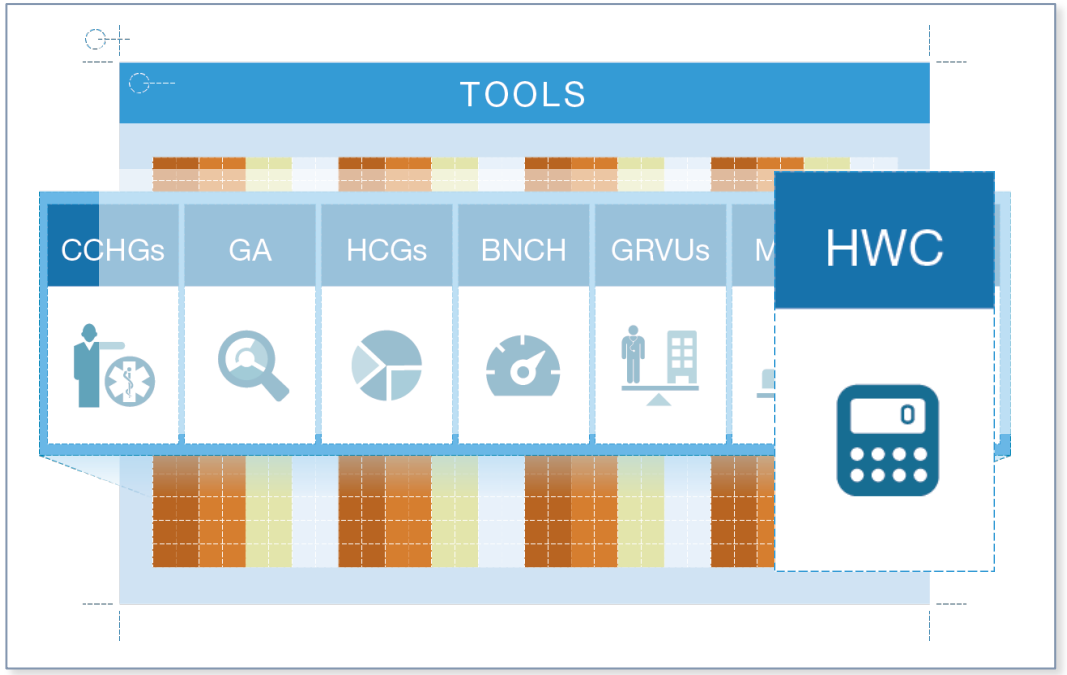
Identifying and Removing Unnecessary Care: Milliman Health Waste Calculator

- 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

VBIDHEALTH

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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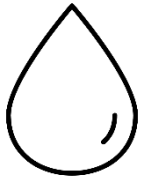
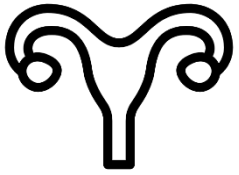
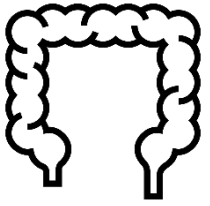
Examples of USPSTF Grade D Services



Prostate cancer screening ≥ 70 years



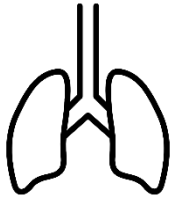
Cervical cancer screening > 65 years



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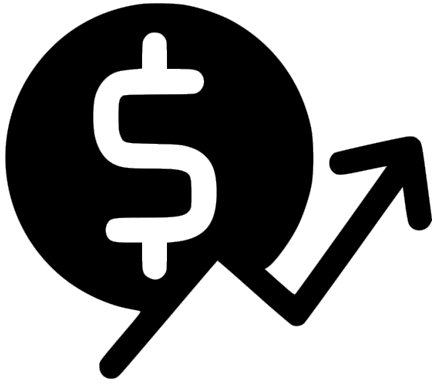
Annual Use and Cost of Seven Grade D Services Among Medicare Enrollees



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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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.

Final Recommendation Statement

Screening for Asymptomatic Carotid Artery Stenosis

February 02, 2021

Recommendation Summary

Population	Recommendation	Grade
Asymptomatic adults	The USPSTF recommends against screening for asymptomatic carotid artery stenosis in the general adult population. See the Practice Considerations section for a description of adults at increased risk.	D

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

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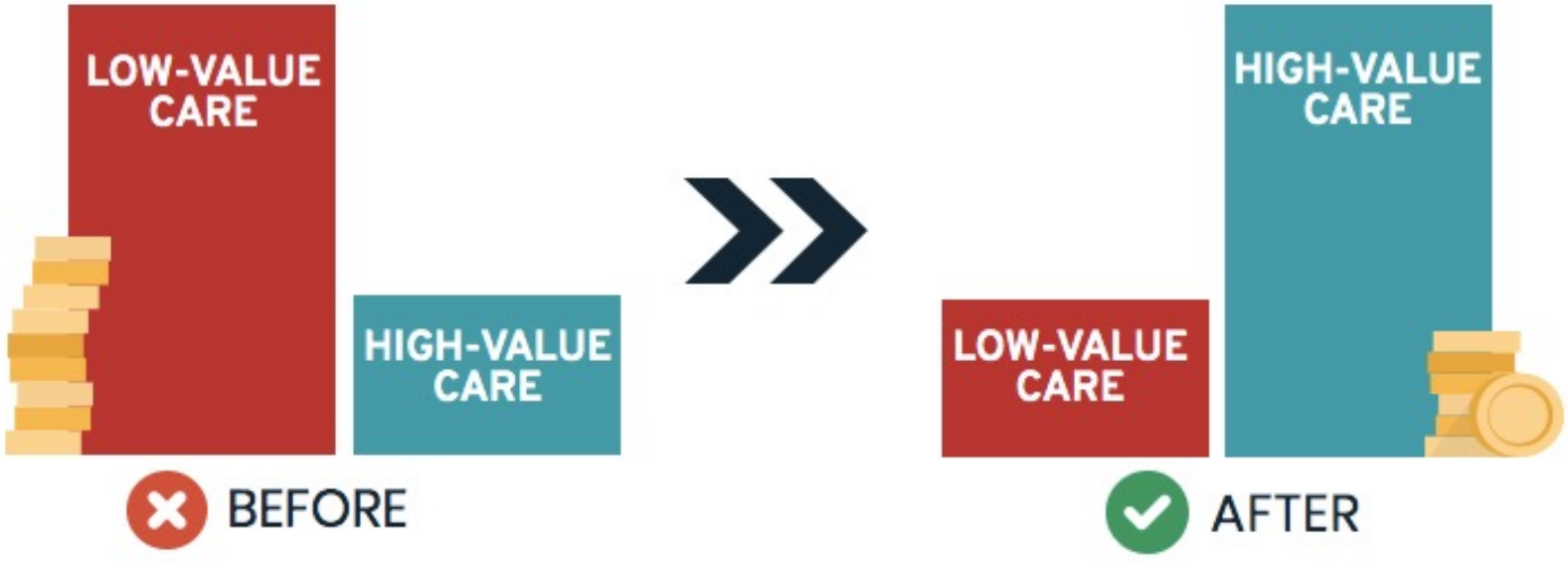
V-BID X: Expanding Coverage of Essential Clinical Care Without Increasing Premiums or Deductibles

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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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.

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
Glucometers and testing strips
LDL testing
Hemoglobin A1C testing
Cardiac rehabilitation
INR testing
Pulmonary rehabilitation
Peak flow meters
Blood pressure monitors

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

Specific Low-Value Services Considered
Spinal fusions
Vertebroplasty and kyphoplasty
Vitamin D testing
Proton beam for prostate cancer
Commonly Overused Service Categories with Increased Cost-Sharing
Outpatient specialist services
Outpatient labs

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MAY 08, 2020 | MORE ON MEDICARE & MEDICAID

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

Much of CMS's framework—including a list of high-value services that insurers could cover with little no impact on premiums but better care incentives—comes from the University of Michigan's Center for Value-Based Insurance Design. The list includes a number of the same preventive care benefits that can be newly provided by a high-deductible health plan paired with a health savings account on a pre-deductible basis under Treasury guidance from July 2019. CMS also notes that PrEP, an HIV prevention medication, must soon be covered without cost-sharing by all non-grandfathered private health plans (including individual, small group, large group, and self-insured plans).

Aligning Payer and Consumer Incentives: As Easy as Peanut Butter and Jelly

Many “supply side” initiatives are restructuring provider incentives to move from volume to value:

- Medical Homes
- Electronic Medical Records
- Accountable Care Organizations
- Bundled Payments/Reference Pricing
- Global Budgets
- High Performing Networks

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Aligning Payer and Consumer Incentives: As Easy as Peanut Butter and Jelly

Unfortunately, some “demand-side” initiatives – including consumer cost sharing - discourage consumers from pursuing the “Triple Aim”

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Aligning Payer and Consumer Incentives: As Easy as PB & J

The alignment of clinically driven, provider-facing and consumer engagement initiatives is a necessary and critical step to improve quality of care, enhance patient experience, and contain cost growth

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Enhancing Access and Affordability to Essential Clinical Services

- 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
  - Start with USPSTF D Rated Services
- Implement clinically-driven plan payment reform, technologies and benefit designs (i.e., V-BID X) that increase use of high-value services and deter low value care

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Thank you

Questions?

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