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

Aligning Incentives to Increase Use of High Value Care and Eliminate Low Value Services

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Avera Health Plans

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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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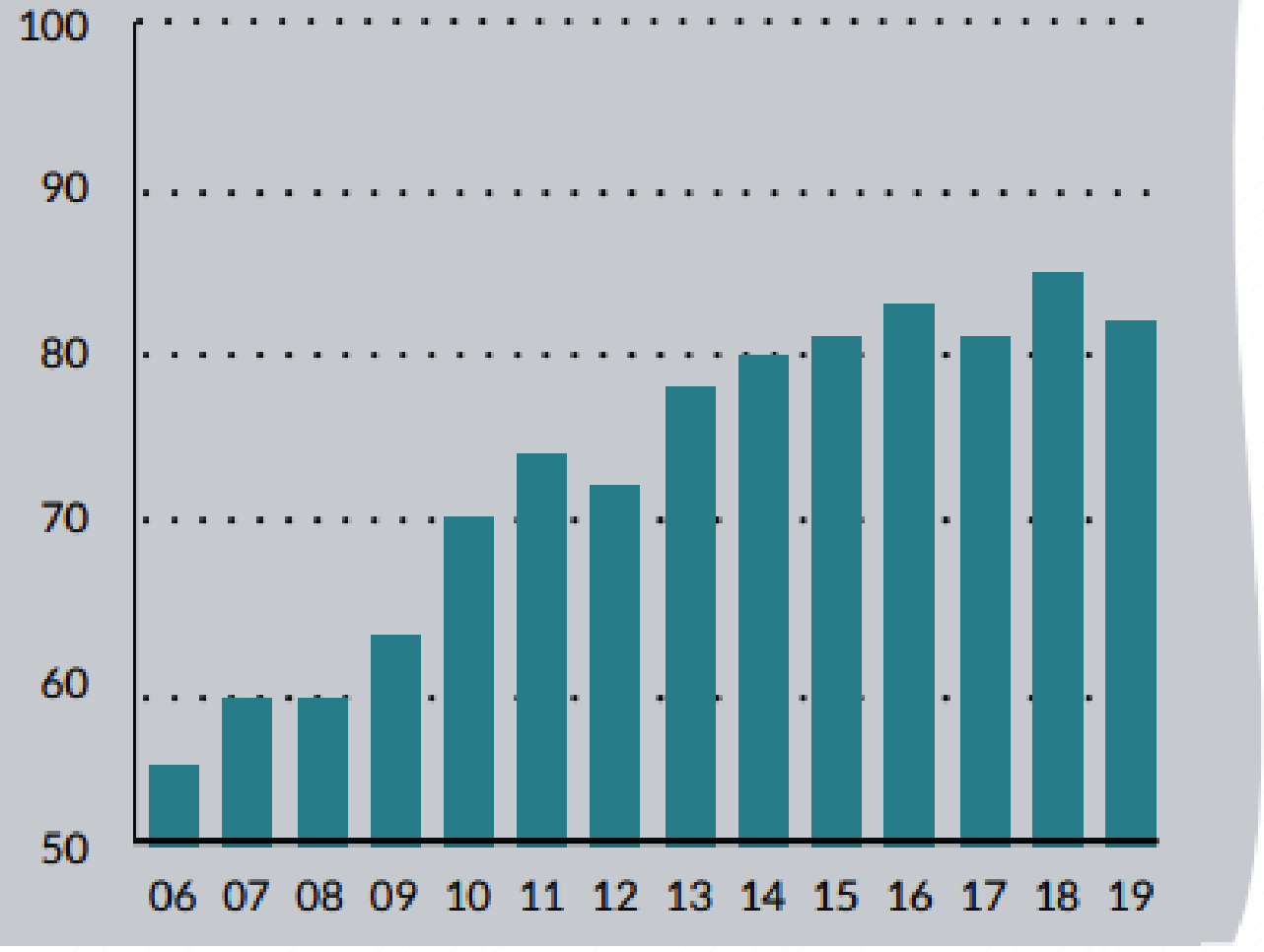
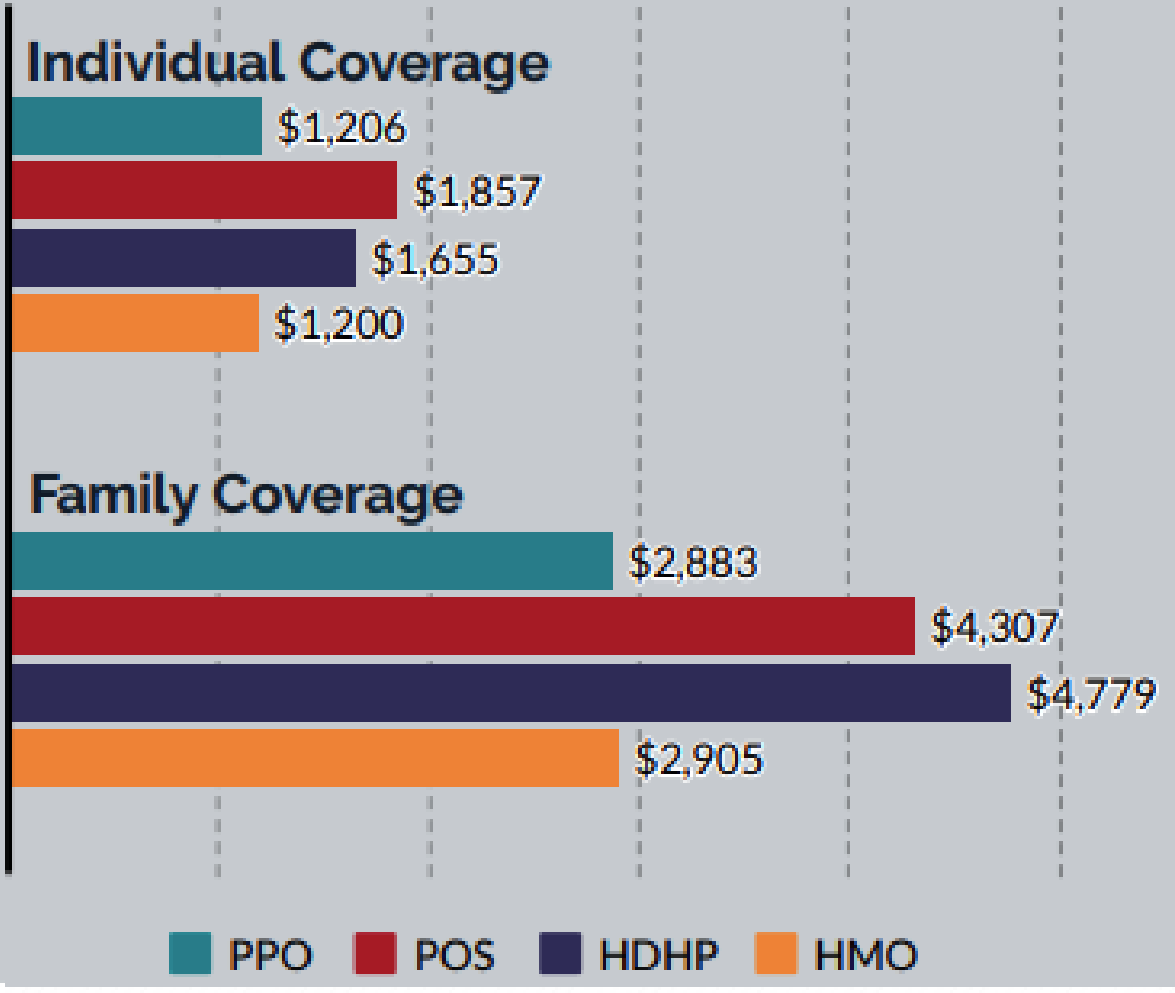
Health Plan Deductibles Deter use of High and Low Value Services

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)

"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.

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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

Putting Innovation into Action: Translating Research into Policy

Medicare

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

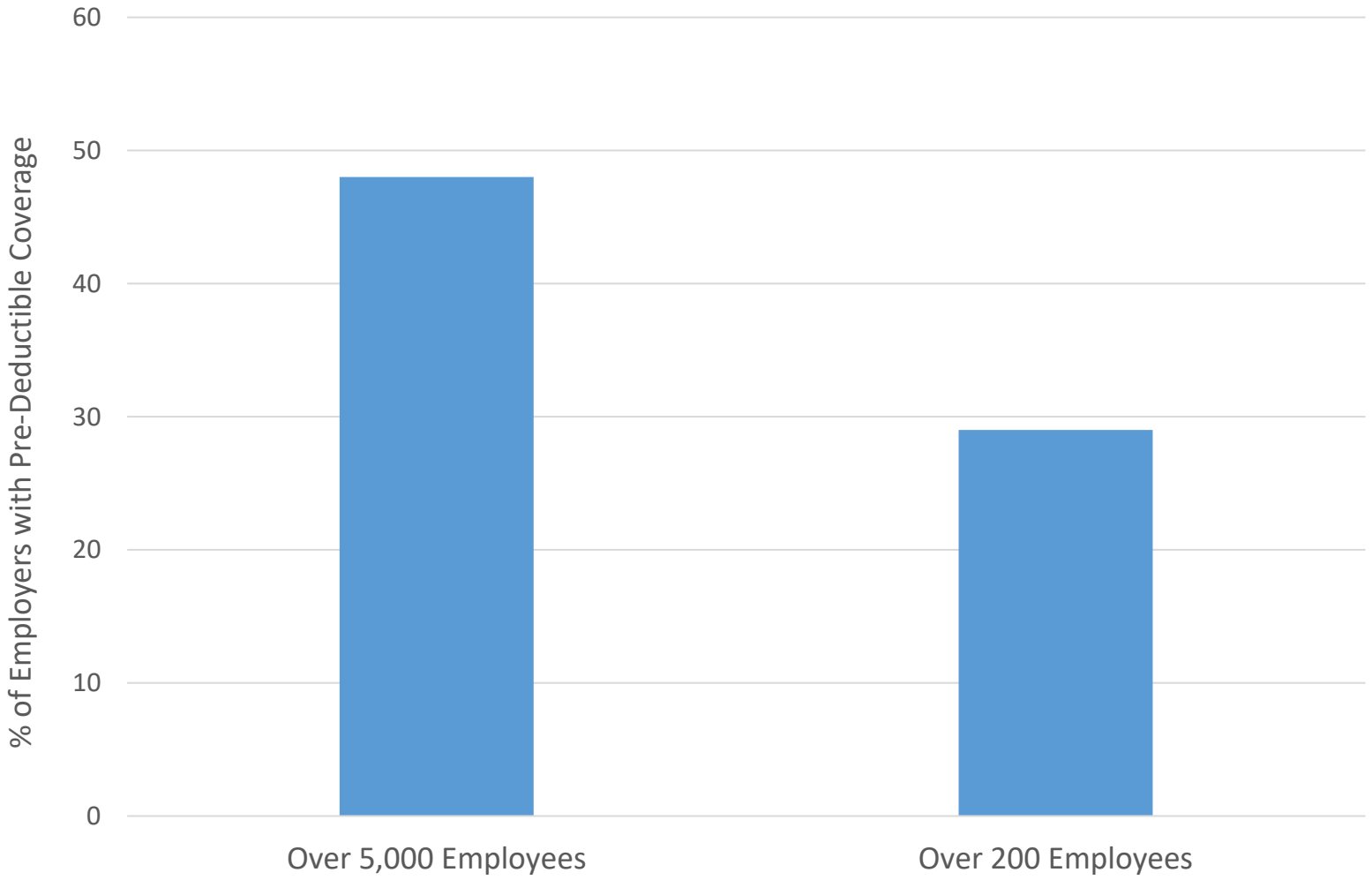
PRESS RELEASES

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 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.

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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

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

Identifying and Measuring Unnecessary Care: Milliman Health Waste Calculator

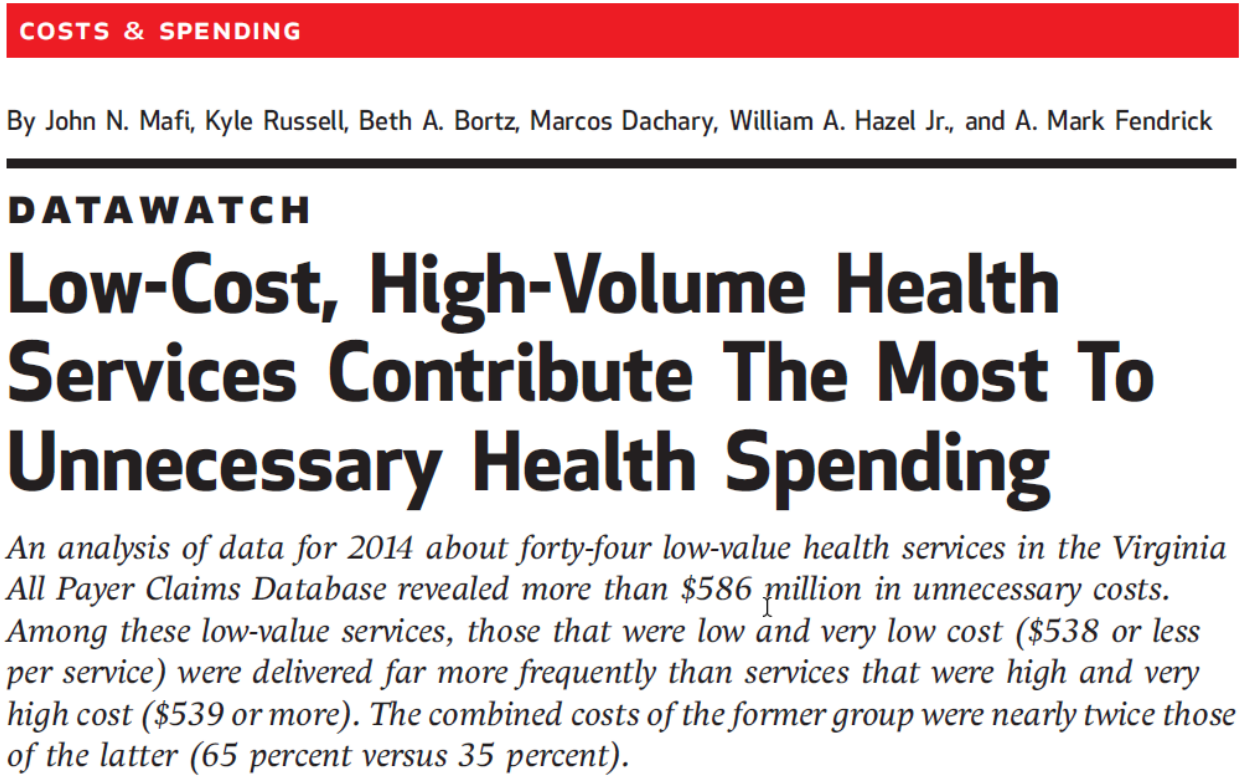
- Uses claims to measure potentially unnecessary services
- Analyze cost savings potential
- Discover ways to enhance equity, improve quality and patient safety
- Generate actionable reports and summaries

Milliman
MedInsight

VBIDHEALTH

Report:
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

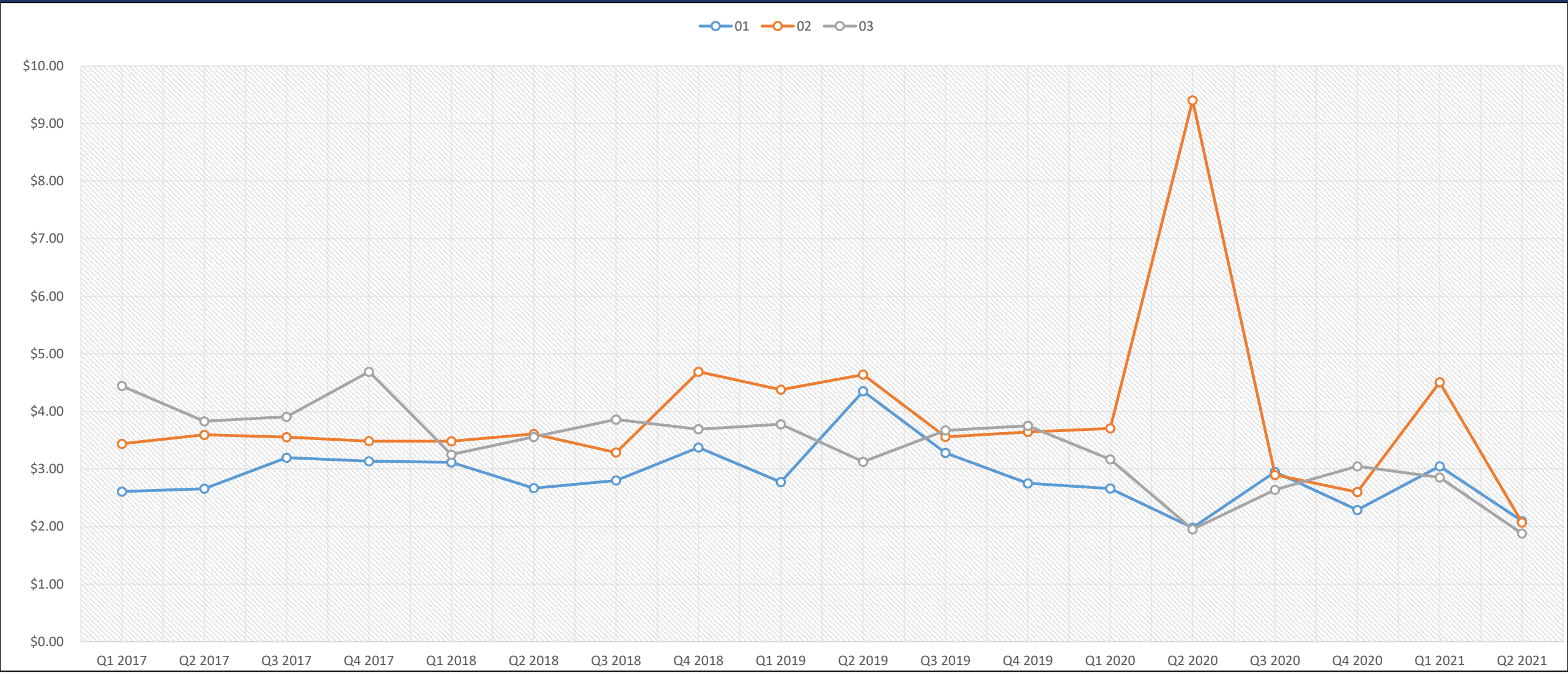
An analysis of data for 2014 about forty-four low-value health services in the Virginia All Payer Claims Database revealed more than $586 million in unnecessary costs. Among these low-value services, those that were low and very low cost ($538 or less per service) were delivered far more frequently than 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

Milliman Health Waste Calculator
Wasteful PMPM Spending by Quarter



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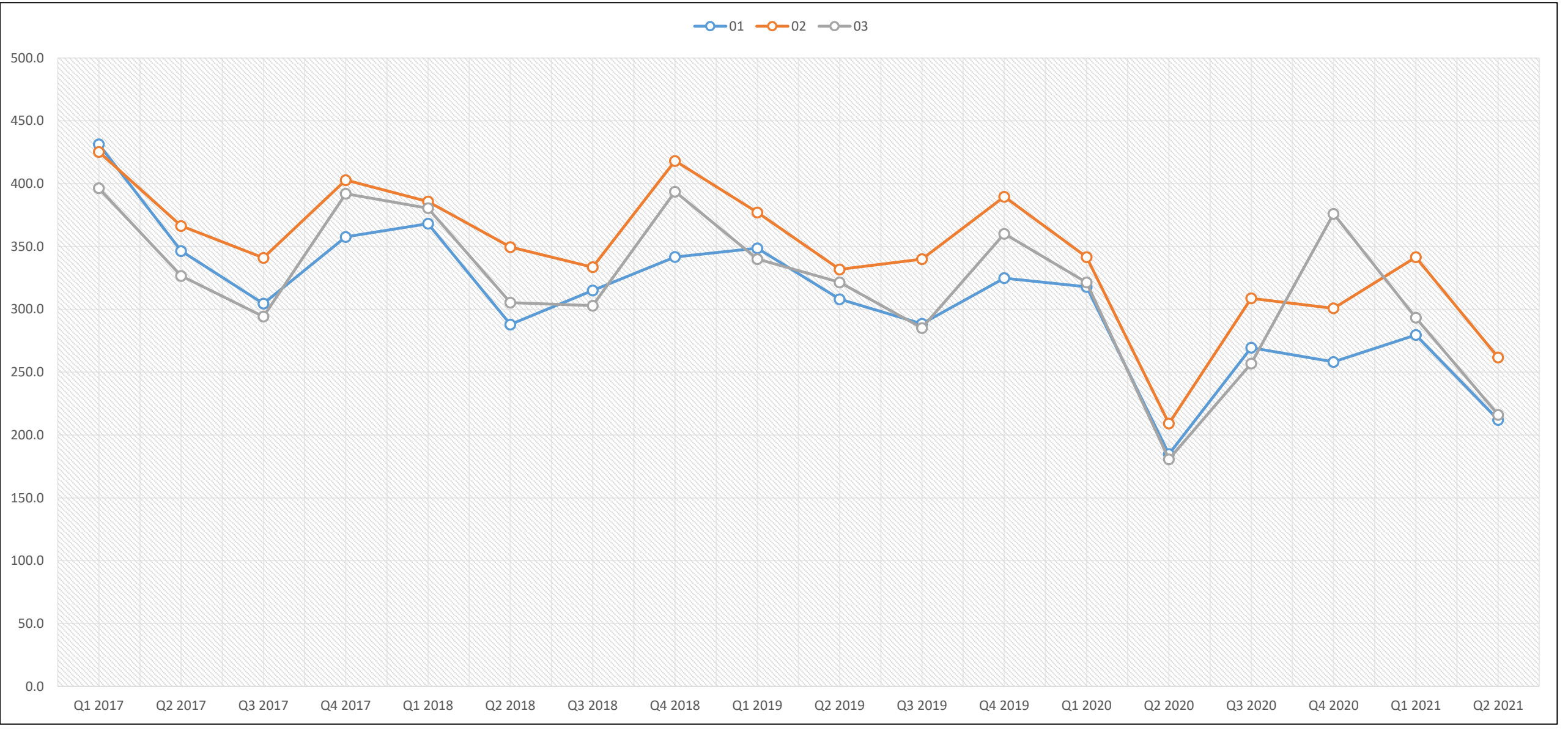
Milliman Health Waste Calculator
Wasteful Events/1,000 by Incurred Quarter



Addressing 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.

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

- Access and affordability to high value care must be a policy priority
- 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
- Align clinically-nuanced payment reform, technologies and health benefit designs (i.e., V-BID X) that enhance patient access to high-value services and deter the use of low value care

Discussion

Thank you

Questions?

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