Value-Based Insurance Design:

Aligning Patient and Provider Incentives to Increase Use of High-value Care and Eliminate Low Value Services

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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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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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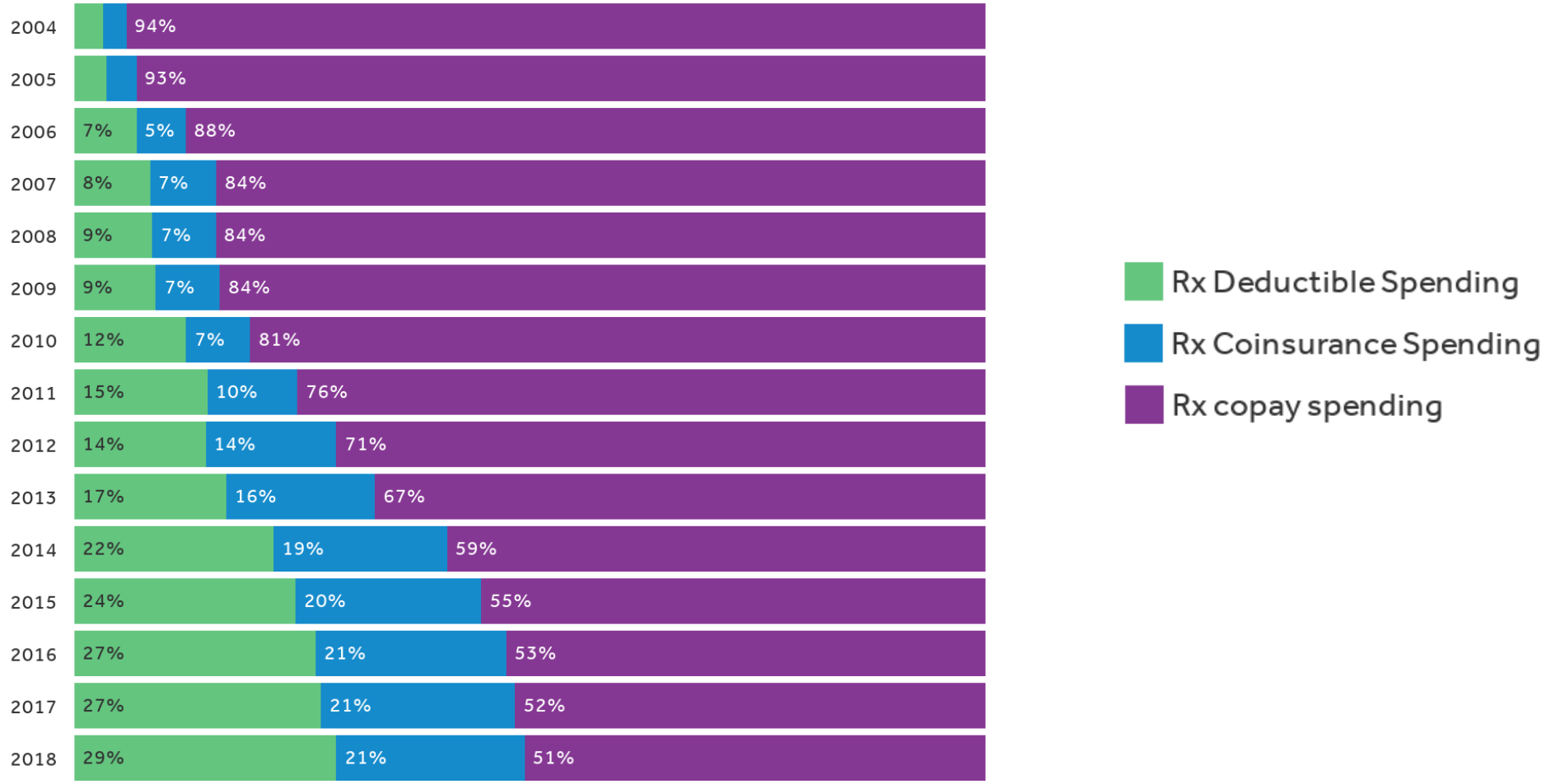
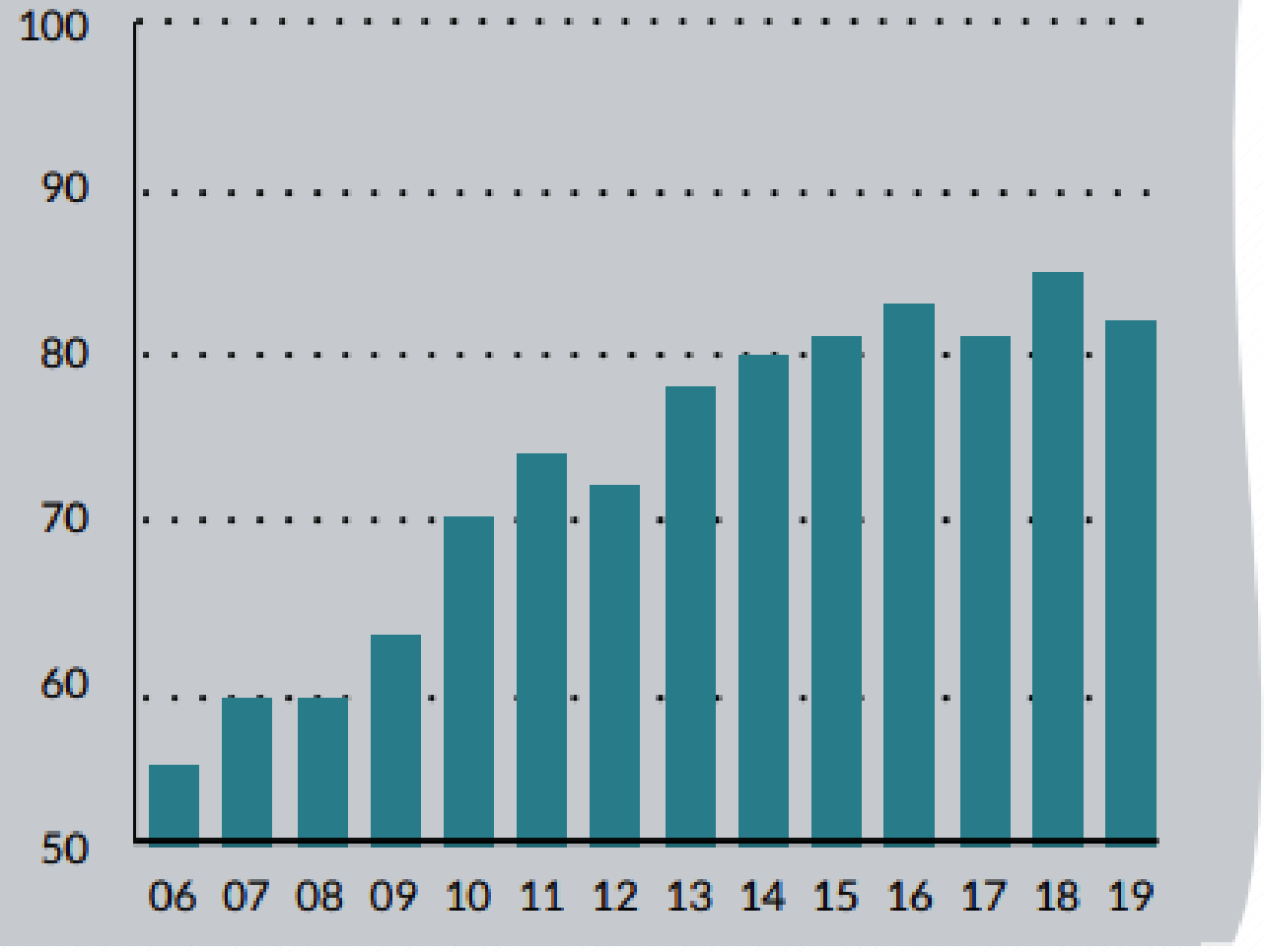
Distribution of cost-sharing payments for retail prescription drugs in large employer plans, by type of payment, 2004-2018



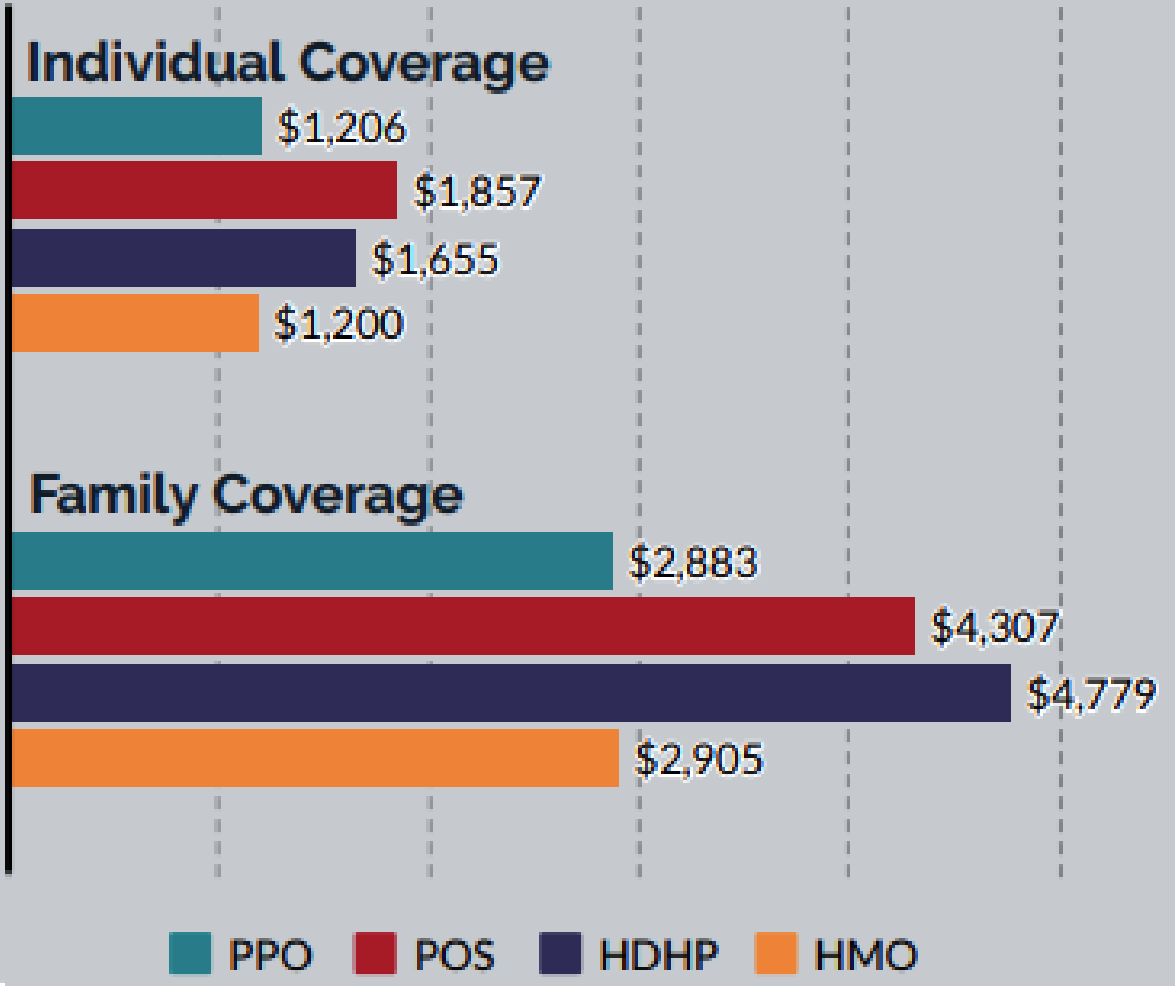
Source: KFF analysis of IBM Market Scan Commercial Claims and Encounters Database, 2004-2018. Accessed at: https://www.healthsystemtracker.org/chart-collection/who-is-most-likely-to-have-high-prescription-drug-costs

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

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)

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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.

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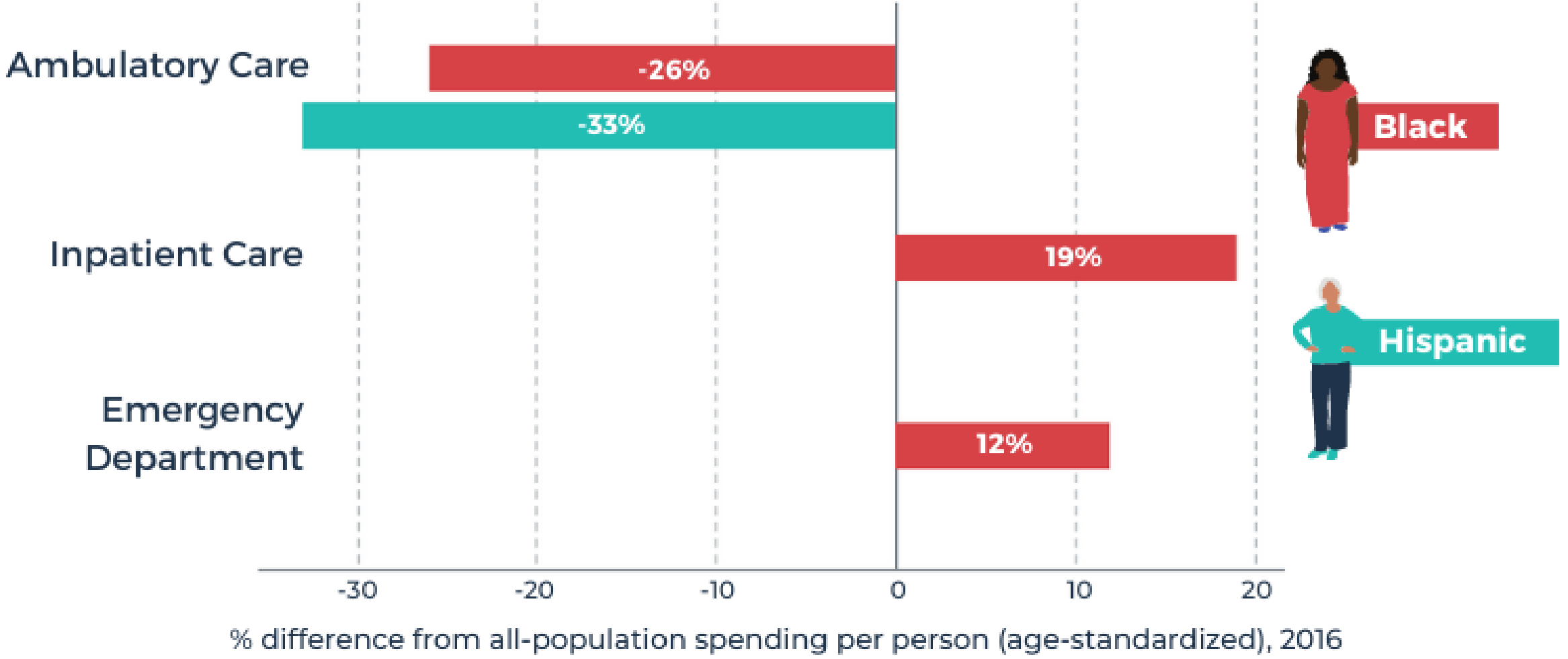
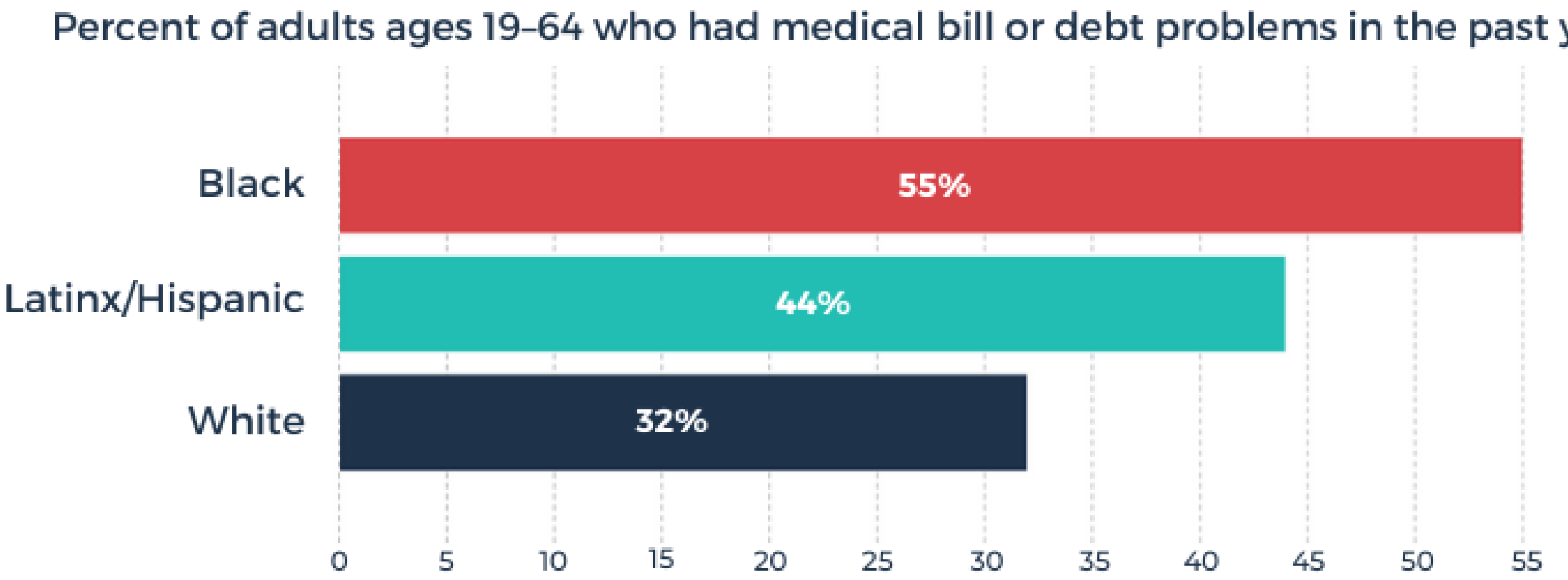
People of color lack access to ambulatory care that can play a critical role in prevention, leading to higher spending on inpatient and emergency department care.



Dieleman JL, Chen C, Crosby SW, et al. US Health Care Spending by Race and Ethnicity, 2002-2016. JAMA. 2021;326(7):649–659. doi:10.1001/jama.2021.9937

Even when stratified by income level, Black and Hispanic adults report medical bill and debt problems at the highest rates.



Source: Sara R. Collins, Gabriella N. Aboulafia, and Munira Z. Gunja, As the Pandemic Eases, What Is the State of Health Care Coverage and Affordability in the U.S.? Findings from the Commonwealth Fund Health Care Coverage and COVID-19 Survey, March–June 2021 (Commonwealth Fund, July 2021).

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

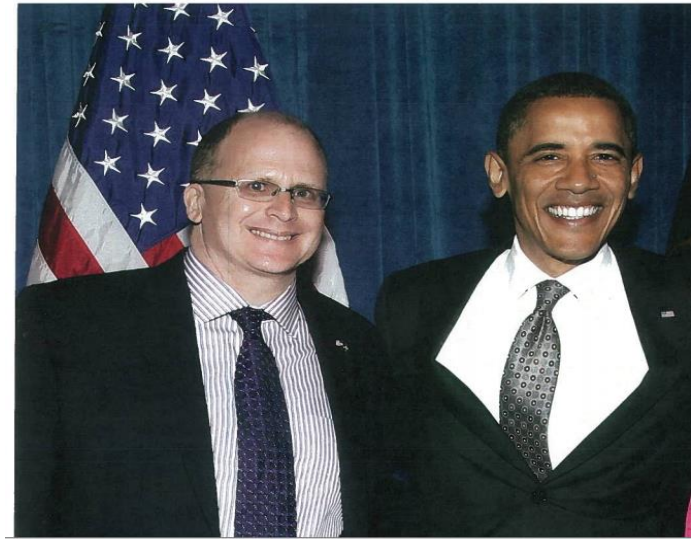
DISPARITIES

By Niteesh K. Choudhry, Katsiaryna Bykov, William H. Shrank, Michele Toscano, Wayne S. Rawlins, Lonny Reisman, Troyen A. Brennan, and Jessica M. Franklin

DOI: 10.1377/hlthaff.201
HEALTH AFFAIRS 33,
NO. 5 (2014): 863–870

Eliminating Medication Copayments Reduces Disparities In Cardiovascular Care

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

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

Your Free Cancer Screen Shows Trouble: What If You Can't Afford the Follow-Up?

- New research shows that out-of-pocket costs are common and non-trivial for necessary follow-up testing after initial no-cost cancer screening test.
  - Breast[1]
  - Cervical[2]
  - Colorectal[3]
  - Lung[4]

JAMA Network Open. 2021;4(8):e2121347
Obstetrics & Gynecology. E-pub ahead of print. 2021. doi:10.1097/AOG.0000000000004582
JAMA Network Open. Accepted for publication
JACR E-pub ahead of print. 2021.DOI:https://doi.org/10.1016/j.jacr.2021.09.015

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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

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

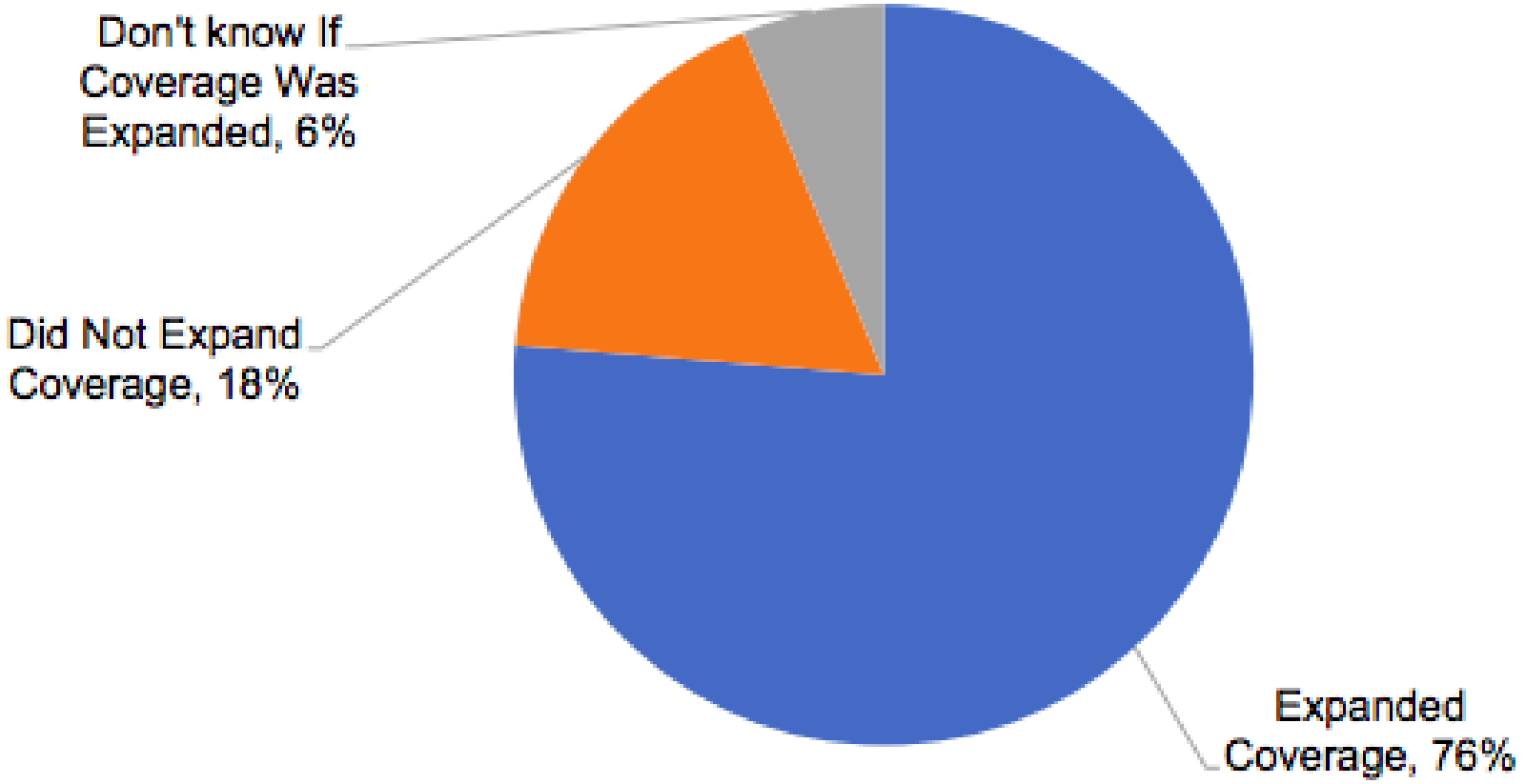
PRESS RELEASES

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

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



Source: Employee Benefit Research Institute survey.

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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

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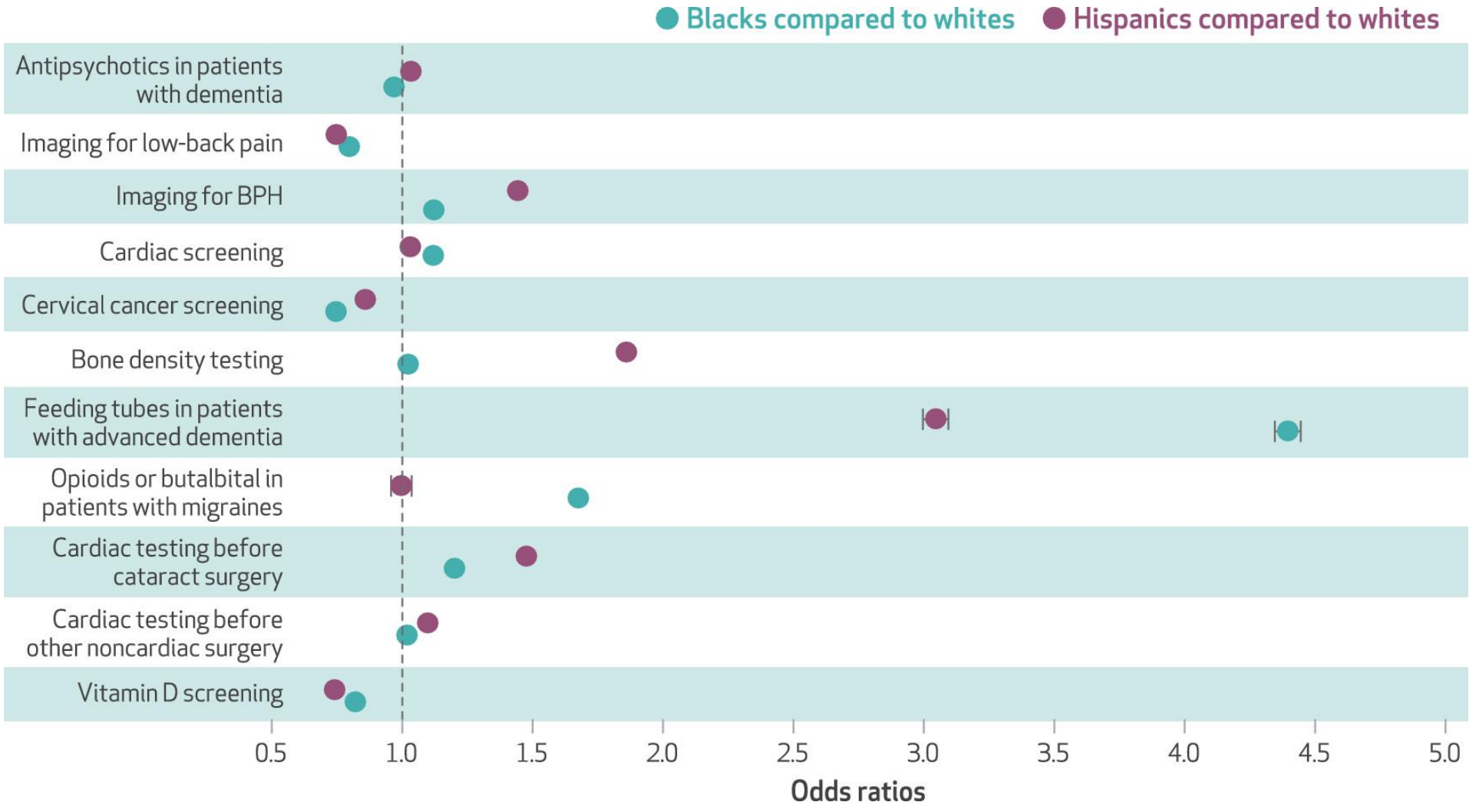
Blacks And Hispanics More Likely To Receive Low-Value Care Than Whites



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

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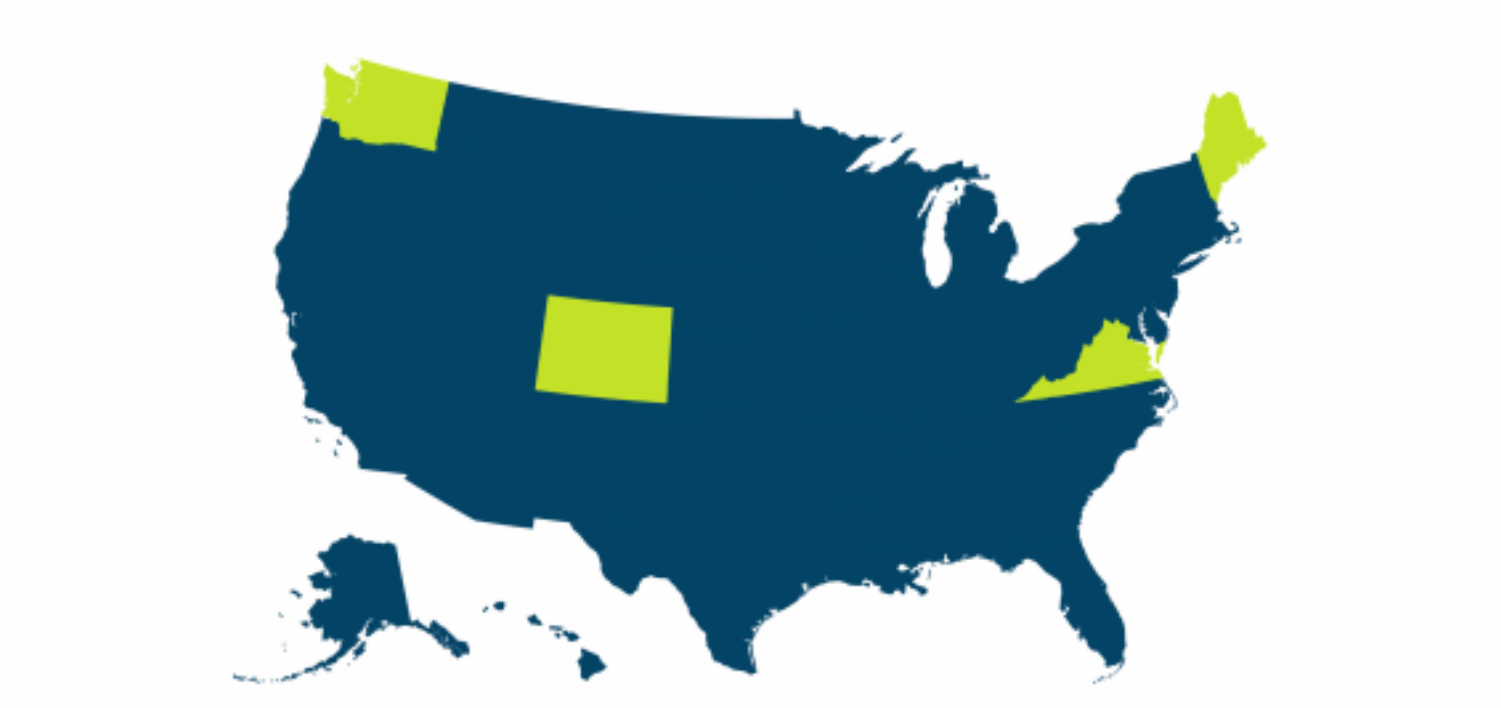
JAMA Internal Medicine | Original Investigation | LESS IS MORE

Low-Value Care at the Actionable Level of Individual Health Systems

- Wide Variation in Use of Low Value Care
- Health System Traits Associated with More LVC use
  - Smaller proportion of primary care physicians
  - Not affiliated with a major teaching hospital
  - Does not have an Accountable Care Organization
  - Larger proportion of non-White patients
  - Headquartered in the South or West of United States
  - Serving areas with more health care spending

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



https://vbidhealth.com/docs/States-LVC-Paper-FINAL-Draft(1).pdf

State APCDs Measuring **Low-value Care**

Enrolled States :

- Virginia
- Washington
- Maine
- Colorado
- Connecticut
- Utah
- Wisconsin

Interested States :

- Delaware
- Minnesota

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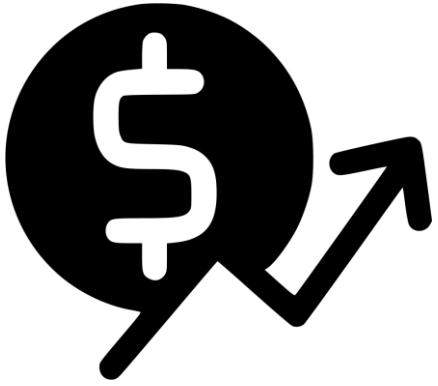
Annual Use and Cost of Seven Grade D Services Among Medicare Enrollees



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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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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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

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Exchanges Using V-BID X Principles to Enhance Equity

- California
- Colorado
- Maryland
- Massachusetts
- District of Columbia

DC Health Benefit Exchange Authority

V-BID Elements Adopted to Achieve Equity in Health Insurance Coverage

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Enhancing Access and Affordability to Essential Clinical Services: Better Patient-Centered Outcomes, Enhanced Equity and Improved Efficiency

- 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
- Align clinically-driven plan payment reform, technologies and benefit designs (i.e., V-BID X) to increase use of high-value services and deter low value care

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Thank you

Questions?

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