V-BID Priorities – 2022

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M | V-BID

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)

PRIORITIES MOVING FORWARD:

Improve access and affordability to essential clinical cervices to produce better outcomes, enhance equity and improve efficiency

- Expand pre-deductible coverage/reduce consumer cost-sharing on essential services
- Identify, measure and reduce low-value care to pay for more generous coverage of high-value services
- 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

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)

COVID-19 Testing and Vaccines Provided without Cost-sharing

ASPE | OFFICE OF HEALTH POLICY
ASSISTANT SECRETARY FOR PLANNING AND EVALUATION

ISSUE BRIEF

January 11, 2022

HP-2022-01

Access to Preventive Services without Cost-Sharing: Evidence from the Affordable Care Act

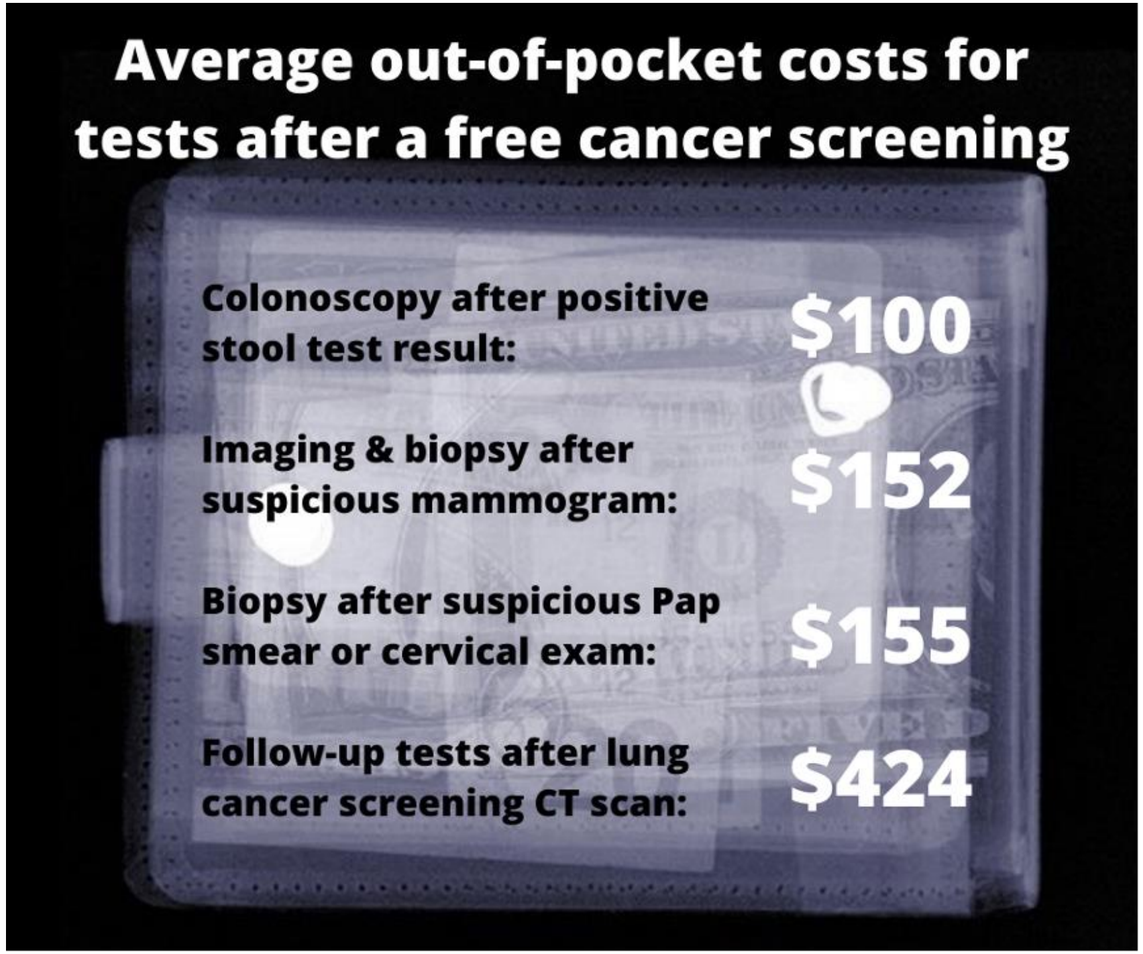
- Over 230 million Americans have enhanced access to preventive services
  - 150 million with private insurance – including 58 M women and 37 M children
  - 61 million Medicare beneficiaries
  - Approximately 20 million Medicaid adult expansion enrollees
- A majority of studies showed increases in use of fully covered services
- Studies that included socioeconomic status reported more substantial increases in utilization of preventive services in financially vulnerable patients, suggesting that the policy reduced disparities in the delivery of preventive care

CANCER SCREENING

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

New VBID Center research shows that out-of-pocket costs are common and non-trivial for necessary follow-up testing after initial, abnormal no-cost cancer screening test.

- Breast [1]
- Cervical [2]
- Colorectal [3]
- Lung [4]



- JAMA Network Open. 2021;4(8):e2121347
- Obstetrics & Gynecology. 2022;139(1): doi:10.1097/AOG.0000000000004582
- JAMA Network Open. 2021;4(12): doi:10.1001/jamanetworkopen.2021.36798
- JACR E-pub ahead of print. 2021.DOI:https://doi.org/10.1016/j.jacr.2021.09.015

FAQS ABOUT AFFORDABLE CARE ACT IMPLEMENTATION PART 51, FAMILIES FIRST CORONAVIRUS RESPONSE ACT AND CORONAVIRUS AID, RELIEF, AND ECONOMIC SECURITY ACT IMPLEMENTATION

January 10, 2022

Q7: Are plans and issuers required to cover, without the imposition of any cost sharing, a follow-up colonoscopy conducted after a positive non-invasive stool-based screening test or direct visualization test (e.g., sigmoidoscopy, CT colonography)?

Yes. A plan or issuer must cover and may not impose cost sharing with respect to a colonoscopy conducted after a positive non-invasive stool-based screening test or direct visualization screening test for colorectal cancer for individuals described in the USPSTF recommendation. As stated in the May 18, 2021 USPSTF recommendation, the follow-up colonoscopy is an integral part of the preventive screening without which the screening would not be complete.[31] The follow-up colonoscopy after a positive non-invasive stool-based screening test or direct visualization screening test is therefore required to be covered without cost sharing in accordance with the requirements of PHS Act section 2713 and its implementing regulations.

MEDICARE ADVANTAGE

High Out of Pocket Costs are Common and Impactful for Medicare Beneficiaries

4 in 10

Paid over $200

34%

of seniors on Medicare with high out-of-pocket costs reduced other spending in order to afford their prescription drugs

Options to Implement V-BID in Medicare Advantage

1 MA V-BID Model Test

Demonstration project by CMMI with waiver of the uniformity rule for participants only

- Formerly available in a few states; will be 25 states in 2019; all 50 by 2020
- Strict participation & application criteria and procedures
- V-BID benefits for MA Parts C and D

2 Increased Plan Flexibility

CMS reinterpretation of uniformity policy in 2019 final rule and HPMS guidance

- Applies to ALL Medicare Advantage Plans
- No "application" required; V-BID benefits submitted in plan benefit package as part of bid
- V-BID benefits for Part C ONLY
- Benefits must relate to clinical condition

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

In 2021, 415 plans covering approximately 4.2 million beneficiaries were available in 47 states and Puerto Rico

Press release

CMS Launches Groundbreaking Model to Lower Out of Pocket Expenses for Insulin

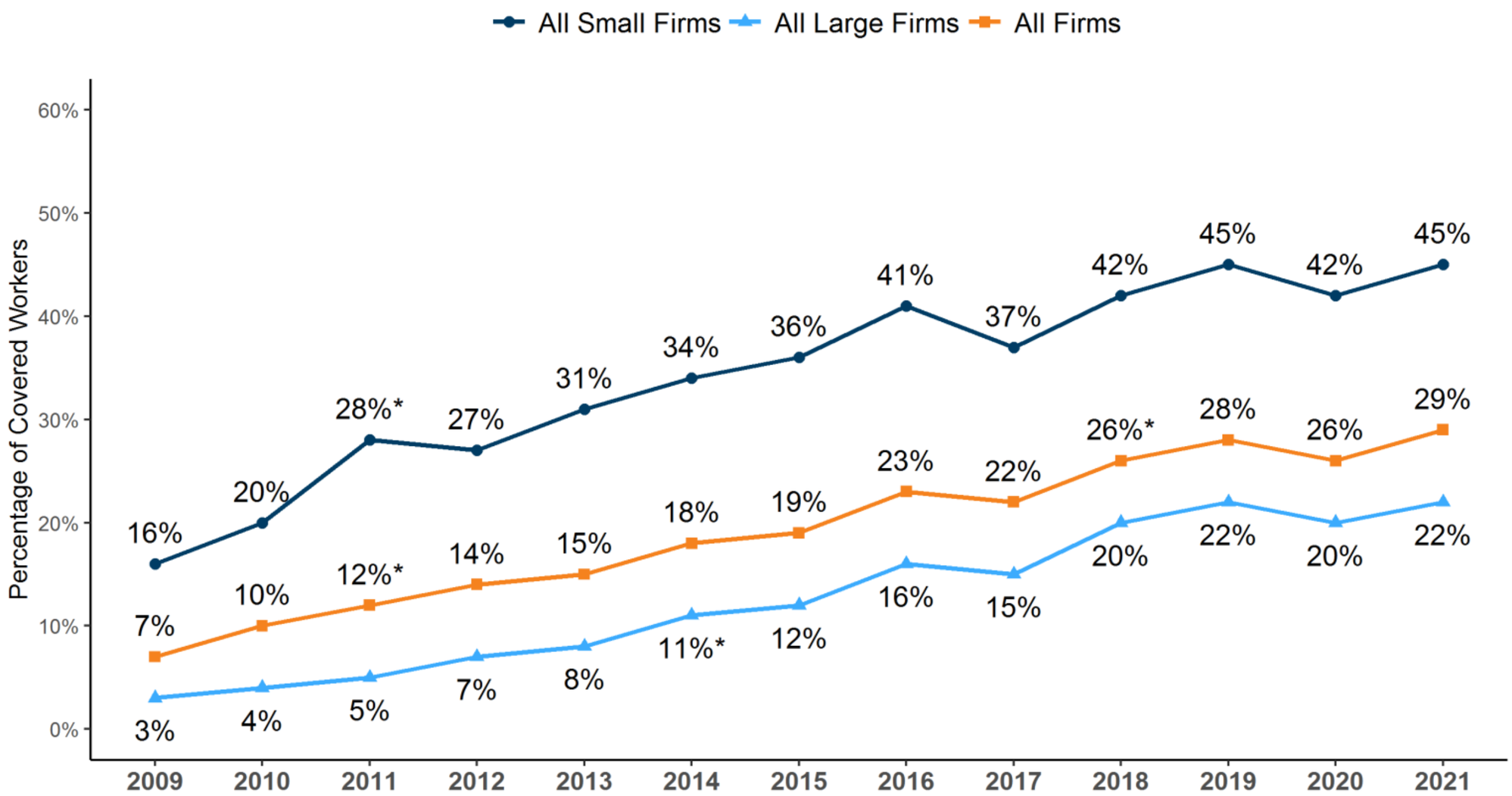
Mar 11, 2020 | Coverage, Innovation models, Medicare Part D, Prescription drugs, Quality

Part D Senior Savings Plan Model

- Part D Senior Savings: a model test that allows MA plans to offer beneficiaries with diabetes a fixed, maximum $35 copayment for their insulin throughout the year
- 30% of MA plans participated in 2021
- Legislation pending that would require national expansion of this policy to all Medicare plans and private plans

HSA-HDHP REFORM

Percentage of Covered Workers Enrolled in a Plan With a General Annual Deductible of $2,000 or More for Single Coverage, by Firm Size



Source: Kaiser Family Foundation Employer Health Benefits Survey. 2021 Employer Health Benefits Survey - Summary of Findings. 10 Nov 2021. Accessed at: https://www.kff.org/report-section/ehbs-2021-summary-of-findings/attachment/figure-e-33/.

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 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

EBRI Issue Brief
October 14, 2021 • No. 542

Employer Uptake of Pre-Deductible Coverage for Preventive Services in HSA-Eligible Health Plans

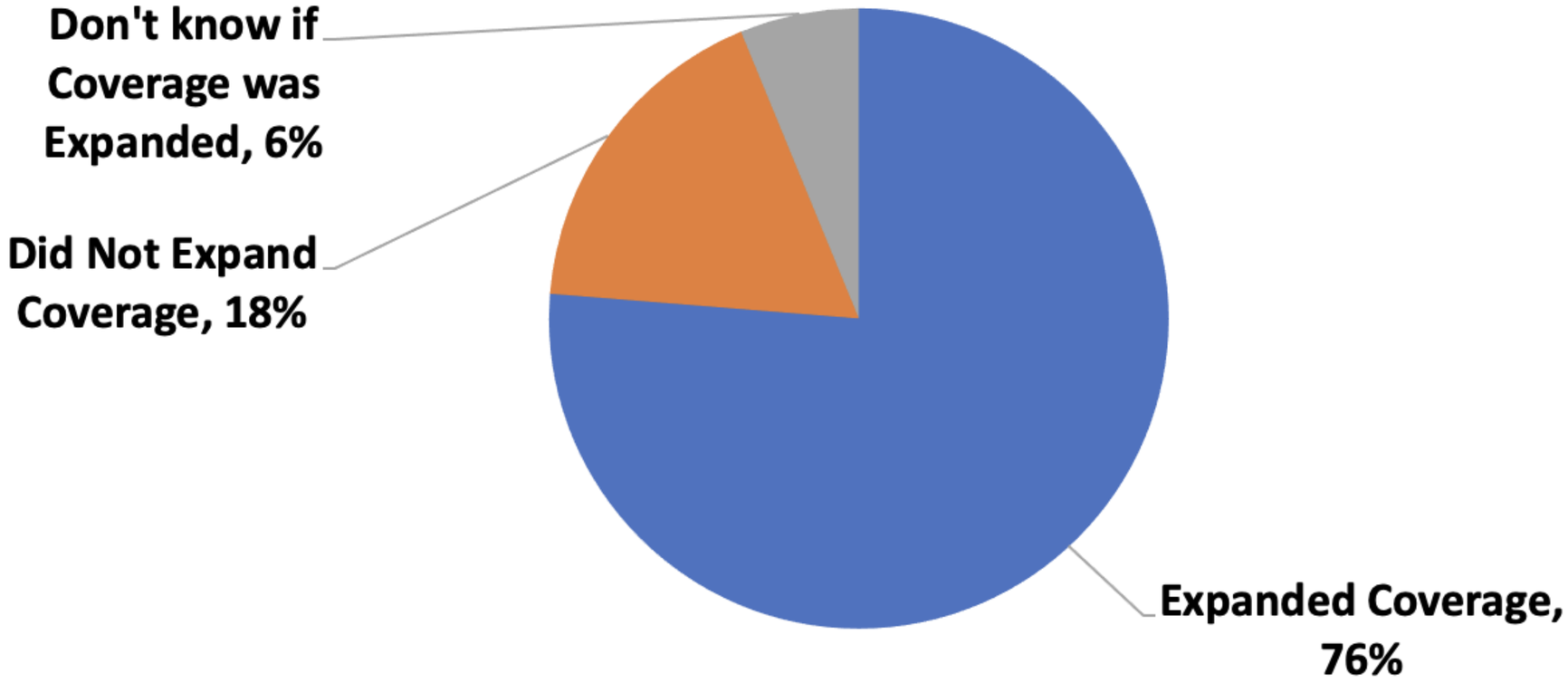
By Paul Fronstin, Ph.D., Employee Benefit Research Institute and A. Mark Fendrick, M.D., University of Michigan

AT A GLANCE

IRS Notice 2019-45 allows health savings account (HSA)-eligible health plans the flexibility to cover 14 medications and services used to prevent the exacerbation of chronic conditions prior to meeting the plan deductible.

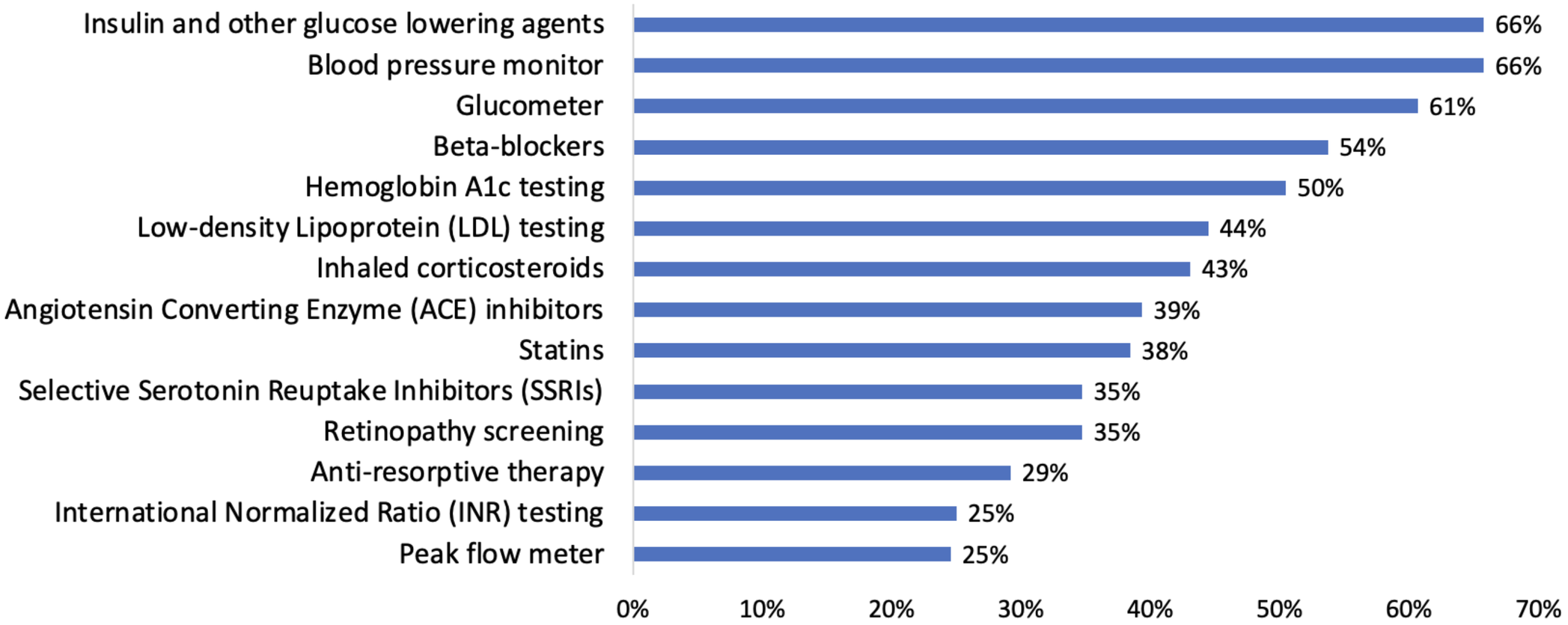
In this *Issue Brief*, we report on the findings from a 2021 Employee Benefit Research Institute (EBRI) survey of employers that collected information on their response to the 2019 guidance. The survey examined not only whether employers added pre-deductible coverage as a result of Notice 2019-45, but also examined each of the allowed services individually; the type of cost sharing, if any, used in lieu of deductibles; and other relevant questions.

Percentage of Employers Who Expanded Pre-Deductible Coverage in HSA-Eligible Health Plan for Preventive Services Allowed Under IRS Rule 2019-45



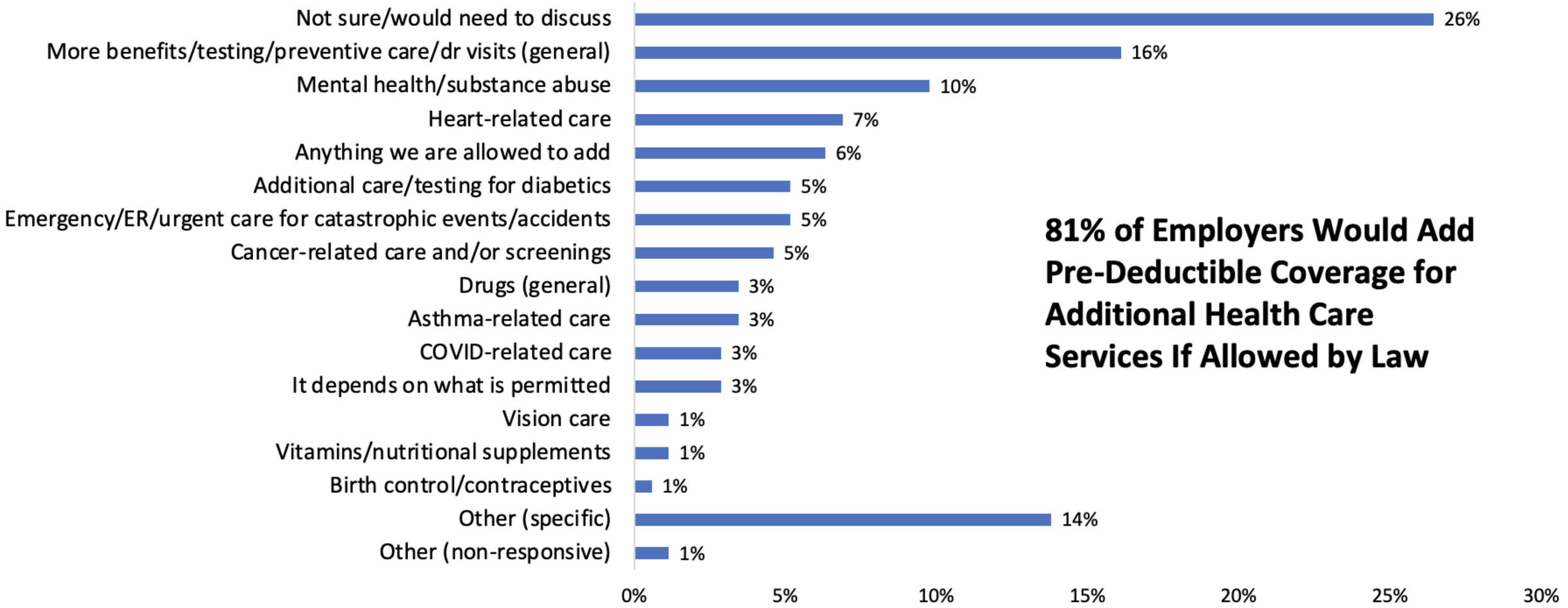
SOURCE: Fronstin, Paul, and A. Mark Fendrick, “Employer Uptake of Pre-Deductible Coverage for Preventive Services in HSA-Eligible Health Plans,” EBRI Issue Brief, no. 542 (October 14, 2021).

Preventive Care Measures Covered on a Pre-Deductible Basis as a Result of IRS Notice 2019-45



SOURCE: Fronstin, Paul, and A. Mark Fendrick, "Employer Uptake of Pre-Deductible Coverage for Preventive Services in HSA-Eligible Health Plans," EBRI Issue Brief, no. 542 (October 14, 2021).

Additional Pre-Deductible Coverage that Employers Would Like to Add (Based on Open Ended Question)



Expand list of services under IRS 2019-45
SHCC Comment Letter

November 29, 2021

The Honorable Janet Yellen
Secretary
U.S. Department of the Treasury
1500 Pennsylvania Avenue NW
Washington, D.C. 20220

The Honorable Charles P. Rettig
Commissioner
Internal Revenue Service
1111 Constitution Avenue NW
Washington, D.C. 20224

Dear Secretary Yellen and Commissioner Rettig:

The Smarter Health Care Coalition (the Coalition) appreciated working with the Department and the Service as you considered and finalized Notice 2019-45, which allows more flexibility for health plans and employers to cover certain chronic disease prevention drugs and services pre-deductible in Health Savings Account-eligible plans. We remain grateful for the broadened preventive care safe harbor detailed in IRS Notice 2019-45, and we write to provide very encouraging data about the number of health plans and employers that have changed their plan benefit designs in response to the guidance. **As a result of this overwhelming, positive response, we urge you to expand the list of items and services that may be covered under the preventive care safe harbor to include additional high-value, low-cost drugs and services used to prevent complications of other chronic conditions, especially those that would prevent exacerbation of mental and behavioral health conditions, helping millions of Americans improve their mental and physical health.**

Chronic Disease Management Act of 2021

117TH CONGRESS
1ST SESSION

S. 1424

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.

IN THE SENATE OF THE UNITED STATES

APRIL 28, 2021

Mr. THUNE (for himself and Mr. CARPER) introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

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.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

LOW-VALUE CARE

How do we pay for better coverage for high value care?

- Raise Premiums
- Increase Deductibles, Copayments and Coinsurance
- Reduce Spending on Low Value Care

Reducing Low-Value Care to Improve Health Equity

M V-BID

Reducing use of low-value care, starting with services that provide no clinical benefit in particular patient populations, is central to improving health equity

ACA Sec 4105: Modify or Eliminate Coverage of Certain Preventive Services

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.

The ACA grants HHS the authority to eliminate coverage for USPSTF 'D' Rated Services in Medicare

USPSTF Grade D Services Commonly used in Medicare Beneficiaries

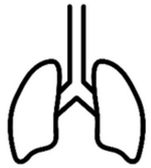
Prostate cancer screening in men ≥ 75 years

Cervical cancer screening > 65 years

Colon cancer screening >85 years

Cardiovascular screening in low risk patients

Asymptomatic bacteriuria screening



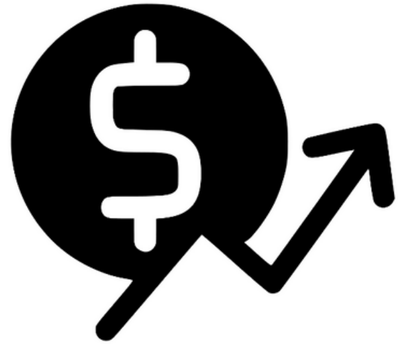
COPD screening

Vitamin D to prevent falls among older women

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

Total Annual Count:

31 million



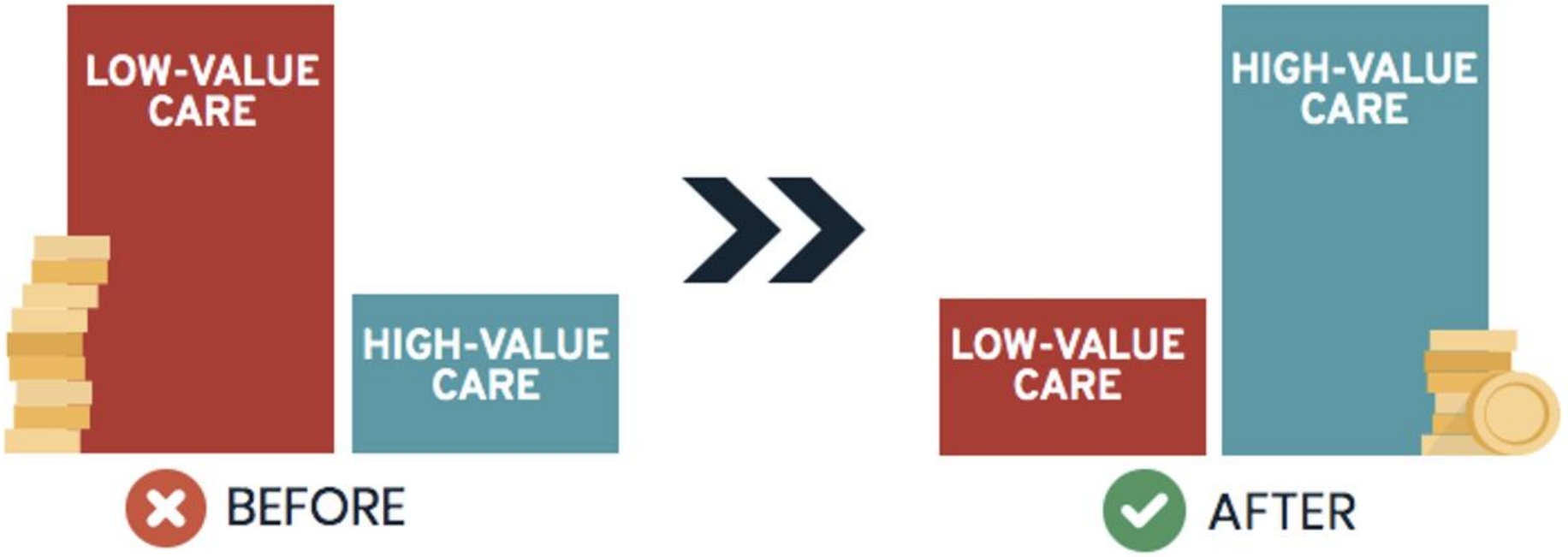
Total Annual Costs:

$478 million

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

V-BID X

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

MAY 08, 2020 | MORE ON MEDICARE & MEDICAID

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

Exchanges Using V-BID X Principles to Enhance Equity

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

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

V-BID PRIORITIES MOVING FORWARD:

Improve access and affordability to essential clinical cervices to produce better outcomes, enhance equity and improve efficiency

- Expand pre-deductible coverage/reduce consumer cost-sharing on essential services
  - Mental health
  - Substance abuse disorder
  - Unhealthy weight
  - Cancer screening
  - Maternity care
  - Trauma services

- Identify, measure and reduce low-value care to pay for more generous coverage of high-value services

- 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

Slides and VBID resources available at www.vbidcenter.org