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

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

www.vbidcenter.org
@um_vbid
Irrespective of remarkable clinical advances, cutting health care spending is the main focus of reform discussions.

Everyone (almost) agrees there is enough money in the US health care system; we just spend it on the wrong services.

Policy deliberations focus primarily on alternative payment models, but moving to value-based system also requires a change in how we engage consumers to seek care.

Health Care Costs Are a Top Issue For Purchasers and Policymakers: Solutions must protect consumers, reward providers and preserve innovation.
CalPERs V-BID Experience

Comparison of enrollees in California Public Employees’ Retirement System (CalPERS) V-BID to a Non-VBID PPO with very similar benefit structures regarding copayment, coinsurance (10%) and maximum out-of-pocket (OOP) limit:

• Enrollment in V-BID program led to higher primary care provider and immunization utilization with no added total costs
• Compared to those not enrolled in a V-BID PPO, V-BID beneficiaries experienced lower out-of-pocket payments, as well as significantly lower rates of hospital and surgical admissions

https://academyhealth.confex.com/academyhealth/2022arm/meetingapp.cgi/Paper/51903
Then Came Coronavirus...
Plan deductibles have grown more than ten times faster than inflation over the last decade.
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)
Impact of Cost-Sharing on Health Care Disparities

Effects of Increased Patient Cost Sharing on Socioeconomic Disparities in Health Care

- Rising copayments worsen disparities and adversely affect health, particularly among economically vulnerable individuals and those with chronic conditions.
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
Eliminating Medication Copayments Reduces Disparities in Cardiovascular Care
Crisis Into Opportunity: Can COVID-19 Help Set a Path to Improved Health Care Efficiency?

The graph shows the trend of weekly utilization per 100,000 people from Pre-COVID-19 to the COVID-19 pandemic and into a hypothetical new normal. The graph is divided into three phases:

1. **Pre-COVID-19**: Low-value cancer screenings (actual data) and indicated cancer screenings (actual data) are depicted. The trend lines show a moderate level of utilization.
2. **COVID-19 Pandemic**: A sharp decline in utilization is observed, especially for low-value cancer screenings. The indicated cancer screenings also show a decrease but to a lesser extent.
3. **Hypothetical New Normal**: The graph projects an increase in utilization back towards pre-COVID-19 levels, with low-value cancer screenings and indicated cancer screenings both showing upward trends.

The graph includes labels for average rates pre-COVID-19, with separate lines indicating the actual data and hypothetical data for both low-value and indicated cancer screenings.
Crisis Into Opportunity: Can COVID-19 Help Set a Path to Improved Health Care Efficiency?

- Build on existing alternative payment models that base reimbursement on patient-centered outcomes; increase reimbursement for high-value services and reduce or cease payment for known low-value care
- Align patient cost-sharing with the value of the underlying services; reduce out of pocket cost on high-value services and increase patient cost on low-value care
- Use value-based principles to leverage the widespread adoption of telehealth
• Lower deductibles
• Access to more services prior to meeting the plan deductible
• Prioritize copays where possible to provide predictability for consumers when seeking services
• Limit premium impacts
  – Particularly at bronze, where consumers may be most premium sensitive and coverage is limited
• Maximize tax credits with silver plan design
• 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
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
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.

- Reduced spending on non-essential activities: 56%
- Reduced spending on every-day purchases: 49%
- Accrued credit card debt: 31%
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)

<table>
<thead>
<tr>
<th>Wellness and Health Care Planning</th>
<th>Targeting Socioeconomic Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advanced care planning</td>
<td>Low-income subsidy</td>
</tr>
<tr>
<td>Incentivize better health behaviors</td>
<td>Improve quality, decrease costs</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rewards and Incentives</th>
<th>Telehealth</th>
</tr>
</thead>
<tbody>
<tr>
<td>$600 annual limit</td>
<td>Service delivery innovations</td>
</tr>
<tr>
<td>Increase participation</td>
<td>Augment existing provider networks</td>
</tr>
<tr>
<td>Available for Part D</td>
<td></td>
</tr>
</tbody>
</table>

In 2021, 415 plans covering approximately 4.2 million beneficiaries were available in 47 states and Puerto Rico
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
Percentage of Covered Workers Enrolled in a Plan With a General Annual Deductible of $2,000 or More for Single Coverage, by Firm Size

Treasury Expands Health Savings Account Benefits for Individuals Suffering from Chronic Conditions
<table>
<thead>
<tr>
<th>Preventive Care for Specified Conditions</th>
<th>For Individuals Diagnosed with</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angiotensin Converting Enzyme (ACE) inhibitors</td>
<td>Congestive heart failure, diabetes, and/or coronary artery disease</td>
</tr>
<tr>
<td>Anti-resorptive therapy</td>
<td>Osteoporosis and/or osteopenia</td>
</tr>
<tr>
<td>Beta-blockers</td>
<td>Congestive heart failure and/or coronary artery disease</td>
</tr>
<tr>
<td>Blood pressure monitor</td>
<td>Hypertension</td>
</tr>
<tr>
<td>Inhaled corticosteroids</td>
<td>Asthma</td>
</tr>
<tr>
<td>Insulin and other glucose lowering agents</td>
<td>Diabetes</td>
</tr>
<tr>
<td>Retinopathy screening</td>
<td>Diabetes</td>
</tr>
<tr>
<td>Peak flow meter</td>
<td>Asthma</td>
</tr>
<tr>
<td>Glucometer</td>
<td>Diabetes</td>
</tr>
<tr>
<td>Hemoglobin A1c testing</td>
<td>Diabetes</td>
</tr>
<tr>
<td>International Normalized Ratio (INR) testing</td>
<td>Liver disease and/or bleeding disorders</td>
</tr>
<tr>
<td>Low-density Lipoprotein (LDL) testing</td>
<td>Heart disease</td>
</tr>
<tr>
<td>Selective Serotonin Reuptake Inhibitors (SSRIs)</td>
<td>Depression</td>
</tr>
<tr>
<td>Statins</td>
<td>Heart disease and/or diabetes</td>
</tr>
</tbody>
</table>
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

- Expanded Coverage, 76%
- Did Not Expand Coverage, 18%
- Don't know if Coverage was Expanded, 6%

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

- Not sure/would need to discuss: 26%
- More benefits/testing/preventive care/dr visits (general): 16%
- Mental health/substance abuse: 10%
- Heart-related care: 7%
- Anything we are allowed to add: 6%
- Additional care/testing for diabetics: 5%
- Emergency/ER/urgent care for catastrophic events/accidents: 5%
- Cancer-related care and/or screenings: 5%
- Drugs (general): 3%
- Asthma-related care: 3%
- COVID-related care: 3%
- It depends on what is permitted: 3%
- Vision care: 1%
- Vitamins/nutritional supplements: 1%
- Birth control/contraceptives: 1%
- Other (specific): 14%
- Other (non-responsive): 1%

81% of Employers Would Add Pre-Deductible Coverage for Additional Health Care Services If Allowed by Law
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

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

$345 BILLION is spent annually on low-value or harmful care in the United States.
In the United States, low-value healthcare disproportionately impacts communities of color.

Reducing Low-Value Care to Improve Health Equity

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

Multi-stakeholder Collaborative Efforts to Reduce Low Value Care

• Low Value Care Task Force
• Altarum Research Consortium on Health Care Value Assessment
• Smarter Care Virginia
• Washington Health Alliance

State APCDs
  ○ Phase 1
    ▪ Colorado
    ▪ Maine
    ▪ Virginia
    ▪ Washington

• State APCDs
  ○ Phase 2
    ▪ Colorado
    ▪ Connecticut
    ▪ Utah
    ▪ Wisconsin

https://vbidhealth.com/elementor-1016/
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.
V-BID X: Guiding Principles

- Make concrete recommendations
- Anticipate and address barriers
- Payers must be able to use template to design a V-BID product
- The best must not be the enemy of the good
- Output would be publicly available
Identification of services:

1. Favor services with the strongest evidence-base
2. Favor services that are more responsive to cost-sharing
3. Favor services with a high likelihood to be high- or low-value, independent of the clinical context
4. Focus on areas with most need for improvement
5. Consider equity, adverse selection, impact on special populations, and the risk pool
V-BID X: Project Members

- Research supported by Arnold Ventures
- Oliver Wyman provided actuarial estimates
V-BID X: Plan Flexibility

The list of services and service categories used in this first iteration of V-BID X represents just one version of what such a plan design could look like.

Payers have significant flexibility regarding how to design a version of V-BID X. Key parameters include:

- Selection of high-value services for reduced cost-sharing
- Level of cost-sharing reduction for high-value services
- Selection of low-value services for increased cost sharing
- Level of cost-sharing increase for low-value services
- Determination of the actuarial value of the plan
CMS promotes value-based insurance design in final payment notice for 2021
<table>
<thead>
<tr>
<th>High Value Services with Zero Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood pressure monitors (hypertension)</td>
</tr>
<tr>
<td>Cardiac rehabilitation</td>
</tr>
<tr>
<td>Glucometers and testing strips (diabetes)</td>
</tr>
<tr>
<td>Hemoglobin a1c testing (diabetes)</td>
</tr>
<tr>
<td>INR testing (hypercoagulability)</td>
</tr>
<tr>
<td>LDL testing (hyperlipidemia)</td>
</tr>
<tr>
<td>Peak flow meters (asthma)</td>
</tr>
<tr>
<td>Pulmonary rehabilitation</td>
</tr>
</tbody>
</table>
Exchanges Using V-BID X Principles to Enhance Equity

- California
- Colorado
- Maryland
- Massachusetts
- District of Columbia
V-BID X: Key Takeaways

- Cost neutral V-BID designs are feasible. Coverage can be enhanced for targeted high-value services, **without** raising premiums and deductibles.

- There are a large number of plausible combinations of services or cost-sharing changes that could fit different needs and goals, depending on the carrier and market.
V-BID X: More Generous Coverage of Essential Clinical Care and Equity Enhancement Without Increasing Premiums or Deductibles

- Expand pre-deductible coverage/reduce cost sharing on high value clinical services
- Identify, measure and reduce low value care to pay for more generous coverage of high value care
- Implement clinically-driven payment models and plan designs that increase use of high value services and deter the use of low value ones
Thank you.

Slides and Resources available at:

www.vbidcenter.org

@um_vbid