Value-Based Insurance Design:

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

A. Mark Fendrick, MD

University of Michigan Center for Value-Based Insurance Design

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@um_vbid

V-BID

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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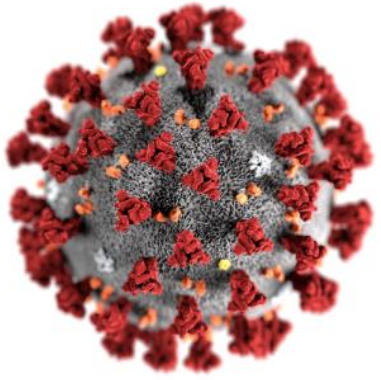
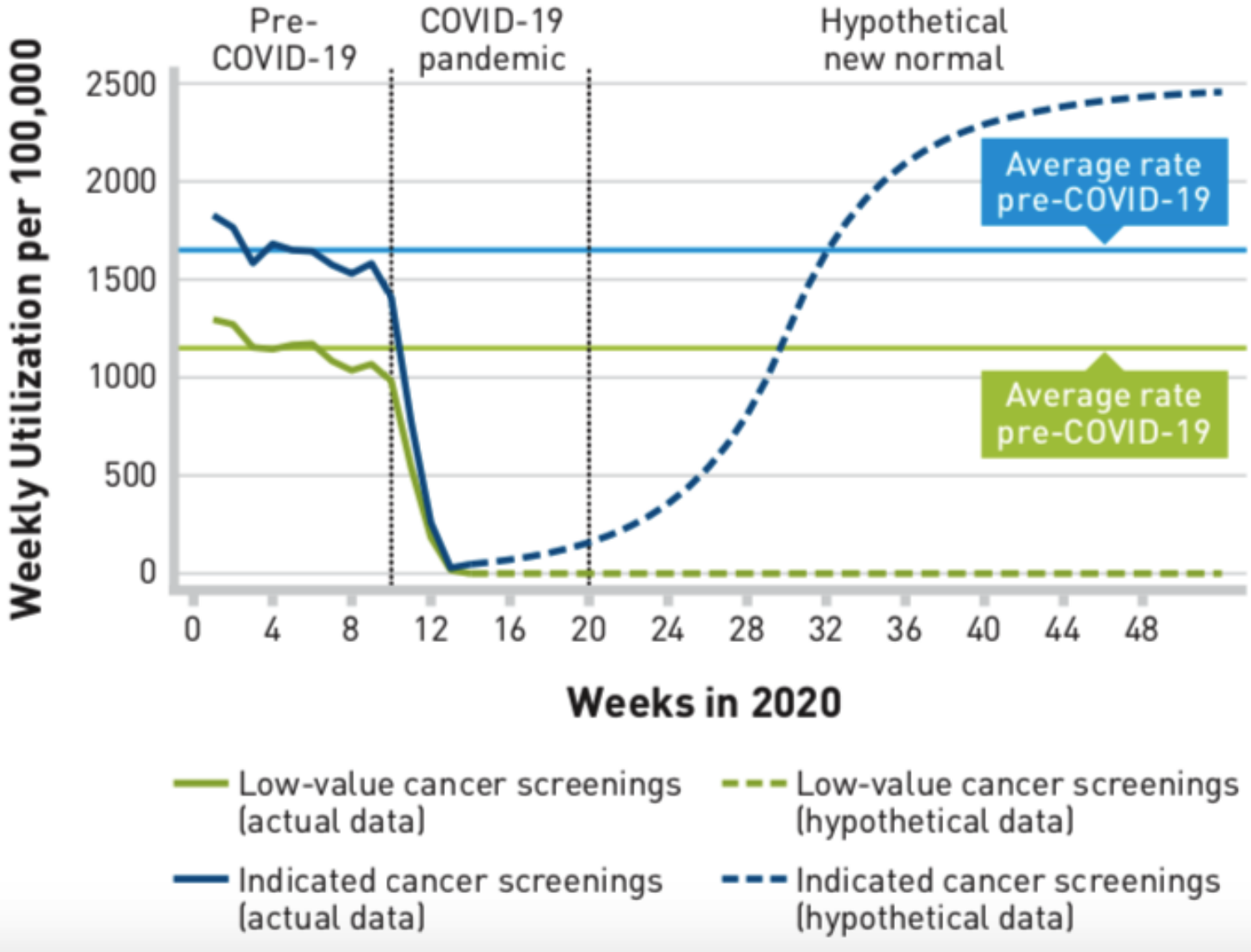
Then Came Coronavirus…



V-BID

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

HEALTH AFFAIRS FOREFRONT

RELATED TOPICS:
TELEHEALTH | ORGANIZATION OF CARE | COVID-19 | VALUE | RESEARCH AGENDAS | COSTS AND SPENDING | ACCESS TO CARE

Establishing A Value-Based 'New Normal' For Telehealth

Christina Cutter, Nicholas L. Berlin, A. Mark Fendrick

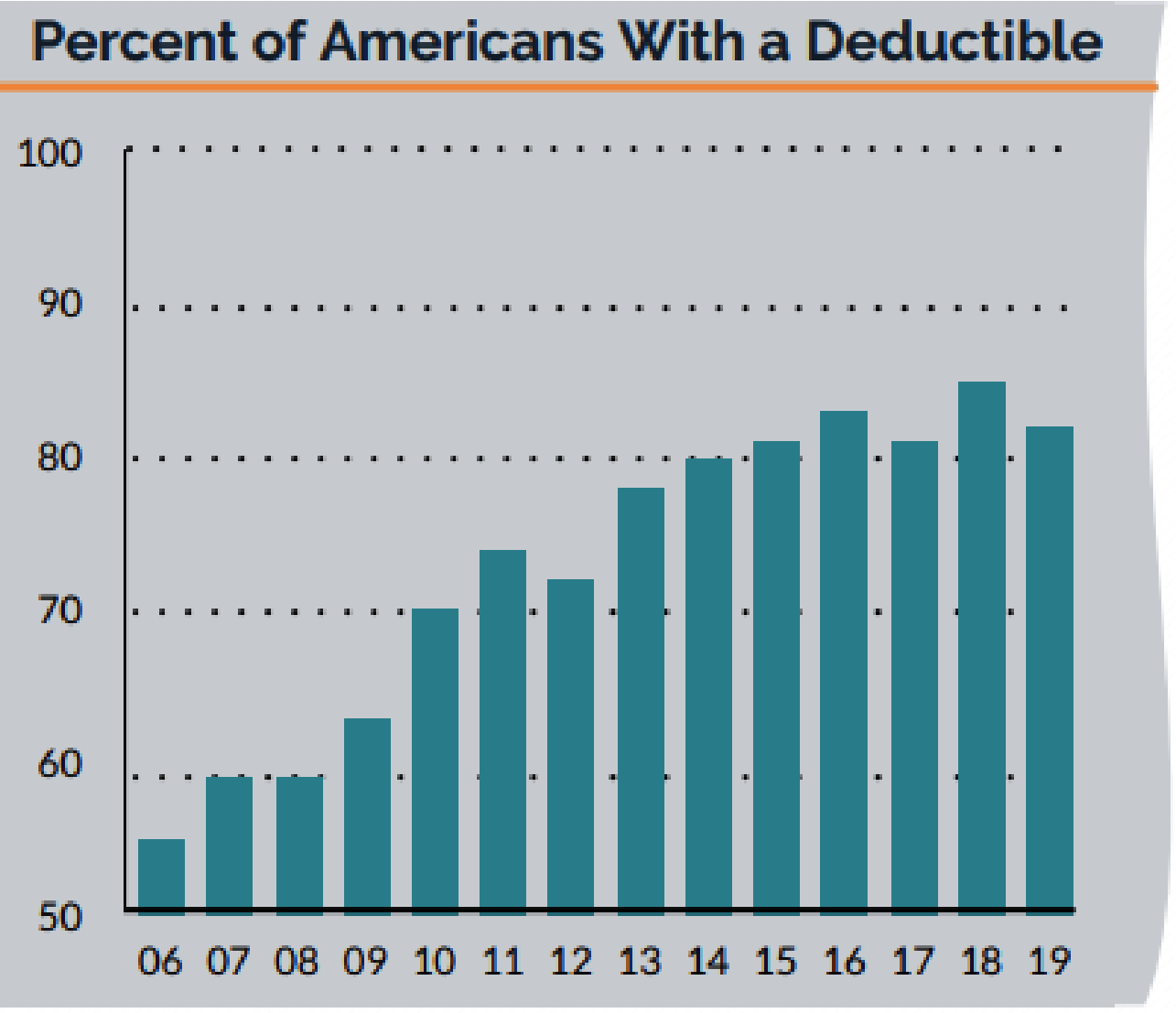
OCTOBER 8, 2020

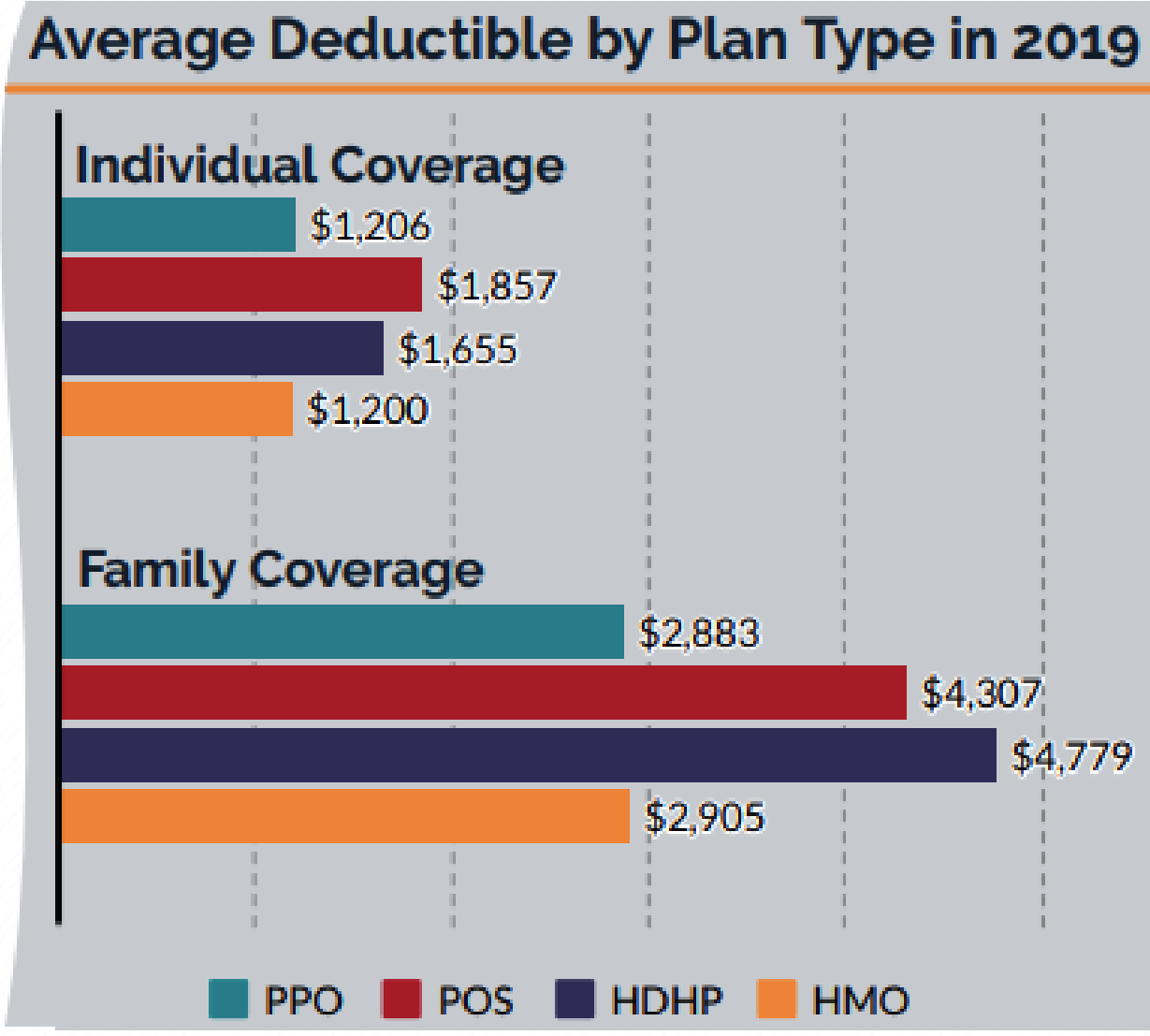
10.1377/forefront.20201006.638022

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

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)

“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

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
- Bipartisan political support
- Enhances equity

The Upshot

Health Plans That Nudge Patients to Do the Right Thing

Austin Frakt
THE NEW HEALTH CARE JULY 10, 2017

RELATED COVERAGE

DISPARITIES

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

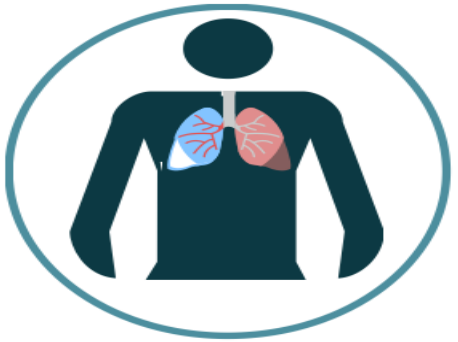
DOI: 10.1377/hlthaff.201:
HEALTH AFFAIRS 33,
NO. 5 (2014): 863–870

Eliminating Medication Copayments Reduces Disparities In Cardiovascular Care

Understanding CLINICAL NUANCE

#1 Clinical Services Differ in the Benefit Produced

Office Visits

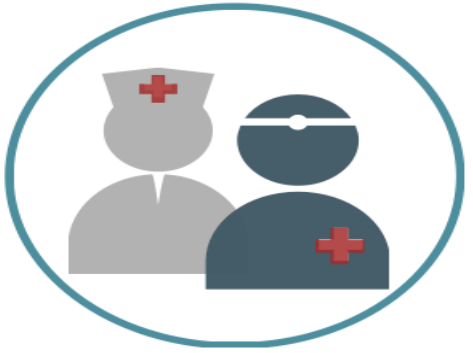


Diagnostic Tests

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...

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

Ambulatory Care Center

$

Hospital

$$$

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)

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

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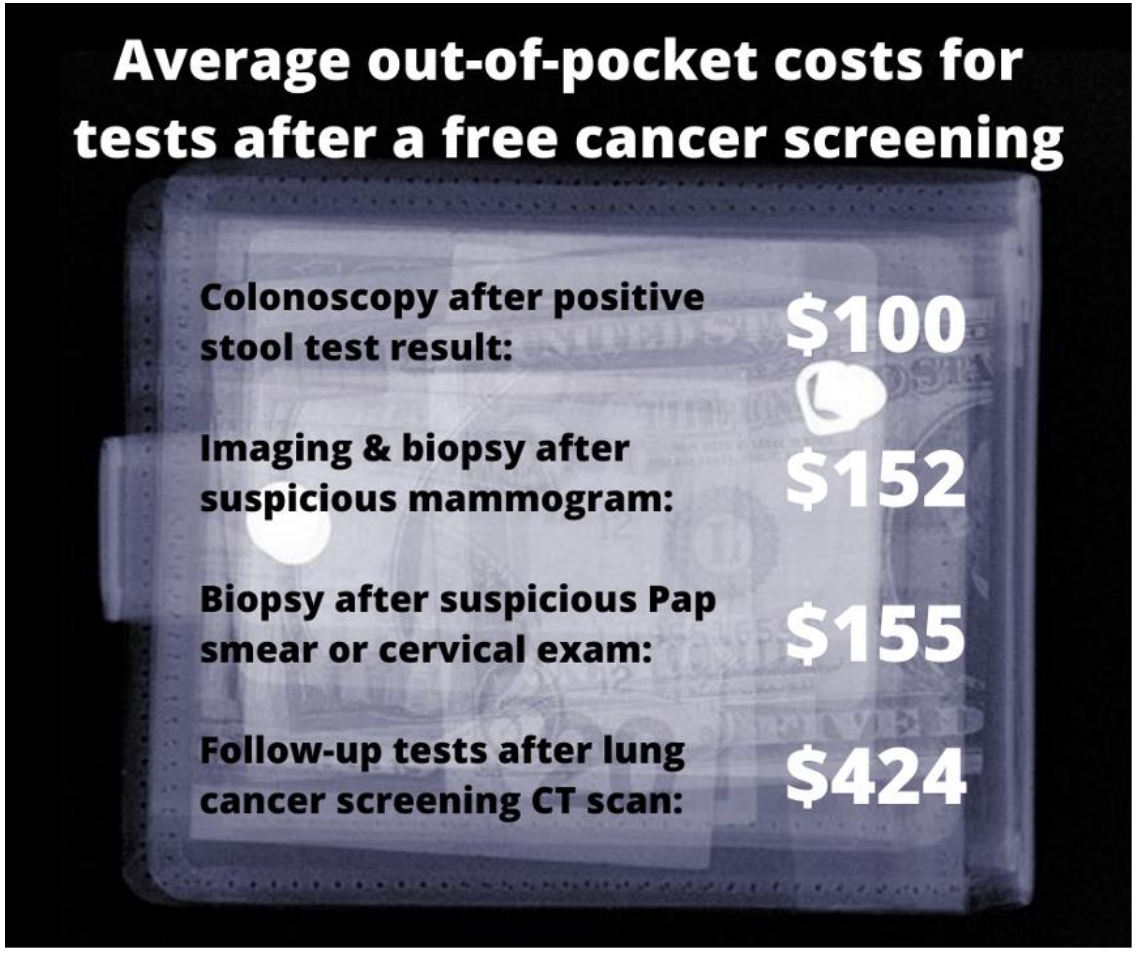
CANCER SCREENING

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.

CMS proposes follow-up colonoscopy after at-home test be considered preventive service

Riz Hatton - Friday, July 8th, 2022

Colorectal Cancer Screening

For CY 2023, we are proposing two updates to expand our Medicare coverage policies for colorectal cancer screening in order to align with recent United States Preventive Services Task Force and professional society recommendations. First, we are proposing to expand Medicare coverage for certain colorectal cancer screening tests by reducing the minimum age payment limitation to 45 years. Second, we are proposing to expand the regulatory definition of colorectal cancer screening tests to include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result. Both of these proposals reflect our desire to expand access to quality care and to improve health outcomes for patients through prevention and early detection services, as well as through effective treatments.

First dollar coverage of the entire cancer screening continuum: 1 down, 3 to go

Cancer Type	Commercial Insurers	Medicare
	✓	✓
		
		
		

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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

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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

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

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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

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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

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

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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.

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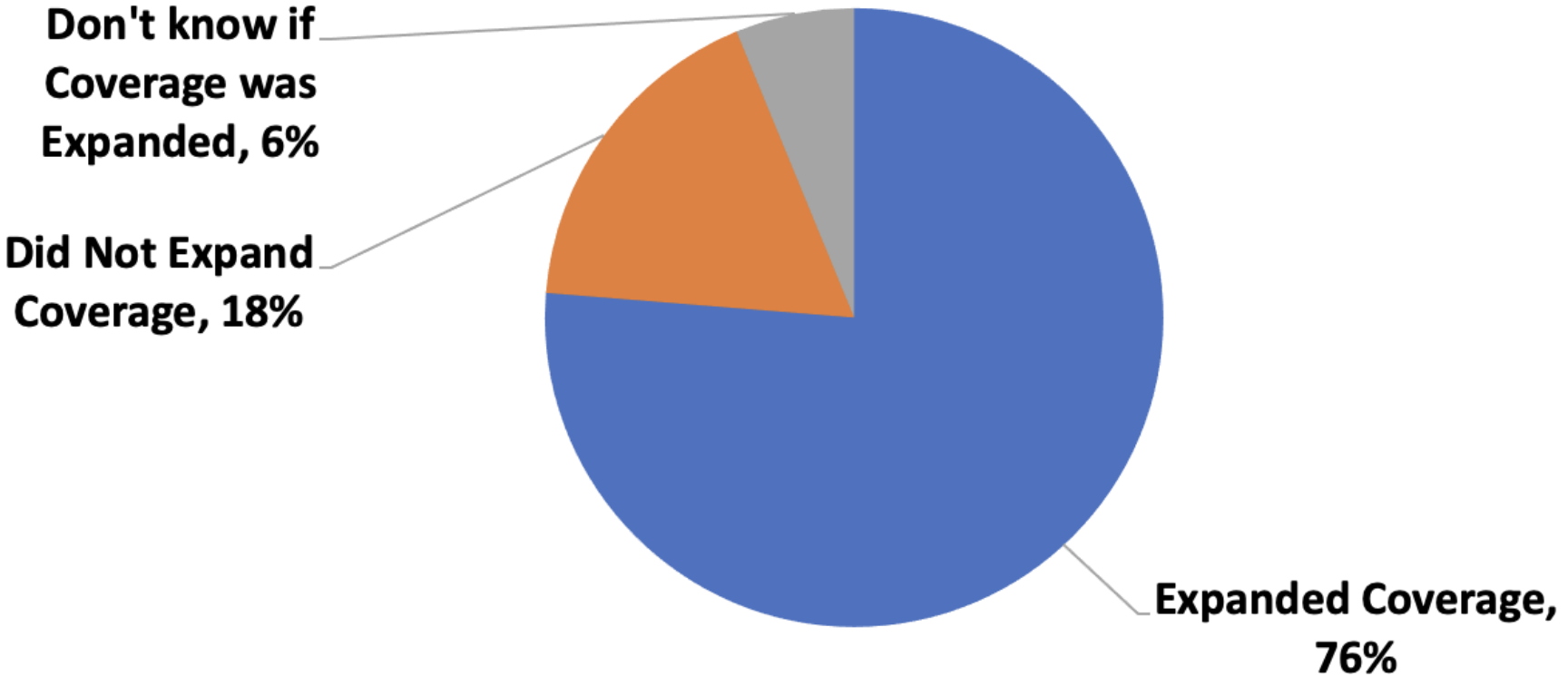
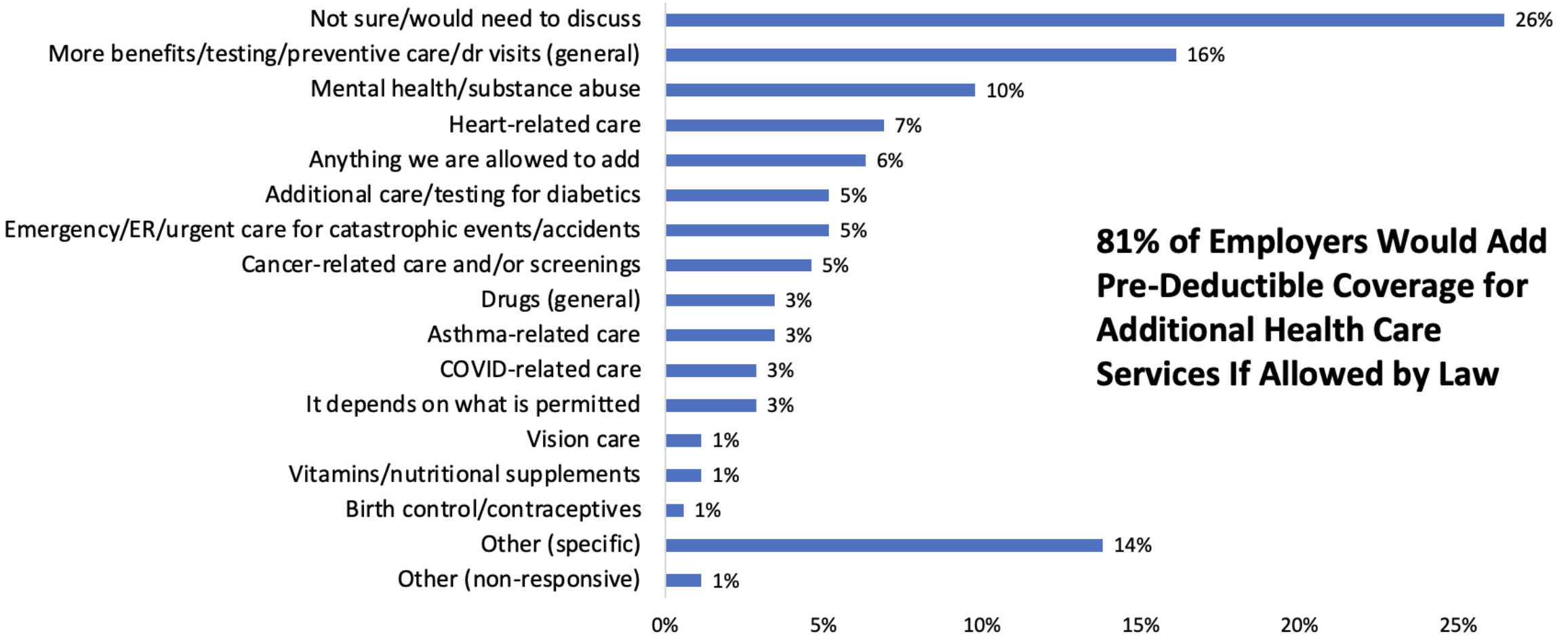
Percentage of Employers Who Expanded Pre-Deductible Coverage in HSA-Eligible Health Plan for Preventive Services Allowed Under IRS Rule 2019-45



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).

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



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

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IRS Notice 2019-45: 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.**

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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

---

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,

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Paying for More Generous Coverage of High Value Care: Reduce Spending on Low Value Care

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

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

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Reducing Low-Value Care to Improve Health Equity

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

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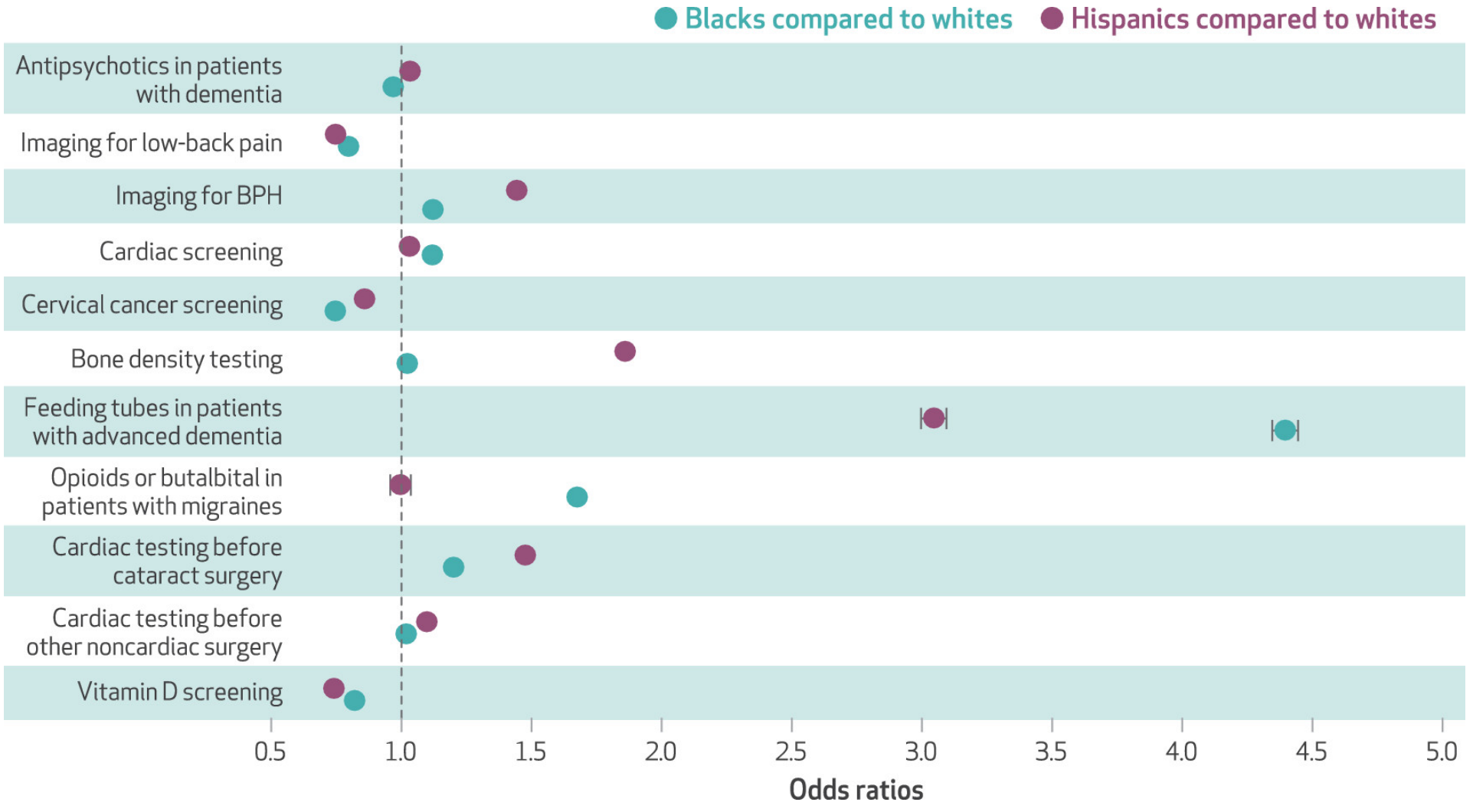
Blacks And Hispanics More Likely To Receive Low-Value Care Than Whites



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

V-BID

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

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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:

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(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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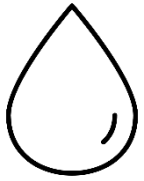
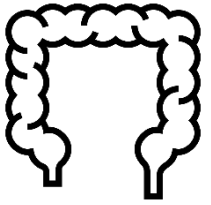
Examples of USPSTF Grade D Services



Prostate cancer screening ≥ 70 years

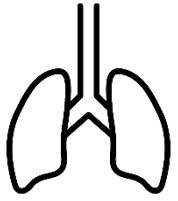
Cervical cancer screening > 65 years



Colon cancer screening >85 years

Cardiovascular screening in low risk patients

Asymptomatic bacteriuria screening

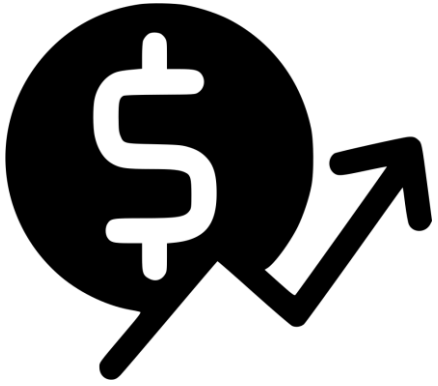


COPD screening

Vitamin D to prevent falls among older women

V-BID

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*.

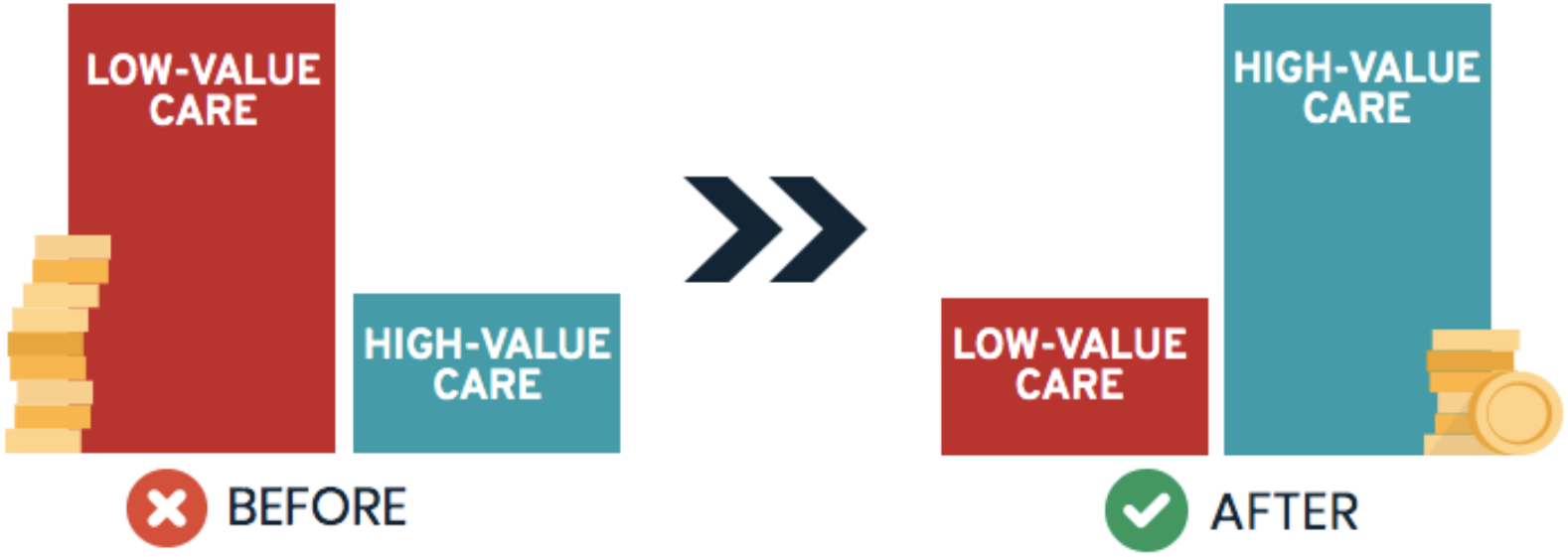
As coverage of preventive services rated a "D" rating needlessly drives up costs with no associated medical benefit, FEHB Carriers are reminded that the accurate processing of claims includes review to ensure that medical services are appropriate and necessary. Therefore, OPM is instructing FEHB Carriers **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.

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

V-BID

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: 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.

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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

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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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).

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

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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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