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

Reducing Low Value Care Use to Fund Spending on High Value Services

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SmarterHealthCare Coalition

V-BID

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

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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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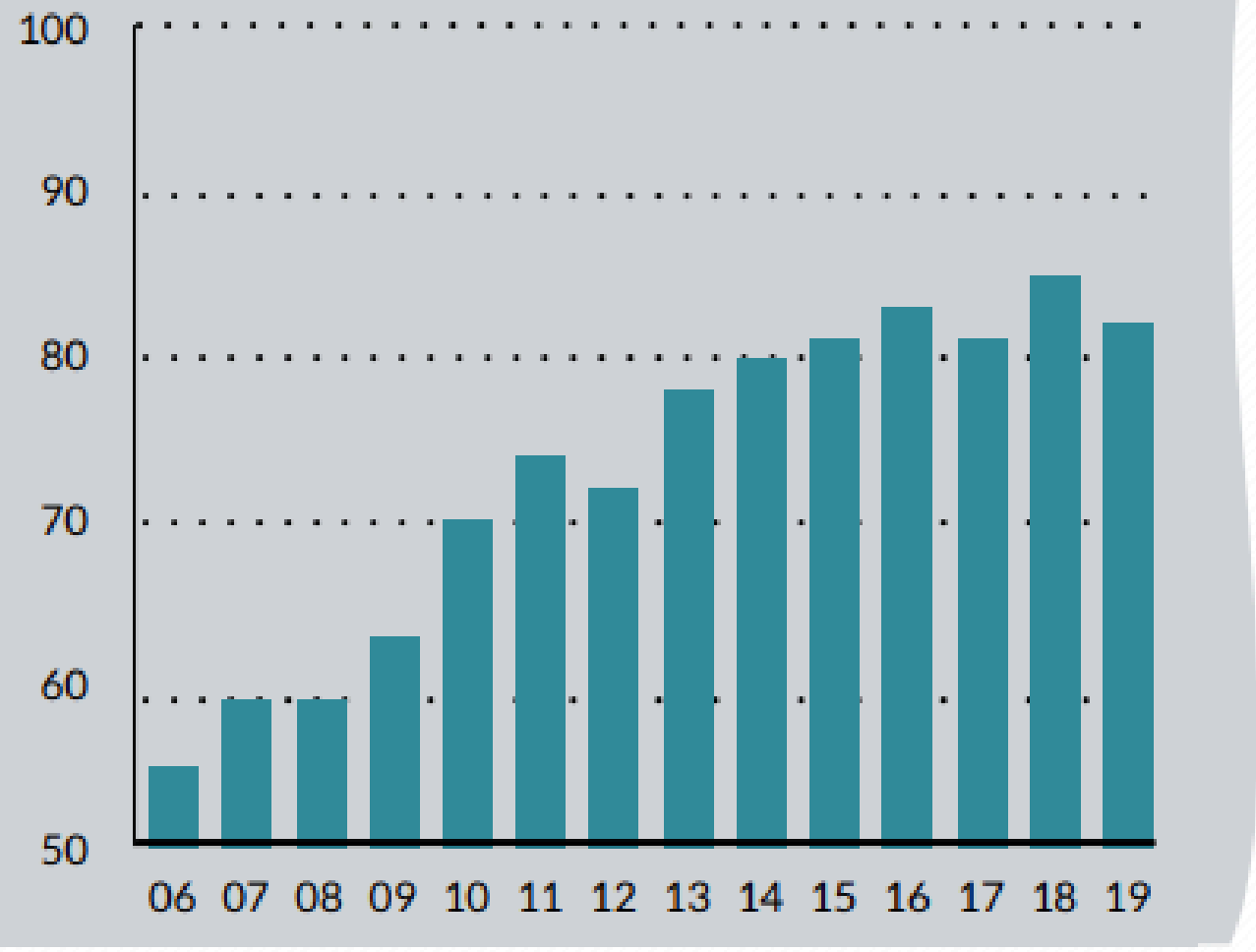
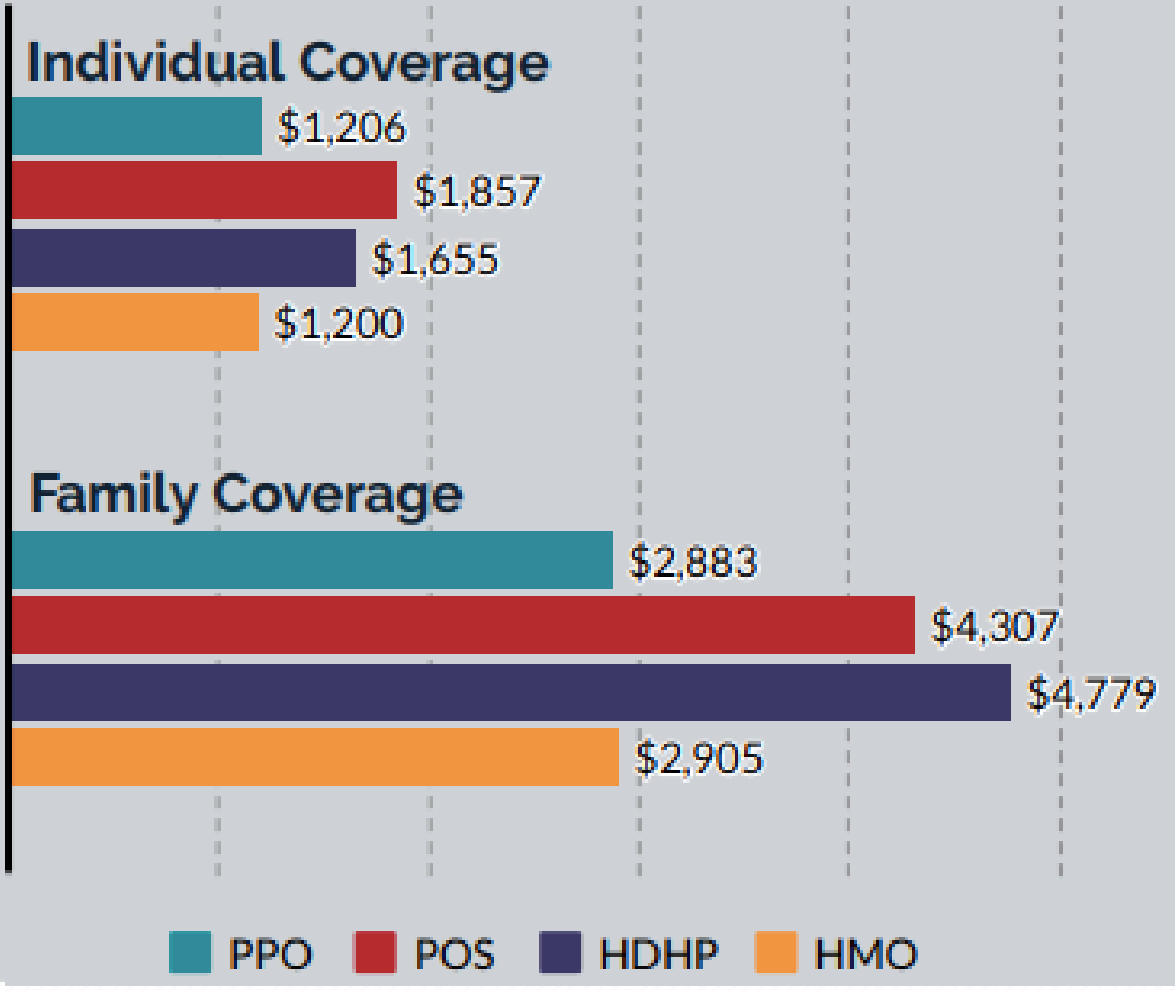
Health Plan Deductibles have grown more than ten times faster than inflation over the last decade

Percent of Americans With a Deductible



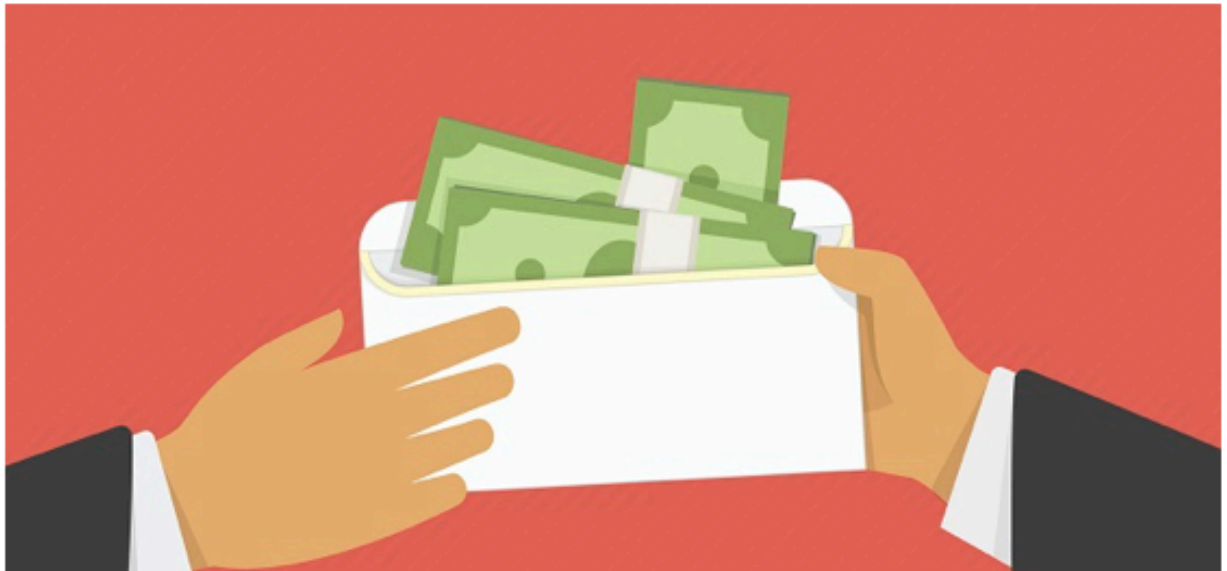
Average Deductible by Plan Type in 2019



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)

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: 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

DISPARITIES

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

Eliminating Medication Copayments Reduces Disparities In Cardiovascular Care

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

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

Low-value care mitigation represents an opportunity to improve health care quality and further health equity, while also controlling unnecessary spending.

- The provision of low-value care is associated with emotional, physical, and financial harm, which can disproportionately affect people of color.
- "Double jeopardy:" minority patients may receive less effective care and more ineffective care.
- Annual spending on health care waste is estimated in the hundreds of billions of dollars;
  - Increasing pressure that health spending imparts on budgets may make states and the federal government uniquely positioned to act on low-value care.

For Selected Services, Blacks And Hispanics More Likely To Receive Low-Value Care Than Whites | Health Affairs

Policy to discourage the structural incentives to provide unnecessary care are less-developed, especially compared to incentivizing high-value care.

- A major barrier to reducing low-value care has been a lack of analytic tools to understand the value of patient care in large datasets.
  - Especially tools that can use available data to manage the heterogeneity of "value" and create actionable insights.
- State ACPDs combined with new analytic tools creates new opportunities to directly measure low-value care.
- Direct measurement of low-value care across payers/lines of business can focus action, compared to broad geographical analyses.

Interventions on Low-Value Care

Demand-side
- Cost-sharing
- Education

Supply-side
- Risk-sharing, value-based pay
- Clinical decision supports
- Provider feedback
- Utilization management

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

Using State All Payer Claims Databases to Measure Low Value Care

Health Waste Calculator measured low-value care spending and utilization using data collected through state APCDs.

- LVC was quantified by analyzing 48 clinical services deemed as low-value by sources such as the United States Preventive Services Task Force (USPSTF) and the Choosing Wisely® campaign.
- Claims from each APCD were run through the Milliman MedInsight Health Waste Calculator
  - Uses logic from clinical guidelines above to classify services as “low-value”, “likely low-value”, and necessary.

Healthcare Big Data Analytics & Benchmarking Software | MedInsight (milliman.com)

APCD 1.0
Colorado, Maine, Virginia, Washington

- We found
  - $2.7 billion over three years in Medicaid and commercial spending on 47 services.
  - $90 million paid out of pocket each year.
  - Substantial portion of plan/patient spending in services almost always low-value.

Table 3. Detailed LVC Spending and Utilization for Medicaid and Commercial, in 2017 Only

	Commercial			*Medicaid*		
	Total Waste Spending	Waste per 1000	PMPM	Total Waste Spending	Waste per 1000	PMPM
Maine	$54,356	322	$10.38	$9,630	317	$4.36
Washington*	$272,382	376	$11.68	$74,125	629	$8.52
Colorado	$150,576	419	$10.39	$69,052	339	$4.98
Virginia	$219,343	477	$6.16	$45,055	106	$3.11

APCD 2.0
Colorado, Connecticut, Utah, Wisconsin

We found

- $630 million in 2019 in Medicaid and commercial spending on 47 services.
- $90 million paid out of pocket.
- Substantial portion of spending on services almost always low-value.

Table 2. Detailed LVC Spending on Utilization for Commercial Plans, 2019 Only

	Patient Waste Spend	Plan Waste Spend	Total Waste Spend	Total PMPM	%Total Health Spending
Colorado	$35,530	$136,080	$171,610	$10.73	2.10%
Connecticut	$24,466	$137,456	$161,922	$9.45	1.93%
Utah	$34,370	$133,832	$168,202	$10.14	2.66%
Wisconsin*	N/A	N/A	$129,197	$9.77	2.36%
Total	$94,366	$536,565	$630,931	$10.02	2.22%

*Notes: Spending in thousands of dollars. Percent total health spending is Total Waste Spend divided by Total Health Dollars (waste + non-waste) in commercial. *Wisconsin estimated total spending based on standard pricing for commercial plans.*

Table 3. Low-Value Spending on Top 10 Services by Volume, 2019

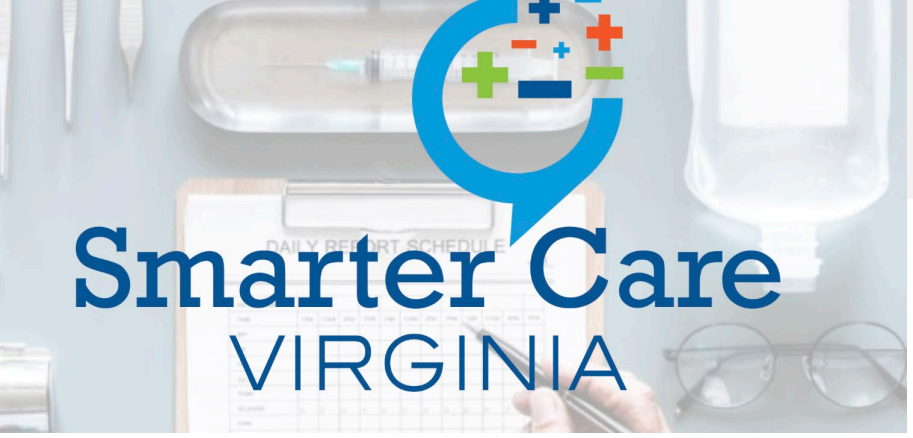
	Total Spend on "Top 10" LVC Services	PMPM	% Total Commercial Waste Spending
Colorado	$129,497	$8.09	75%
Connecticut	$125,664	$7.33	78%
Utah	$130,332	$5.49	77%
Wisconsin*	$104,980	$7.93	81%
Total	$490,472	$7.79	78%

*Notes: Spending in thousands $. PMPM = total spending on the top 10 services divided by total member months provided by states in 2019. These data only include commercial spending. *Wisconsin estimated total spending based on standard pricing for Commercial plans.*

Moving Forward

Opportunities to Reduce Low Value Care

- Multi-stakeholder efforts that involve deep, regional collaboration
  - Smarter Care Virginia
  - Washington Health Authority Low-Back Pain Implementation Collaborative



Components

CLINICAL LEARNING COMMUNITY

Six health systems and 3 clinically integrated networks working together to reduce seven provider-driven measures.

EMPLOYER TASK FORCE

16 Virginia employers working together to increase their knowledge of low-value care and identify consumer-driven measures to drive change through benefit design and employee education.

PLAN TO IMPROVE HEALTH VALUE

Developed at a joint conference of the clinical learning community and employer task force members.

Measures

"Drop the Pre-Op"

- Don't obtain baseline laboratory studies in patients without significant systemic disease (ASA I or II) undergoing low risk surgery - specifically complete blood count, basic or comprehensive metabolic panel, coagulation studies when blood loss or fluid shifts is/are expected to be minimal
- Don't obtain baseline diagnostic cardiac testing (trans-thoracic /esphophageal echocardiography) or cardiac stress testing in asymptomatic stable patients with known cardiac disease (ie. CAD, valvular disease) undergoing low or moderate risk non-cardiac surgery
- Don't obtain EKG, chest x-rays or pulmonary function test in patients without significant systemic disease (ASA I or II) undergoing low-risk surgery

Opportunities to Reduce Low Value Care

- Multi-stakeholder efforts that involve deep, regional collaboration
  - Smarter Care Virginia
  - Washington Health Authority Low-Back Pain Implementation Collaborative
- Address Low Value Care through the Health Plan RFP Process

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.

Opportunities to Reduce Low Value Care

- Multi-stakeholder efforts that involve deep, regional collaboration
  - Smarter Care Virginia
  - Washington Health Authority Low-Back Pain Implementation Collaborative
- Address Low Value Care through the Health Plan RFP Process
- Iterative federal policy
  - Expand CMMI MA V-BID Model Test to include LVC
  - Implement ACA Section 4105

Implement 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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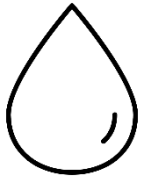
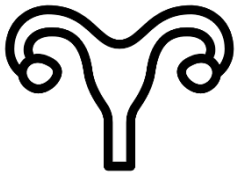
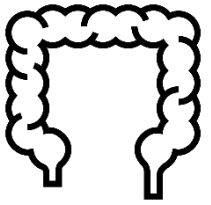
Examples of USPSTF Grade D Services



Prostate cancer screening ≥ 70 years



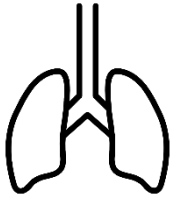
Cervical cancer screening > 65 years



Colon cancer screening >85 years

Cardiovascular screening in low risk patients

Asymptomatic bacteriuria screening



COPD screening

Vitamin D to prevent falls among older women

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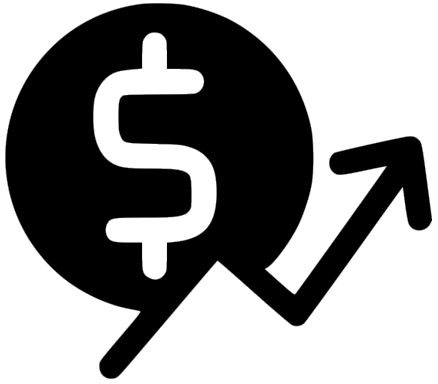
Annual Use and Cost of Seven Grade D Services Among Medicare Enrollees



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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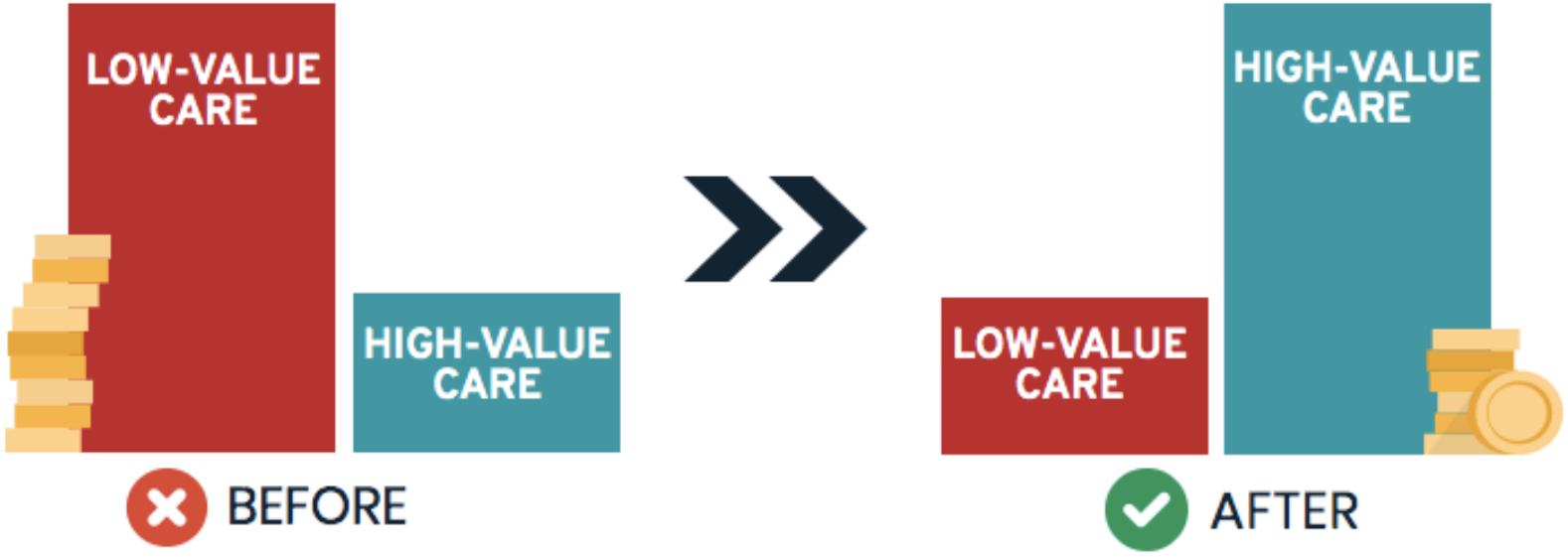
Opportunities to Reduce Low Value Care

- Multi-stakeholder efforts that involve deep, regional collaboration
  - Smarter Care Virginia
  - Washington Health Authority Low-Back Pain Implementation Collaborative
- Address Low Value Care through the Health Plan RFP Process
- Iterative federal policy
  - Expand CMMI MA V-BID Model Test to include LVC
  - Implement ACA Section 4105
- Innovative benefit designs that discourage LVC
  - Cost-sharing offsets focused on services commonly low-value (V-BID X)

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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RELATED TOPICS:
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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.

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

DC Health Benefit Exchange Authority

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

Diabetes - 01/01/23
Pediatric mental and behavioral health - 01/01/24?

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Using V-BID to Enhance Access to Essential Clinical Services, Reduce Low Value Care and Enhance Equity

- Expand pre-deductible coverage/reduce consumer cost-sharing on essential services
  - Chronic Disease Management Act
- 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

Discussion

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