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

Leveraging APCDs to Increase Use of High value Care, Enhance Equity, and Eliminate Low Value Services

A. Mark Fendrick, MD

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WISCONSIN HEALTH INFORMATION ORGANIZATION

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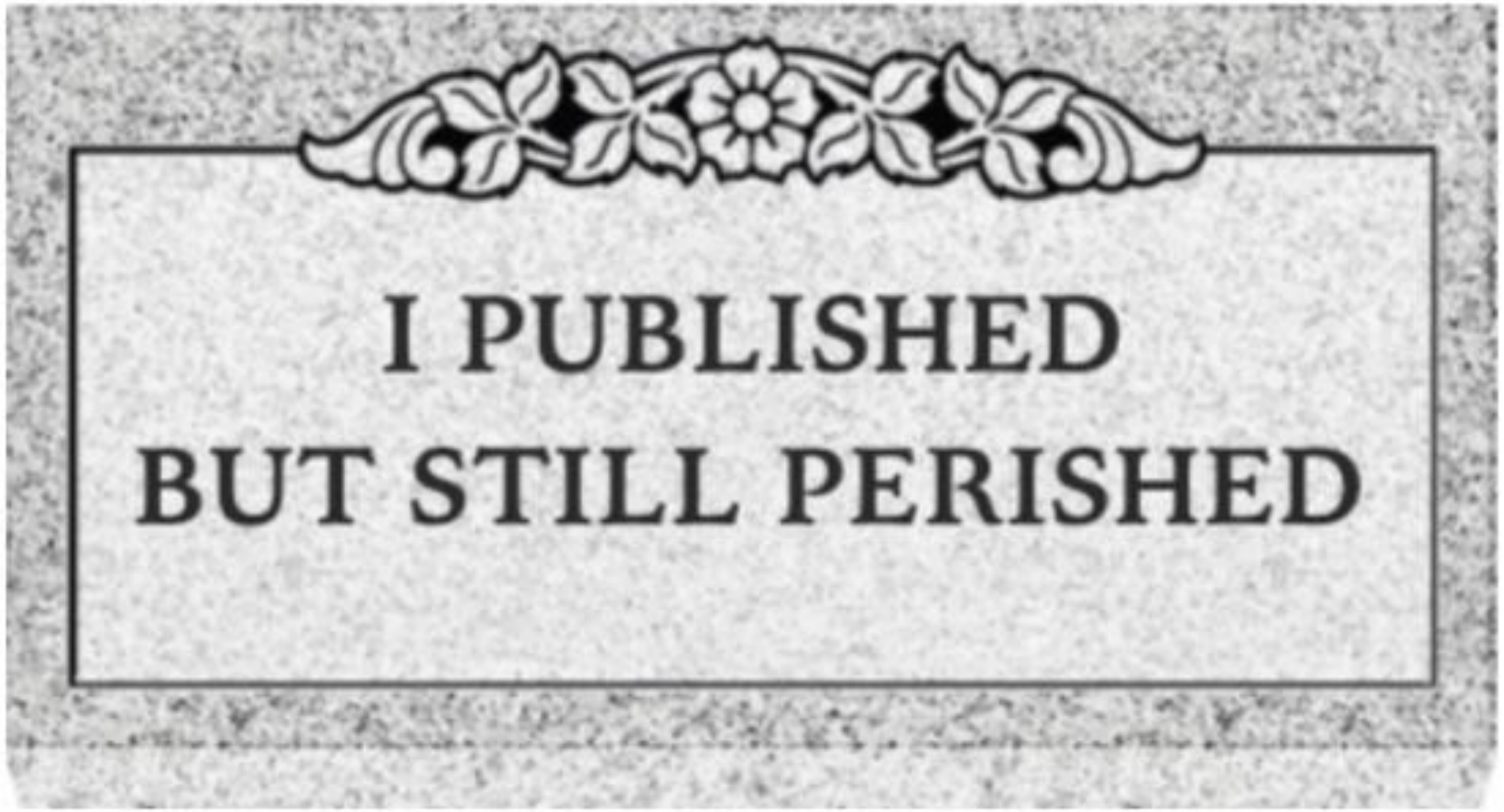
I PUBLISHED
BUT STILL PERISHED

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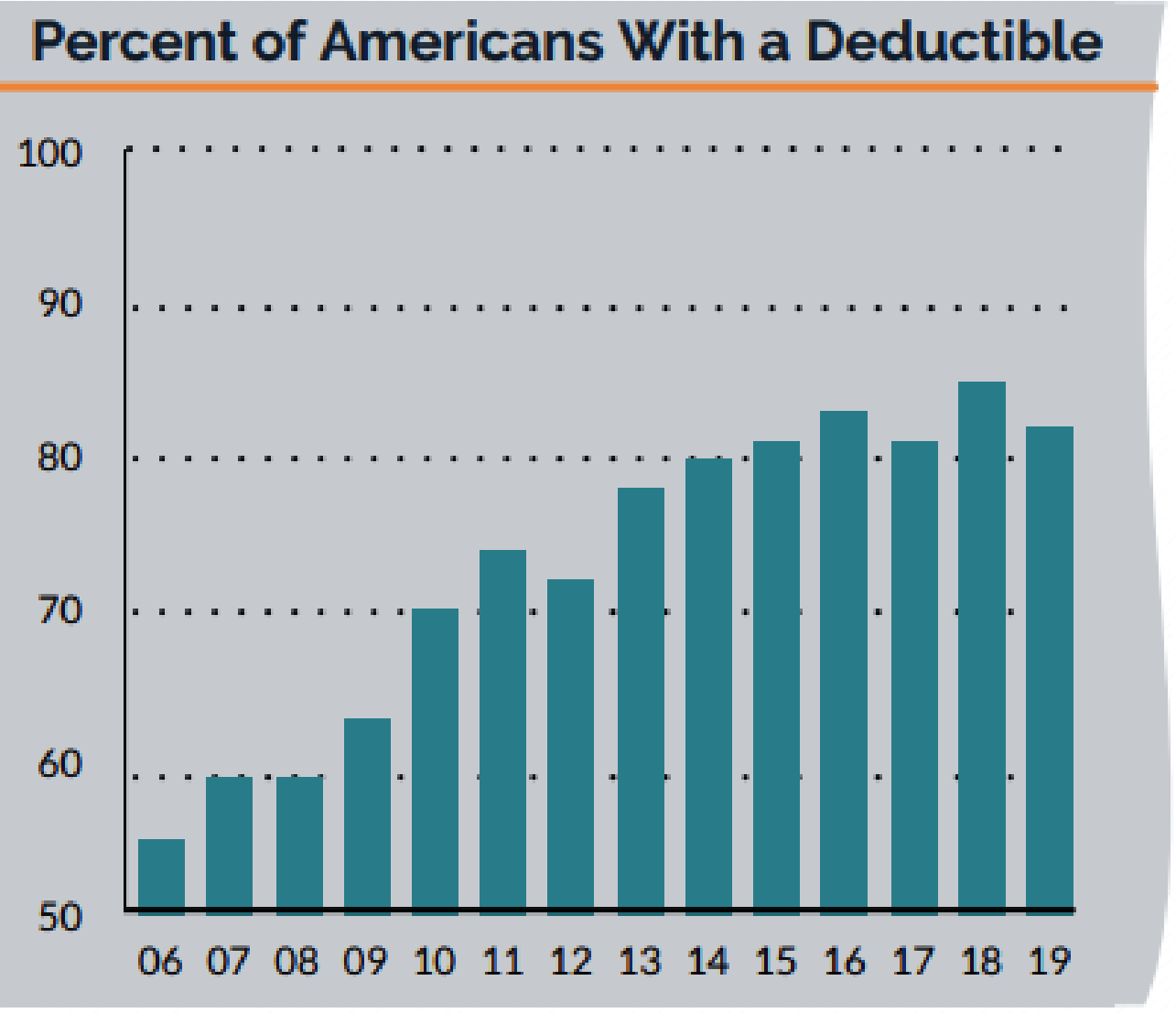
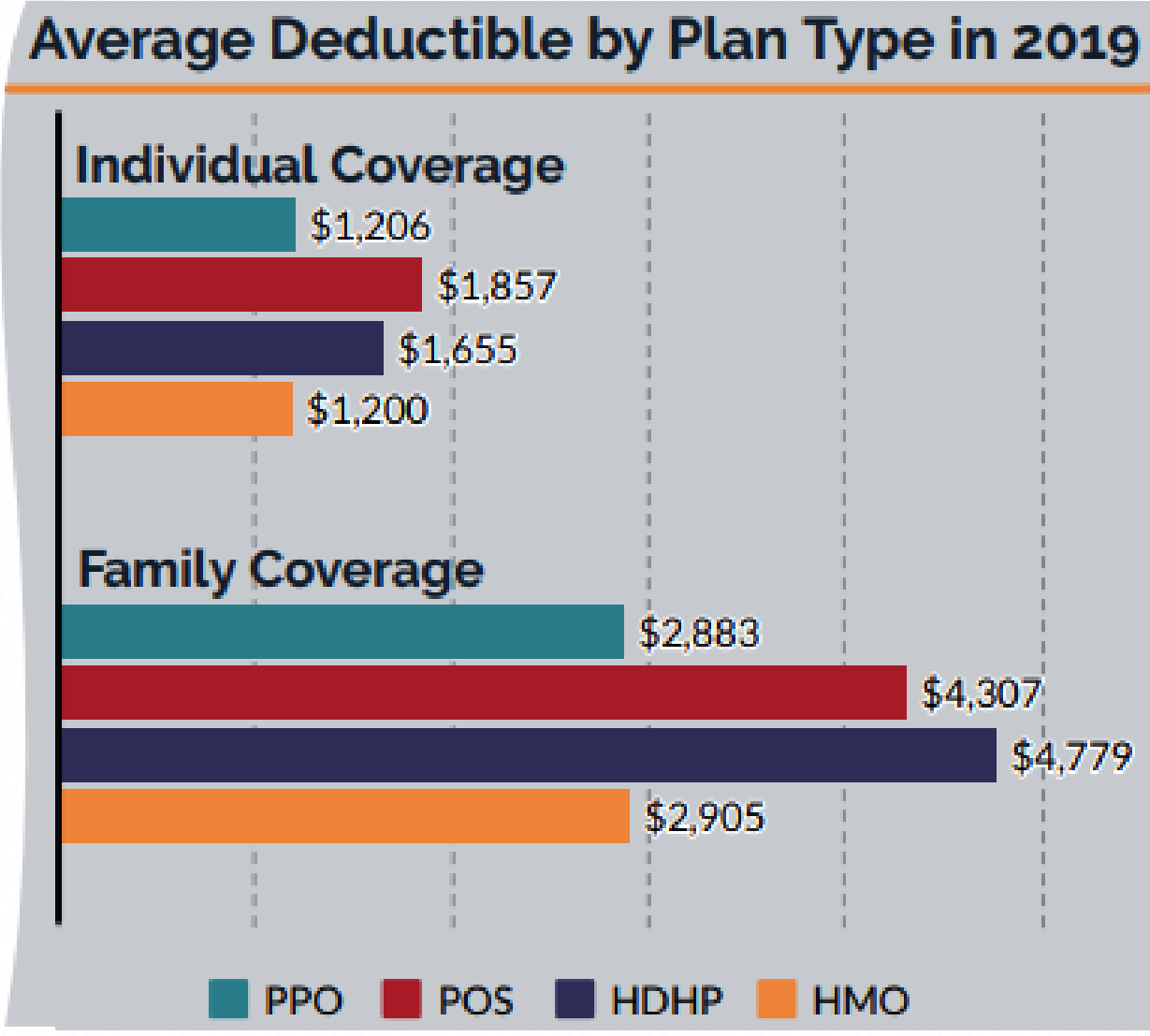
Health Plan Deductibles have grown more than ten times faster than inflation over the last decade





The New York Times

OPINION

GUEST ESSAY

What's Wrong With Health Insurance? Deductibles Are Ridiculous, for Starters.

July 7, 2022

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

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

Texas Judge Finds ACA Requirement for Preventive Services Without Cost Sharing Invalid

- Several outstanding questions remain, but it is possible that this ruling will mean that employers will no longer have to provide first-dollar coverage for the 52 services that have received an “A” or “B” rating from the U.S. Preventive Services Task Force
- This requirement benefitted almost 152 million people in 2020 and led to increases in cancer screening and vaccinations, improved access to contraceptives, and earlier detection and treatment of chronic health conditions, including hypertension depression, high cholesterol and diabetes.

MEDICARE ADVANTAGE

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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Inflation Reduction Act of 2022 Includes Several V-BID Elements

The Inflation Reduction Act of 2022, which passed the Senate on August 7th, includes several V-BID related items, notably:

- Caps Medicare patients' out-of-pocket costs at $2,000 per year, with the option to break that amount into affordable monthly payments
- Covers adult vaccines recommended by the Advisory Committee on Immunization Practices under Medicare Part D without cost-sharing
- Amends the Internal Revenue Code to create a safe-harbor allowing Health Sav plans to cover insulin prior to meeting the plan deductible
- Caps Medicare patients' out-of-pocket costs for insulin at $35 per month

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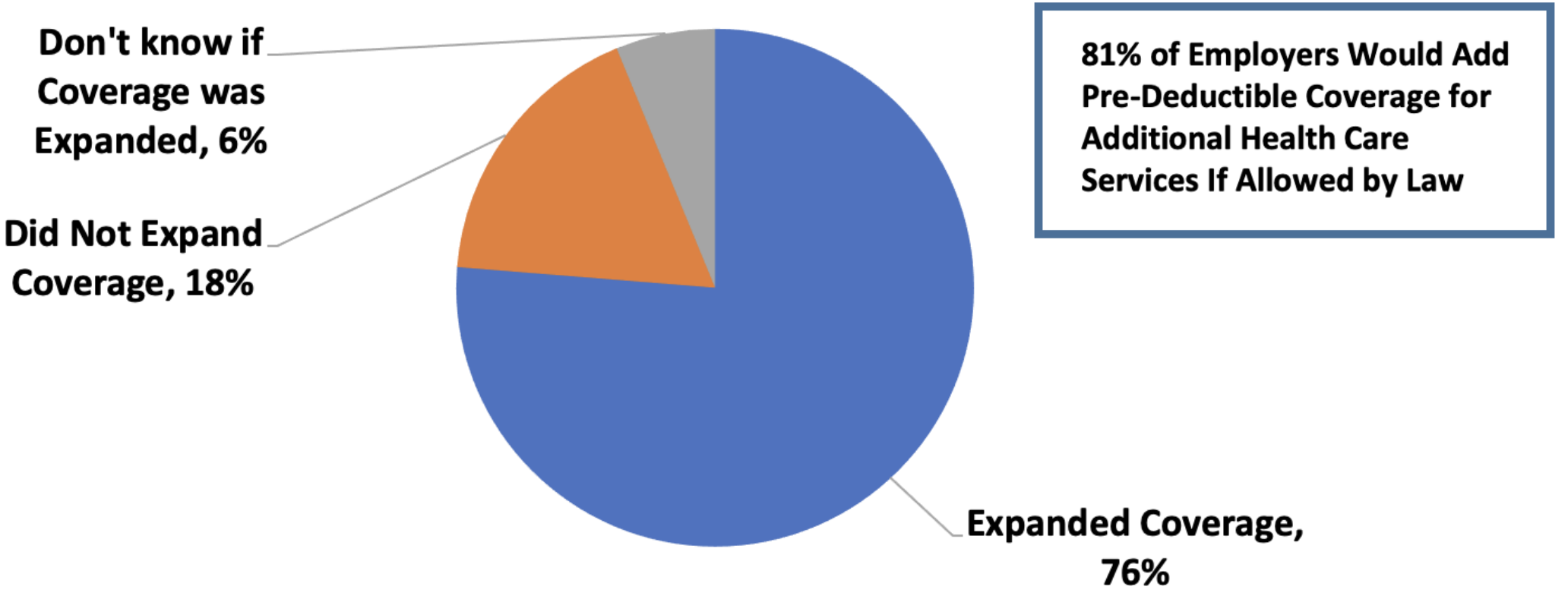
Percentage of Employers Who Expanded Pre-Deductible Coverage in HSA-Eligible Health Plan for Preventive Services Allowed Under IRS Rule 2019-45



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).

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

V-BID

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

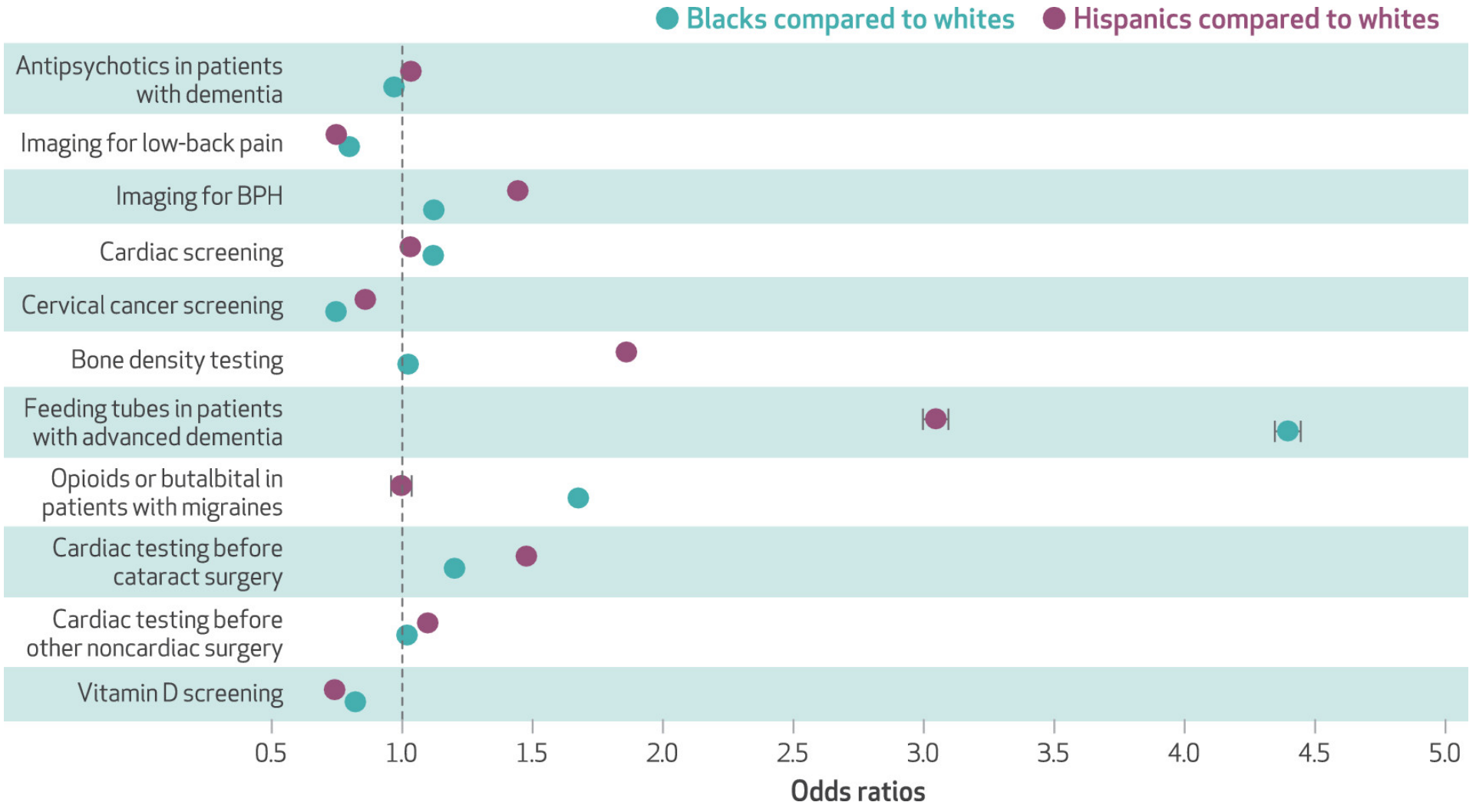
Identifying and Measuring Unnecessary Care: Milliman Health Waste Calculator

- 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

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



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

V-BID

Background

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 state budgets may make *states 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

Motivation

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

Four States 2.0
Methods

The paper leverages the Health Waste Calculator to measure low-value care spending and utilization in 2019 using Commercial 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.

Table 1. Claims Data Sources by Payer and State

	Commercial	Medicaid	Medicare FFS	Medicare Advantage	Patient *and* Plan Spending
Colorado	✕	✕	✕	✕	No Plan Spending
Connecticut	✕			✕	✕
Utah	✕	✕	✕	✕	✕
Wisconsin	✕	✕		✕	No Patient Spending

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

Four States 2.0

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Utah	✕	✕	✕	✕	✕
Wisconsin	✕	✕		✕	No Patient Spending

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

Key Findings
Total LVC Spending and Utilization

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.*

Key Findings
Top 10 Services

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.*

Key Findings
High Waste Index

Table 5. Total Spending on High-Waste Index Services in 2019, Spending in Thousands $, N>50

	Total Spending on High-Waste Index LVC	Total Spending PMPM	% of Commercial Spending
Colorado	$69,346.94	$4.34	40%
Connecticut	$73,425.57	$4.28	45%
Utah	$86,435.85	$5.21	51%
Wisconsin*	$69,113.10	$5.23	53%
TOTAL	$298,321.47	$4.74	47%

*Notes: Includes services with >50 uses per state. Total spending = plan + patient spending on LVC in commercial plans. Waste index means the number of wasteful services provided divided by the total number of those services provided. PMPM = total spending divided by total member months. % waste spending = total spending on just high-waste index services divided by total waste spending in Commercial for that state. *Wisconsin estimated total spending based on standard pricing.*

Table 6. Services That Are Both High-Spend And High-Waste Index, N>50

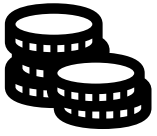
Routine General Health Checks
Opiates in Acute Disabling Low Back Pain
PSA
Preoperative Baseline Laboratory Studies
PICC Line in Stage III-V CKD Patients

- The waste index is calculated by dividing the number of low-value instances for a specific service by the total number of times that service is delivered.
- Table 6 highlights services with greater than 80% waste index and greater than $1 million total spend, in at least 3 of the 4 states.

Key Takeaways and Next Steps

Top 10 services account for three-quarters of LVC spending with overlap across states.

Many services that are both high waste index and high spend were “screening tests.”



Patients paid a substantial amount out of pocket – between 15.1% and 20.7% on the 48 LVC services.

Overall results consistent with States 1.0 (e.g., variation in total waste spending, high OOP costs, spending concentrated in a small number of high volume).

Limitations

Payer Comparisons: Apples to Oranges

- Analyses do not adjust for population demographics across states, disease burden, or clinical practice patterns; any comparisons across states are not apples to apples.
- Comparisons across payer types (not present in this paper) could be skewed by rates and demographics, as well

Underestimates Aggregate Waste

- Only measured 48 services among scope of LVC.
- Accuracy of the tool/data (claims) to identify low-value vs appropriate care
- Cost of care cascades, especially for certain types of services
- Out of pocket costs do not include other opportunity costs for patients

Missing Data

- Most APCDs do not collect data from all payers or all people (e.g., uninsured).
- Other missing data from claims, e.g., pharmacy claims may not include dispensing fee.

https://www.ajmc.com/view/stopping-the-flood-reducing-harmful-cascades-of-care

Moving Forward

Opportunities to Leverage APCD

- Multi-stakeholder efforts that involve deep, regional collaboration
  - Smarter Care Virginia
  - Washington Health Authority Low-Back Pain Implementation Collaborative
- Iterative federal policy
  - Expand MA V-BID Model 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)
- Address Low Value Care through the Health Plan RFP Process


REPORT
DECEMBER 2020

The Commonwealth Fund

STATE ALL-PAYER CLAIMS DATABASES
Tools for Improving Health Care Value

Part 2: The Uses and Benefits of State APCDs

Douglas McCarthy
Senior Research Advisor
The Commonwealth Fund

ABSTRACT

ISSUE: Many states and stakeholders are seeking to control the rising cost of health care and increase its value. All-payer claims databases (APCDs) facilitate such efforts by aggregating data on health care services paid for by health insurers and public programs, thereby offering a broad perspective on cost, utilization, and quality of care.

GOALS: Describe the uses and benefits of state-level APCDs as well as challenges to realizing their value, including data limitations and antitrust concerns.

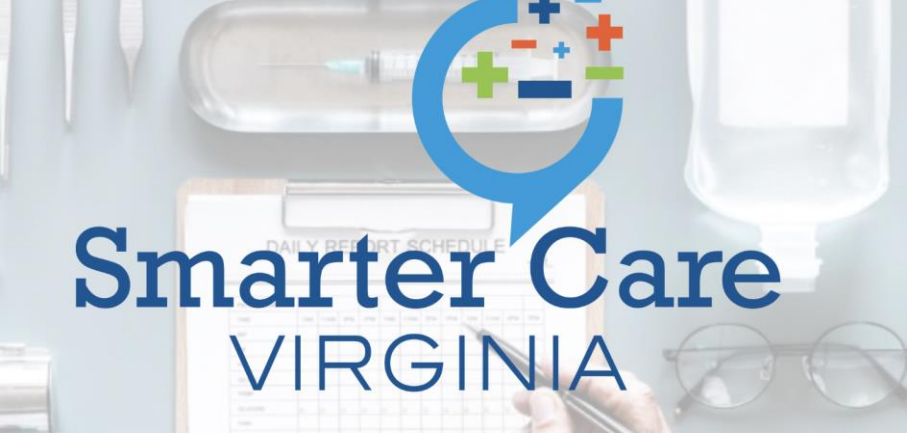
METHODS: Interviews with staff and stakeholders of eight diverse state-level APCDs, supplemented by a review of documentary evidence.

KEY FINDINGS AND CONCLUSIONS: APCDs are used to: 1) report on health system spending, utilization, and performance; 2) enhance stat
policy and regulatory analysis; 3) inform the public about health ca

TOPLINES

- All-payer claims databases can help state health care purchasers "buy smart," raise awareness of the need for health system change, and fuel data-informed policymaking.
- To reap t enefits of an all-payer database, states ne ate relationships ders and learn how meet their needs.

"All-payer claims databases can help state health care purchasers "buy smart," raise awareness of the need for health system change, and fuel data-informed policymaking."



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

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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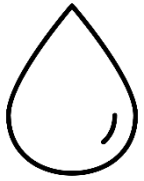
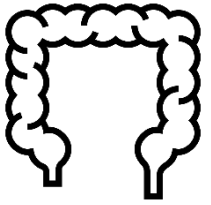
Examples of USPSTF Grade D Services



Prostate cancer screening ≥ 70 years

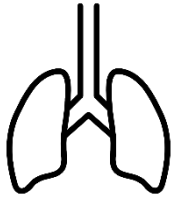
Cervical cancer screening > 65 years



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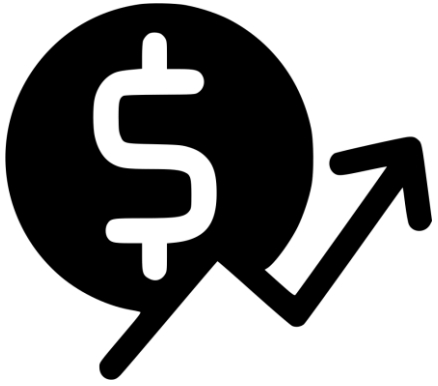
Annual Use and Cost of Seven Grade D Services Among Medicare Enrollees



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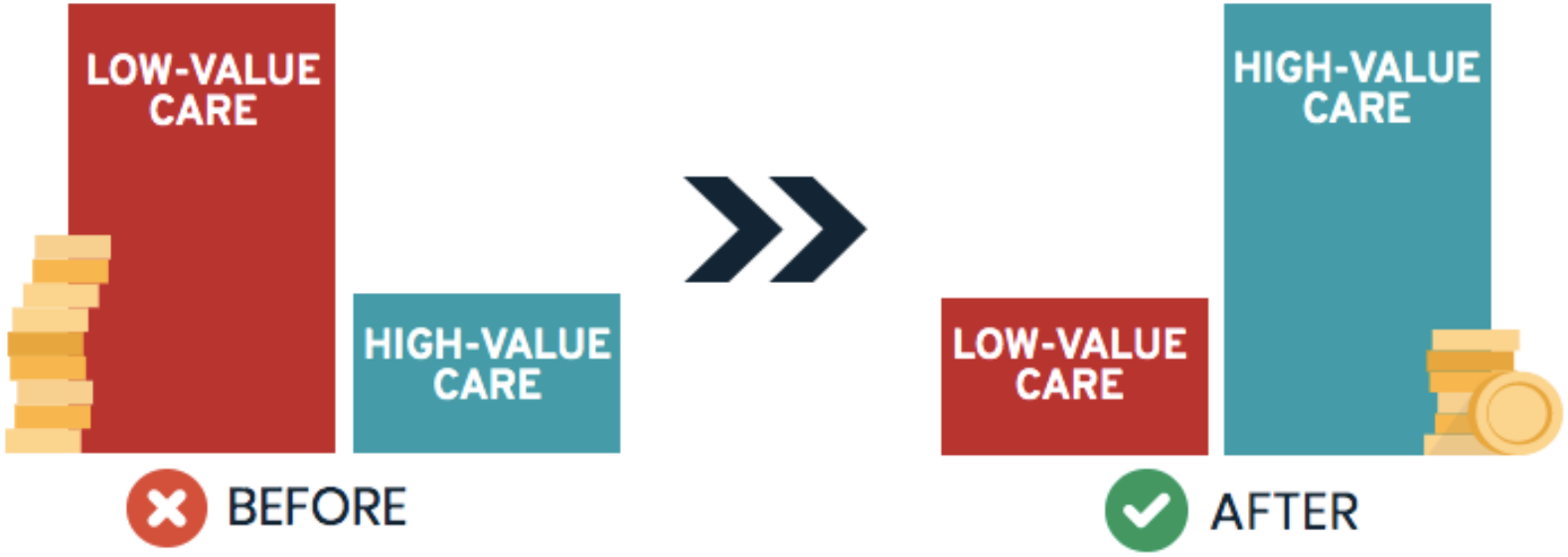
V-BID X: Expanding Coverage of Essential Clinical Care Without Increasing Premiums or Deductibles

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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HEALTH AFFAIRS BLOG

RELATED TOPICS:
COST SHARING | DEDUCTIBLES | COSTS AND SPENDING | PHARMACEUTICALS | PREMIUMS | AFFORDABLE CARE ACT | MEDICARE ADVANTAGE

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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Address Low Value Care through the RFP Process

1. Indirect mentions in RFP:

> “Please describe general coverage policies and, where applicable, use of relevant edits and/or prior authorization requirements, for commonly overused services.”

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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.

Address Low Value Care through the RFP Process

2. Directly quantifiable LVC measures as part of the RFP

- Pay bonus if LVC < benchmark
- Pay bonus if LVC falls

- Charge penalty if LVC > benchmark
- Do not pay admin cost on top of LVC
- Do not pay 100% fees for LVC

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Using APCD to Enhance Access and Affordability to Essential Clinical Services and Reduce Low Value Care

- Expand pre-deductible coverage/reduce consumer cost-sharing on high-value clinical COVID-19 related care and other essential chronic disease services
- Use APCD to identify, measure and reduce low-value care to pay for more generous coverage of high-value care
- Explore opportunities that leverage APCD that increase use of high-value services and deter low value care

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Thank you

Discussion

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