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

www.vbidcenter.org
I published
but still perished
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.
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.

Moving from the Stone Age to the Space Age: Change the health care cost discussion from “How much” to “How well”
Americans Do Not Care About Health Care Costs; They Care About **What It Costs Them**
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\textsuperscript{1} Teresa B. Gibson, PhD\textsuperscript{2} Kristina Yu-Ilsenberg, PhD, RPh\textsuperscript{3} Michael C. Sokol, MD, MS\textsuperscript{4} Allison B. Rosen, MD, ScD\textsuperscript{5}, and A. Mark Fendrick, MD\textsuperscript{5}

• Cost-sharing worsens disparities and adversely affect health, particularly among economically vulnerable individuals and those with chronic conditions
Record High in U.S. Putting Off Medical Treatment Due to Cost, 2001-2022

Within the last 12 months, have you or a member of your family put off any sort of medical treatment because of the cost you would have to pay?

- Sets consumer cost-sharing on clinical benefit – not price
- Little or no out-of-pocket cost for high-value care; higher cost-sharing for low-value care
- Implemented by hundreds of public and private payers
- Bipartisan political support
- Enhances equity
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
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)
  - Screening for depression in the adult population, including pregnant and postpartum persons as well as older adults.
  - Screening for major depressive disorder (MDD) in adolescents aged 12 to 18 years.
- Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP)
- Preventive care and screenings supported by the Health Resources and Services Administration (HRSA)
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.
Percentage of Employers That Would Impose Cost Sharing for Preventive Services if Allowed by Law

Would not 80%

Would 8%

Depends 12%

2 in 5 individuals report that they will not use preventive services if they are no longer fully covered.

Source: Employee Benefit Research Institute (EBRI) Pulse Survey of Health Benefits Decision Makers, n=25, representing over 600,000 employees.
High Out of Pocket Costs are Common and Impactful For Medicare Beneficiaries

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)

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<thead>
<tr>
<th>Wellness and Health Care Planning</th>
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<tr>
<td>Advanced care planning</td>
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<td>Incentivize better health behaviors</td>
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<tr>
<th>Targeting Socioeconomic Status</th>
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<tr>
<td>Low-income subsidy</td>
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<tr>
<td>Improve quality, decrease costs</td>
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<thead>
<tr>
<th>Rewards and Incentives</th>
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<tr>
<td>$600 annual limit</td>
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<tr>
<td>Increase participation</td>
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<td>Available for Part D</td>
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<th>Telehealth</th>
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<tr>
<td>Service delivery innovations</td>
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<td>Augment existing provider networks</td>
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Inflation Reduction Act of 2022 Includes Several V-BID Elements

- 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 Savings Account-eligible plans to cover insulin prior to meeting the plan deductible
- Caps Medicare patients’ out-of-pocket costs for insulin at $35 per month
Creating ‘Smarter’ Deductibles
PREVENTIVE CARE COVERED
Dollar one

CHRONIC DISEASE CARE
NOT covered until deductible is met
PRESS RELEASES

Treasury Expands Health Savings Account Benefits for Individuals Suffering from Chronic Conditions
List of services and drugs for certain chronic conditions that will be classified as preventive care under Notice 2019-45

<table>
<thead>
<tr>
<th>Preventive Care for Specified Conditions</th>
<th>For Individuals Diagnosed with</th>
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<tbody>
<tr>
<td>Angiotensin Converting Enzyme (ACE) inhibitors</td>
<td>Congestive heart failure, diabetes, and/or coronary artery disease</td>
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<tr>
<td>Anti-resorptive therapy</td>
<td>Osteoporosis and/or osteopenia</td>
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<tr>
<td>Beta-blockers</td>
<td>Congestive heart failure and/or coronary artery disease</td>
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<tr>
<td>Blood pressure monitor</td>
<td>Hypertension</td>
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<tr>
<td>Inhaled corticosteroids</td>
<td>Asthma</td>
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<tr>
<td>Insulin and other glucose lowering agents</td>
<td>Diabetes</td>
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<tr>
<td>Retinopathy screening</td>
<td>Diabetes</td>
</tr>
<tr>
<td>Peak flow meter</td>
<td>Asthma</td>
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<tr>
<td>Glucometer</td>
<td>Diabetes</td>
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<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>
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<tr>
<td>Selective Serotonin Reuptake Inhibitors (SSRIs)</td>
<td>Depression</td>
</tr>
<tr>
<td>Statins</td>
<td>Heart disease and/or diabetes</td>
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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

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

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

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

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

$345 BILLION
HHS granted authority to not pay for USPSTF ‘D’ Rated Services
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
Annual Use and Cost of Seven Grade D Services Among Medicare Enrollees

Total Annual Count: 31 million
Total Annual Costs: $478 million

V-BID X:
Better Coverage, Same Premiums and 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.
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
TABLE 5 – HIGH AND LOW VALUE SERVICES AND DRUG CLASSES

<table>
<thead>
<tr>
<th>High-Value Services with Zero Cost-Sharing</th>
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<tbody>
<tr>
<td>Glucometers and testing strips</td>
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<tr>
<td>LDL testing</td>
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<tr>
<td>Hemoglobin A1C testing</td>
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<tr>
<td>Cardiac rehabilitation</td>
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<tr>
<td>INR testing</td>
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<td>Pulmonary rehabilitation</td>
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<td>Peak flow meters</td>
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<td>Blood pressure monitors</td>
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V-BID X: Enhancing Access and Affordability to Essential Clinical Services in Addition to COVID-19 Related Care

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<tr>
<th>Specific Low-Value Services Considered</th>
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<tbody>
<tr>
<td>Spinal fusions</td>
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<td>Vertebroplasty and kyphoplasty</td>
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<tr>
<td>Vitamin D testing</td>
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<tr>
<td>Proton beam for prostate cancer</td>
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<th>Commonly Overused Service Categories with Increased Cost-Sharing</th>
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<tbody>
<tr>
<td>Outpatient specialist services</td>
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<tr>
<td>Outpatient labs</td>
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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).
State Exchanges Using V-BID X Principles to Enhance Equity

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

Diabetes - 01/01/23
Pediatric mental and behavioral health - 01/01/24
Using V-BID to Enhance Access to Essential Services, Reduce Low Value Care and Enhance Equity

• Expand pre-deductible coverage/reduce consumer cost-sharing on essential services
  • Generous coverage likely not enough to increase use and reduce disparities
• 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
“If we don’t succeed then we will fail.”

Dan Quayle
Questions?