



Value-Based Insurance Design:

Changing the Discussion from "How Much" to "How Well" We Spend
our Health Care Dollars

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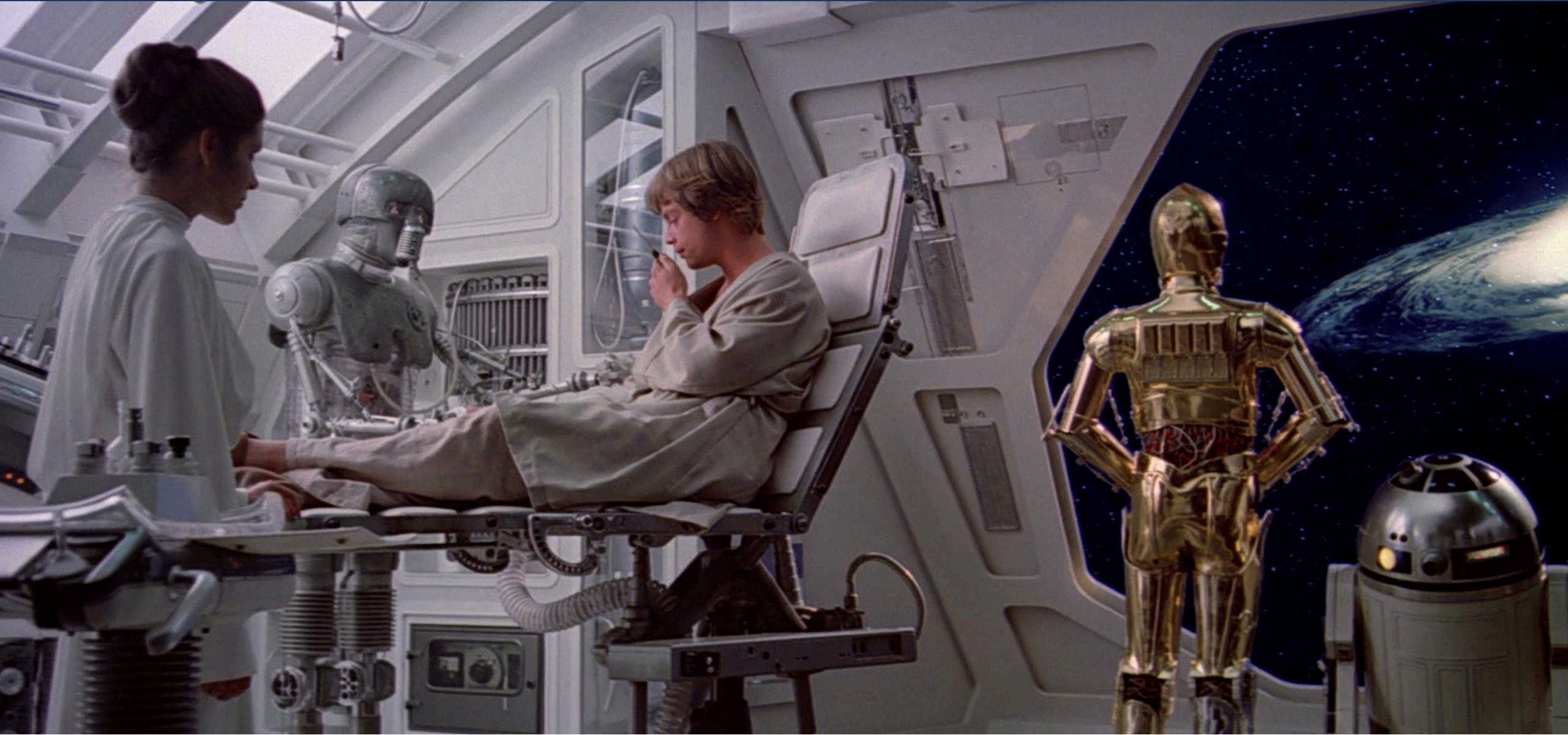


**I PUBLISHED
BUT STILL PERISHED**

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

Star Wars Science



Flintstones Delivery



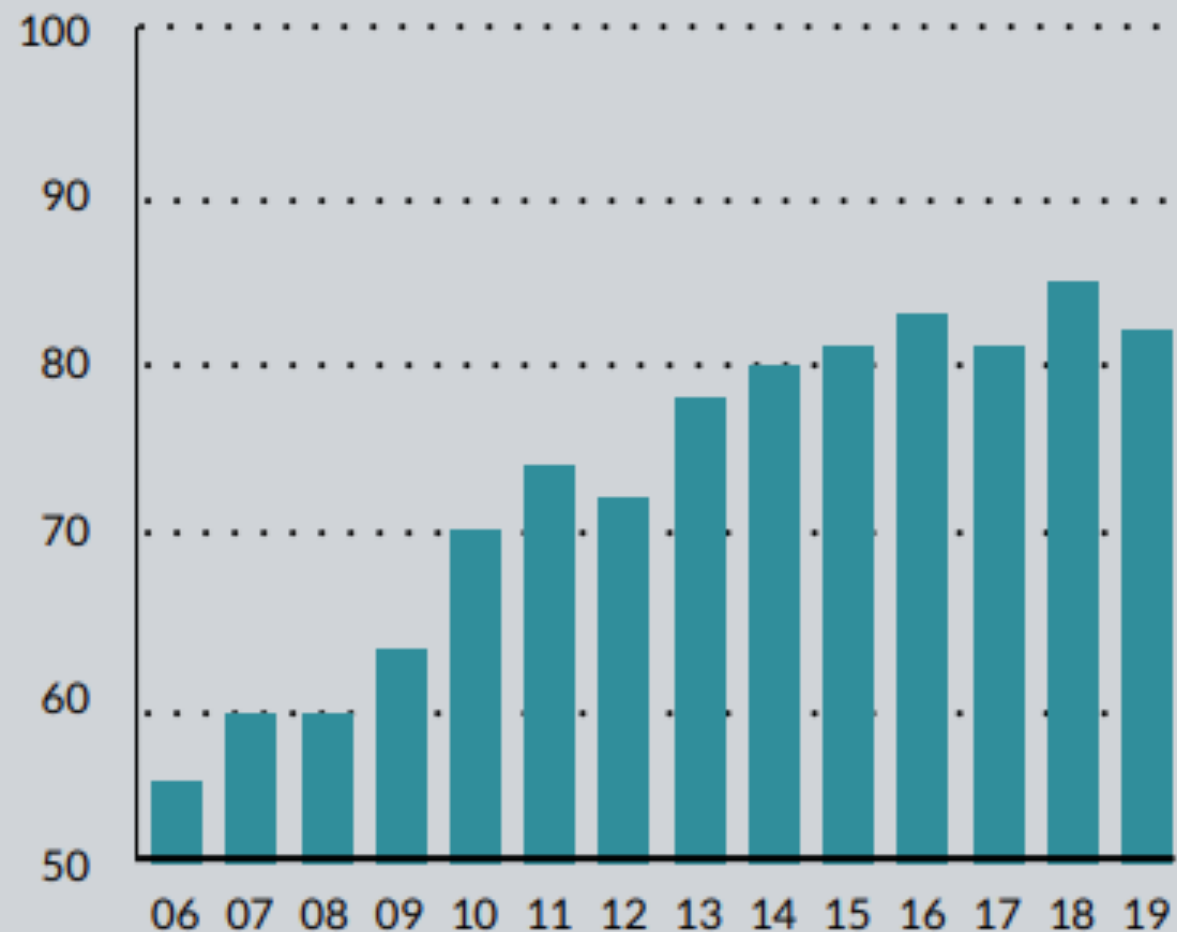
Moving from the Stone Age to the Space Age:

Change the health care cost discussion from “How much” to “How well”

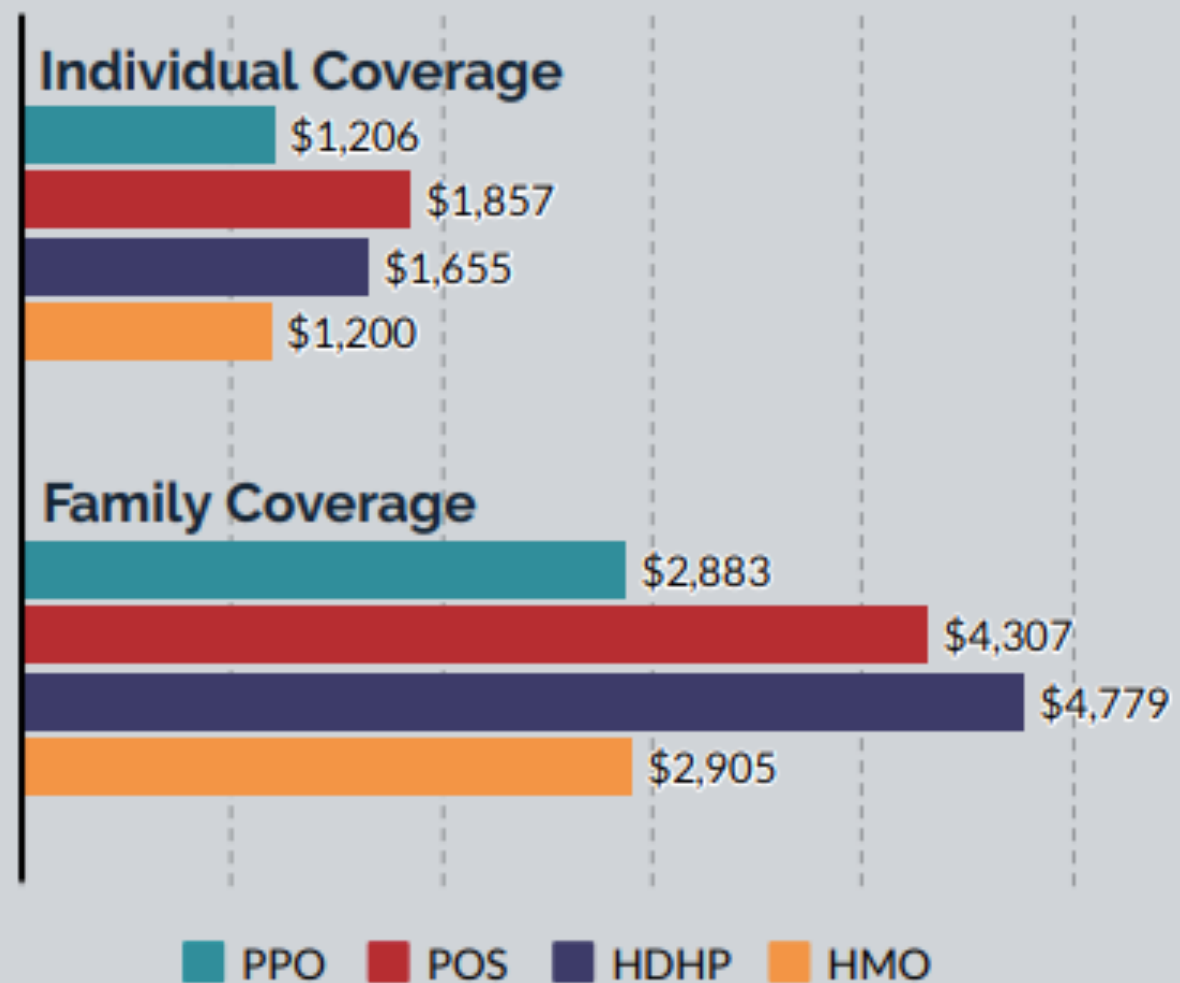
- Everyone (almost) agrees there is enough money in the US health care system; we just spend it on the wrong services and in the wrong places
- Moving from a volume-driven to value-based system requires a change in both how we pay for care and how we engage consumers to seek care
- The most common patient-facing strategy - consumer cost-sharing – is a ‘blunt’ instrument, in that patients pay more out of pocket for **ALL** care regardless of clinical value

Americans Do Not Care About Health Care Costs; They Care About **What It Costs Them**

Percent of Americans With a Deductible



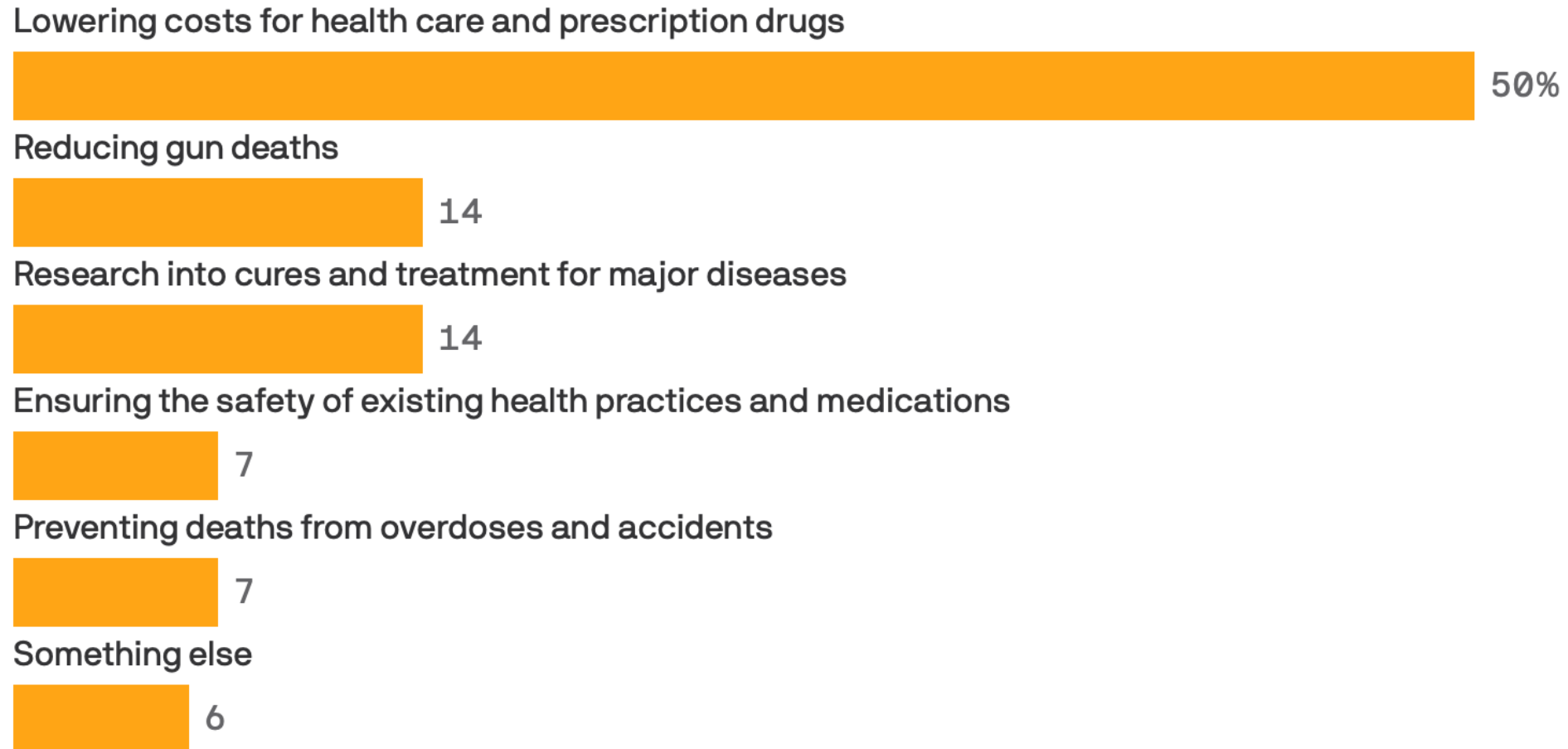
Average Deductible by Plan Type in 2019



Americans Do Not Care About Health Care Costs; They Care About **What It Costs Them**

What Americans say government efforts should prioritize when it comes to U.S. public health

Survey of 1,213 U.S. adults conducted Feb. 17-21, 2023



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)

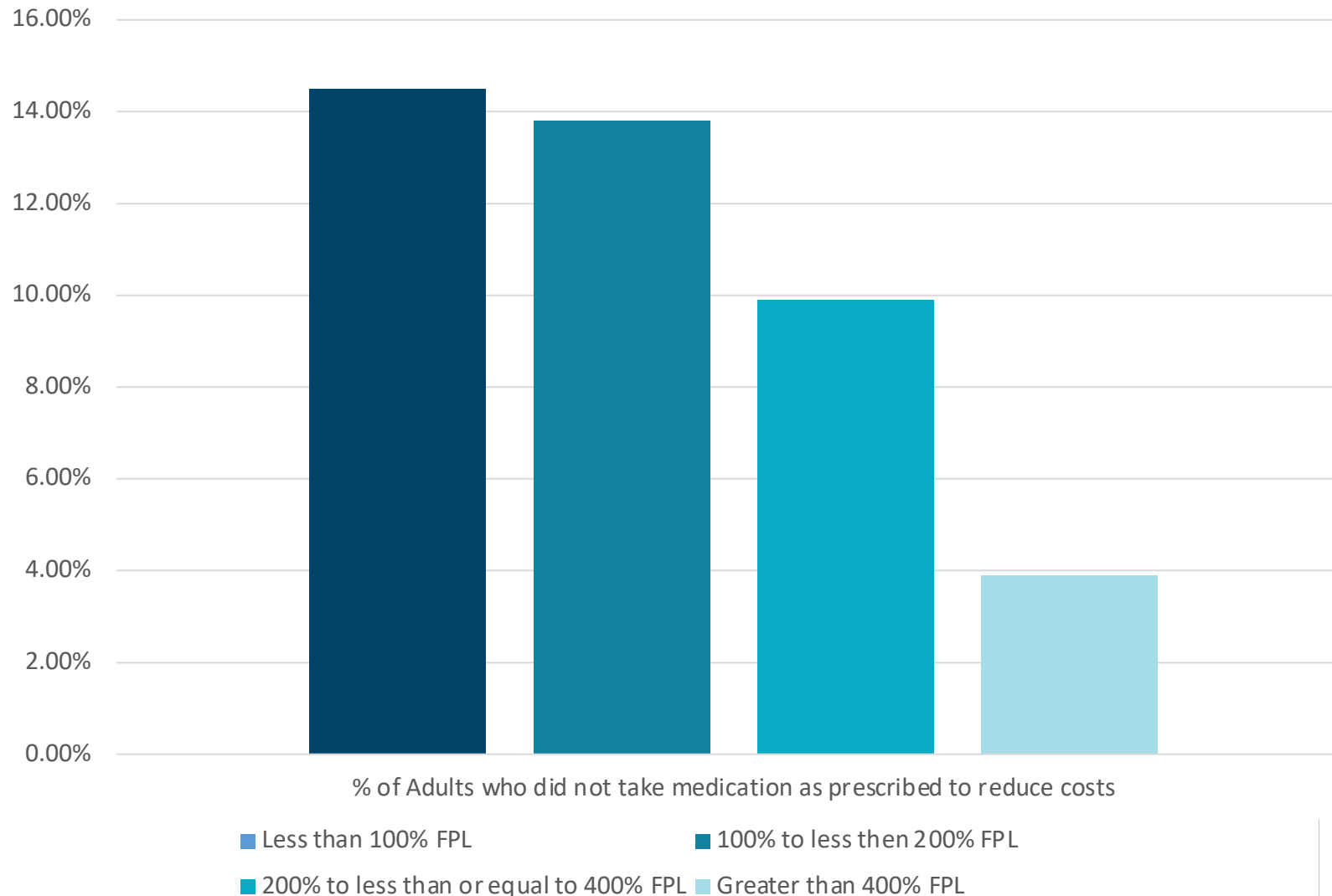
“Blunt” Cost-Sharing Worsens Health Care Disparities

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

*Michael Chernew, PhD¹ Teresa B. Gibson, PhD² Kristina Yu-Isenberg, PhD, RPh³
Michael C. Sokol, MD, MS⁴ Allison B. Rosen, MD, ScD⁵, and A. Mark Fendrick, MD⁵*

- Cost-sharing worsens disparities and adversely affect health, particularly among economically vulnerable individuals and those with chronic conditions

Percentage of adults who do not take medication as prescribed due to costs by family income (% of the Federal Poverty Level), U.S. 2021



Source: [CDC: Characteristics of Adults Aged 18–64 Who Did Not Take Medication as Prescribed to Reduce Costs: United States, 2021](#), June 2023



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

A Clinically Nuanced Alternative to “Blunt” Consumer Cost-sharing: Value-Based Insurance Design - More of the Good Stuff and Less of the Bad Stuff

- 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



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

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



ACA Sec 2713: Selected Preventive Services be Provided without Cost-Sharing

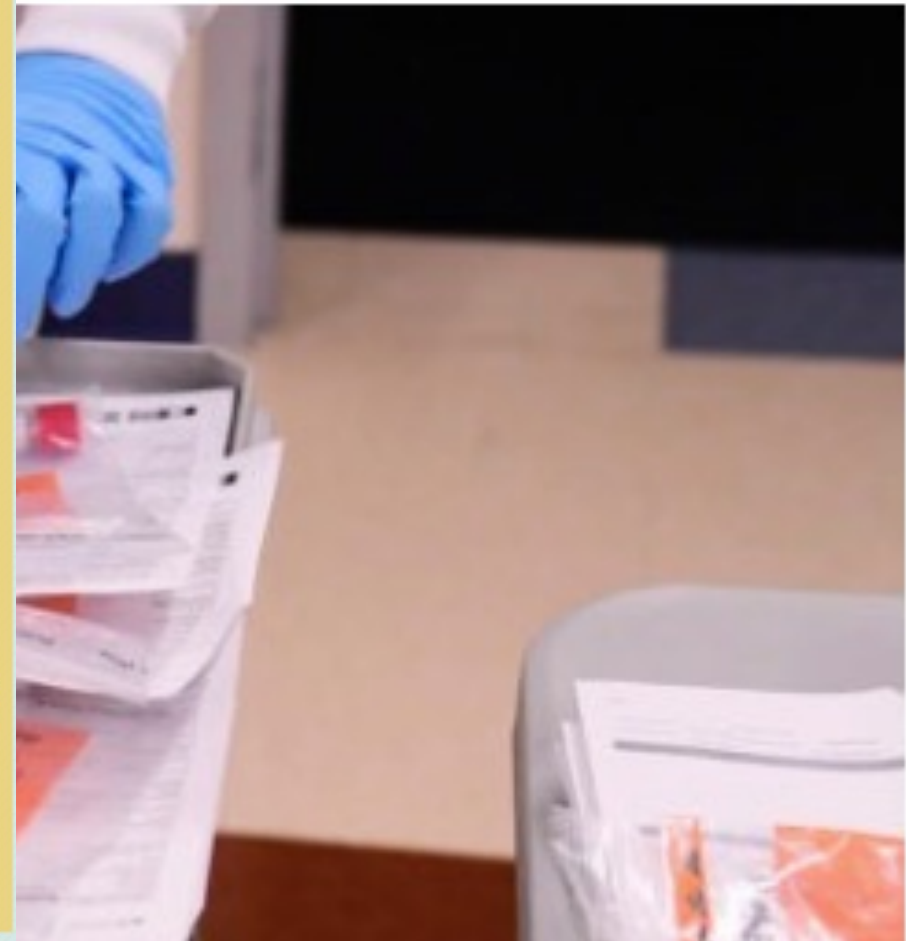
- Receiving an A or B rating from the United States Preventive Services Taskforce (USPSTF)
- Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP)
- Preventive care and screenings supported by the Health Resources and Services Administration (HRSA)

COVID-19 Testing and Vaccines Provided without Cost-sharing



March 27, 2020: Coronavirus Aid, Relief, and Economic Security Act (CARES)

- Mandates coverage of COVID-19 testing by all plans without cost-sharing
- Allows HSA-HDHPs to cover telehealth services - including care not associated with COVID-19 - on a pre-deductible basis
- Requires first dollar coverage of a COVID-19 vaccine in all plans by amending Public Health Service Act Section 2713



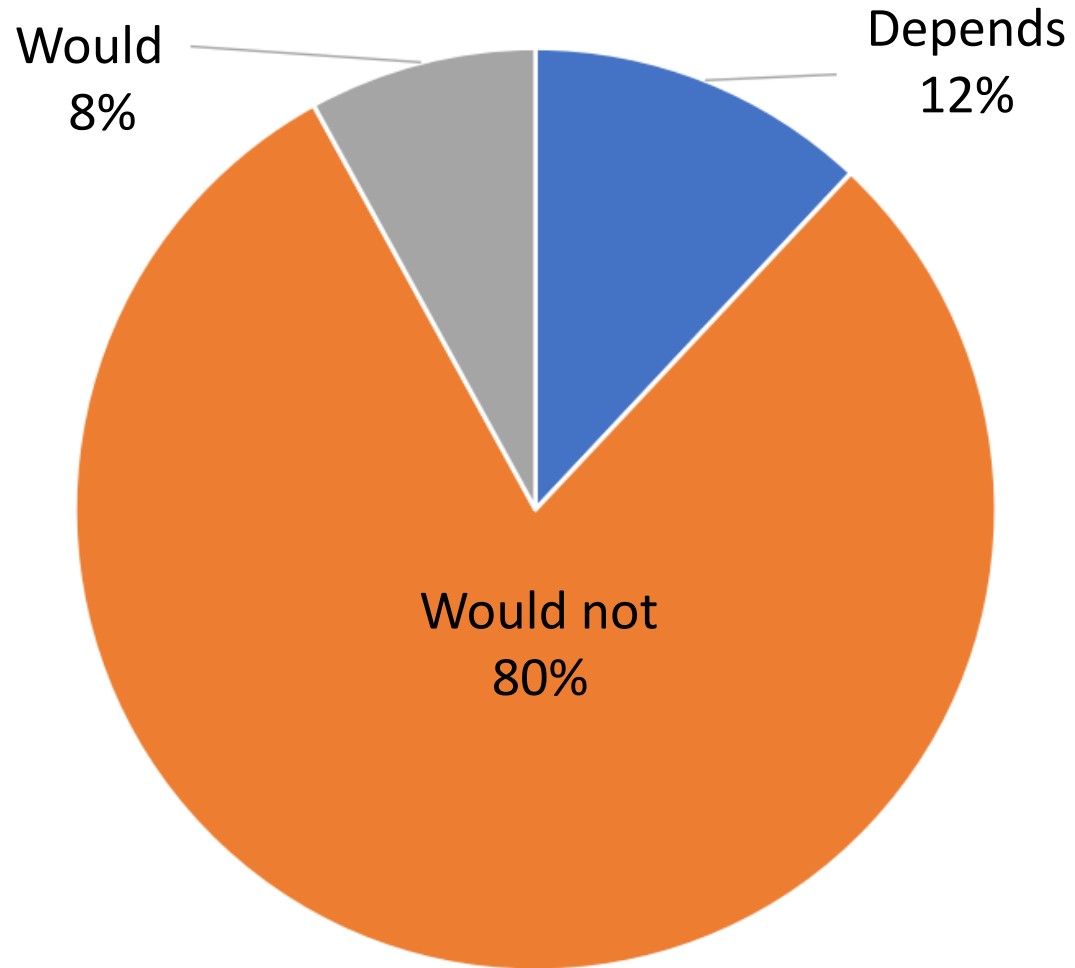


Access to Preventive Services without Cost-Sharing: Evidence from the Affordable Care Act

- 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

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

Percentage of Employers That Would Impose Cost Sharing for Preventive Services if Allowed by Law



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.



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

56%
Reduced spending on non-essential activities

49%
Reduced spending on every-day purchases

31%
Accrued credit card debt

Medicare Advantage V-BID Model Test

For first time, reduced cost-sharing is 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

Rewards and Incentives

\$600 annual limit

Increase participation

Available for Part D

Targeting Socioeconomic Status

Low-income subsidy

Improve quality, decrease costs

Telehealth

Service delivery innovations

Augment existing provider networks

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





ASPE
ASSISTANT SECRETARY FOR
PLANNING AND EVALUATION

OFFICE OF
HEALTH POLICY

RESEARCH REPORT

July 7, 2023

HP-2023-19

—Inflation Reduction Act Research Series—
Medicare Part D Enrollee Out-Of-Pocket Spending:
Recent Trends and Projected Impacts of the
Inflation Reduction Act

The Inflation Reduction Act's redesign of Medicare Part D will reduce enrollee out-of-pocket spending by about \$7.4 billion annually among more than 18.7 million enrollees (36 percent of Part D enrollees) in 2025 – nearly \$400 per person among enrollees who have savings in out-of-pocket costs under the IRA.

Figure 12

Majorities Of The Public Do Not Know About Inflation Reduction Act Provisions

As far as you know, is there a federal law in place that...

■ Yes, there is a law that does this ■ Not sure ■ No, there is not a law that does this

Requires the federal government to negotiate the price of some prescription drugs for people with Medicare



Caps the cost of insulin for people with Medicare at \$35 per month



Places an annual limit on out-of-pocket prescription drug costs for people with Medicare



Penalizes drug companies for increasing prices faster than the rate of inflation for people with Medicare



NOTE: See topline for full question wording.

SOURCE: KFF Health Tracking Poll (Oct. 31-Nov. 7, 2023)

Allowing High Deductible Health Plans the Flexibility to Cover Chronic Disease Services Before Plan Deductible is Met



The New York Times

OPINION
GUEST ESSAY

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

July 7, 2022

IRS Rules Prohibited Coverage of Chronic Disease Care Until Deductible is Met

PREVENTIVE CARE COVERED

Dollar one



CHRONIC DISEASE CARE

NOT covered until deductible is met





U.S. DEPARTMENT OF THE TREASURY

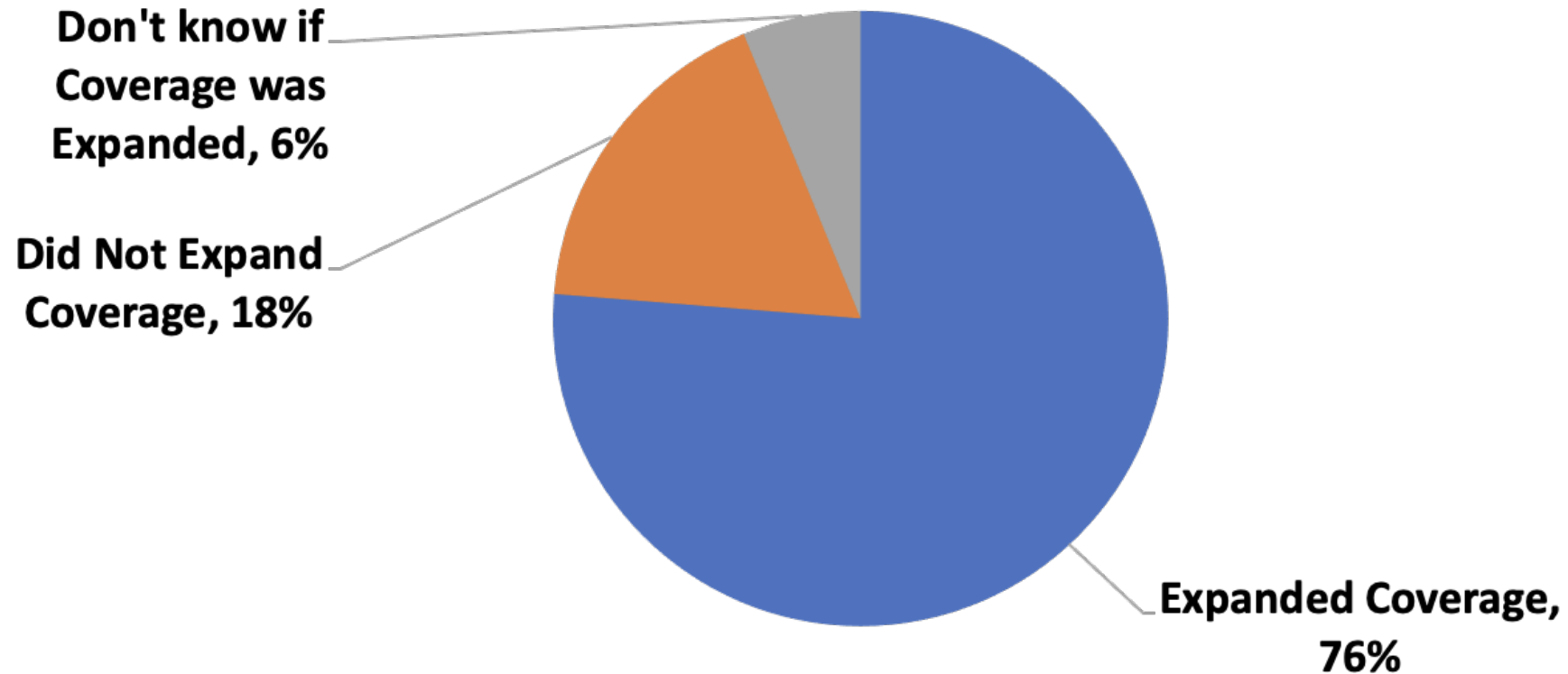
PRESS RELEASES

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 IRS Notice 2019-45

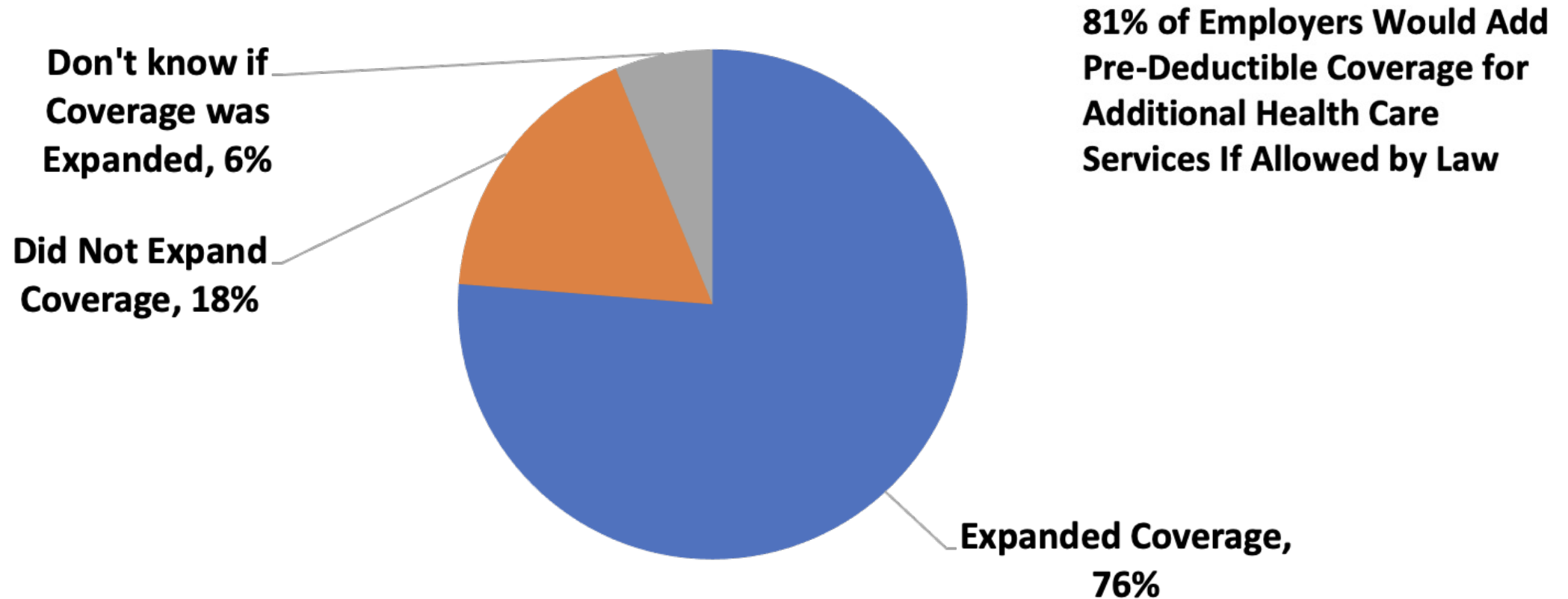
Preventive Care for Specified Conditions	For Individuals Diagnosed with
Angiotensin Converting Enzyme (ACE) inhibitors	Congestive heart failure, diabetes, and/or coronary artery disease
Anti-resorptive therapy	Osteoporosis and/or osteopenia
Beta-blockers	Congestive heart failure and/or coronary artery 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

Three Quarters of Employers Expanded Coverage of Chronic Disease 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).

8 in 10 Employers Would Cover Additional Chronic Disease Services if Allowed by Law



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).

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**

**\$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

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).

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

The ACA grants HHS the authority to eliminate coverage for USPSTF 'D' Rated Services in Medicare

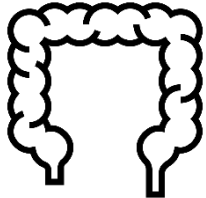
- The 7 most commonly used USPSTF D rated services are used over 30 million times a year at a cost to the Medicare program of over \$500 Million annually**



Prostate cancer screening ≥ 70 years



Cervical cancer screening > 65 years



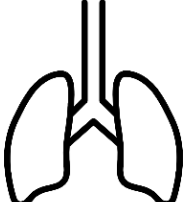
Colon cancer screening >85 years



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



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**

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](https://doi.org/10.1377/hblog20190714)

V-BID X: Enhancing Access and Affordability to Essential Clinical Services in Addition to COVID-19 Related Care

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

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



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

Diabetes - 01/01/23

Pediatric mental and behavioral health - 01/01/24

Enhancing Access and Affordability to Essential Clinical Services

- Save preventive care mandate
- Expand pre-deductible coverage/reduce consumer cost-sharing on high-value, 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

Thank you

Questions?



**Kansas Business
Group on Health**

www.vbidcenter.org

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