2024 V-BID Center Advisory Board Meeting

March 12, 2024

Webinar Logistics

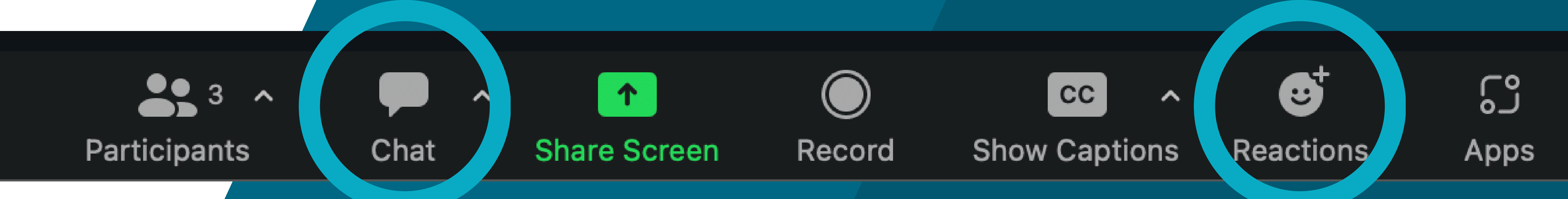
At this time, please:

- turn your microphone off
- turn your webcam on
- select "Active Camera" view from the view tab

We would like this meeting to be as interactive as possible.

When you would like to make a comment and/or ask a question, please raise your hand (under the "More" or "Reactions" tab) or submit via the chat function.

- Mark will do his best to call on members in the order that questions are submitted.
- When it is your turn to speak, please unmute yourself.



Welcome

John Z. Ayanian

Director, Institute for Healthcare Policy and Innovation
Chair, Advisory Board, Center for Value-Based Insurance Design University of Michigan

V-BID Center Update

Mark Fendrick
Director, Center for Value-Based Insurance Design
University of Michigan

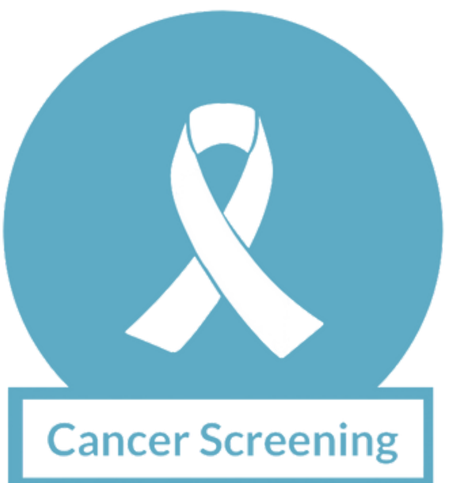
THANK YOU TO OUR SPONSORS!

OUR MISSION

Since its launch in 2005, the V-BID Center has collaborated with multiple stakeholders to identify, evaluate, and implement strategies that improve access to essential care, enhance equity, and improve the efficiency of the health care delivery system.

STRATEGIC PLAN

To advance our mission, *"To ensure that every American has the option to enroll in a health plan incorporating V-BID principles"*, the Center is focusing on several strategic equity enhancing initiatives, including:



Today's Agenda

Welcome

New Member/New Role Introductions

Updates and accomplishments on key strategic initiatives

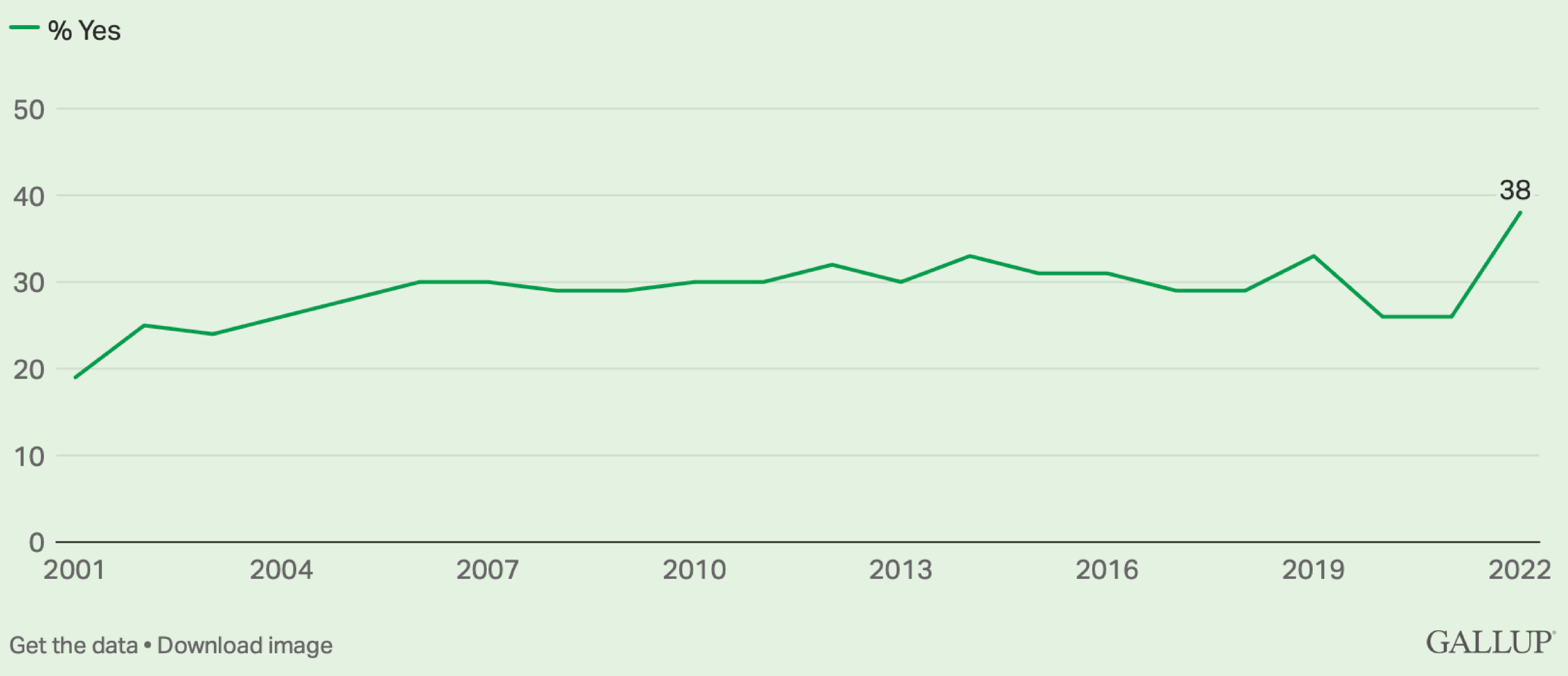
- Legal Challenge to the ACA Preventive Care Mandate
- Closing the Cancer Screening Coverage Gap
- Episode-Based Cost-Sharing
- Inflation Reduction Act
- HSA-HDHP
- Low-Value Care

Adjourn

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)


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?
% Yes
50
40
30
20
10
0
38
2001
2004
2007
2010
2013
2016
2019
2022
Get the data • Download image
GALLUP

AMERICANS DO NOT CARE ABOUT HEALTH CARE COSTS; THEY CARE ABOUT WHAT IT COSTS THEM

- Health care costs are persistently among the leading causes of:
  - Personal debt

    100 Million People in America Are Saddled With Health Care Debt

  - On-line fundraisers

    GoFundMe Has Become a Health Care Utility

  - Personal Bankruptcy

    EDITORIAL | VOLUME 122, ISSUE 8, P699, AUGUST 2009 Download Full Issue

    Only in America: Bankruptcy Due to Health Care Costs

    James E. Dalen, MD, MPH

"Just look for something in my price range."

Paying for It: How Health Care Costs and Medical Debt Are Making Americans Sicker and Poorer

Findings from the Commonwealth Fund 2023 Health Care Affordability Survey

- Large shares of insured working-age adults surveyed said it was very or somewhat difficult to afford their health care
- Many insured adults said they or a family member had delayed or skipped needed health care or prescription drugs because they couldn’t afford it in the past 12 months
- Cost-driven delays in getting care or in missed care made people sicker
- Insurance coverage didn’t prevent people from incurring medical debt
- Medical debt is leading many people to delay or avoid getting care or filling prescriptions

March 4, 2024

Associations of Medical Debt With Health Status, Premature Death, and Mortality in the US

Xuesong Han, PhD[1]; Xin Hu, PhD[1,2]; Zhiyuan Zheng, PhD[1]; Kewei Sylvia Shi, MPH[1]; K. Robin Yabroff, PhD[1]

- Findings suggest that medical debt is associated with worse health status, more premature deaths, and higher mortality rates at a county level
- Policies increasing access to affordable health care, such as expanding health insurance coverage, may improve population health

Most Voters Say Out-of-Pocket Costs Are Top Health Policy Priority

Most Voters Say Out Of Pocket Costs Are Top Health Priority

Which of the following health care priorities do you think is most important for the country to address?

Priority	Percent
Lowering out of pocket health care costs for people	48%
Getting more value for health care spending	18%
Ensuring the financial sustainability of Medicare	18%
Reducing national spending on health care	7%
Reducing the costs employers pay for health insurance for their workers	7%
Easing the effect of Medicaid on state budgets	

KFF. 20 Feb 2024. Accessed at: https://www.kff.org/other/perspective/why-affordability-is-the-big-tent/

Review Article | Open Access

Expanding the Catalog of Patient and Caregiver Out-of-Pocket Costs: A Systematic Literature Review

Theresa Schmidt, MA[1], Christine Juday, MPH[1], Palak Patel, MHA[1], Taruja Karmarkar, PhD, MHS[2], Esther Renee Smith-Howell, PhD, MSHP, RN[2], and A. Mark Fendrick, MD[3]

Key Takeaways

- OOP costs are multifarious and systematically underestimated
- Many (31) subcategories of OOP costs were identified
  - direct medical (eg, insurance premiums)
  - direct non-medical (eg, transportation)
  - indirect spending (eg, absenteeism)
- A comprehensive catalog of OOP costs can inform future research, interventions, and policies related to financial barriers to ensure the full range of costs for patients are acknowledged and addressed

Assessment of racial and ethnic inequities in copay card utilization and enrollment in copay adjustment programs

Mike Ingham, MSc; Kay Sadik, PharmD, PhD; Xiaohui Zhao, PhD; Ji Song, PhD; A. Mark Fendrick, MD

- Copay card use did not differ by the race and ethnicity of patients
- However, the potential for a patient to be included in a copay adjustment program (CAP) was higher among non-White patients compared to White patients
- Non-White patients may therefore be more impacted by this loss of copay assistance, resulting in unexpected clinical and economic concerns

DISCUSSION

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)

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

BRAIDWOOD V. BECERRA

A Texas Judge Just Invalidated The Preventive Services Mandate. What Happens Next?

Nicholas Bagley, A. Mark Fendrick

MARCH 30, 2023 10.1377/forefront.20230330.177353

Several outstanding questions remain, but it is possible that this ruling will mean that qualified payers will no longer have to provide first-dollar coverage for the 50+ services that have received an "A" or "B" rating from the U.S. Preventive Services Task Force (after March 2010) as well as those receiving future "A" or "B" rating

Clinical Implications Of The *Braidwood* Ruling: Use Of Pre-ACA Task Force Recommendations

Zoey Chopra, A. Mark Fendrick

MAY 2, 2023

10.1377/forefront.20230426.482809

POTENTIAL IMPLICATIONS

16 Current A/B Services that Would No Longer Require Coverage Without Cost-Sharing

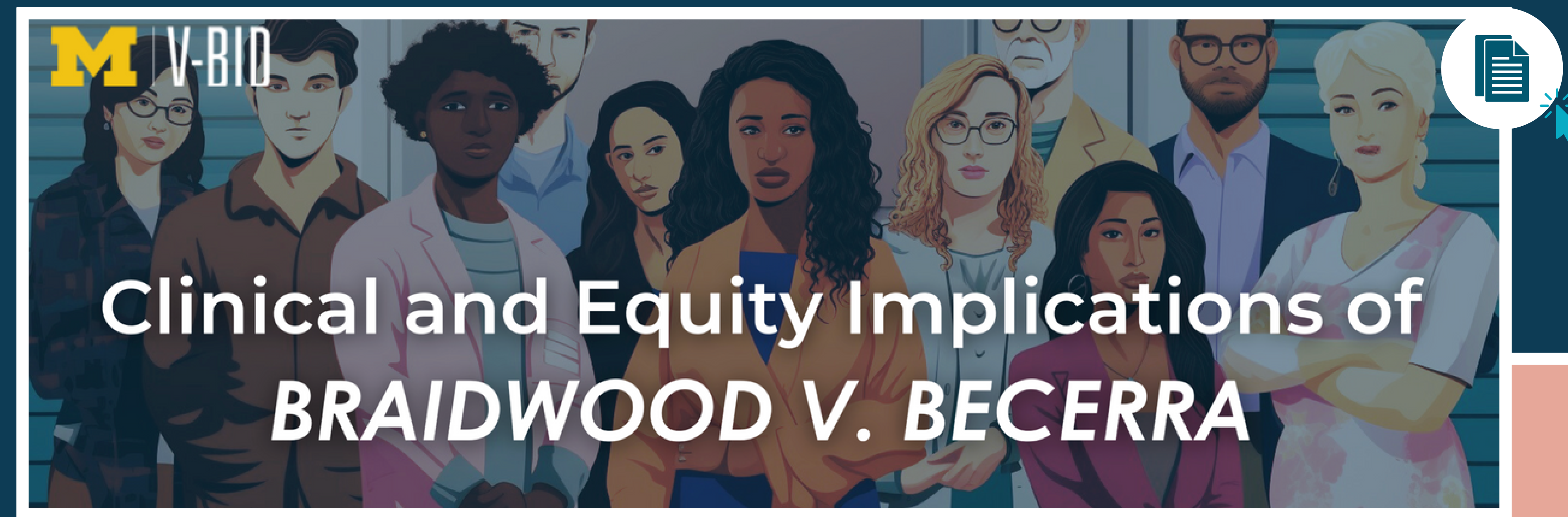
- **6** Received A/B Rating After March 2010
  Example: Screening for Anxiety in Children/Adolescents
- **10** Upgraded to A/B Rating After 2010
  Example: Screening for Lung Cancer

5 Services Receiving a "DRAFT" A/B Rating that Would Not Require Coverage without Cost-Sharing

- **1** New Draft Recommendations with Draft A/B Grade
  Ex.: Screening for Hypertensive Disorders in Pregnancy
- **4** Updated Recommendations with Draft A/B Grade
  Example: Breast Cancer Screening

31 Current A/B Services that Would Require Coverage Without Cost-Sharing Using Pre-2010 Recommendations

- **18** Pre-2010 A/B Rating with Significant Updates After 2010
  Example: Screenings for Colorectal & Cervical Cancer
- **13** Pre-2010 A/B Rating with No Significant Updates
  Example: Screening for Abdominal Aortic Aneurysm



BRAIDWOOD V. BECERRA:
A THREAT TO THE LANDSCAPE OF PREVENTIVE CARE

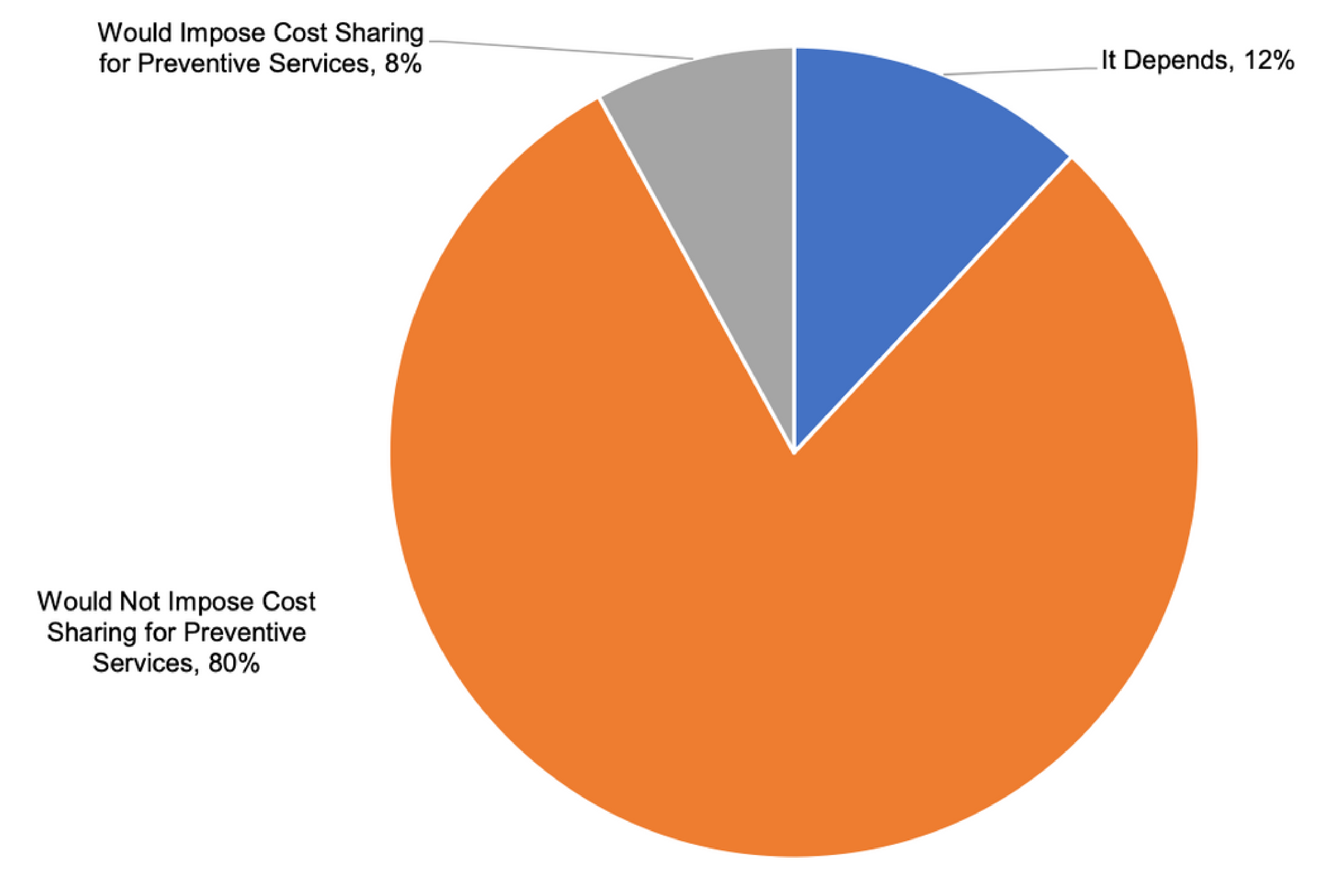
0:11 / 4:27

BRAIDWOOD VS. BECERRA

Paul Fronstin, Ph.D.
Employee Benefit Research Institute

Will Employers Introduce Cost Sharing for Preventive Services? Findings From EBRI's First Employer Pulse Survey

- Cost savings is low.
- Employers may not want to cut benefits during a time when unemployment is low, and recruitment and retainment of workers is of concern.
- There is already precedent for covering preventive services without cost sharing in HDHPs prior to passage of the ACA.



© Employee Benefit Research Institute 2023

BRAIDWOOD VS. BECERRA

EBRI analyses demonstrated two important findings if the Braidwood ruling is upheld and cost sharing is imposed:

1. Reintroduction of patient cost sharing will have a minimal impact on overall employer health care spending, because when spread across the entire pool of covered lives, the costs of covering select preventive services are very low.
2. Enrollees using preventive services may face a substantial increase in their individual out-of-pocket spending.

Overall Use and Employer Savings Related to Select “A” and “B” Rated Services Affected by the Judicial Ruling, 2019

	Percent of Members Utilizing Service	Percent of Total Cost	Employer Savings from 20% Coinsurance
Screening for anxiety in children and adolescents (ages 8-18)	2%	<0.01%	<0.01%
Behavioral counseling interventions for healthy weight and weight gain in pregnancy	0.04%	<0.01%	<0.01%
Preventive interventions for perinatal depression	1%	0.09%	0.02%
Pre-exposure Prophylaxis (PrEP) for prevention of HIV infection	0.2%	0.38%	0.08%
Screening for gestational diabetes	1%	<0.01%	<0.01%
Screening for Hepatitis B Virus infection in adolescents and adults	1%	<0.01%	<0.01%
Screening for Hepatitis C Virus in adolescents and adults	3%	0.01%	<0.01%
Primary care interventions for tobacco use in children and adolescents	0.2%	<0.01%	<0.01%
Screening for HIV infection (for those not at increased risk) (pregnant women)	1%	<0.01%	<0.01%
Screening for HIV infection (for those not at increased risk) Adolescents and Adults (ages 15-64)	3%	0.01%	<0.01%

Total Allowed Cost and Possible Cost Sharing of Select "A" and "B" Rated Services Receiving Recommendation or Upgrade After March 2010

	Total Allowed Cost Per User in 2019	Enrollee Out-of-Pocket If 20% Coinsurance
Screening for anxiety in children and adolescents (ages 8-18)	$10	$2
Behavioral counseling interventions for healthy weight and weight gain in pregnancy	$163	$33
Preventive interventions for perinatal depression	$454	$91
Pre-exposure Prophylaxis (PrEP) for prevention of HIV infection	$13,733	$2,747
Screening for gestational diabetes	$20	$4
Screening for Hepatitis B Virus infection in adolescents and adults	$25	$5
Screening for Hepatitis C Virus in adolescents and adults	$27	$5
Primary care interventions for tobacco use in children and adolescents	$38	$8
Screening for HIV infection (for those not at increased risk) (pregnant women)	$38	$8
Screening for HIV infection (for those not at increased risk) Adolescents and Adults (ages 15-64)	$34	$7

TAKEAWAYS

Employers may continue to provide these services at no cost to members for at least a few reasons.

- Employers may not want to cut benefits during a time when unemployment is low, and recruitment and retainment of workers is of concern.
- Employers may continue to offer coverage for these services in full if they believe that incentivizing their use reduced aggregate health spending in the long-term.
- There is precedent for covering these services without cost sharing in the absence of the ACA mandate. When HRAs were introduced in the early 2000s, some employers provided first-dollar coverage for preventive services. Comparable generous coverage was implemented when HSA-eligible health plans were introduced. Similarly, recent research has found that when the IRS allowed employers and health plans to cover certain preventive services outside HSA-eligible health plan deductibles, about three-quarters of them chose to do so, often without cost sharing.

Employers could realize more measurable cost reductions if the addition of cost sharing reduced use of these preventive services. However, imposing cost sharing for preventive services would reverse a growing movement among employers in recent years to expand coverage of clinically effective care without deductibles or copays.

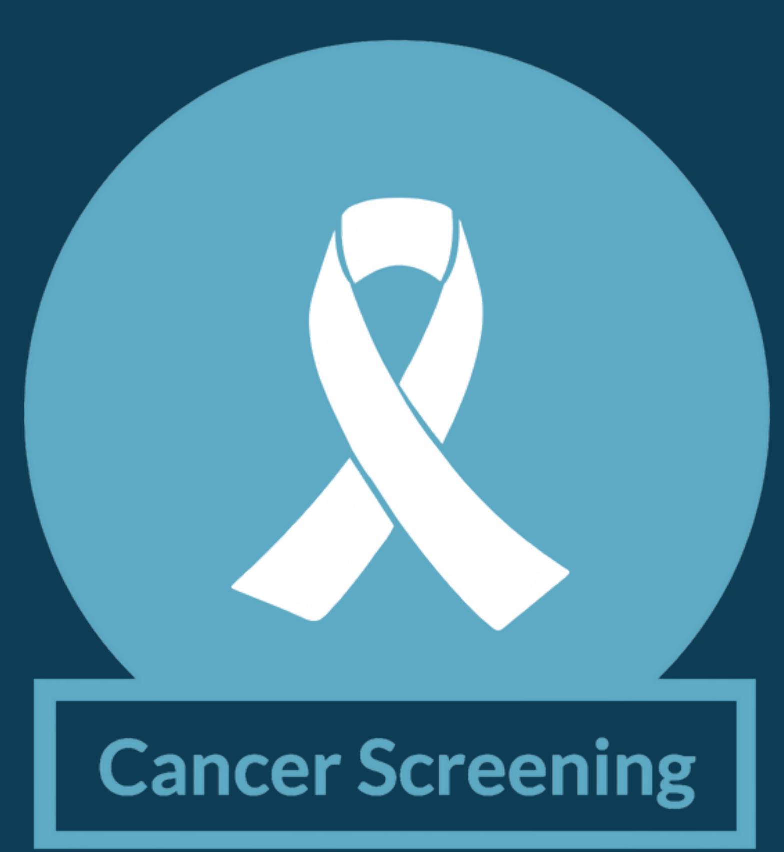
March 4, 2024, Judges on the U.S. Court of Appeals for the 5th Circuit (New Orleans):

- Didn't ask about ACIP or HRSA recommendations (including the contraception mandate)
- Spent a lot of time on remedy of the case, rather than the substance
- Therefore, it appears likely that the UPSTF guidelines will be to "set aside" on a nationwide basis, not just as to the plaintiffs
- Supreme Court likely next step (don't expect to see an opinion until the summer, though that's highly uncertain)

BRAIDWOOD V. BECERRA

DISCUSSION: What activities should the V-BID Center pursue as *Braidwood v Becerra* progresses through the courts?

CANCER SCREENING



Research | Open access | Published: 07 August 2023

The aggregate value of cancer screenings in the United States: full potential value and value considering adherence

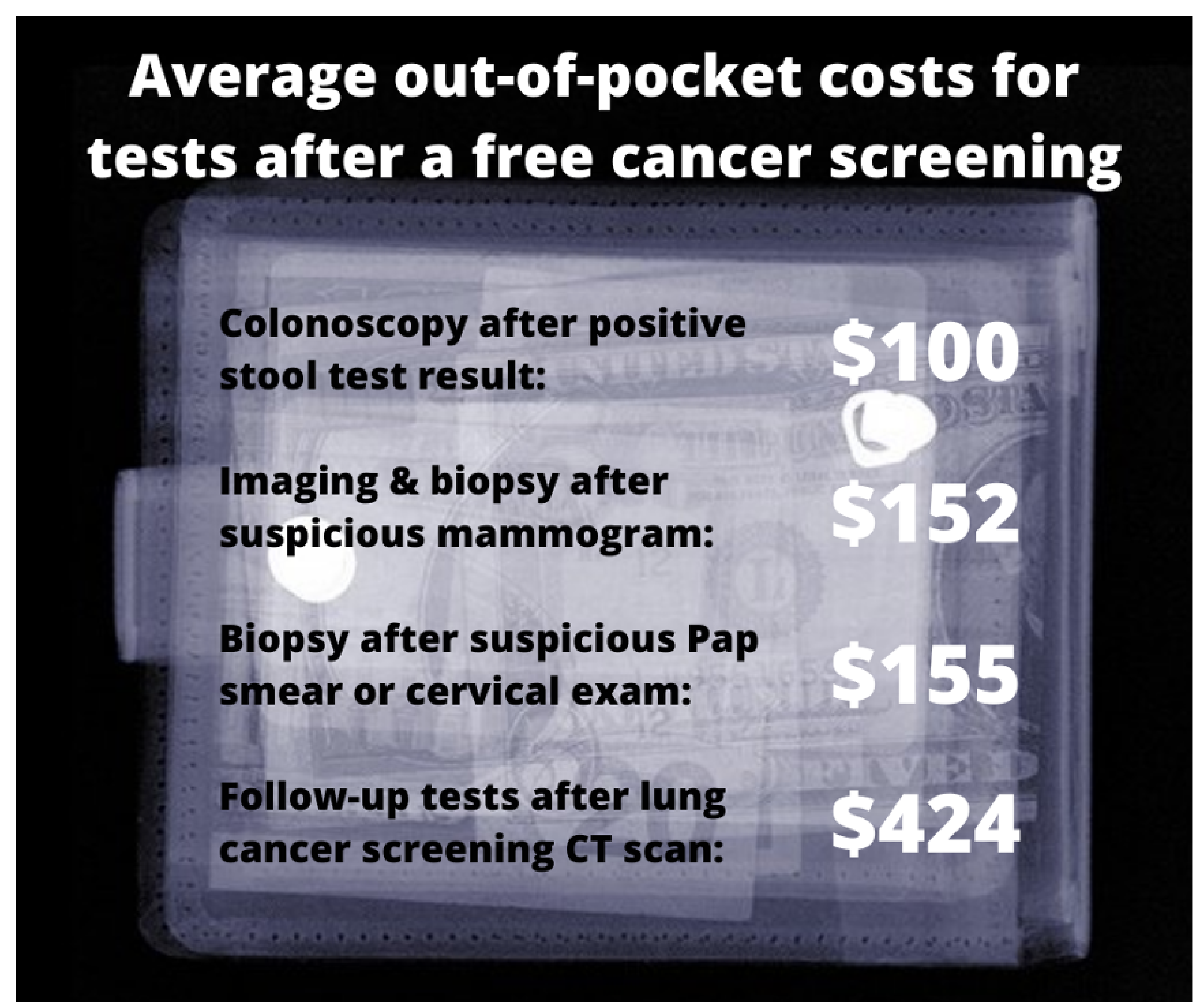
Tomas J. Philipson, Troy Durie, Ze Cong & A. Mark Fendrick

Technologies and policy interventions that can improve adherence and/or expand the number of cancer types tested will provide considerably more value and save significantly more patient lives.

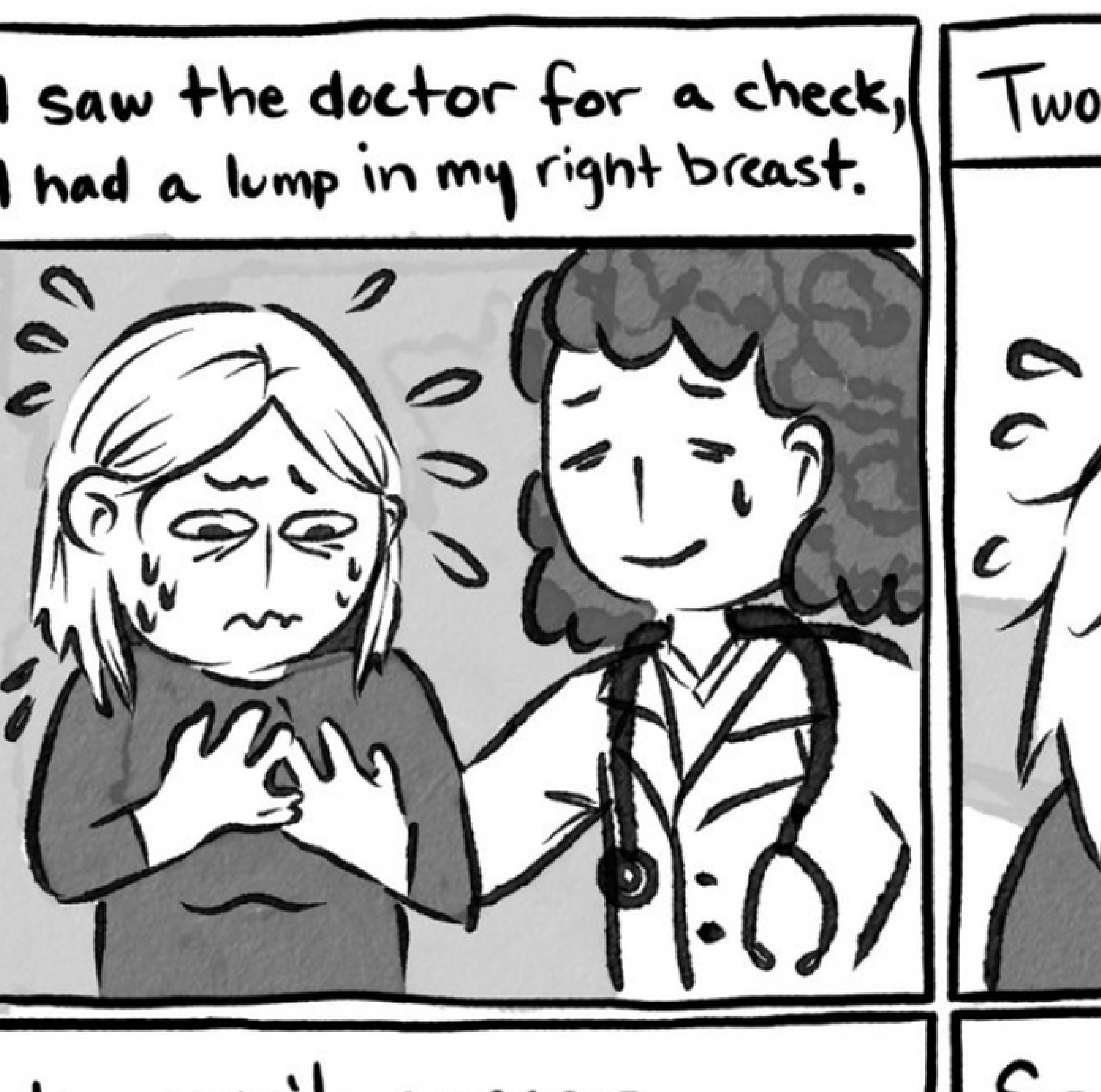
Your Free Cancer Screen Shows Trouble: What If You Can't Afford the Follow-Up?

New V-BID 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]



1. JAMA Network Open. 2021;4(8):e2121347
2. Obstetrics & Gynecology. 2022;139(1): doi:10.1097/AOG.0000000000004582
3. JAMA Network Open. 2021;4(12): doi:10.1001/jamanetworkopen.2021.36798
4. JACR E-pub ahead of print. 2021.DOI:https://doi.org/10.1016/j.jacr.2021.09.015


I saw the doctor for a check,
I had a lump in my right breast.

Two weeks for the answer.

NO NEW MAIL
click click click click click click click click click click click click click click click click click

It wasn't cancer.
NEW TEST RESULT

So instead of death,
I'm in debt.
$ Your $ BIG BILL $ $
ART: oona T. / KFF HEALTH NEWS
POEM: SUNSHINE MOORE ANGER

RESEARCH ARTICLE

https://doi.org/10.1158/2767-9764.CRC-23-0322

Impact of Eliminating Cost-Sharing by Medicare Beneficiaries for Follow-Up Colonoscopy After a Positive Stool-based Colorectal Cancer Screening Test

A. Mark Fendrick[1], David Lieberman[2], Jing Voon Chen[3], Vahab Vahdat[3], A. Burak Ozbay[3], and Paul J. Limburg[3]

Significance: A follow-up colonoscopy after a positive stool-based colorectal cancer screening test is necessary to complete the full screening process. Policies that remove cost barriers to completing colorectal cancer screening may lead to increases in overall participation rates and use of follow-up colonoscopy, improving clinical and economic outcomes.

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.

> Womens Health Issues. 2022 Dec 16;S1049-3867(22)00175-X. doi: 10.1016/j.whi.2022.11.009. Online ahead of print.

Coverage for the Entire Cervical Cancer Screening Process Without Cost-Sharing: Lessons From Colorectal Cancer Screening

Allison Ruff [1], Diane M Harper [2], Vanessa Dalton [3], A Mark Fendrick [4]

Original Research

OPEN

Lives Saved Through Increasing Adherence to Follow-Up After Abnormal Cervical Cancer Screening Results

Diane M. Harper, MD, MPH, *Tiffany M. Yu*, BS, and *A. Mark Fendrick*, MD

CONCLUSION: The consequences of not attending routine screening or follow-up after an abnormal cervical cancer screening result are associated with preventable cervical cancer morbidity and premature mortality. Given the potential for the removal of consumer cost sharing to increase the use of necessary follow-up after abnormal screening results and to ultimately reduce cervical cancer morbidity and mortality, public and private payers should remove cost barriers to these essential services.

Reallocating Cervical Cancer Preventive Service Spending from Low- to High-Value Clinical Scenarios

Michelle S. Rockwell[1], Shannon D. Armbruster[2], Jillian C. Capucao[3], Kyle B. Russell[3], John A. Rockwell[4], Karen E. Perkins[1], Alison N. Huffstetler[5,6], John N. Mafi[7], and A. Mark Fendrick[8]

Prevention Relevance: Out-of-pocket fees are a barrier to follow-up care after an abnormal cervical cancer screening test. Among commercially insured Virginians, out-of-pocket costs for follow-up services averaged $144/patient; 34% of cervical cancer screenings were classified as low value. Reallocating low-value cervical cancer screening expenditures to enhance coverage for follow-up care can improve screening outcomes.

Original Investigation | Health Policy

March 27, 2023

Patient Cost-Sharing and Utilization of Breast Cancer Diagnostic Imaging by Patients Undergoing Subsequent Testing After a Screening Mammogram

Danny R. Hughes, PhD[1,2,3]; William Espinoza, MS[4,5]; Sarah Fein, MS[5,6]; Elizabeth Y. Rula, PhD[7]; Geraldine McGinty, MD, MBA[8]

March 27, 2023

Eliminating Financial Barriers to Breast Cancer Screening—When Free Is Not Really Free

Ilana B. Richman, MD, MHS[1]; A. Mark Fendrick, MD[2]

Financial barriers exist for follow-up care for adults with a positive lung cancer screening examination

Journal of the American College of Radiology
Volume 19, Issue 1, Part A, January 2022, Pages 35-46

Health Services Research and Policy
Original Article

Total and Out-of-Pocket Costs of Procedures After Lung Cancer Screening in a National Commercially Insured Population: Estimating an Episode of Care

Tina D. Tailor MD [a], Sarah Bell MS, MPH [b], A. Mark Fendrick MD [c], Ruth C. Carlos MD, MS [d]

- In lung cancer screening episodes necessitating downstream procedures, the range of out-of-pocket costs incurred were wide, with patient costs ranging from $0 to $7,500 with an average per-episode cost of $424.
- Removal of financial barriers for essential follow-up tests will increase their use, prevent the further exacerbation of existing health care inequities and allow patients to reap the benefits of lung cancer prevention.

ARTICLE

Screening for lung cancer: 2023 guideline update from the American Cancer Society

- The failure to follow-up a positive screening test in a manner that is concordant with Lung-RADS guidance undermines the screening process, can delay diagnosis, or can result in unnecessary imaging examinations and radiation exposure.
- In addition, if a positive screening test is not followed according to recommendations, the screening process is incomplete.
- It is the position of the ACS that follow-up tests are integral to the screening process, and patients should not face cost sharing for any follow-up procedure associated with a positive LCS test.

American Cancer Society Position Statement on the Elimination of Patient Cost-Sharing Associated with Cancer Screening and Follow-up Testing

- It is the position of the ACS that cancer screening should be understood as a continuum of testing rather than a single screening test.
- Screening is a process that includes a recommended screening test and all follow-up tests described as diagnostic and judged to be integral and necessary to resolve the question of whether an adult undergoing screening has cancer.
- These tests should be covered without any patient cost-sharing consistent with the 2022 FAQ specifying no patient cost-sharing for follow-up colonoscopy after a positive non-colonoscopy colorectal cancer screening examination.
- Insurers must cover and should not impose cost-sharing for these recommended examinations, regardless of the patient's designated risk.

TRADEOFFS

HOME EPISODES RESEARCH CORNER SUBSCRIBE ABOUT US DONATE JOBS

The Push to End Cancer Screening Purgatory

SEPTEMBER 29, 2022

CANCER SCREENING

DISCUSSION: What activities should the V-BID Center pursue to advocate for policies that eliminate cost-sharing for the entire cancer screening continuum?

FULLY TRANSPARENT, EPISODE-BASED COST-SHARING

Invited Commentary

September 18, 2023

Health Care Transparency—What You See Should Be What You Get

Aaron S. Parzuchowski, MD, MPH, MSc[1,2]; A. Mark Fendrick, MD[2]

Michal Horný, PhD
Department of Radiology and Imaging Sciences, Emory University School of Medicine, Atlanta, Georgia; and Department of Health Policy and Management, Rollins School of Public Health, Emory University, Atlanta, Georgia.

David M. Anderson, MSSPM
Department of Population Health Sciences, Duke University, Durham, North Carolina.

A. Mark Fendrick, MD
Department of Internal Medicine, University of Michigan Medical School, Ann Arbor; and Department of Health Management and Policy, University of Michigan School of Public Health, Ann Arbor.

VIEWPOINT

Episode-Based Cost Sharing to Prospectively Guarantee Patients' Out-of-Pocket Costs

The elimination of unexpected patient expenses resulting from factors outside of their control through the offering of an "out the door" price when care is scheduled could improve patients' trust in health care systems and advance the transparency movement, while expanding the use of high-value care. Providing prospectively guaranteed consumer prices would be an important step toward equitable health care; nevertheless, championing health equity would require implementation of additional policies addressing the sheer magnitude of patients' out-of-pocket costs.

EPISODE-BASED COST-SHARING

DISCUSSION: Should the V-BID Center seem to identify payers to pilot this idea in specific clinical episodes for which episode-based payments are already in place (e.g., childbirth, joint replacement?

INFLATION REDUCTION ACT OF 2022

MORE THAN DRUG PRICE NEGOTIATION

Inflation Reduction Act of 2022 Includes Several V-BID Elements

- 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
- Covers adult vaccines recommended by the Advisory Committee on Immunization Practices under Medicare Part D without cost-sharing
- Caps Medicare patients' out-of-pocket costs at $2,000 per year, with the option to break that amount into affordable monthly payments

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	32%	58%	10%
Caps the cost of insulin for people with Medicare at $35 per month	26%	61%	13%
Places an annual limit on out-of-pocket prescription drug costs for people with Medicare	23%	63%	14%
Penalizes drug companies for increasing prices faster than the rate of inflation for people with Medicare	13%	64%	23%

NOTE: See topline for full question wording.
SOURCE: KFF Health Tracking Poll (Oct. 31-Nov. 7, 2023)

Figure 13

A Minority Of Adults Ages 65 And Over Know About The Medicare Prescription Drug Provisions In The Inflation Reduction Act

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	36%	52%	12%
Caps the cost of insulin for people with Medicare at $35 per month	44%	48%	8%
Places an annual limit on out-of-pocket prescription drug costs for people with Medicare	25%	60%	15%
Penalizes drug companies for increasing prices faster than the rate of inflation for people with Medicare	8%	59%	32%

NOTE: Among adults ages 65 and older. See topline for full question wording.
SOURCE: KFF Health Tracking Poll (Oct. 31-Nov. 7, 2023)

MY MOTHER ON IRA V-BID ELEMENTS

Please don't tell me that you did a study to show that if you make people pay less for something, they'll buy more of it?

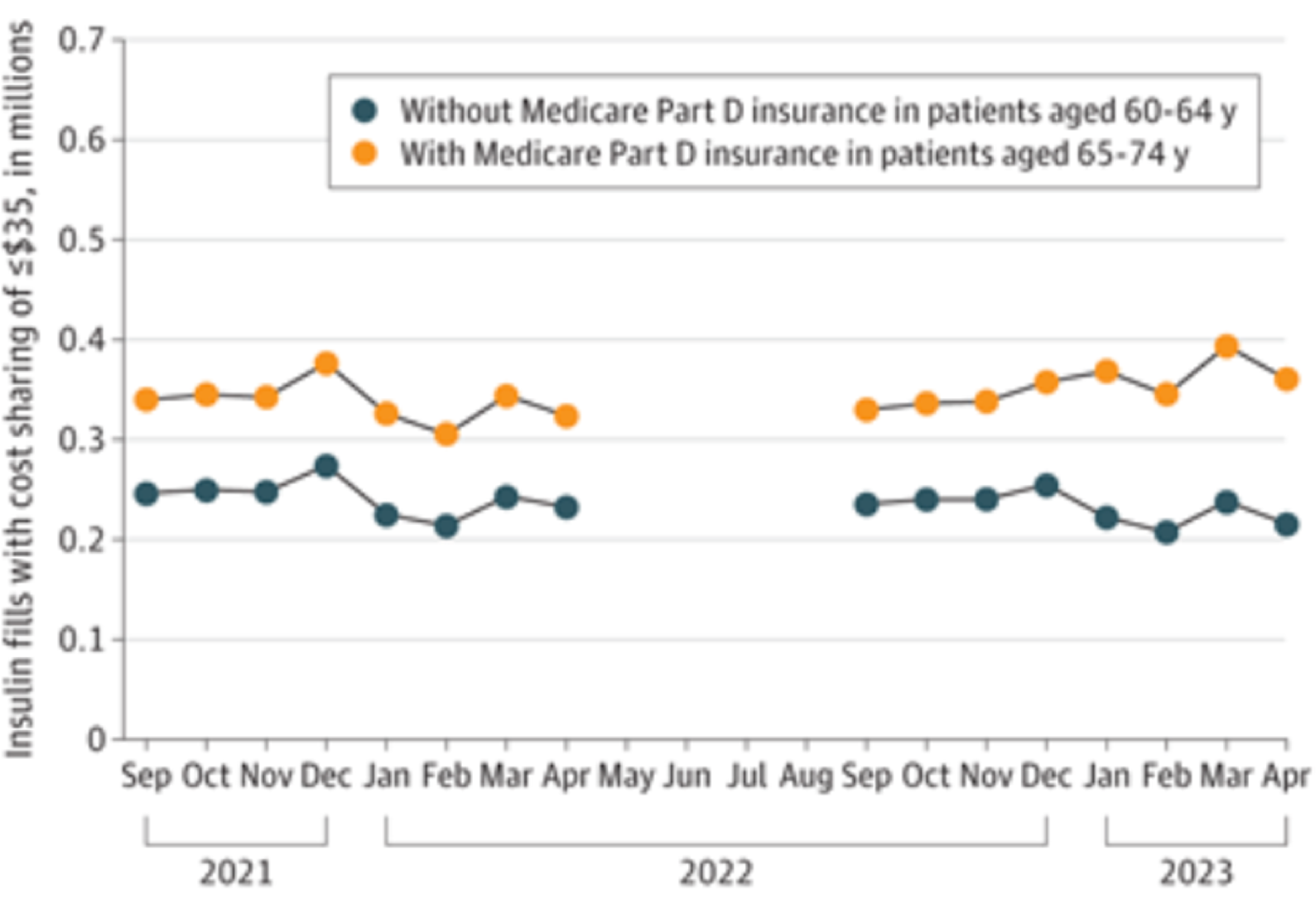
-Barbara Fendrick

While insulin fills increased among Medicare Part D enrollees after the cap, the number of fills for those without Medicare dropped during the same period.

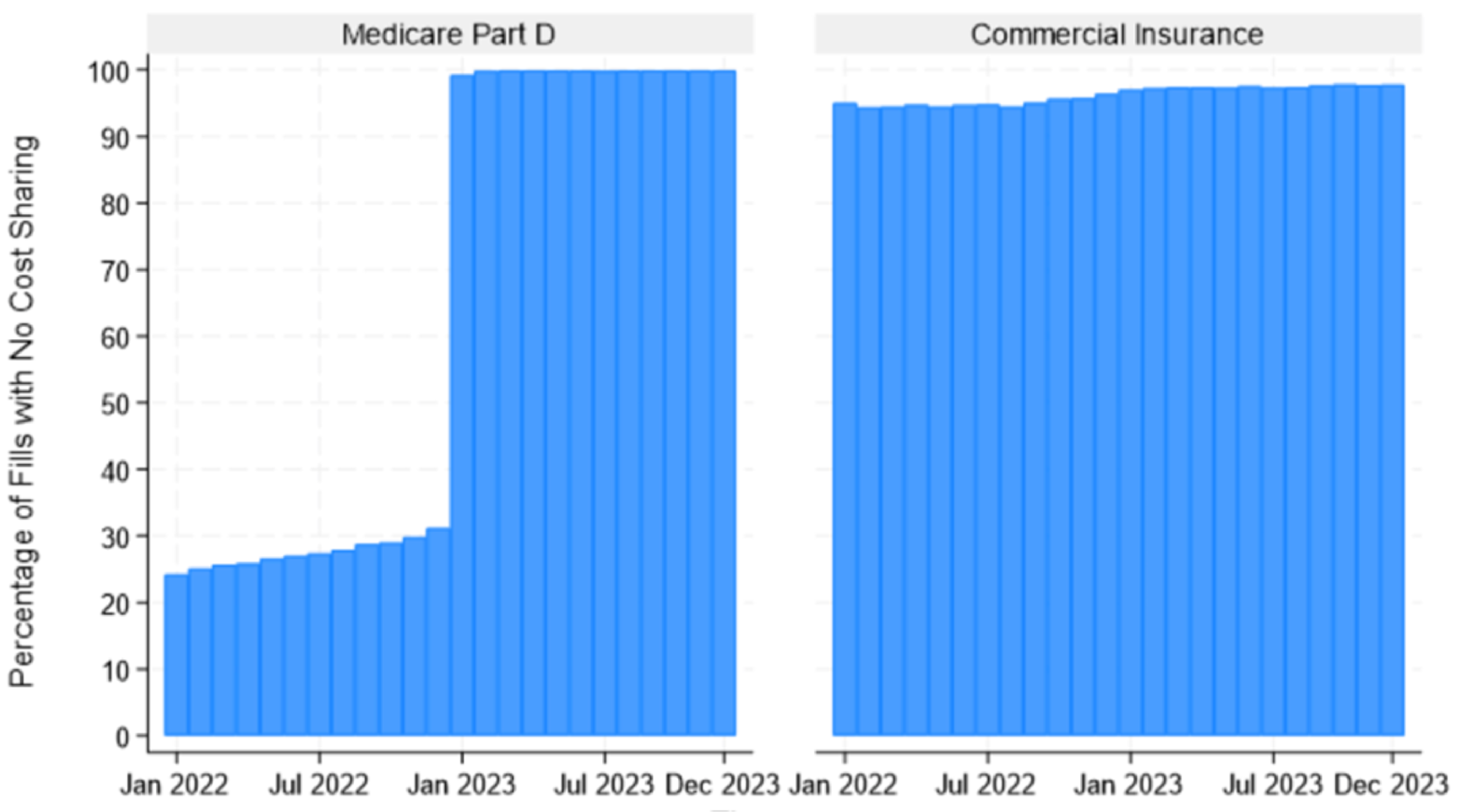
July 24, 2023

Insulin Fills by Medicare Enrollees and Out-of-Pocket Caps Under the Inflation Reduction Act

Rebecca Myerson, MPH, PhD[1]; Dima M. Qato, PharmD, MPH, PhD[2]; Dana P. Goldman, PhD[3]; John A. Romley, PhD[3]



Shingles Vaccinations in Medicare Part D After Elimination of Beneficiary Cost-Sharing Under the Inflation Reduction Act



[a] These data are from IQVIA's National Prescription Audit and measure monthly fills for shingles vaccines dispensed and administered at retail pharmacies.

Following the IRA implementation, Part D shingles vaccinations increased by 46% and decreased among commercial insurance over the same period

Figure 1

Five Million Medicare Part D Enrollees Spent $2,000 or More Out of Pocket on Prescription Drugs in at Least One Year Between 2012 and 2021

Number of Medicare Part D enrollees with out-of-pocket drug spending of $2,000 or more in:

2021	1,537,000
At least 1 year over 5 years (2017-2021)	3,338,000
At least 1 year over 10 years (2012-2021)	4,986,000
At least 1 year since Part D started* (2007-2021)	6,760,000

NOTE: Estimates exclude Part D enrollees receiving Low-Income Subsidies. Estimates rounded to the nearest thousand. *2007 was the first full year of Part D coverage.
SOURCE: KFF analysis of 2007-2021 Medicare Part D claims from the CMS Chronic Conditions Data Warehouse. • PNG

On IRA Price Negotiations

How To Make Sure The Inflation Reduction Act Works For All Patients

A. Mark Fendrick

AUGUST 24, 2023

10.1377/forefront.20230823.186201

- IRA requires medicines with government-set prices to be covered on Part D formularies (good for patients for whom these medicines are the best choice)
- Plans retain the authority to control use by placing drugs on tiers with varying levels of cost sharing or impose restrictive use management (bad for patients with conditions treated by negotiated drugs but needing an alternative option)

On IRA Price Negotiations

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CMS ought to:

- Establish clinician advisory panels, as it has in the past for other facets of Medicare, throughout the negotiation process.
- Publish how that input was used after decisions are finalized.
- Monitor access to available treatment options for conditions treated by negotiated drugs:
  - formulary placement
  - utilization management (eg, step-therapy, prior authorization)
  - non-medical switching

INFLATION REDUCTION ACT

DISCUSSION

HSA-HDHP REFORM

The New York Times

OPINION

GUEST ESSAY

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

July 7, 2022

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

October 14, 2021 • **No. 542**

Issue BRIEF

Employer Uptake of Pre-Deductible Coverage for Preventive Services in HSA-Eligible Health Plans

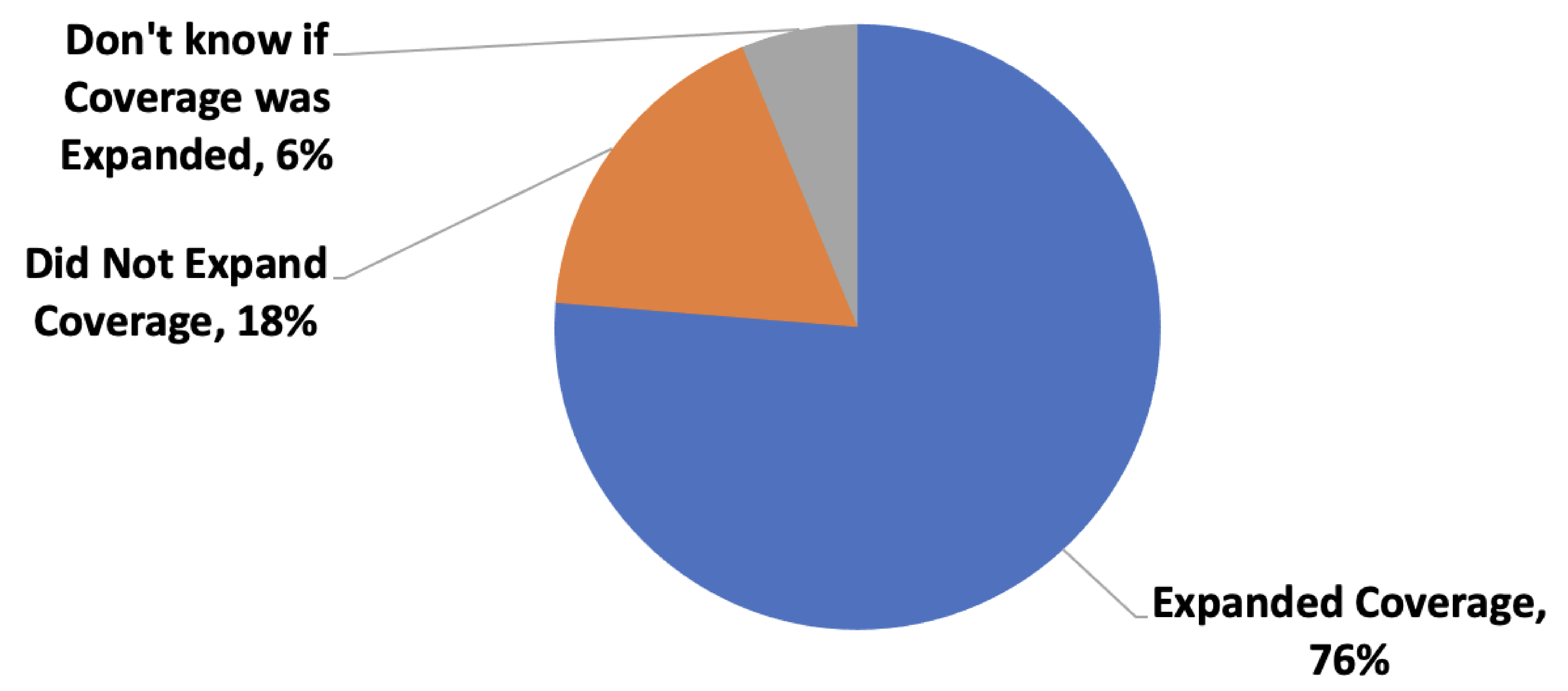
By Paul Fronstin, Ph.D., Employee Benefit Research Institute and A. Mark Fendrick, M.D., University of Michigan

A T A G L A N C E

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.

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).

FEATURES

High Deductibles are Associated With Severe Disease, Catastrophic Out-of-Pocket Payments for Emergency Surgical Conditions

Scott, John W. MD, MPH[*,†]; Neiman, Pooja U. MD, MPA[‡]; Scott, Kirstin W. MD, MPhil, PhD[§]; Ibrahim, Andrew M. MD, MPH[*,†]; Fan, Zhaohui MD, MPH[*]; Fendrick, A. Mark MD[†,‖]; Dimick, Justin B. MD, MPH[*,†]

Conclusions:

For privately insured patients presenting with common surgical emergencies, high-deductible health plans are associated with increased disease severity at admission and a greater financial burden after discharge—especially for vulnerable populations. Strategies are needed to improve financial risk protection for common surgical emergencies.

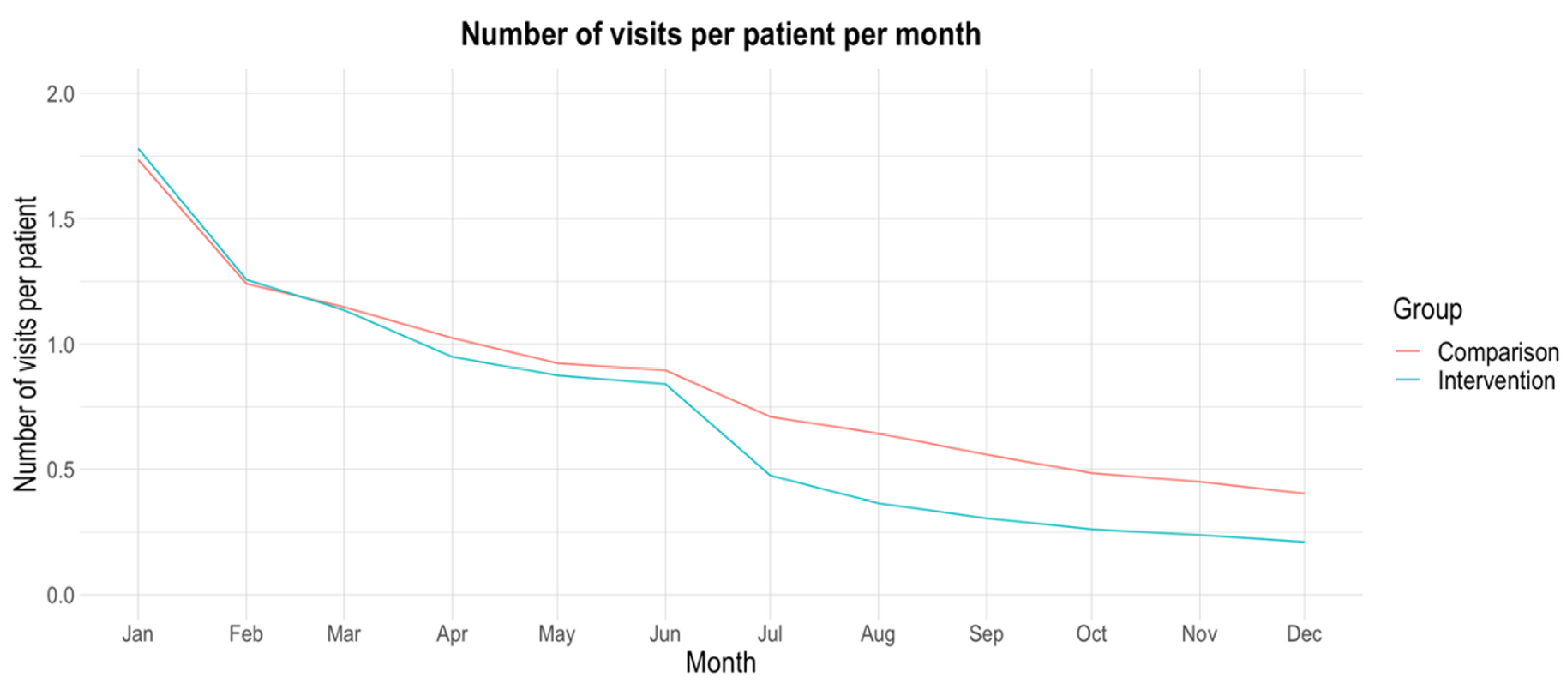
February 9, 2024

Acute Diabetes Complications After Transition to a Value-Based Medication Benefit

J. Franklin Wharam, MD, MPH[1,2,3]; Stephanie Argetsinger, MS, MPH[3]; Matthew Lakoma, MPH[3]; Fang Zhang, PhD[3]; Dennis Ross-Degnan, ScD[3]

Reducing out-of-pocket costs for cardiometabolic medications may be associated with modestly improved short-term health outcomes among commercially insured patients with diabetes.

Impact of Restoration of Out-of-Pocket Costs on Receipt of Tele-Mental Health Visits



^ Cost-sharing for telehealth visits introduced in July 2021 in intervention group

HSA-HDHP REFORM

DISCUSSION: What activities should the V-BID Center undertake to expand pre-deductible coverage/reduce consumer cost-sharing on essential services?

LOW-VALUE CARE

REDUCING LOW-VALUE CARE

IDENTIFY.

MEASURE.

REDUCE.

REPORT.

DISCUSSION

V-BID X

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

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

Diabetes - 01/01/23
Pediatric mental & behavioral health - 01/01/24

Moving Forward: Enhancing Access and Affordability to Essential Clinical Services to Produce Better Outcomes, Enhanced Equity and Improved Efficiency

- Expand pre-deductible coverage/reduce consumer cost-sharing on essential services
  - Chronic conditions
  - Cancer screening follow-up care
  - Substance abuse disorder/mental health
  - Maternity care
  - Trauma surgery
- Identify, measure and reduce low-value care to pay for more generous coverage of high-value care
- Align clinically-driven plan payment reform, technologies and benefit designs (i.e., V-BID X) to increase use of high-value services and deter low-value care

COMMUNICATIONS

OUTREACH

12.2K ListServ Contacts

18 V-BID Center newsletters

3,351 followers

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890 connections

VIRTUAL SUMMIT AGENDA

SESSION 1 | 12:15-1:00 PM ET

SESSION 1: HIGH-DEDUCTIBLE HEALTH PLANS AT 20 YEARS: SUCCESSES AND CHALLENGES

SPEAKERS

FRANK WHARAM

Professor of Medicine, Physician, and Health Policy Researcher at Duke University

STEPHEN PARENTE

Professor at University of Minnesota Carlson School of Management

KATY SPANGLER

Principal at Spangler Strategies

SESSION 2 | 1:00-1:45 PM ET

SESSION 2: ENHANCING PREVENTIVE SERVICES USE IN THE BACKDROP OF BRAIDWOOD V. BECERRA

SPEAKERS

ANAND PAREKH

Chief Medical Advisor at Bipartisan Policy Center

NICK BATH

Partner at Manatt

SESSION 3 | 2:00-2:45 PM ET

SESSION 3: ENHANCING ACCESS TO ESSENTIAL MEDICATIONS

SPEAKERS

STACIE DUSETZINA

Professor of Health Policy and Ingram Professor of Cancer Research at Vanderbilt School of Medicine, Department of Health Policy

INMA HERNANDEZ

Professor at University of California, San Diego Skaggs School of Pharmacy and Pharmaceutical Sciences

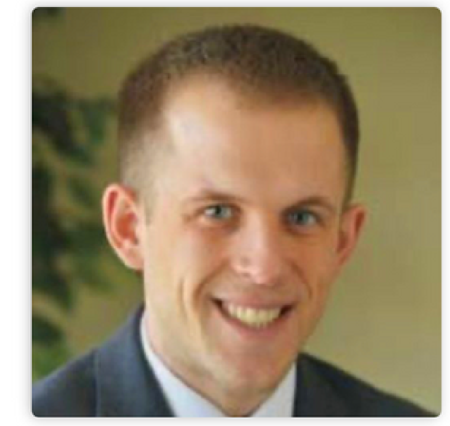
SESSION 4 | 2:45-3:30 PM ET

SESSION 4: WHY IT'S SO HARD TO REDUCE LOW-VALUE CARE

SPEAKERS

MICHAEL CHERNEW

Director at the Healthcare Markets and Regulation Lab, Harvard Medical School



JOSHUA FANGMEIER

Assistant Director for Plan Strategy at Minnesota Management and Budget

THANK YOU TO OUR SPONSORS!

Please Join us for our virtual V-BID Summit!

Tomorrow, March 13th
12-4 PM ET

REGISTER NOW!