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

Value-Based Insurance Design:

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

A. Mark Fendrick, MD

University of Michigan Center for Value-Based Insurance Design

www.vbidcenter.org

@um_vbid

CHRT

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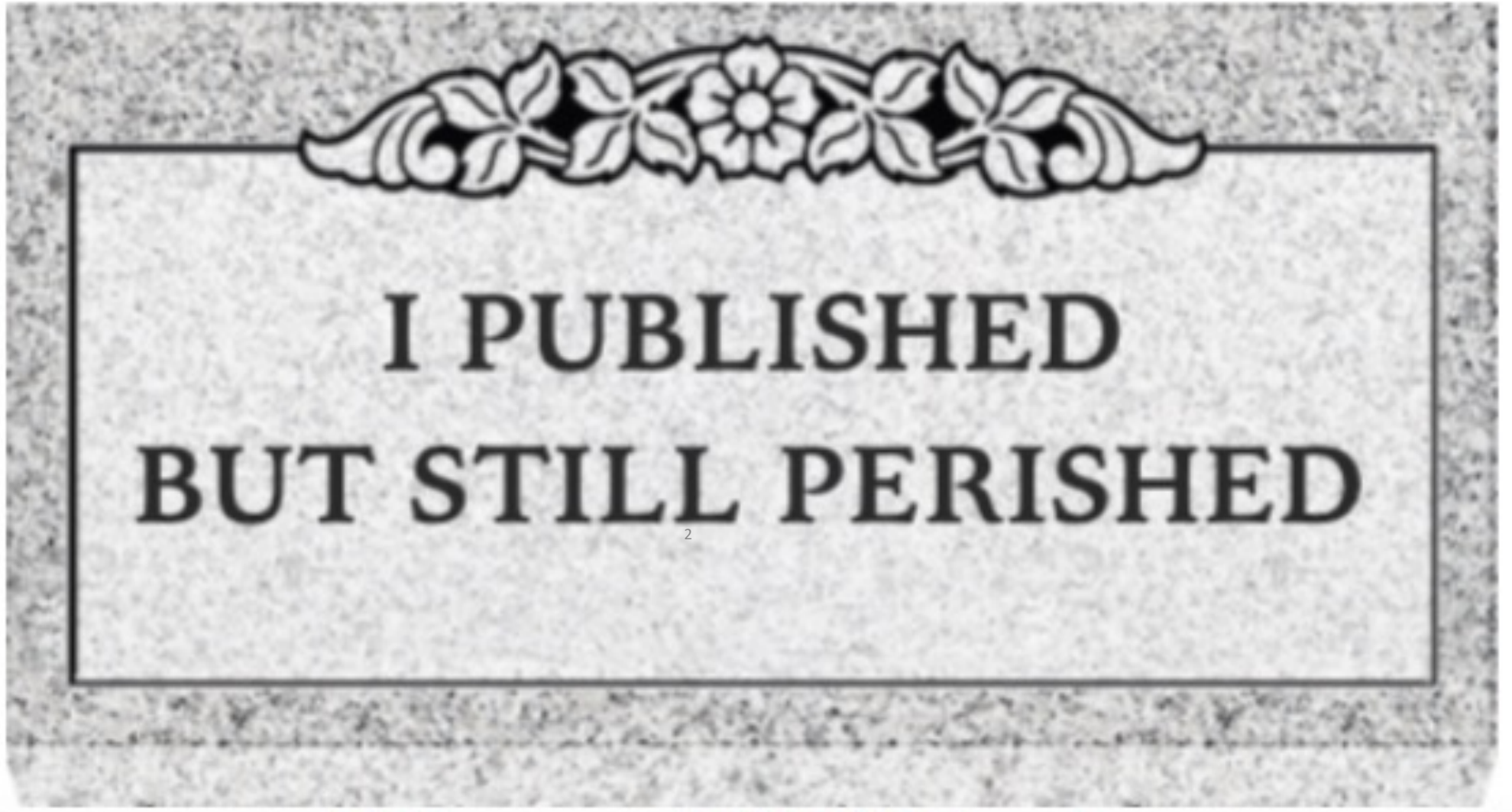
I PUBLISHED
BUT STILL PERISHED

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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International Journal of Technology Assessment in Health Care

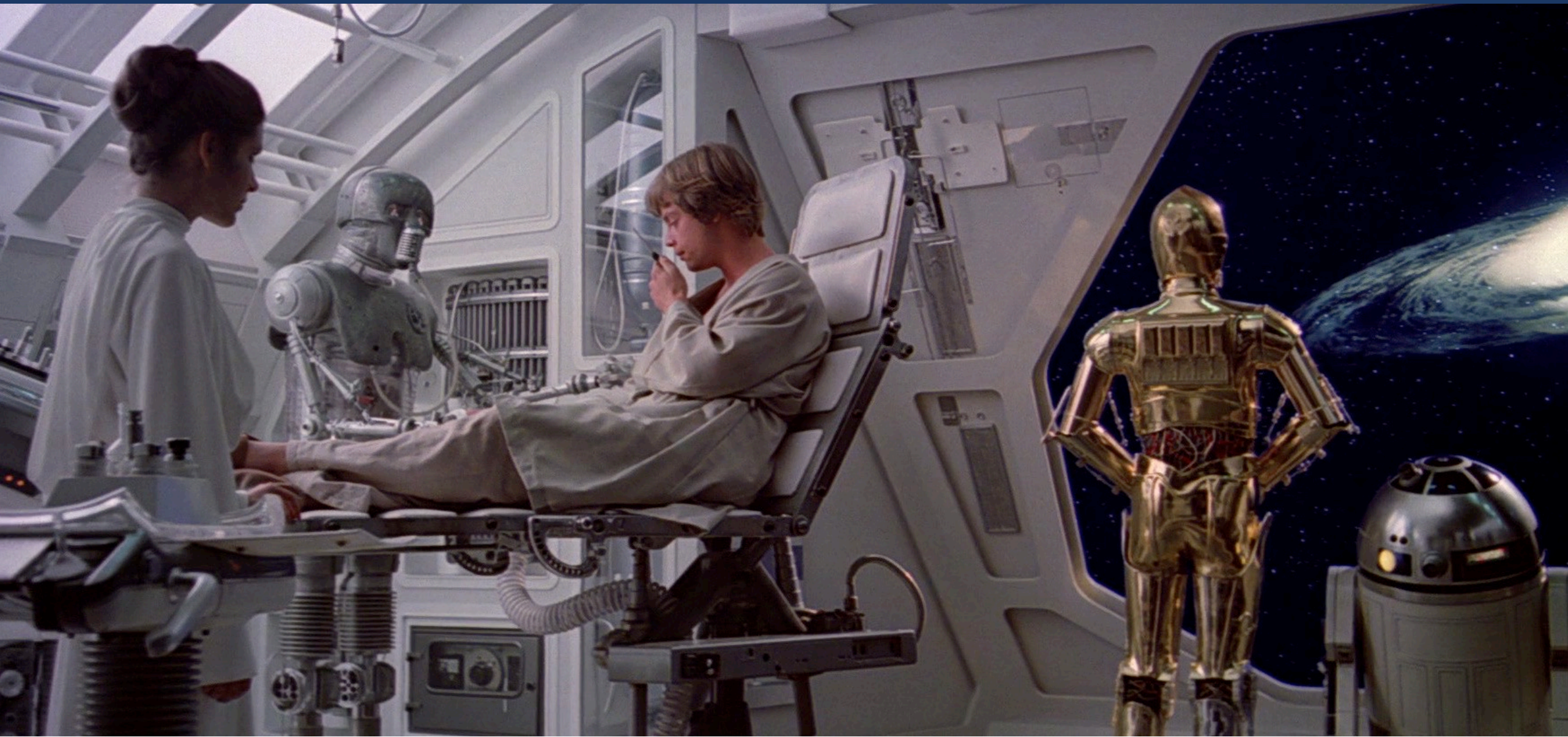
Article Metrics

Volume 12, Issue 1 January 1996, pp. 1-8

The Tension Between Cost Containment and the Underutilization of Effective Health Services

Bernard S. Bloom [a1] and A. Mark Fendrick [a2]

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

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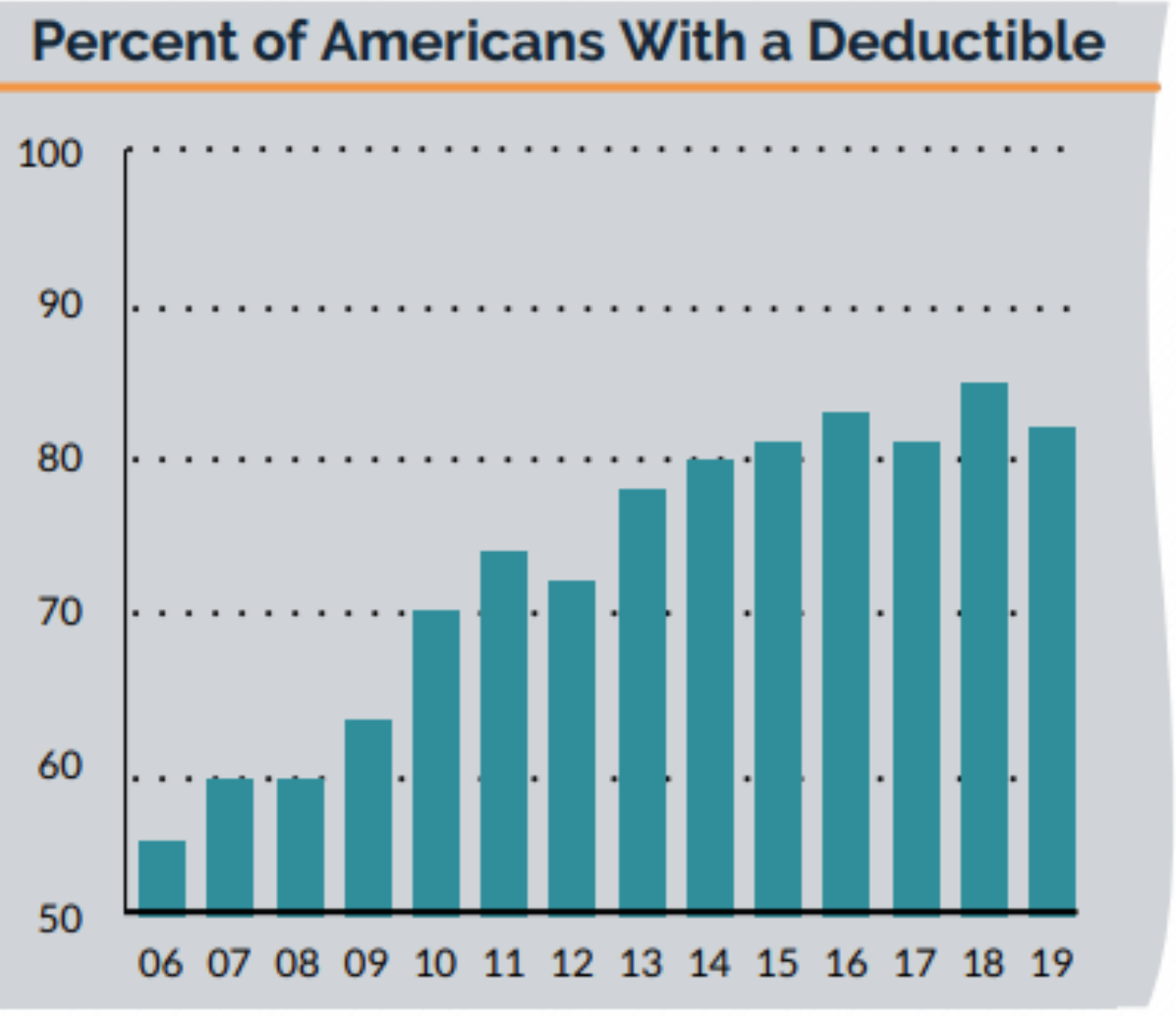
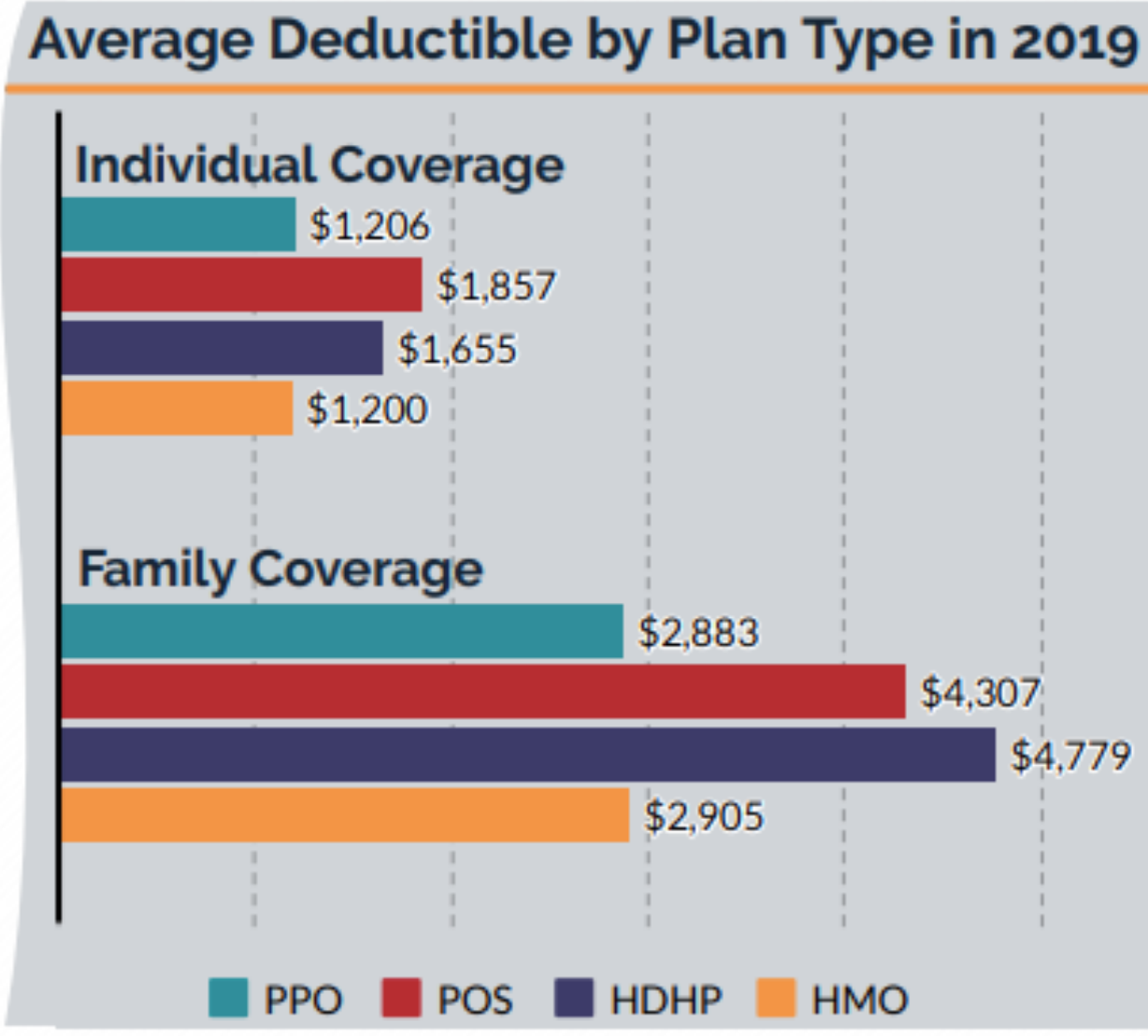
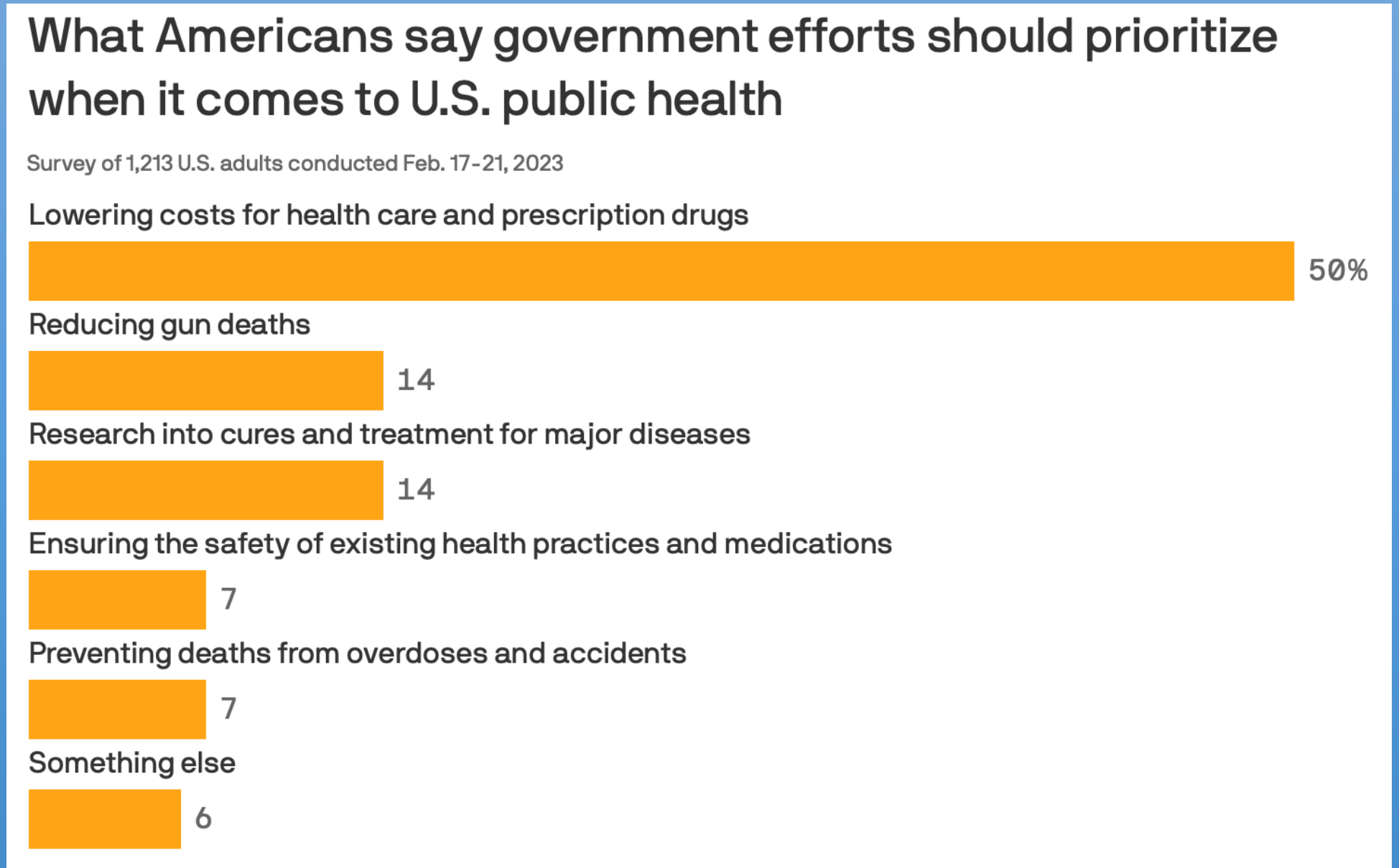
Americans Do Not Care About Health Care Costs; They Care About What It Costs Them





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



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, 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.

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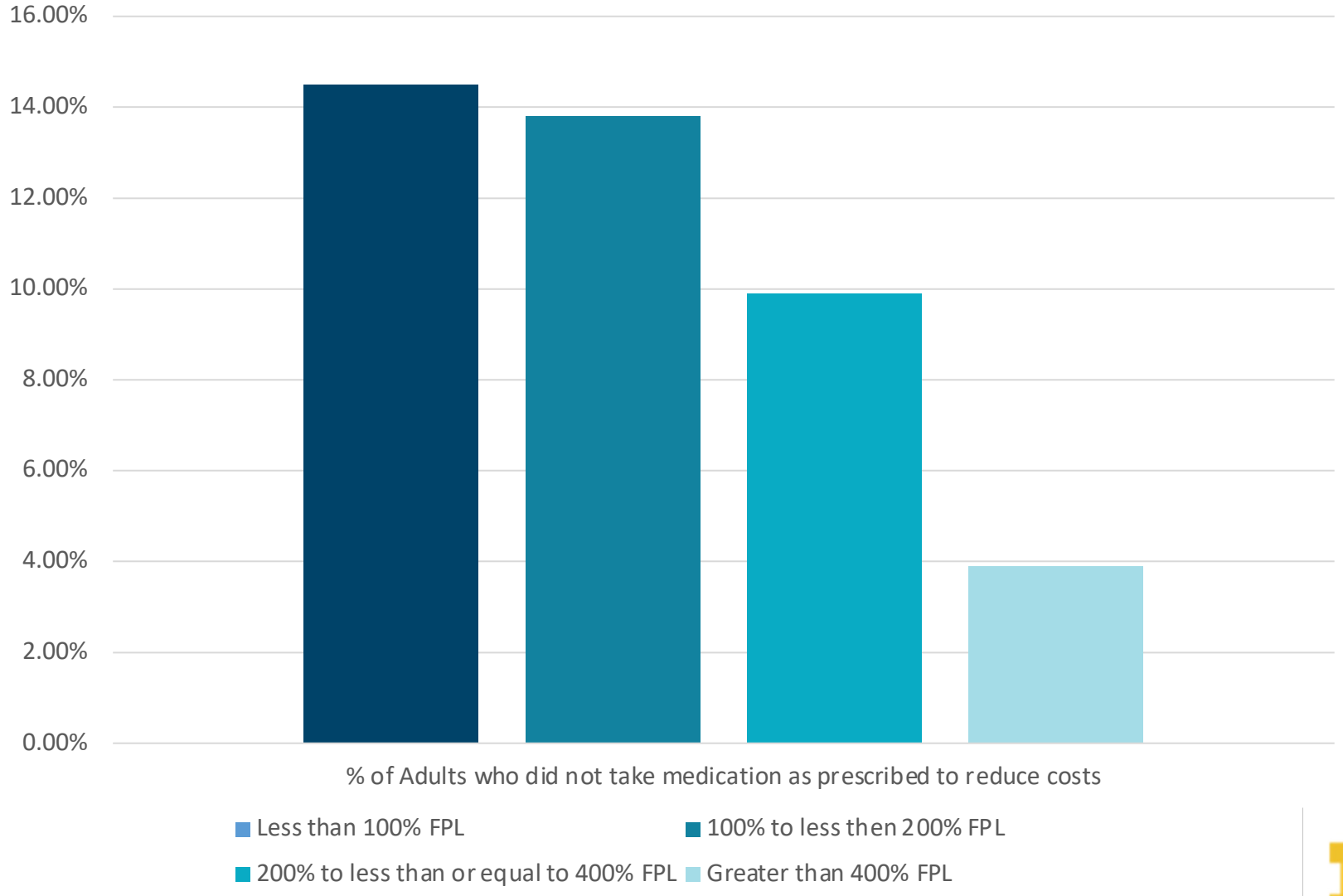
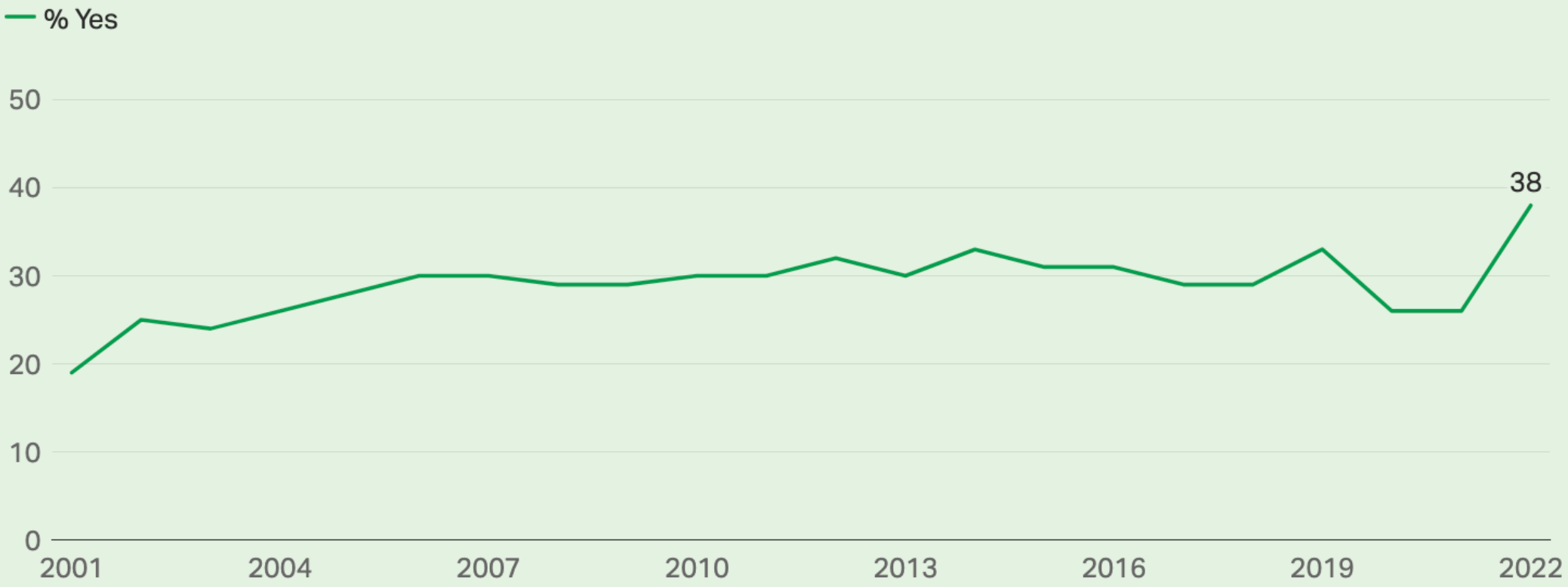
Percentage of adults who do not take medication as prescribed due to costs by family income (% of the Federal Poverty Level), U.S. 2021



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

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?



Get the data • Download image

GALLUP

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

Detroit Free Press

Opinion: State lawmakers must act to lower insulin costs

Kirstin Woody Scott and A. Mark Fendrick

Published 6:00 a.m. ET June 12, 2022

One in ten Michiganders has a diagnosis of diabetes, and roughly one quarter of people with diabetes rely on insulin injections to keep their sugar levels under control. But rising insulin prices have made it difficult for some patients to take their insulin, which for some can be the difference between life and death.

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

THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

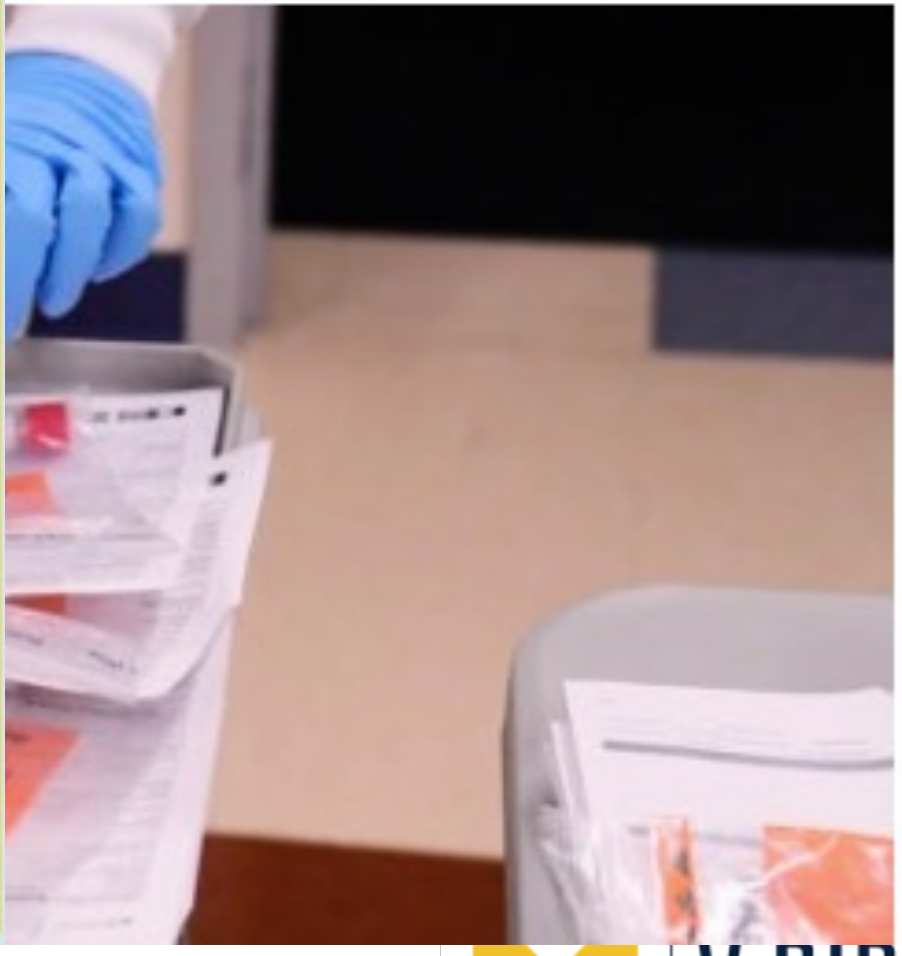
ACA Sec 2713: Selected Preventive Services be Provided without Cost-Sharing

- 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

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



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ASPE | OFFICE OF HEALTH POLICY
ASSISTANT SECRETARY FOR PLANNING AND EVALUATION

ISSUE BRIEF

January 11, 2022

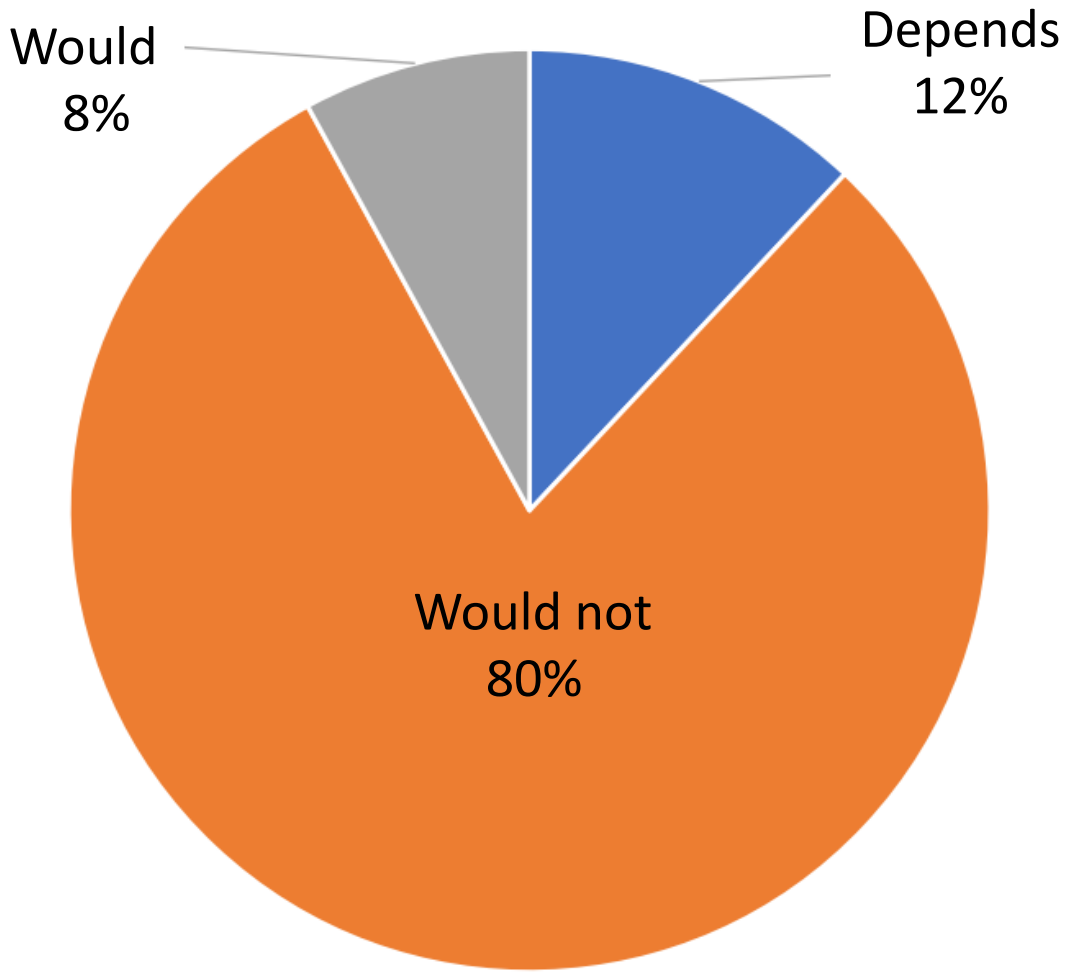
HP-2022-01

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

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.

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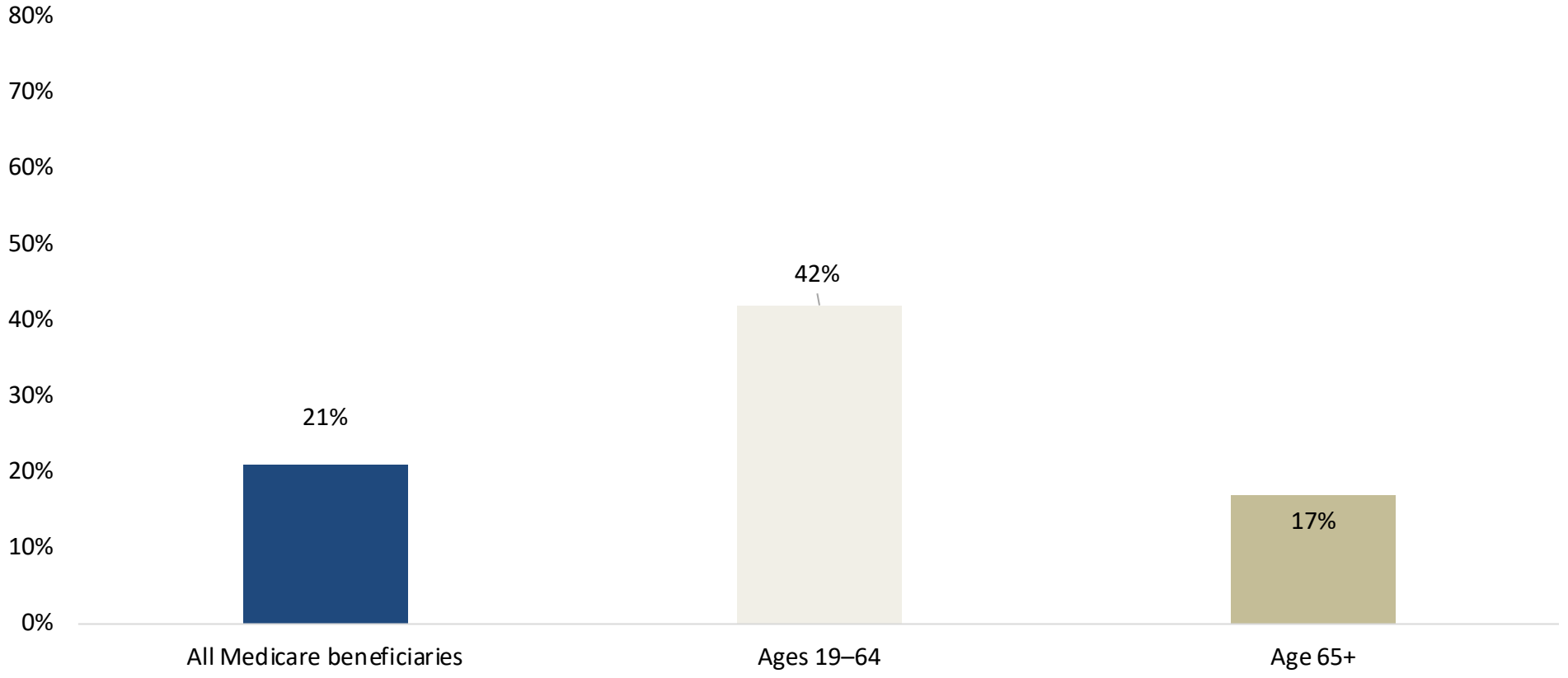
Medicare Advantage

EXHIBIT 4

More than one in five Medicare beneficiaries said they or a family member delayed or skipped needed care because of the cost in the past 12 months, including more than four in 10 under age 65.

Percentage of Medicare beneficiaries reporting they or family member delayed or skipped any needed health care, including prescription drugs, because of cost in the past 12 months, by age



Base: Adults age 19+ with Medicare coverage who were insured all year (n=1,978).

Note: Survey respondents were asked the following question: At any time in the last 12 months, have you or a family member delayed or skipped any needed health care, including prescription drugs, because you or they couldn't afford it?

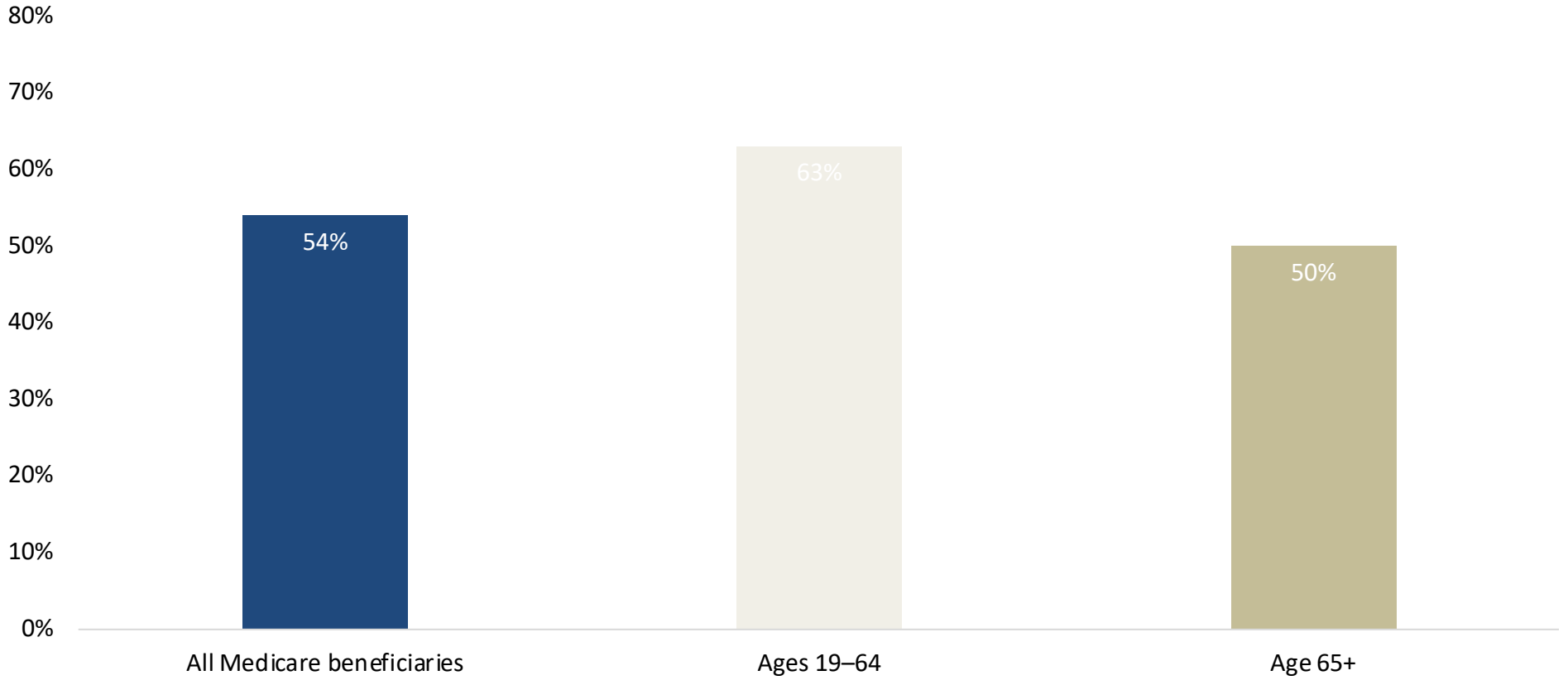
Data: Commonwealth Fund 2023 Health Care Affordability Survey.

Source: Sara R. Collins, Shreya Roy, and Relebohile Masitha, *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* (Commonwealth Fund, Oct. 2023). https://doi.org/10.26099/bf08-3735

EXHIBIT 5

Among Medicare beneficiaries who reported delaying or skipping needed care, more than half said health problems worsened as a consequence.

Percentage of Medicare beneficiaries saying they or family member delayed or skipped needed care for cost reasons in the past 12 months and a health problem got worse, by age



Base: Adults age 19+ with Medicare coverage who were insured all year and reported skipping or delaying health care because of cost (n=464).

Note: Survey respondents who said they or a family member delayed or skipped needed care in the past 12 months were asked the following question: You said you or a family member delayed or skipped needed health care or prescription drugs. Did a health problem get worse because of it?

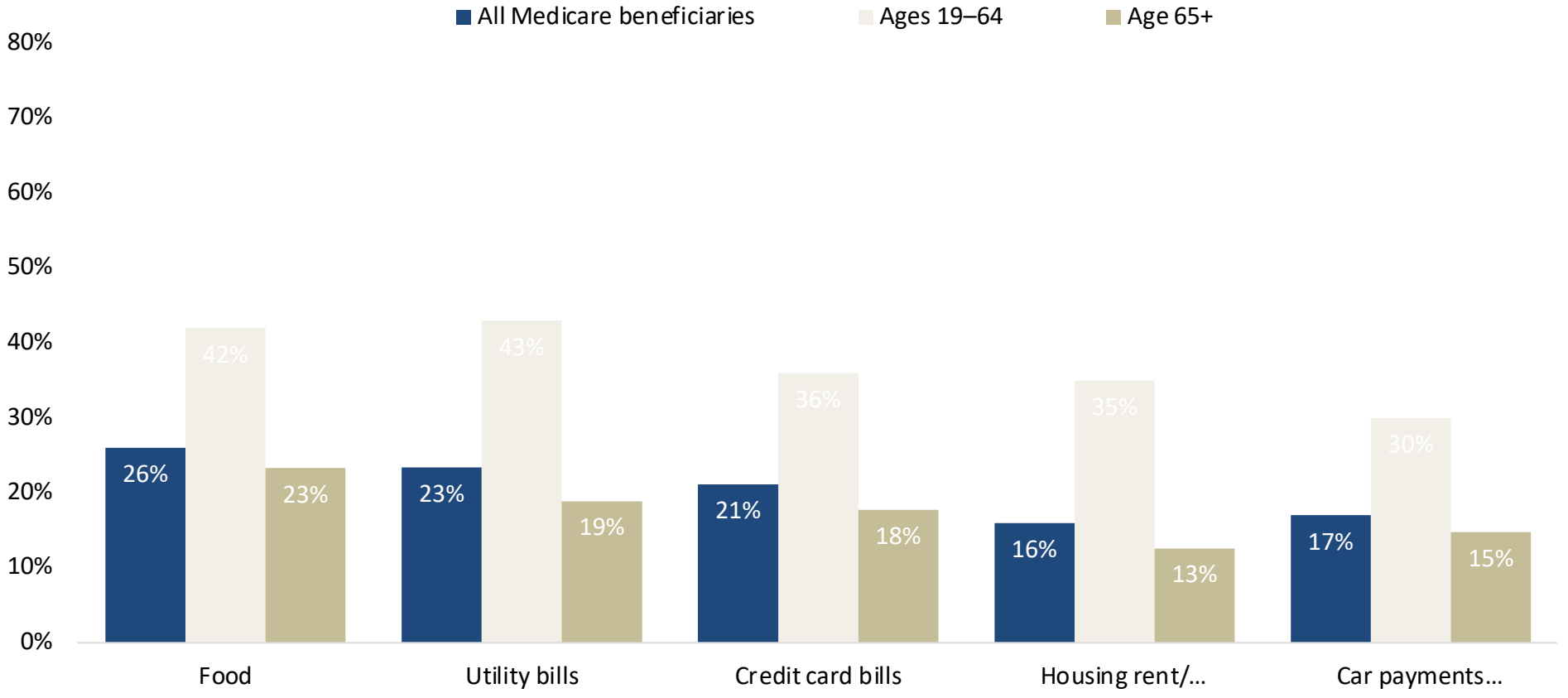
Data: Commonwealth Fund 2023 Health Care Affordability Survey.

Source: Sara R. Collins, Shreya Roy, and Relebohile Masitha, *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* (Commonwealth Fund, Oct. 2023). https://doi.org/10.26099/bf08-3735

EXHIBIT 6

More than one in four Medicare beneficiaries said health care costs made it harder for them to afford food and utility bills in the past 12 months, including more than four in 10 under age 65.

Percentage of Medicare beneficiaries reporting that health care costs made it harder for them to afford other expenses in the past 12 months, by type of expense, by age



Base: Adults age 19+ with Medicare coverage who were insured all year (n=1,978).

Notes: Survey respondents were asked the following question: In the past 12 months, have health costs made it harder for you and your family members to pay for any of the following expenses? "Utility bills" include electric, heating, phone, and internet bills.

Data: Commonwealth Fund 2023 Health Care Affordability Survey.

Source: Sara R. Collins, Shreya Roy, and Relebohile Masitha, *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* (Commonwealth Fund, Oct. 2023). https://doi.org/10.26099/bf08-3735

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

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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

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

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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

ASPE
ASSISTANT SECRETARY FOR PLANNING AND EVALUATION
OFFICE OF HEALTH POLICY

RESEARCH REPORT
July 7, 2023

HP-2023-19

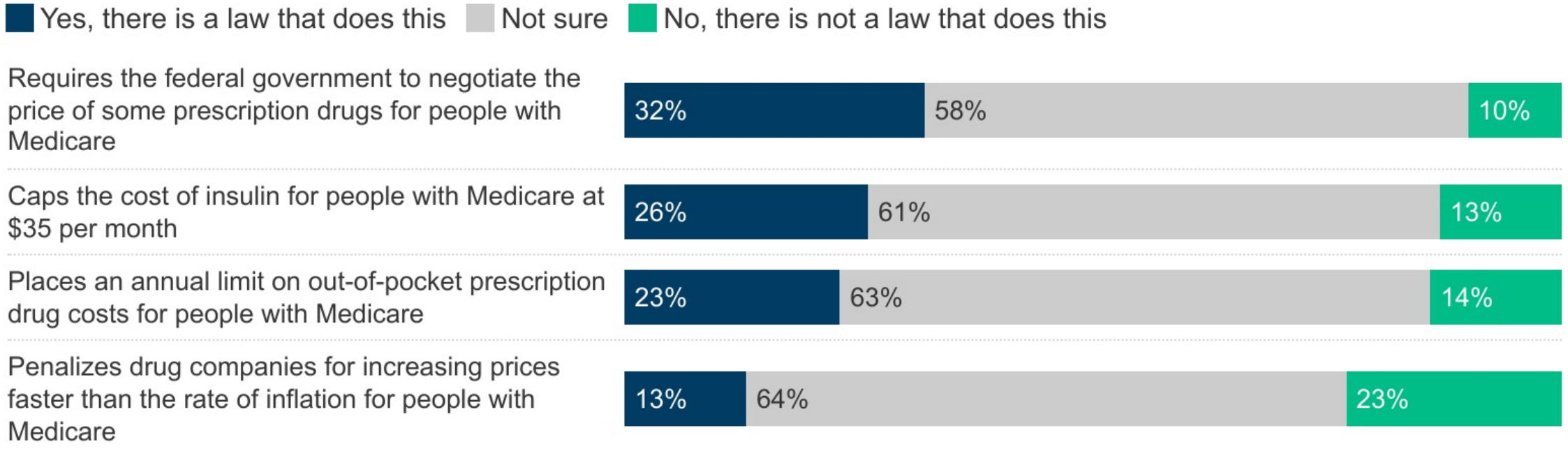
—Inflation Reduction Act Research Series—
Medicare Part D Enrollee Out-Of-Pocket Spending: Recent Trends and Projected Impacts of the Inflation Reduction Act

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...



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

KFF

Putting Innovation into Action: Translating Research into Policy

TRICARE®

Value-based insurance coming to millions of people in Tricare

- 2017 NDAA: Obama Administration - reduce or eliminate co-pays and other cost sharing for certain high services and providers
- 2018 NDAA: Trump Administration – reduce cost sharing for high value drugs on the uniform formulary

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

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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

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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 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

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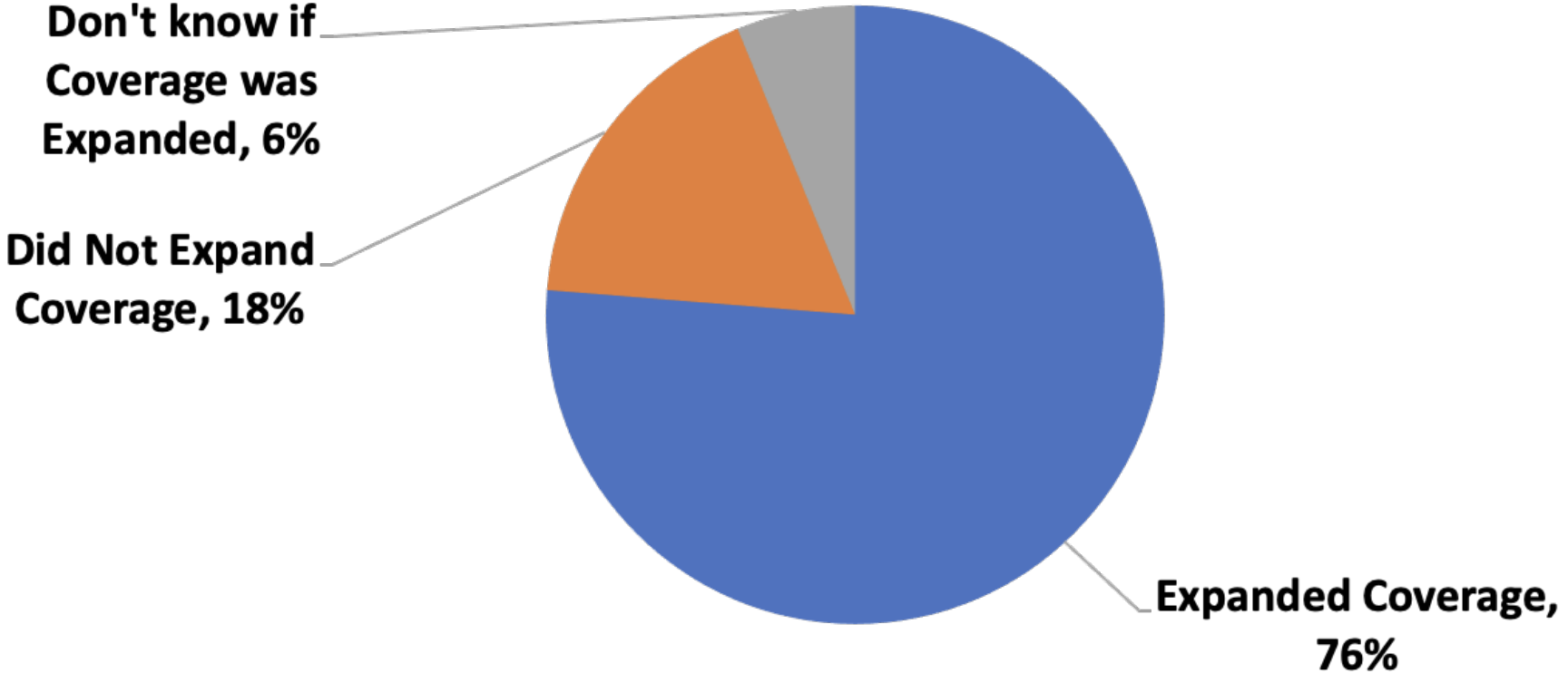
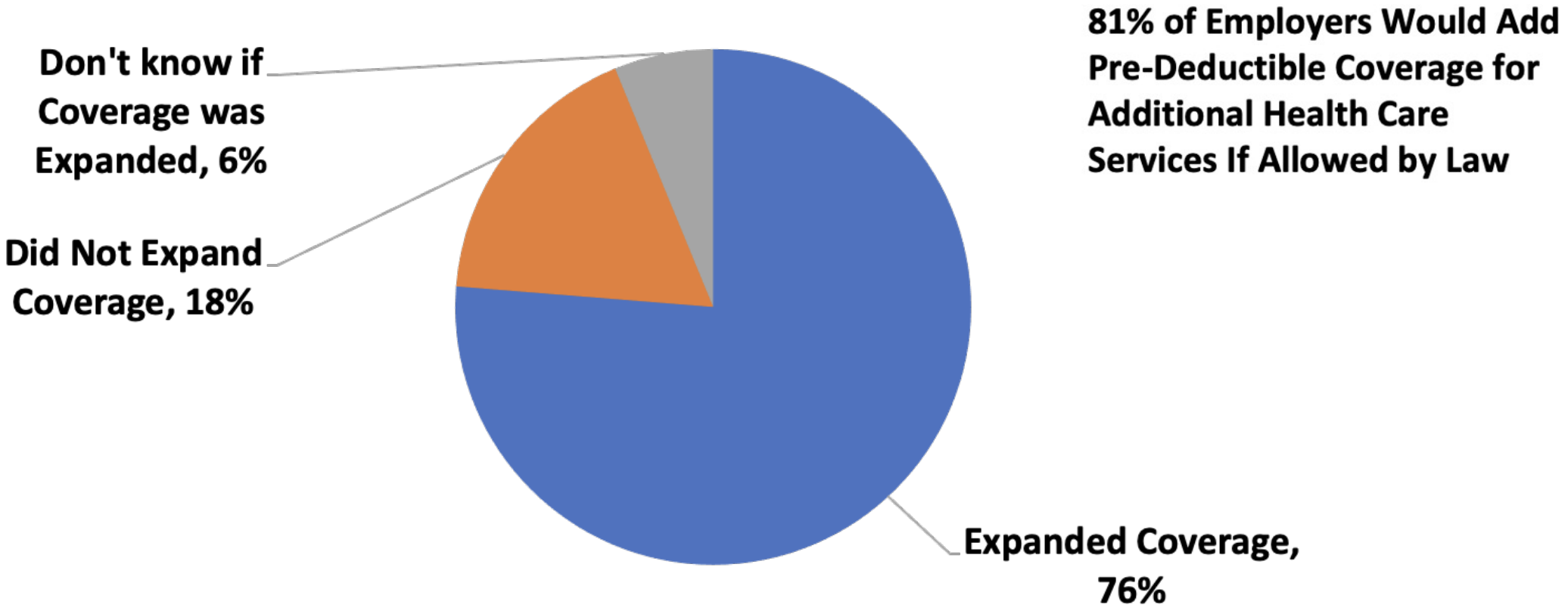
Three Quarters of Employers Expanded Coverage of Chronic Disease Services Allowed Under IRS Rule 2019-45



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).

Chronic Disease Management Act of 2023: Expands Services and Drugs for Chronic Conditions Classified as Preventive Care

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

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In the United States, low-value healthcare disproportionately impacts communities of color

Reducing Low-Value Care to Improve Health Equity

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Reducing use of low-value care, starting with services that provide no clinical benefit in particular patient populations, is central to improving health equity

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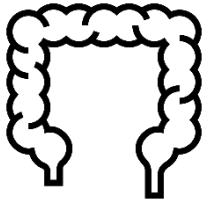
- The ACA grants HHS the authority to eliminate coverage for USPSTF ‘D’ Rated Services in Medicare

  - 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

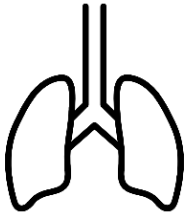
Cervical cancer screening > 65 years



Colon cancer screening >85 years

Cardiovascular screening in low risk patients

Asymptomatic bacteriuria screening



COPD screening

Vitamin D to prevent falls among older women

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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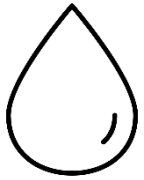
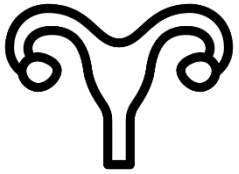
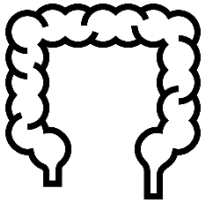
Examples of USPSTF Grade D Services



Prostate cancer screening ≥ 70 years



Cervical cancer screening > 65 years



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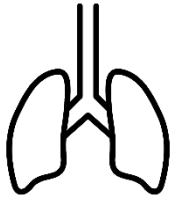
Asymptomatic bacteriuria screening

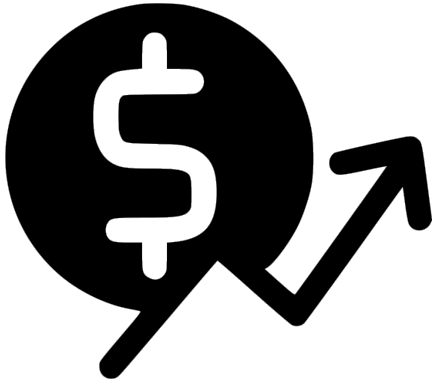


COPD screening

Vitamin D to prevent falls among older women

V-BID

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.*

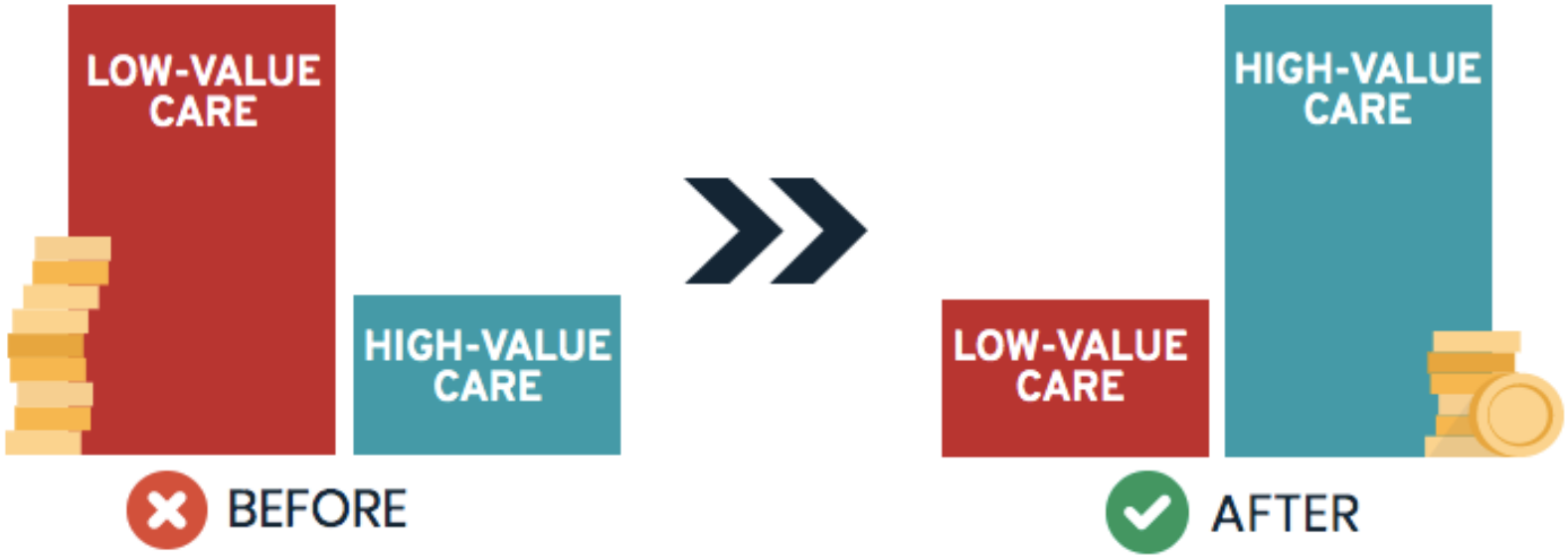
V-BID

V-BID X:
Better Coverage, Same Premiums and Deductibles

V-BID

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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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).

State Exchanges Using V-BID X Principles to Enhance Equity

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

DC Health Benefit Exchange Authority

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

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

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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

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Thank you

Questions?

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