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.
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.
Flintstones Delivery
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**

**Percent of Americans With a Deductible**

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</tr>
</thead>
<tbody>
<tr>
<td>Value</td>
<td>50</td>
<td>55</td>
<td>60</td>
<td>65</td>
<td>70</td>
<td>75</td>
<td>80</td>
<td>85</td>
<td>90</td>
<td>95</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

**Average Deductible by Plan Type in 2019**

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>PPO</th>
<th>POS</th>
<th>HDHP</th>
<th>HMO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Coverage</td>
<td>$1,206</td>
<td>$1,206</td>
<td>$1,206</td>
<td>$1,206</td>
</tr>
<tr>
<td>Family Coverage</td>
<td>$2,883</td>
<td>$4,307</td>
<td>$4,779</td>
<td>$4,205</td>
</tr>
</tbody>
</table>

Legend:
- PPO
- POS
- HDHP
- HMO
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

- Lowering costs for health care and prescription drugs: 50%
- Reducing gun deaths: 14
- Research into cures and treatment for major diseases: 14
- Ensuring the safety of existing health practices and medications: 7
- Preventing deaths from overdoses and accidents: 7
- Something else: 6
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-Ilsenberg, 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
A “smarter” cost-sharing approach that encourages consumers to use more high value services and providers, but discourages the use of low value ones.

- 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
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

- 80% Would not impose cost sharing
- 8% Would impose cost sharing
- 12% Depends on the situation

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

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%
For the 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
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...

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Yes, there is a law that does this</th>
<th>Not sure</th>
<th>No, there is not a law that does this</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requires the federal government to negotiate the price of some prescription drugs for people with Medicare</td>
<td>32%</td>
<td>58%</td>
<td>10%</td>
</tr>
<tr>
<td>Caps the cost of insulin for people with Medicare at $35 per month</td>
<td>26%</td>
<td>61%</td>
<td>13%</td>
</tr>
<tr>
<td>Places an annual limit on out-of-pocket prescription drug costs for people with Medicare</td>
<td>23%</td>
<td>63%</td>
<td>14%</td>
</tr>
<tr>
<td>Penalizes drug companies for increasing prices faster than the rate of inflation for people with Medicare</td>
<td>13%</td>
<td>64%</td>
<td>23%</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Preventive Care for Specified Conditions</th>
<th>For Individuals Diagnosed with</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angiotensin Converting Enzyme (ACE) inhibitors</td>
<td>Congestive heart failure, diabetes, and/or coronary artery disease</td>
</tr>
<tr>
<td>Anti-resorptive therapy</td>
<td>Osteoporosis and/or osteopenia</td>
</tr>
<tr>
<td>Beta-blockers</td>
<td>Congestive heart failure and/or coronary artery disease</td>
</tr>
<tr>
<td>Blood pressure monitor</td>
<td>Hypertension</td>
</tr>
<tr>
<td>Inhaled corticosteroids</td>
<td>Asthma</td>
</tr>
<tr>
<td>Insulin and other glucose lowering agents</td>
<td>Diabetes</td>
</tr>
<tr>
<td>Retinopathy screening</td>
<td>Diabetes</td>
</tr>
<tr>
<td>Peak flow meter</td>
<td>Asthma</td>
</tr>
<tr>
<td>Glucometer</td>
<td>Diabetes</td>
</tr>
<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>
</tr>
<tr>
<td>Selective Serotonin Reuptake Inhibitors (SSRIs)</td>
<td>Depression</td>
</tr>
<tr>
<td>Statins</td>
<td>Heart disease and/or diabetes</td>
</tr>
</tbody>
</table>
Three Quarters of Employers Expanded Coverage of Chronic Disease Services Allowed Under IRS Rule 2019-45

Don't know if Coverage was Expanded, 6%

Did Not Expand Coverage, 18%

Expanded Coverage, 76%

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

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

<table>
<thead>
<tr>
<th>Specific Low-Value Services Considered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spinal fusions</td>
</tr>
<tr>
<td>Vertebroplasty and kyphoplasty</td>
</tr>
<tr>
<td>Vitamin D testing</td>
</tr>
<tr>
<td>Proton beam for prostate cancer</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Commonly Overused Service Categories with Increased Cost-Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient specialist services</td>
</tr>
<tr>
<td>Outpatient labs</td>
</tr>
</tbody>
</table>
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
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?

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