SOCIETY OF ACTUARIES®

Health

2024 SOA MEETING

Session 6C: Improving Health Outcomes by Focusing on Cost Effectiveness Rather than Costs

American Academy of Actuaries
Health Practice Council—Health Equity Committee

Thursday July 25th, 2024, 11:00 am–12:00 p.m. EDT

Health
2024 SOA MEETING

Moderator/Presenter:
Annette James, FSA, MAAA

Presenters:
Dele Solaru, PharmD., MBA
Maggie Ruzicka, ASA, MAAA
Mark Fendrick, PHD

SOCIETY OF ACTUARIES®

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Presenters

Moderator & Presenter

Annette James, FSA, MAAA
Co-Chairperson, Health Equity Committee
American Academy of Actuaries

Presenters

Dele Solaru, PharmD., MBA
Chief Pharmacy Officer
U.S. Office of Personnel Management (OPM)

Maggie Ruzicka, ASA, MAAA
Member, Health Equity Committee
American Academy of Actuaries

Mark Fendrick, MD
Director, Center for Value-Based Insurance Design, Professor of Internal Medicine, School of Medicine, and Professor of Health Management and Policy, School of Public Health, University of Michigan

Agenda

- Overview of the American Academy of Actuaries' Health Equity Committee
- Understanding cost effectiveness and its importance
- Getting the data needed to evaluate cost effectiveness
- Pharmacy perspective
- Quality metrics—Medicaid perspective
- Value-Based Insurance Design (VBID)

American Academy of Actuaries Health Equity Committee

- Created to contribute actuarial perspective to health equity
- Focus:
  - Evaluate actuarial practices in the context of health equity
  - Educate actuaries and other stakeholders on health equity issues
  - Apply an equity lens when considering the impact of current or proposed health care policies
- Published issue briefs that explore health equity topics in actuarial practice
- Held a symposium focused on equity-enhancing benefits in the employer coverage space

Cost Effectiveness

- Reflects not only health costs but also desired health outcomes, and the impact on total benefits
- Supports using a longer time horizon to see the value of the benefit
- Helps to reframe evaluation of benefit options to prioritize high-value care that improves health

The importance of cost effectiveness

- Health care disparities arise in part because of the underutilization of services among underserved and under-resourced populations
- Closing those gaps may increase short-term spending and can also improve health and clinical outcomes
- May decrease long term spending

Challenges of Implementing a Cost-Effective Approach to Evaluating Benefits

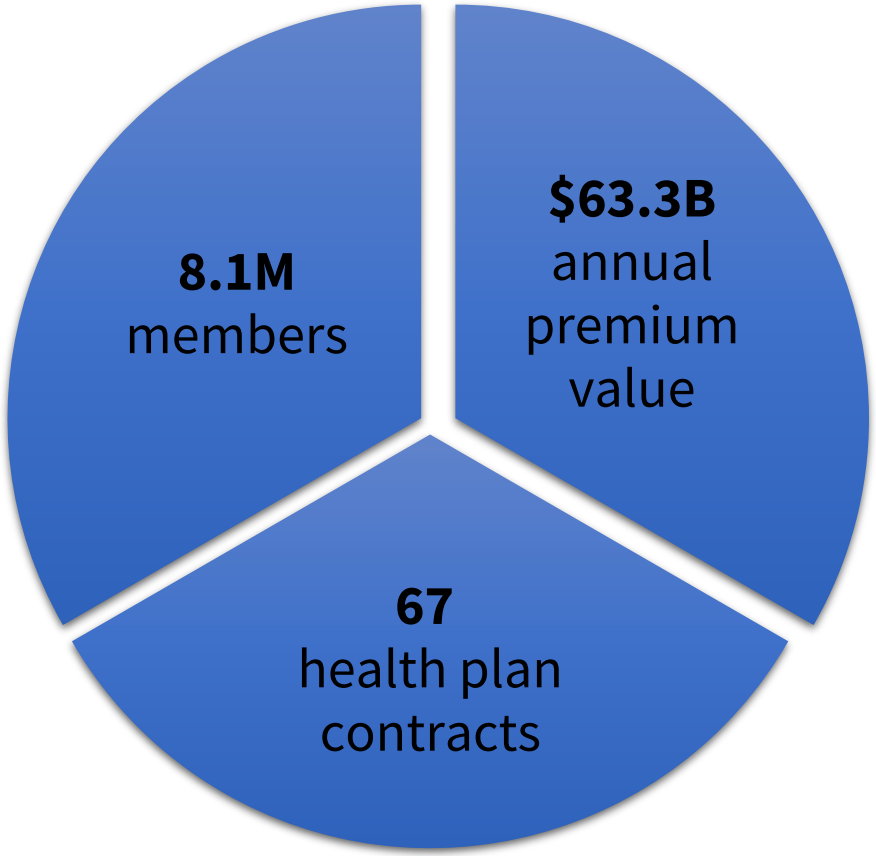
- Attribution of results to specific benefits/initiatives
- Measurement of health and health outcomes
  - Difficult to incorporate subjective metrics such as quality and health outcomes.
  - No consensus on the best metric(s) to assess health and clinical outcomes.
- Risk of misinterpreting clinical and other information
- Cost is much more easily understood and accepted. Decisionmakers may not prioritize cost-effectiveness.
- Lack of data to support a cost-effective approach
  - Data on health plan costs are readily available and easily assessed, which encourages the emphasis on costs.

Pharmacy Perspective

Dele Solaru, PharmD., MBA
Chief Pharmacy Officer
U.S. Office of Personnel Management (OPM)

FEHB Snapshot

- FEHB offered since 1960
- Largest employer-sponsored health insurance program
- Comprehensive health coverage
- Member choice from a variety of plans
- Strong population health focus



Cost Effectiveness of Pharmaceuticals

Impacted Population

- Prevalence, previously treated conditions, clinical guidelines, formulary placement

Mechanism of Action

- New or existing drug class, novel mechanism of action, side effect profile

Cost Impacts

- Cost offsets – pharmacy vs. medical benefit, prevention, impact on disease severity or progression

Employer Perspective

- Employee wellness, quality of life, presenteeism, absenteeism

Quality Metrics—Medicaid Perspective

Maggie Ruzicka, ASA, MAAA
Member, Health Equity Committee

Aims and Foundation of Quality Measures

- Work towards achieving the triple aims:
  - Better Care
  - Healthy People/Healthy Communities
  - Affordable Care
- Four foundational principles:
  - Eliminate racial and ethnic disparities
  - Strengthen infrastructure and data systems
  - Enable local innovations
  - Foster learning organizations

National Quality Strategy (NQS) Priorities

- Six Priorities:
  - Making care safer by reducing harm caused in the delivery of care
  - Ensuring each person and his/her family members are engaged in their care
  - Promoting effective communication and coordination of care
  - Promoting most effective prevention and treatment practices
  - Working with communities to promote wide use of best practices to enable healthy living
  - Making quality care more affordable by developing and spreading new healthcare delivery models

Types of Performance Measures

- **Access**—focuses on a patient or enrollee's attainment of timely and appropriate care
- **Process**—focuses on clinical process to ensure the standard of care is met
- **Outcome**—assesses the results of care that are experienced by patients (e.g., patients' clinical events, health status, and efficiency/cost)
- **Patient Experience**—based on patient reported experiences
- **Structural**—assessing features of an organization/clinician

Measure Stewards

- Defined as "An individual or organization that owns a measure and is responsible for maintaining the measure"
- Often the same as the measure developers
- Examples:
  - NCQA
  - AHRQ
  - CMS

Common Measure Sets Encountered

- NCQA **Healthcare Effectiveness Data and Information Set** (HEDIS)
- CMS **Core Set of Adult Health Care Quality Measures** for Medicaid-Eligible Adults
- CMS **CHIPRA Core Set of Children's Health Care Quality Measures**
- CMS **Inpatient Quality Reporting (IQR)** Program Measures
- CMS **Outpatient Quality Reporting (OQR)** Reporting Measures
- CMS **Ambulatory Surgical Center Quality Reporting (ASCQR)** Program Measures
- CMS **Physician Quality Reporting System (PQRS)** Measures
- CMS **Nursing Home Quality Initiative (NHQI)** Measures
- CMS **EHR Meaningful Use** Measures
- CMS **Financial Alignment Demonstration (FAD) Core and State-specific** Measures
- CMS **National Patient Experience and Patient Reported (Survey)** Measures

HEDIS

- Healthcare Effectiveness Data and Information Set
- Developed and maintained by NCQA
- 88 measures across 7 domains of care
  - Effectiveness of Care
  - Access/Availability of Care
  - Experience of Care
  - Utilization and Risk Adjusted Utilization
  - Relative Resource Use
  - Health Plan Descriptive Information
  - Measures Collected Using Electronic Clinical Data Systems

HEDIS Measure Relevant to Actuarial Work

Access Measure

- **Adults' access to preventive/ambulatory health services**
  - Unit of Evaluation: Health plan or health system
  - Description: This measure is used to assess the percentage of health plan members 20 to 44 years, 45 to 64 years, and 65 years and older who had an ambulatory or preventive care visit
  - Rationale: Without a patient visit, members do not receive counseling on their health, diet, exercise, smoking cessation, seat belt use, and behaviors that put them at risk. If a plan's services are not being used, this could be indicative of barriers to care. Maintaining access to care requires more than making providers and services available—it involves analysis and systematic removal of all barriers.

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

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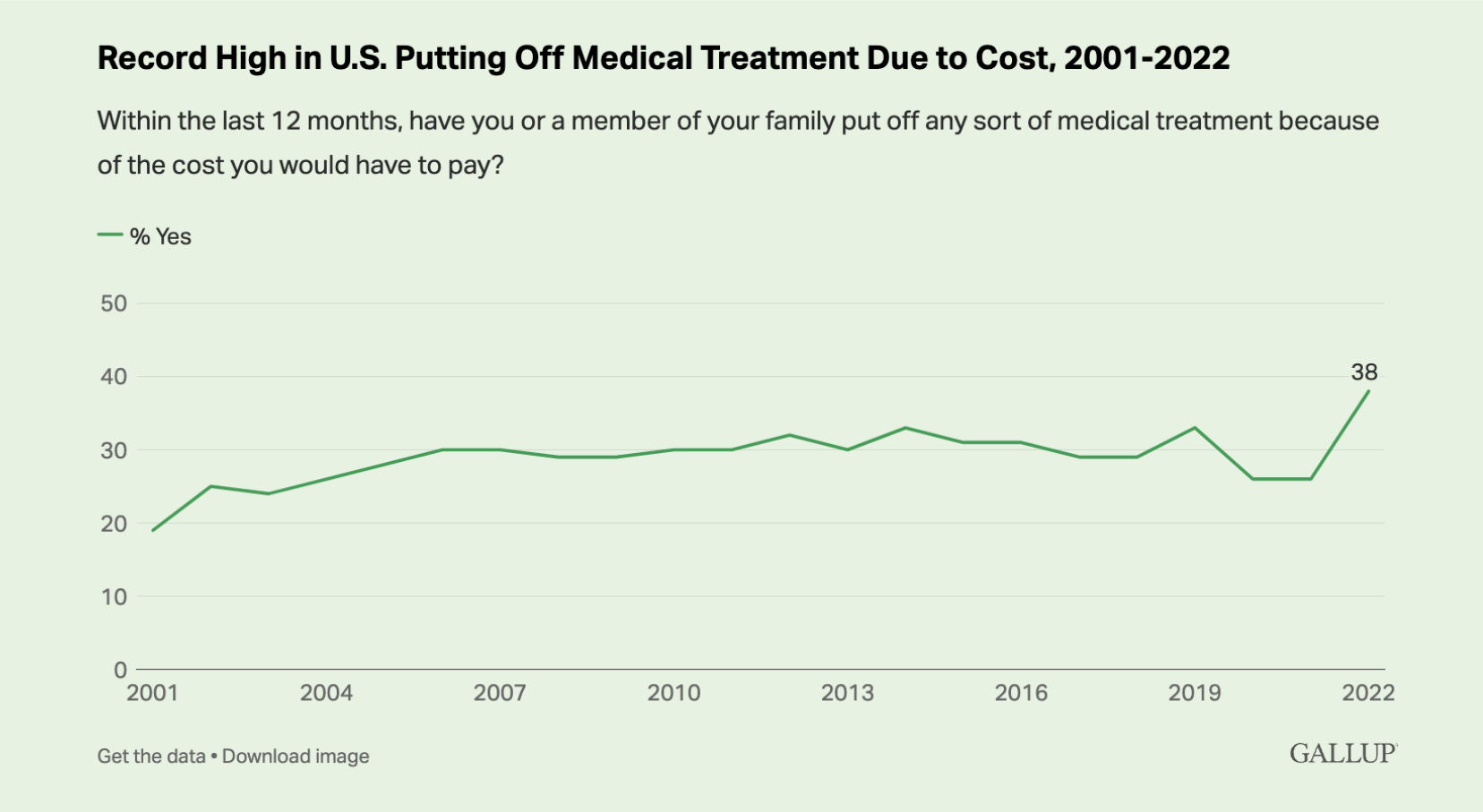
Health Care Costs Are a Top Issue For Patients, Purchasers and Policymakers: Solutions must protect consumers, reward providers and preserve innovation

- 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

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

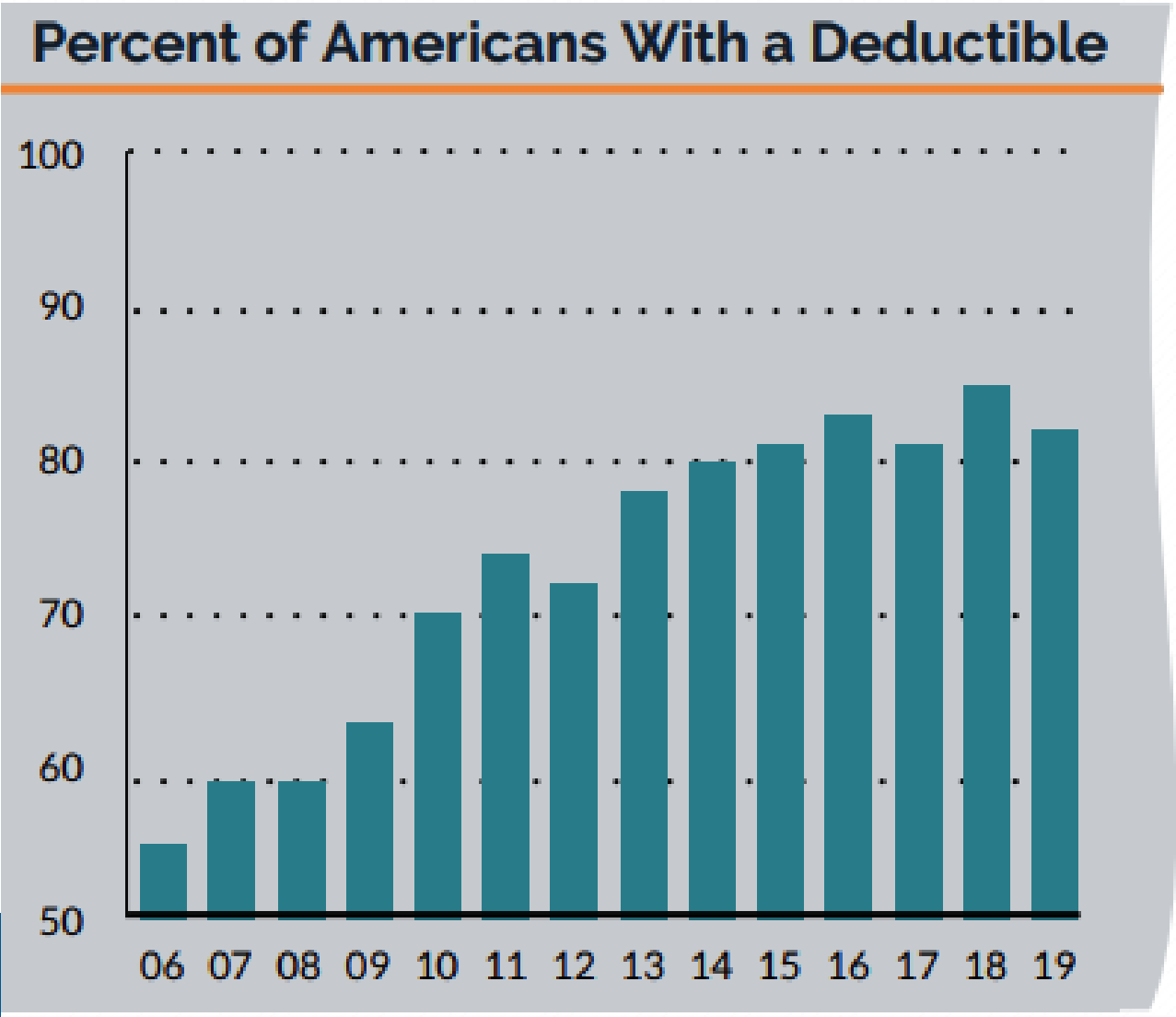
Americans Do Not Care About Health Care Costs; They Care About What It Costs Them

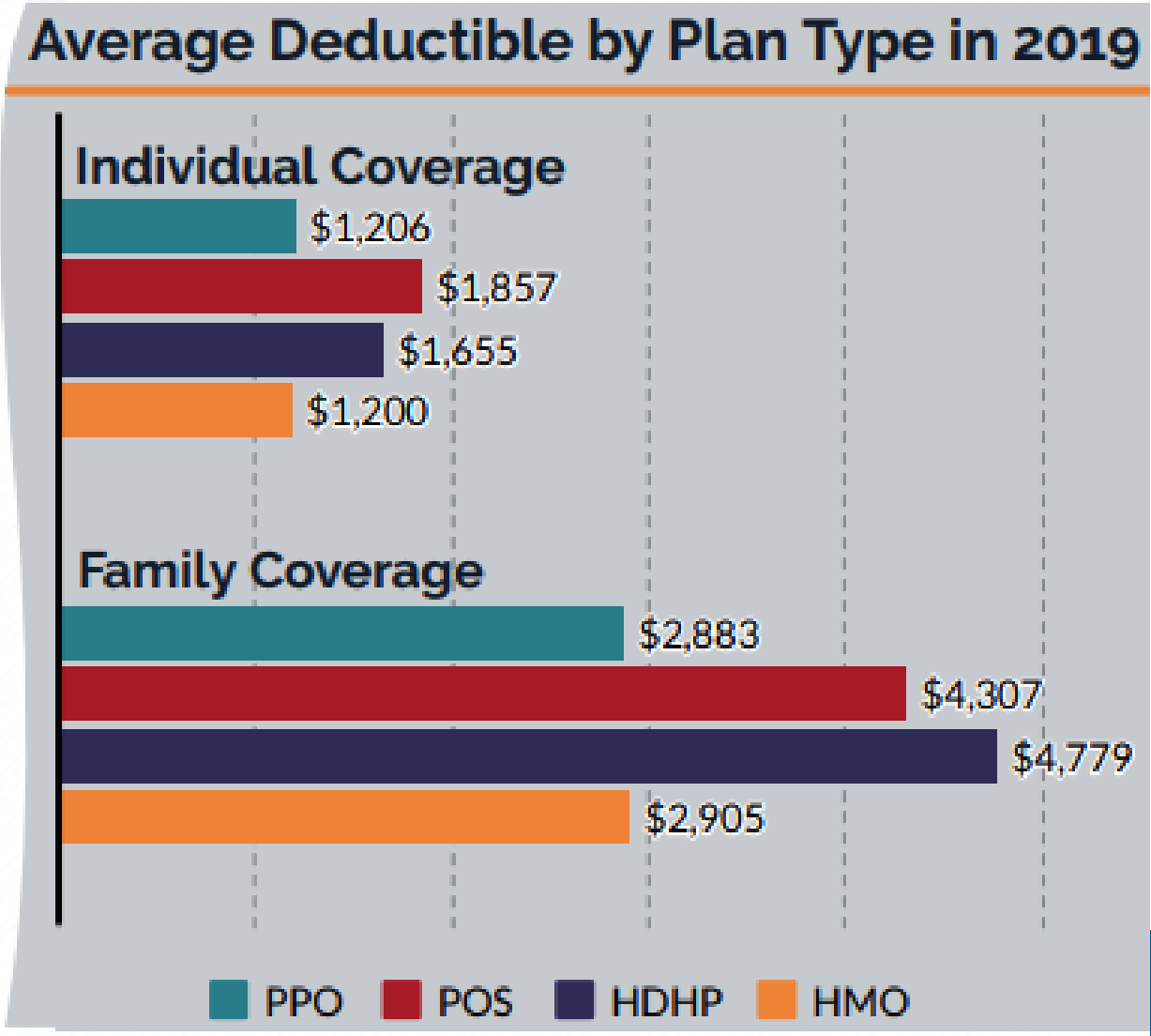


Health care costs are among the leading causes of:

- Personal debt
- Personal bankruptcy
- On-line fundraisers

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, 1934-2024)

“Blunt” Cost-Sharing Worsens Health Care Disparities

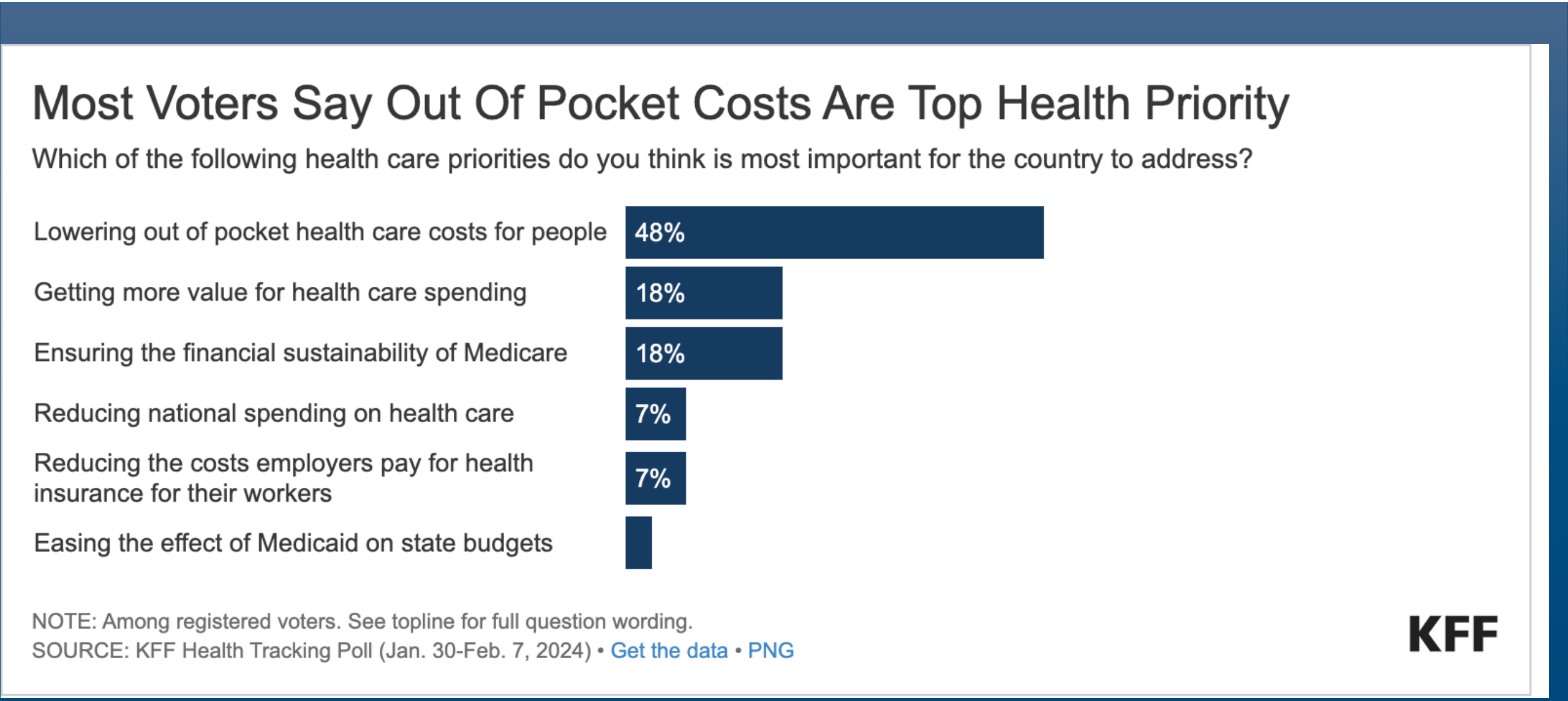
Effects of Increased Patient Cost Sharing on Socioeconomic Disparities in Health Care

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.

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



Alternative to “Blunt” Consumer Cost-Sharing: A Clinically Driven 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 Driven 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
- Improves health outcomes
- 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

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]

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)

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 increased uptake in use of fully covered services
- Substantial increases in utilization of preventive services in financially vulnerable patients, suggesting that the policy reduced disparities

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


Medicare Advantage

High Out of Pocket Costs are Common and Impactful For Medicare Beneficiaries

- One-third of Medicare beneficiaries said it was somewhat or very difficult to afford health care costs, including half of people under age 65
- 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
- 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

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

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

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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.

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]

Research Letter | Health and the 2024 US Election

May 23, 2024

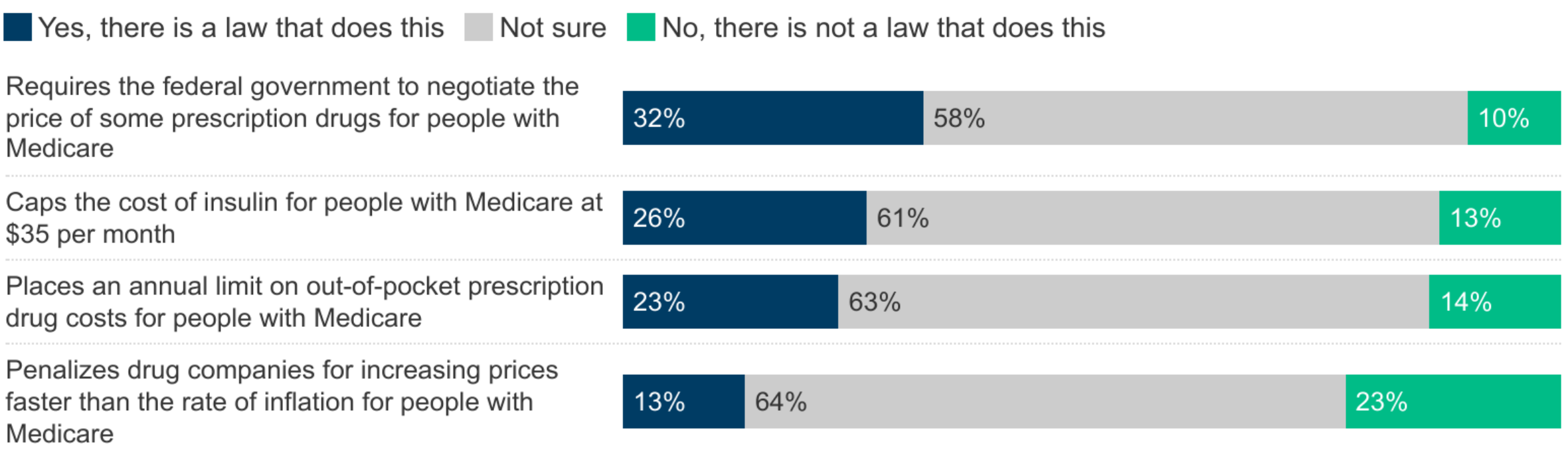
Shingles Vaccination in Medicare Part D After Inflation Reduction Act Elimination of Cost Sharing

Dima M. Qato, PharmD, MPH, PhD[1,2]; John A. Romley, PhD[2,3]; Rebecca Myerson, MPH, PhD[2,4]; et al

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

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

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

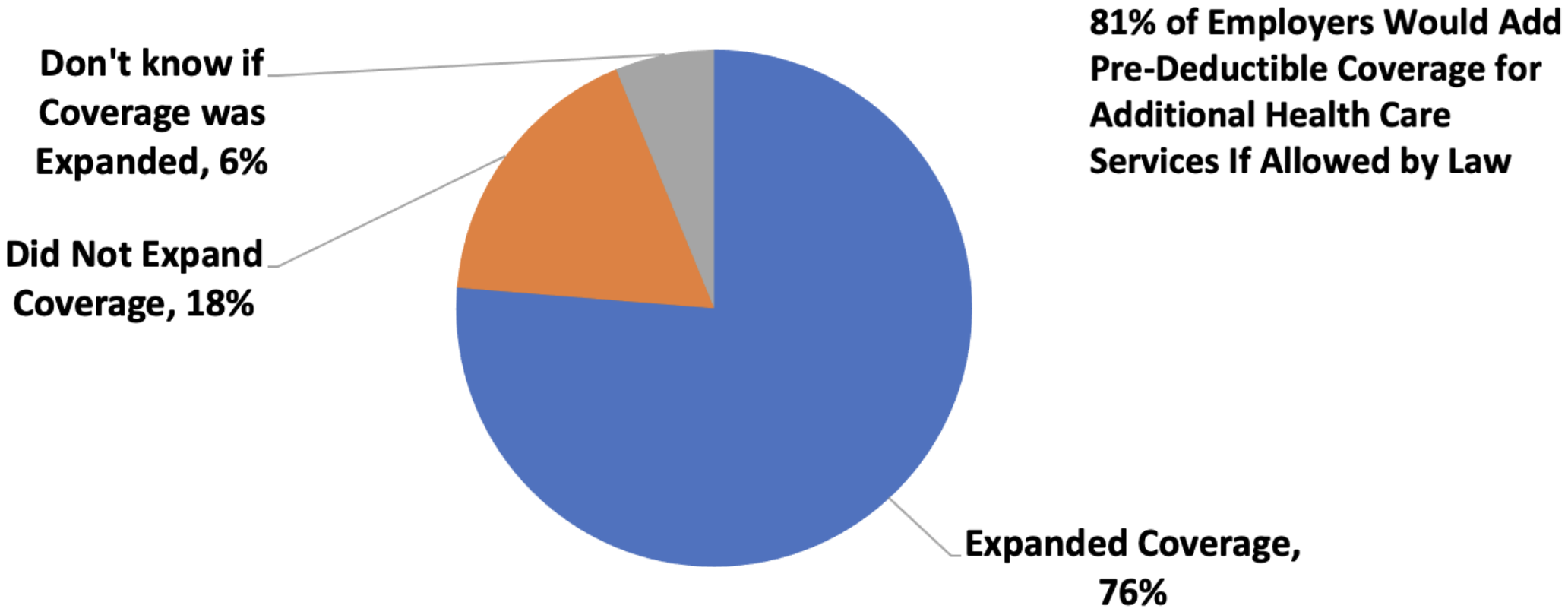
PRESS RELEASES

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

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).

The Impact of Expanding Pre-Deductible Coverage in HSA-Eligible Health Plans on Medication Adherence

By Paul Fronstin, Ph.D., Employee Benefit Research Institute, and M. Christopher Roebuck, Ph.D., RxEconomics, LLC

"expanding pre-deductible coverage in HSA-eligible health plans increased medication adherence"

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,

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

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

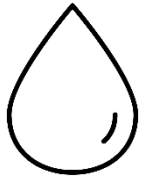
"(B) the services included in the initial preventive physical examination described in subparagraph (B) of such section; and

"(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.".

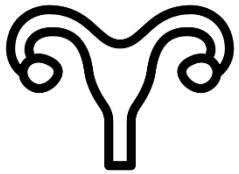
(b) CONSTRUCTION.—Nothing in the amendment made by paragraph (1) shall be construed to affect the coverage of diagnostic or treatment services under title XVIII of the Social Security Act.

HHS granted authority to not pay for USPSTF 'D' Rated Services

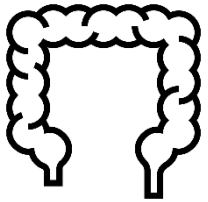
The 7 most commonly ordered USPSTF D rated services are used over 30 million times a year at a cost to Medicare of over $500 Million annually



Prostate cancer screening ≥ 70 years



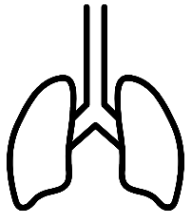
Cervical cancer screening > 65 years



Colon cancer screening >85 years

Cardiovascular screening in low risk patients

Asymptomatic bacteriuria screening



COPD screening

Vitamin D to prevent falls among older women

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

MAY 08, 2020 | MORE ON MEDICARE & MEDICAID

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

HBX
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

V-BID: Enhancing Access and Affordability to Essential Clinical Services

- Reduce consumer cost-sharing/expand pre-deductible coverage on high-value, essential clinical 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

Q&A

Thank You

For more information, please contact

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