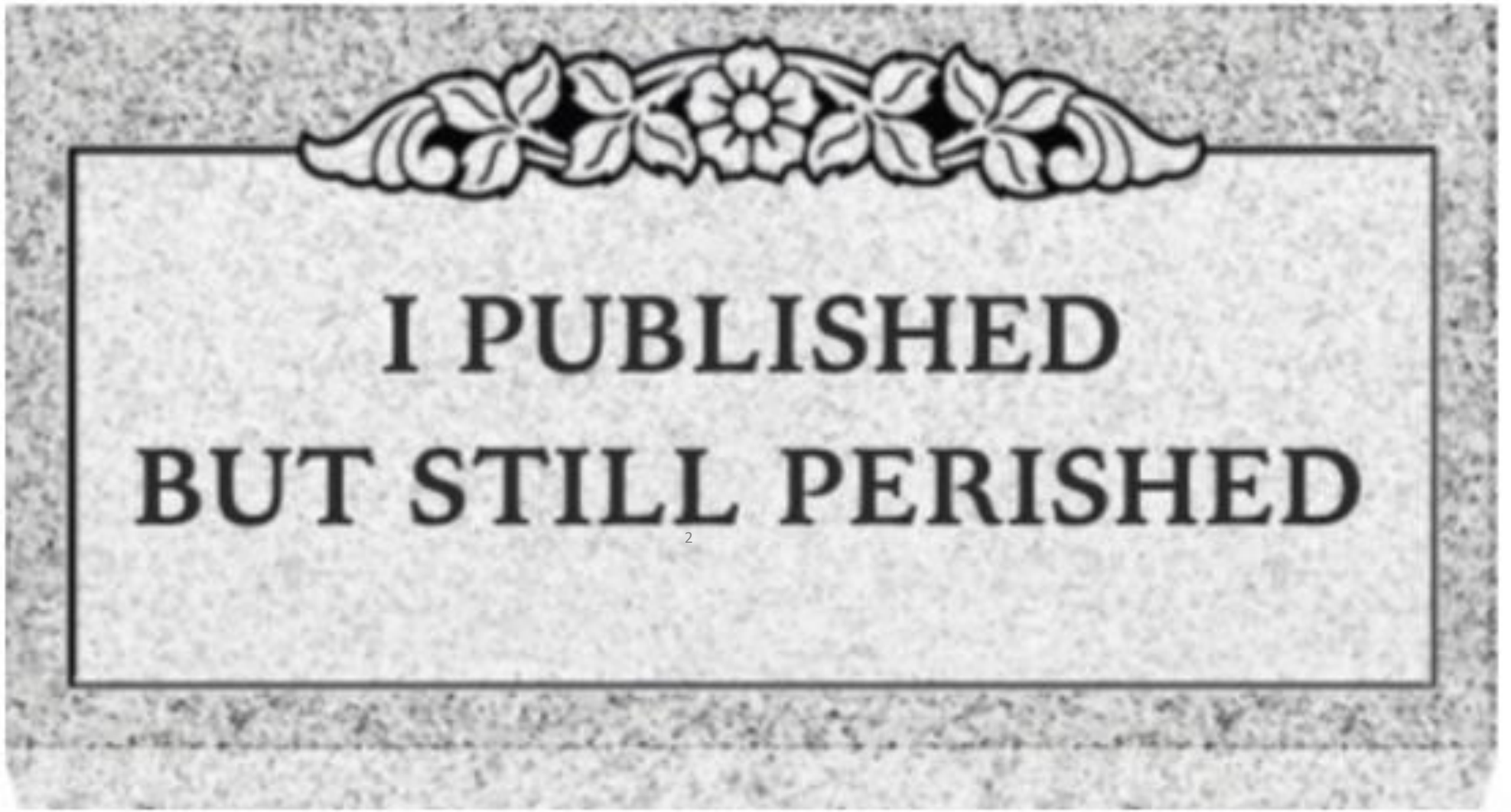
Value-Based Insurance Design:

Aligning Patient and Provider Incentives to Increase Use of High value Care, Enhance Equity, and Eliminate Low Value Services

A. Mark Fendrick, MD

University of Michigan Center for Value-Based Insurance Design

www.vbidcenter.org


I PUBLISHED
BUT STILL PERISHED

THE ISLAND OF MISFIT TOYS™

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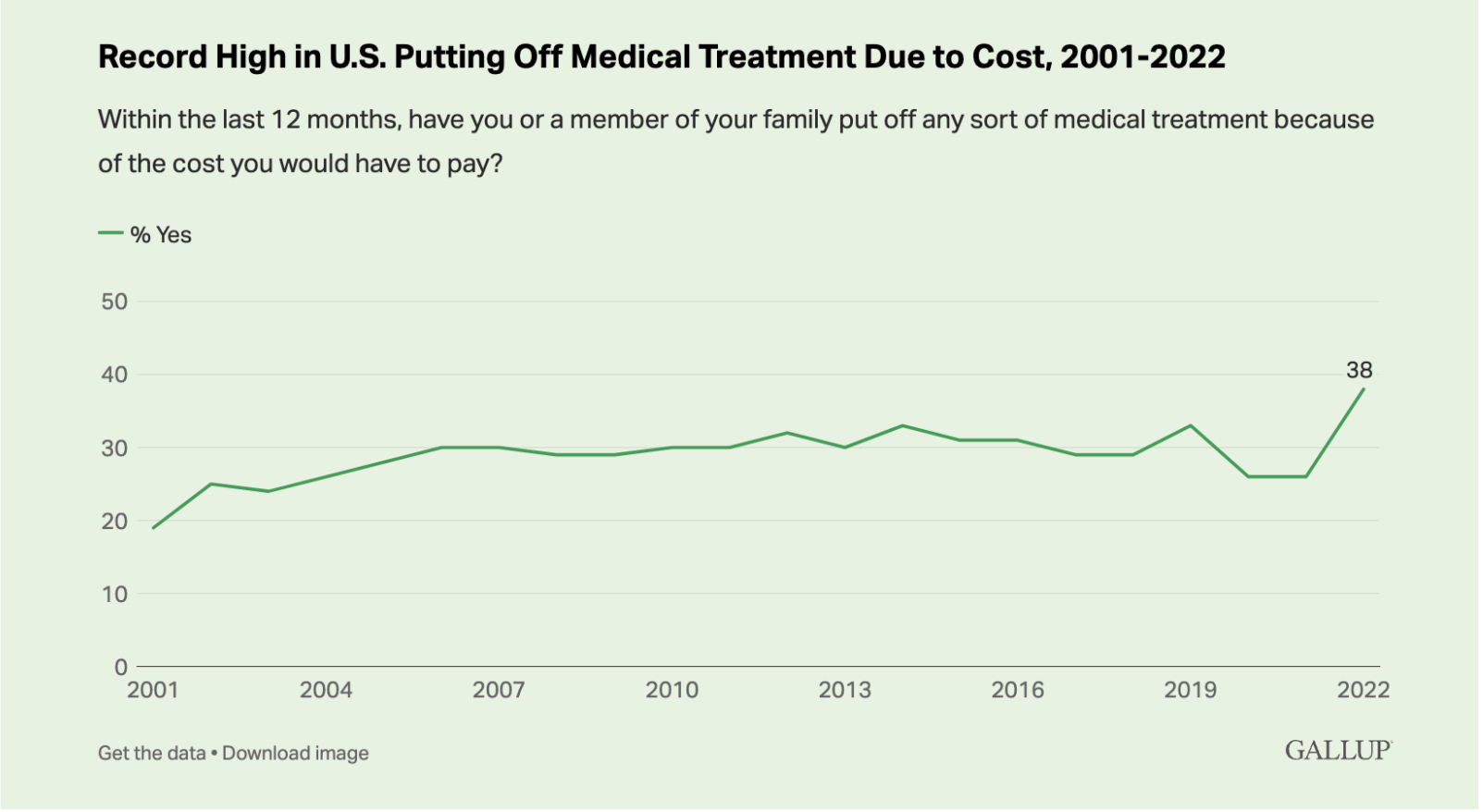
Americans Do Not Care About Health Care Costs; They Care About What It Costs Them



Health care costs are among the leading causes of:

- Personal debt
- On-line fundraisers
- Personal bankruptcy

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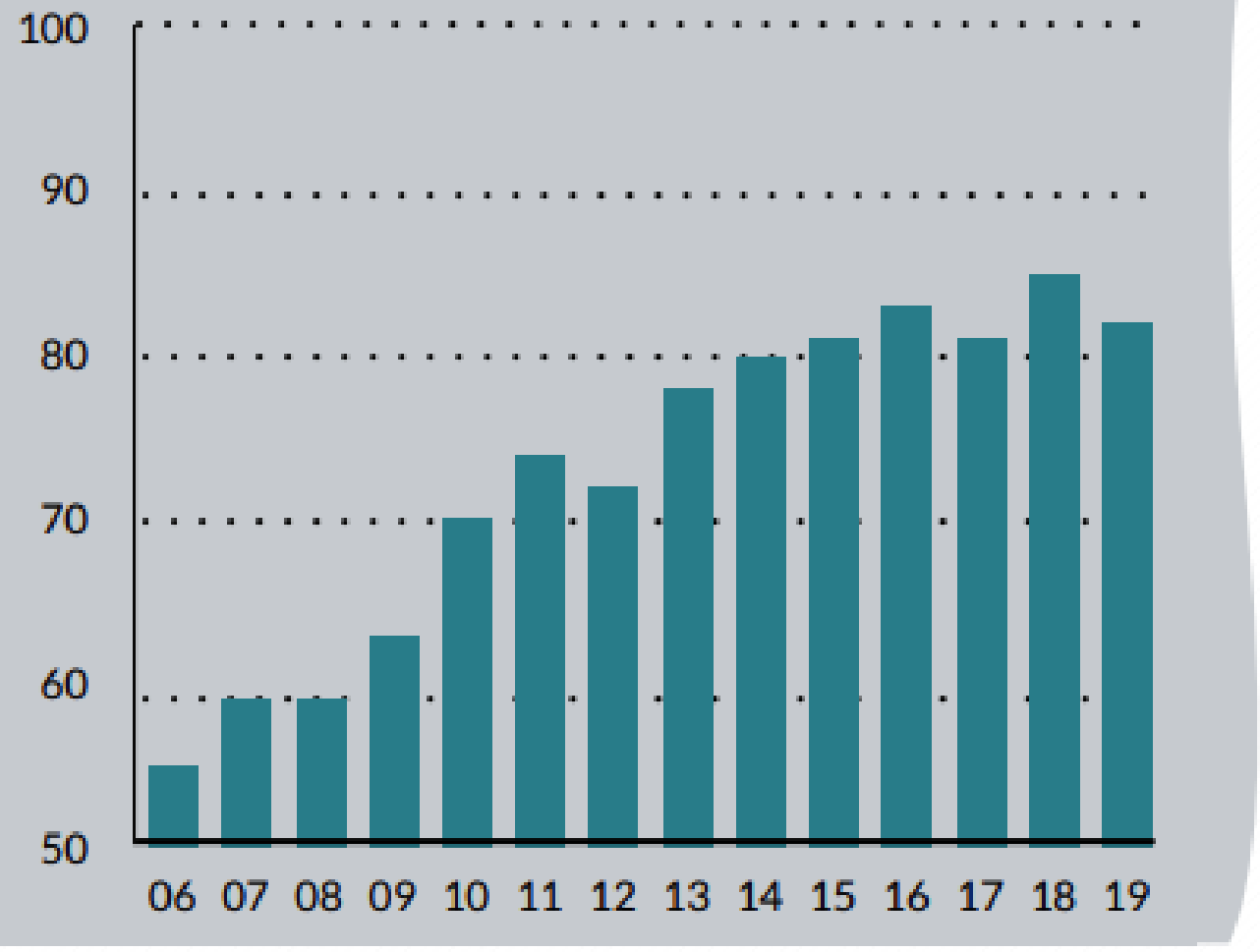
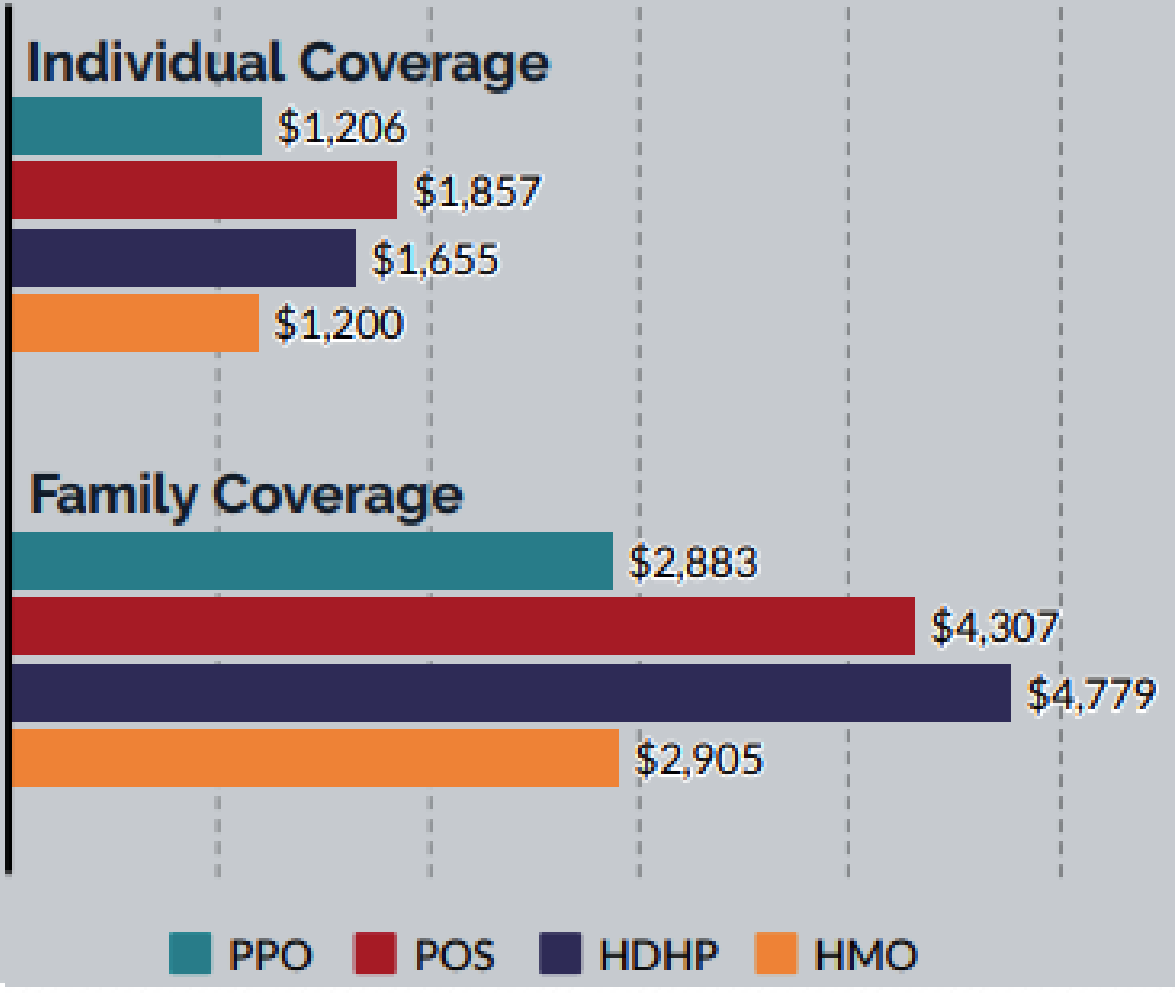
Americans Do Not Care About Health Care Costs; They Care About What It Costs Them

Percent of Americans With a Deductible



Average Deductible by Plan Type in 2019



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.

FORTUNE

COMMENTARY · MEDICAL COSTS

If you have insurance, you shouldn't be paying full price for insulin

BY MARK FENDRICK AND DAVID A. RICKS
January 29, 2020 at 4:06 PM EST

The New York Times

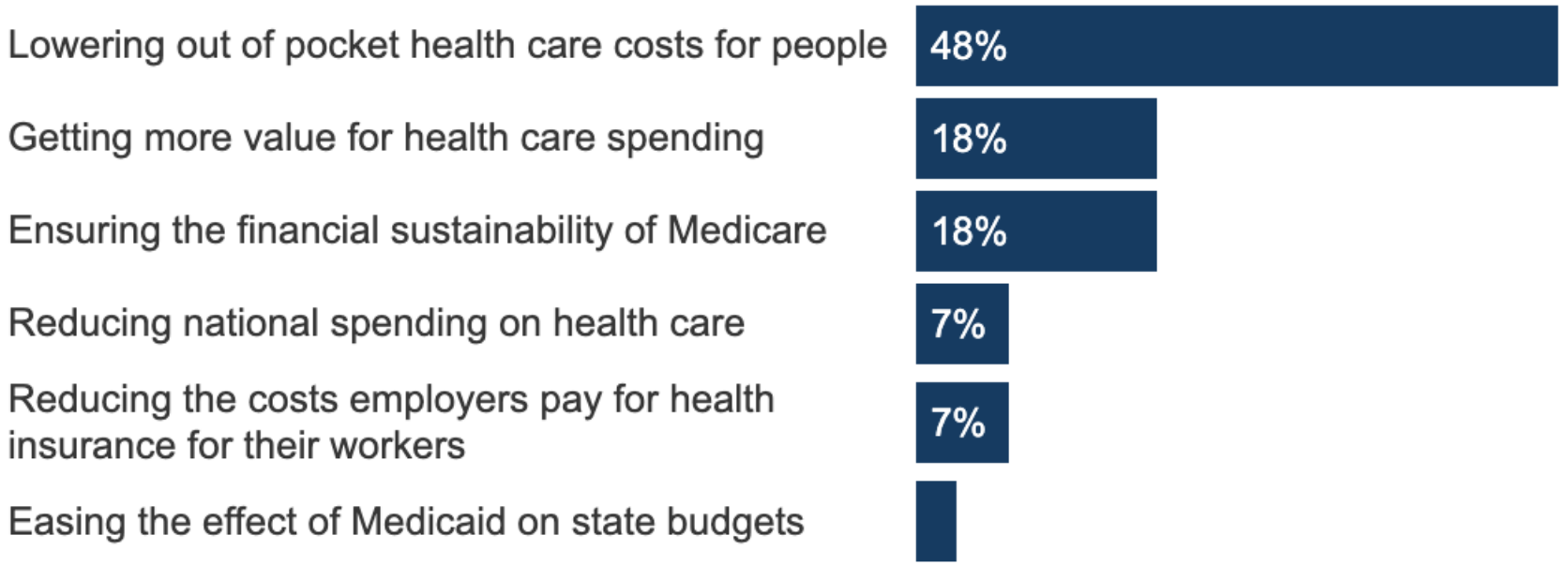
What's Wrong With Health Insurance? Deductibles Are Ridiculous, for Starters.

July 7, 2022

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

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?



NOTE: Among registered voters. See topline for full question wording.
SOURCE: KFF Health Tracking Poll (Jan. 30-Feb. 7, 2024) • Get the data • PNG

KFF

Alternative to “Blunt” Consumer Cost-Sharing: A Clinically Nuanced Approach

A “smarter” cost-sharing approach that encourages consumers to use more high value services and providers, but discourages the use of low value ones

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

- Sets consumer cost-sharing on clinical benefit – not price
- Little or no out-of-pocket cost for high-value care; higher cost-sharing for low-value care
- Implemented by hundreds of public and private payers
- Bipartisan political support
- Improves health outcomes
- Enhances equity

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]

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

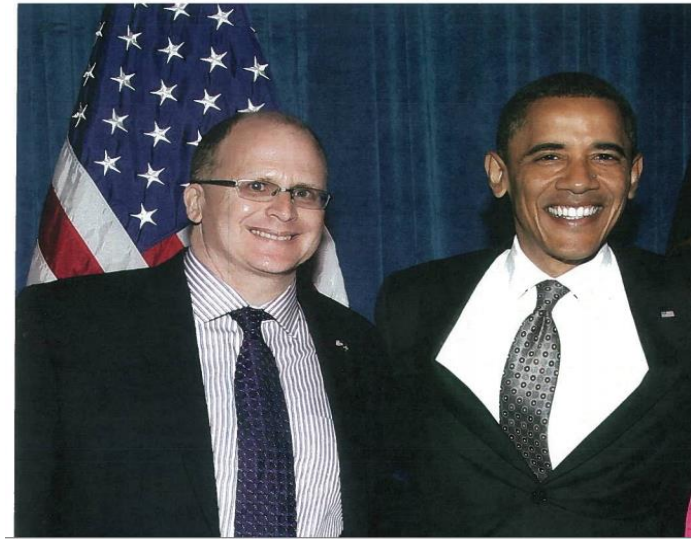
- HHS
- CBO
- SEIU
- MedPAC
- Brookings Institution
- Commonwealth Fund
- NBCH
- American Fed Teachers
- Families USA
- AHIP
- AARP
- DOD
- BCBSA
- National Governor's Assoc.
- US Chamber of Commerce
- Bipartisan Policy Center
- Kaiser Family Foundation
- American Benefits Council
- National Coalition 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)



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

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)
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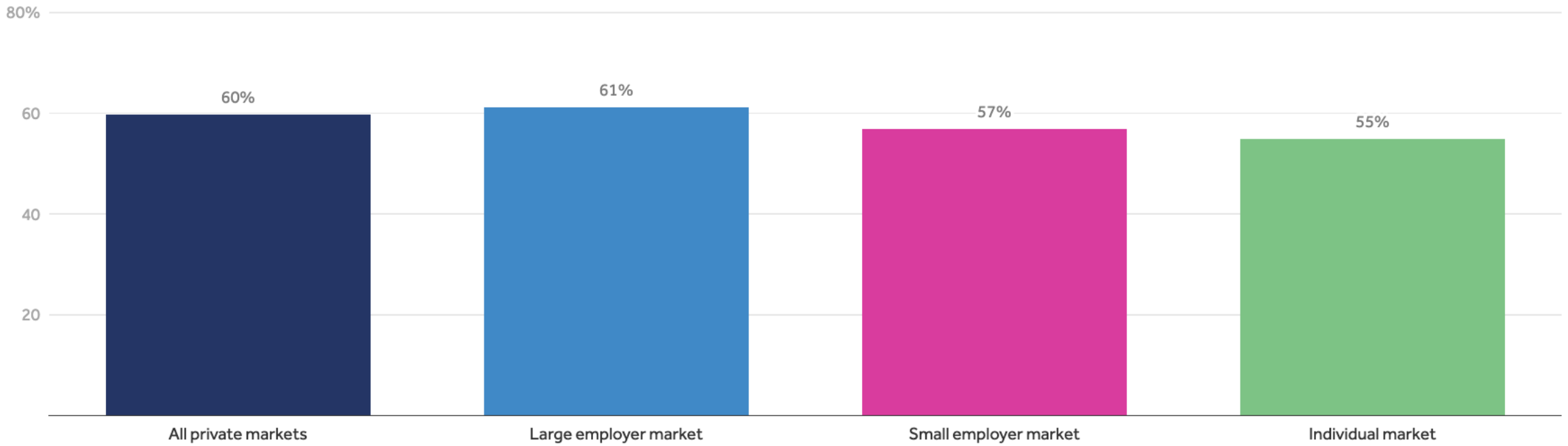
By amending Sec 2713, the CARES Act of 2020 mandated COVID-19 testing and vaccines to be provided without patient cost-sharing

About 6 in 10 privately insured people received ACA preventive care in 2018

Share of privately insured enrollees receiving preventive care, 2018



Source: KFF and RTI International analysis of 2018 Merative MarketScan and 2018 EDGE data • Get the data • PNG

Peterson-KFF
Health System Tracker

The NEW ENGLAND JOURNAL of MEDICINE

CURRENT I

PERSPECTIVE

Preventive Care at the Supreme Court

Author: Nicholas Bagley, J.D. Author Info & Affiliations

Published July 23, 2025 | DOI: 10.1056/NEJMp2506684 |

- Supreme Court upholds the ACA preventive care mandate
- HHS secretary can exercise control over the task force

Primary Care > Preventive Care

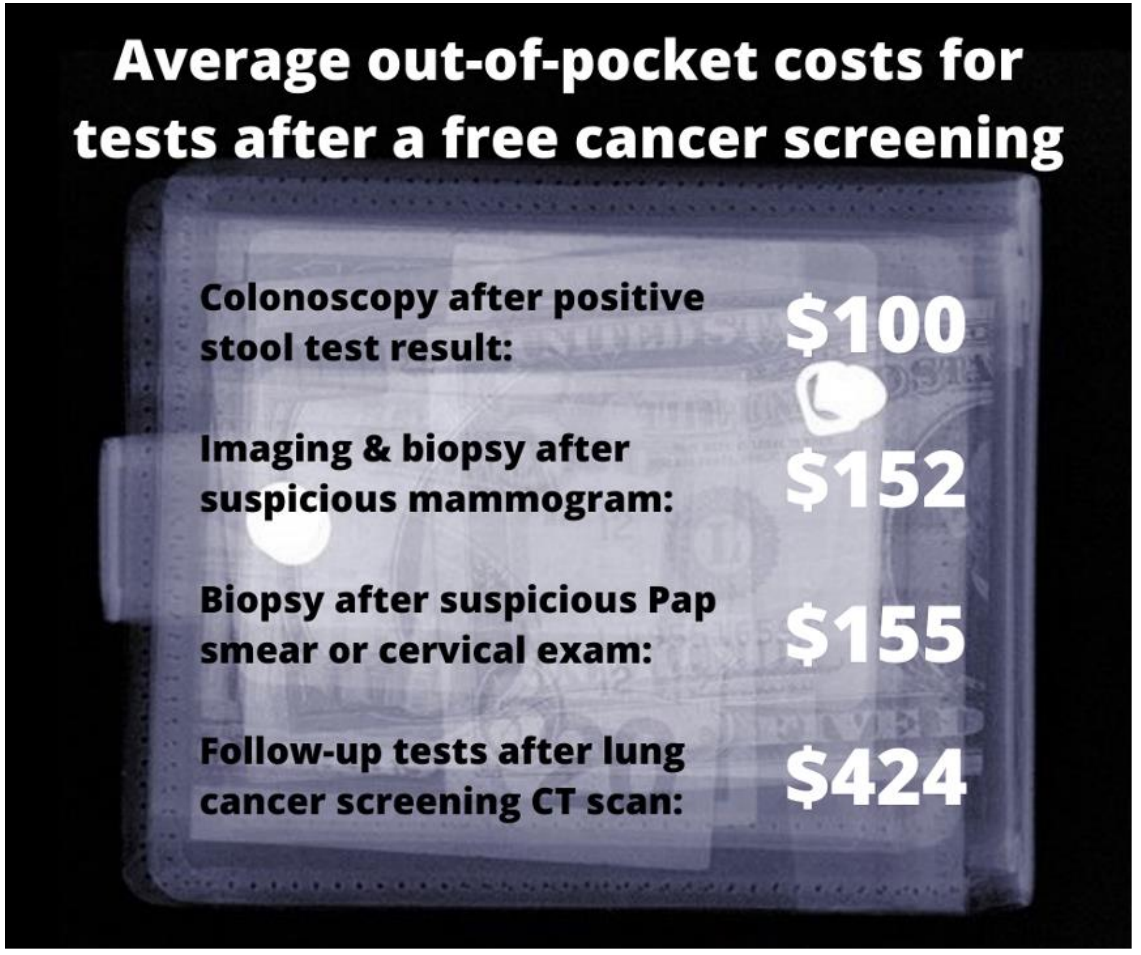
RFK Jr. Reportedly Planning to Fire All USPSTF Members

CANCER SCREENING

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

New VBID 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]



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

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.

CMS proposes follow-up colonoscopy after at-home test be considered preventive service

Riz Hatton - Friday, July 8th, 2022

Colorectal Cancer Screening

For CY 2023, we are proposing two updates to expand our Medicare coverage policies for colorectal cancer screening in order to align with recent United States Preventive Services Task Force and professional society recommendations. First, we are proposing to expand Medicare coverage for certain colorectal cancer screening tests by reducing the minimum age payment limitation to 45 years. Second, we are proposing to expand the regulatory definition of colorectal cancer screening tests to include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result. Both of these proposals reflect our desire to expand access to quality care and to improve health outcomes for patients through prevention and early detection services, as well as through effective treatments.

From Breast Cancer Screening to Diagnosis

New Recommendations for Expanded Coverage and Patient Navigation

Table. Recommendations for Breast Cancer Screening and Patient Navigation for Breast and Cervical Cancer Screening[a]

Recommendation	Eligibility	Prevention services included
Breast cancer screening	Women at average risk of breast cancer who are 40 years and older[b]	Annual or biennial mammography screening beginning no earlier than age 40 years and no later than age 50 years, and continuing through at least age 74 years; age alone should not be the basis for discontinuing screening
		Additional imaging (eg, magnetic resonance imaging, ultrasonography, mammography) and pathology evaluation when needed to complete the screening process or address findings on the initial screening mammography
Patient navigation services for breast and cervical cancer screening and follow-up	Patients eligible for breast or cervical cancer screening and needing assistance accessing screening and follow-up services	Individualized navigation services based on assessment of the patient's needs and involving person-to-person contact with the patient can include person-centered assessment and planning, health care access and health system navigation, referrals to appropriate support services (eg, language translation, transportation, social services), and patient education

Now approved by the Health Resources & Services Administration, these services will be covered without co-pay or deductible charges for most women under the prevention services no-cost coverage requirements of the Patient Protection and Affordable Care Act beginning in 2026.

JAMA Internal Medicine

Cancer Screening	Elimination of Patient Cost-sharing for follow-up diagnostic services	Elimination of Patient Cost-sharing for navigation services
Colorectal 	✓ 2023	
Breast 	✓ 2026	✓ 2026
Cervical 		✓ 2026
Lung 		

Work by several Clinical Scholars has contributed to policy discussions aimed to improve coverage of the entire cancer screening process

Redefining Cancer Screening Coverage—Screening to Diagnosis

Crystal D. Taylor, MD, MPH, MS[1]; A. Mark Fendrick, MD[2]; Lesly A. Dossett, MD, MPH[1]

The Cost to Breathe: Eliminating Cost Sharing Associated with Lung Cancer Screening

J'undra N. Pegues[1,5], Erin E. Isenberg[2,4,6], and A. Mark Fendrick[3]

Eliminating Consumer Cost-Sharing for the Entire Prostate Cancer Screening Pathway

A. Mark Fendrick

Arnav Srivastava and A. Mark Fendrick

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

Allison Ruff, MD, MPHE[a,*], Diane M. Harper, MD, MPH, MS[b,c,d], Vanessa Dalton, MD[c], A. Mark Fendrick, MD, MPH[a]

V-BID Policies Implemented During the First Trump Administration: Considerations for the Second Trump Administration

- Medicare
- High Deductible Health Plan Reform
- VBID-X

V-BID


DEPARTMENT OF HEALTH & HUMAN SERVICES • USA
Medicare

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

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 (begins in January 2025)
- Covers adult vaccines recommended by the Advisory Committee on Immunization Practices under Medicare Part D without cost-sharing (implemented 2023)
- Caps Medicare patients' out-of-pocket costs for insulin at $35 per month (implemented 2023)

Impact of V-BID Elements of the Inflation Reduction Act of 2022

If you make people pay less for something, they will buy more of it

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]

"The IRA cap on cost-sharing was associated with increases in the total number of insulin fills for Medicare enrollees."

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

"Following IRA implementation, Part D shingles vaccinations increased by 46%."

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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.

HSA-HDHP Reform

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 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, Enhancing Access for Millions of Enrollees

New Research Finds That Expanding Pre-Deductible Coverage in Health Savings Account–Eligible Health Plans Increased Patient Compliance with Medication Regimens

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).

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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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PRESS RELEASES

Home / Media / Press Releases

House Passes Buchanan's Bill to Expand Coverage Options for Chronic Disease Treatment and Prevention

March 4, 2025

Allows Employers Offering High Deductible Health Plans to Offer Pre-Deductible Coverage of 14 Chronic Healthcare Services

One Big Beautiful Bill Act (OBBBA) introduces changes to HSA-HDHPs, effective January 1, 2026

- Permanently allowing telehealth to be covered without disqualifying an HSA,
- Expanding HSA eligibility to include individuals with Bronze and Catastrophic ACA plans,
- Direct Primary Care (DPC) arrangements no longer prevent HSA contributions, provided their cost is within certain limits

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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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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Research Letter

Projected Savings From Reducing Low-Value Services in Medicare

David D. Kim, PhD[1,2]; A. Mark Fendrick, MD[3,4]

Medicare could save $3.6B without risk to older adults, study suggests

Fewer low-value tests, scans and procedures could also save older adults $800M in out-of-pocket costs

August 1, 2025 11:00 AM

Author Kara Gavin

CMS Launches WiSeR Model to reduce wasteful, low-value services

CMS.gov Centers for Medicare & Medicaid Services

Medicare Medicaid/CHIP Marketplace & Private Insurance Initi

Priorities > Overview > Innovation Models > WISeR (Wasteful and Inappropriate Service Reduction) Model

WISeR (Wasteful and Inappropriate Service Reduction) Model

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/hblog20190714.437267

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.

High Value Generic Drug Classes with Zero Cost Sharing
ACE inhibitors and ARBs
Anti-depressants
Antipsychotics
Anti-resorptive therapy
Antiretrovirals
Antithrombotics/anticoagulants
Beta blockers
Buprenorphine-naloxone
Glucose lowering agents
Inhaled corticosteroids
Naloxone
Rheumatoid arthritis medications
Statins
Thyroid-related
Tobacco cessation treatments

High Value Branded Drug Classes with Reduced Cost Sharing
Anti-TNF (tumor necrosis factor)
Hepatitis C direct-acting combination
Pre-exposure prophylaxis for HIV (PrEP) [1]

Specific Low Value Services Considered
Proton beam therapy for prostate cancer
Spinal fusions
Vertebroplasty and kyphoplasty
Vitamin D testing

Enhancing Access and Affordability to Essential Clinical Services

- Keep watchful eye on future of the USPSTF
- 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
- Implement clinically-driven plan payment reform, technologies and benefit designs (e.g., V-BID X) that increase use of high-value services and deter low value care

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“If we don’t succeed then we will fail.”

Dan Quayle

Thank you

Questions?

www.vbidcenter.org

@UM_VBID

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