Value-Based Insurance Design: Using “Smarter” Cost-sharing to Align Consumer Incentives with Alternative Payment Models

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#VBID
Shifting the Discussion from “How much” to “How well”

Overview

• Impact of Consumer Cost-sharing
• New Approach: “Clinically Nuanced” Cost-sharing
• Value-Based Insurance Design
• Putting Innovation into Action
• Identifying and Removing Waste
• Synergies with Alternative Payment Models
• Innovations to prevent and treat disease have led to impressive reductions in morbidity and mortality

• Regardless of these advances, cost growth is the principle focus of health care reform discussions

• Despite unequivocal evidence of clinical benefit, substantial underutilization of high-value services persists across the entire spectrum of clinical care

• Attention should turn from how much to how well we spend our health care dollars
For today’s discussion, the focus is on costs paid by the consumer, not the employer or third party administrator.

Consumer cost-sharing is rising rapidly.

Health Affairs 2014. doi: 10.1377/hlthaff.2014.0792
“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)
Deductibles on the rise
Percentage of covered workers with an annual deductible of $1,000 or more for single coverage

Source: Kaiser Family Foundation and Health Research and Educational Trust
Percentage of Workers Enrolled in HDHPs

- HSA-eligible HDHP
- HDHP/HRA

Source: Kaiser/HRET Survey of Employer Sponsored Health Benefits
A growing body of evidence concludes that increases in consumer cost-sharing leads to a reduction in the use of essential services, worsens health disparities, and in some cases leads to greater overall costs.
Americans Reporting Problems Paying Medical Bills in Past Year

- Uninsured: 53%
- Income <$50,000: 47%
- Adults 18-64: 37%
- HDHP: 26%
- All private insurance: 23%
- Source: Kaiser Family Foundation/New York Times Medical Bills Survey
Getting to Health Care Value
Consumer Solutions Needed to Enhance Efficiency

• While important, the provision of accurate price and quality data does not address appropriateness of care nor substantially impact consumer behavior

• Additional solutions are necessary to better allocate health expenditures on the clinical benefit – not only the price or profitability – of services
Understanding Clinical Nuance

Clinical Services Differ in the Benefit Produced

- Office Visits
- Diagnostic Tests
- Prescription Drugs
Despite these differences in clinical value, consumer out-of-pocket costs are the same for every clinician visit within a network...
...for all diagnostic tests...

Blood Sugar Monitoring

CT Imaging for Back Pain
Consumer out-of-pocket costs are the same for all drugs within a formulary tier.
The Clinical Benefit Derived From a Service Depends On...

- Who receives it
- Who provides it
- Where it's provided

#2
Clinical benefit depends on who receives it

Screening for Colorectal Cancer

Screening Recipients

- First-degree relative of colon cancer sufferer: Exceptional Value
- Average risk 50 year old: High Value
- 30 year old with no family history of colon cancer: Low Value
Clinical benefit depends on **where** care is provided.

- **Ambulatory Care Center**: $ $$$
- **Hospital**: $$$$

The cost of care varies significantly between an ambulatory care center and a hospital.
Implementing Clinical Nuance:
Value-Based Insurance Design

Sets cost-sharing to encourage greater utilization of high-value services and providers and discourage use of low-value care

- Successfully implemented by hundreds of public and private payers

From 'One Size Fits All' To Tailored Co-Payments

University of Michigan researchers say a patient's drug should depend on how much he or she will use it, a move that would likely lower costs.
V-BID Momentum Continues

Source: 19th Annual Towers Watson/National Business Group on Health Employer Survey
V-BID: Who Benefits and How?

**Consumers**
- Improves access
- Lowers out-of-pocket costs

**Payers**
- Promotes efficient expenditures
- Reduces wasteful spending

**Providers**
- Enhances patient-centered outcomes
- Aligns with provider initiatives
Putting Innovation into Action
Broad Multi-Stakeholder Support

- HHS
- CBO
- SEIU
- MedPAC
- Brookings Institution
- The Commonwealth Fund
- NBCH
- PCPCC
- Families USA
- AHIP
- AARP
- National Governor’s Assoc.
- US Chamber of Commerce
- Bipartisan Policy Center
- Kaiser Family Foundation
- NBGH
- National Coalition on Health Care
- Urban Institute
- RWJF
- IOM
- PhRMA

Lewin. JAMA. 2013;310(16):1669-1670
Putting Innovation into Action: Translating Research into Policy

- Patient Protection and Affordable Care Act
- Medicare
- HSA-qualified HDHPs
- High Cost Drugs
- State Health Reform
• 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)

Over 137 million Americans have received expanded coverage of preventive services; over 76 million have accessed preventive services without cost-sharing
A sharp uptick in use of preventive care coincided with the Affordable Care Act’s preventive services provision

U.S. per capita disease-based health spending, cost per case, and treated prevalence indexes for CCS Condition Category, Exam or Evaluation, 2005 - 2012

Source: Kaiser Family Foundation and Bureau of Economic Analysis (BEA) analysis of BEA’s Health Care Satellite Account (Blended Account), which combines data from the Medical Expenditure Panel Survey and large claims databases. Notes: Beginning in September 2010, the ACA mandated that most insurers cover certain recommended preventive services. Many of these services are included in the "exam or evaluation" category shown in this chart. The requirement that most plans cover contraceptives went into effect in August 2012. Contraceptives are not included in this chart.
Putting Innovation into Action: Translating Research into Policy

- Patient Protection and Affordable Care Act
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Why not lower cost-sharing on high-value services?

The anti-discrimination clause of the Social Security Act does not allow clinically nuanced consumer cost-sharing.

"providers may not deny, limit, or condition the coverage or provision of benefits"
H.R.2570/S.1396: Bipartisan “Strengthening Medicare Advantage Through Innovation and Transparency”

- Directs HHS to establish a V-BID demonstration for MA beneficiaries with chronic conditions

- Passed US House with strong bipartisan support in June 2015
CMS Announces Medicare Advantage Value-Based Insurance Design Model Test

A 5-year demonstration program will test the utility of structuring consumer cost-sharing and other health plan design elements to encourage patients to use high-value clinical services and providers.

*Red denotes states included in V-BID model test*
Putting Innovation into Action: Translating Research into Policy

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HSA-HDHP enrollment and out-of-pocket expenses continue to grow

Maximum Out-of-pocket expense 2006 to 2014

- Individual: $5,000 to $6,350
- Family: $10,000 to $12,700

IRS Safe Harbor Guidance allows zero consumer cost-sharing for specific preventive services

INCLUDING:

✓ periodic health evaluations/screenings
✓ routine prenatal and well-child care
✓ child and adult immunizations
✓ tobacco cessation programs
✓ obesity weight-loss programs

However, IRS guidance requires that services used to treat "existing illness, injury or conditions" are not covered until the minimum deductible is met.

As HSA-HDHP enrollees with existing conditions are required to pay out-of-pocket for necessary services, they utilize less care, potentially resulting in poorer health outcomes and higher costs.
How Enrollees Judge the Value of Their Health Plans

Lower-Deductible Health Plans
- Excellent Value: 19%
- Good Value: 49%
- Only a Fair Value: 22%
- Poor Value: 9%

High-Deductible Health Plans
- Excellent Value: 32%
- Good Value: 30%
- Only a Fair Value: 28%
- Poor Value: 7%

Source: Kaiser Family Foundation
Potential Solution: High Value Health Plan

Flexibility to expand IRS "Safe Harbor" to allow coverage of additional evidence-based services prior to meeting the plan deductible
Putting Innovation into Action: Translating Research into Policy

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Motivation for "Dynamic" Benefit Design

- The natural history of chronic conditions often necessitate multiple therapies to achieve desired clinical outcomes.
- Health plans frequently require certain steps be performed before access to additional therapies.
- Increasing out-of-pocket costs for alternative therapies may prevent consumers from accessing recommended treatment.

RIGHT DRUG. RIGHT PERSON. RIGHT TIME. RIGHT PRICE.
REWARD THE GOOD SOLDIER

RIGHT DRUG. RIGHT PERSON. RIGHT TIME. RIGHT PRICE.

A benefit design that lowers consumer cost-sharing for those who diligently follow the required steps for their condition, but require an alternative option.
Reward the Good Soldier™
A Dynamic Approach to Consumer Cost-sharing

- Commitment to established policies that encourage lower cost, first-line therapies
- Acknowledgment that clinical scenarios may require multiple treatment options
- Reduces cost-related non-adherence
- Enhances access to effective therapies when clinically appropriate

RIGHT DRUG. RIGHT PERSON. RIGHT TIME. RIGHT PRICE.
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Getting to Health Care Value - What’s Your State's Path?
V-BID Role in State Health Reform

- State Exchanges – Encourage V-BID (CA, MD)
- Medicaid – Michigan
- State Innovation Models – NY, PA, CT, VA
- State Employee Benefit Plans
Value-Based Insurance Design
Growing Role in State Employee Plans
Connecticut’s Value-Based Insurance Plan Increased The Use Of Targeted Services And Medication Adherence
### Value-Based Insurance Design

V-BID sets cost-sharing to encourage use of high-value services and providers and discourage use of low-value care.

<table>
<thead>
<tr>
<th>Current Plans</th>
<th>V-BID Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase out-of-pocket costs</td>
<td>Lower cost-sharing for high-value services and providers</td>
</tr>
<tr>
<td>Offer one-size-fits-all cost-sharing</td>
<td>Enhance patient-centered outcomes</td>
</tr>
<tr>
<td>Misalign consumer and provider incentives</td>
<td>Align with provider initiatives</td>
</tr>
</tbody>
</table>

[Image of V-BID logo]
Motivation for Benefit Design Change

- Address state budget deficits
- Reduce disparities and quality gaps
- Encourage employee engagement
- Improve individual and population health
Key Features of the HEP
Align out-of-pocket costs with healthy behaviors

- Voluntary Enrollment
- Full Preventive Care Coverage
- Reduced cost-sharing for visits & medications to better manage specific clinical conditions
- Increased cost-sharing for non-emergent ED visits

Participatory Requirement:
To maintain enrollment, members must complete age-appropriate preventive care & recommended chronic disease services.
Relative change for HEP members compared to enrollees in control states.
HEP Impact: 2 Year Results

[2] Preventive Care Utilization

**Lipid Screening**
- % Using Service
  - Baseline: 50
  - Year 1: 70
  - Year 2: 90

**Mammography**
- % Using Service
  - Baseline: 25
  - Year 1: 45
  - Year 2: 65

HEP, Comparison
HEP Impact: 2 Year Results

[3] Resource Use

ED Visits per 1,000 enrollees

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>Year 1</th>
<th>Year 2</th>
</tr>
</thead>
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<tr>
<td>HEP</td>
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<tr>
<td>Comparison</td>
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</tbody>
</table>

Spending - Year 2

<table>
<thead>
<tr>
<th></th>
<th>Full Sample</th>
<th>Chronic Conditions</th>
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<tr>
<td>US Dollars ($)</td>
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City overhauls health plans for municipal workers in shift toward preventive care

Changes to employees' co-pays will make primary care cheaper while ER visits and urgent care will be pricier
City overhauls health plans for municipal workers in shift toward preventive care

Changes to employees’ co-pays will make primary care cheaper while ER visits and urgent care will be pricier

“These changes will not only secure the promised health savings, but will also promote better utilization of health care resources and improved health outcomes for City employees”
## Combining ‘Carrots’ and ‘Sticks’ to Enhance the Financial Impact of V-BID Programs: Identify Waste

<table>
<thead>
<tr>
<th>Category</th>
<th>Sources</th>
<th>Estimate of Excess Costs</th>
<th>% of Waste</th>
<th>% of Total</th>
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<tbody>
<tr>
<td>Unnecessary Services</td>
<td>• Overuse beyond evidence-established levels</td>
<td>$210 billion</td>
<td>27%</td>
<td>9.15%</td>
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<tr>
<td></td>
<td>• Discretionary use beyond benchmarks</td>
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<tr>
<td>Inefficiently Delivered Services</td>
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<td>$130 billion</td>
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<td>• Care fragmentation</td>
<td></td>
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<td>• Operational inefficiencies at care delivery sites</td>
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<td>• Insurance paperwork costs beyond benchmarks</td>
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<td>• Insurers’ administrative inefficiencies</td>
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<td>• Primary prevention</td>
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**SOURCE:** “Best Care at Lower Cost: The Path to Continuously Learning Health Care in America.” Institute of Medicine (2013)
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Removing Waste
Health Waste Calculator

Software tool designed to identify wasteful medical spending:
• U.S. Preventive Services Task Force
• Choosing Wisely

Underlying algorithms process claims, billing or EMR data to identify waste
Defines services with a degree of appropriateness of care
• Necessary
• Likely to be wasteful
• Wasteful
## Top 5 Measures by Cost Overall- 2014

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<tr>
<th>Measure</th>
<th>Total Services Measured</th>
<th>Waste Index (%)</th>
<th>Unnecessary Services (#)</th>
<th>Unnecessary Spending ($)</th>
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<td>Baseline laboratory studies in patients without systemic disease undergoing low-risk surgery</td>
<td>571,600</td>
<td>79%</td>
<td>453,447</td>
<td>$184,781,018</td>
</tr>
<tr>
<td>Stress cardiac or advanced non-invasive imaging in the initial evaluation of patients w/o symptoms</td>
<td>219,878</td>
<td>13%</td>
<td>27,817</td>
<td>$185,997,938</td>
</tr>
<tr>
<td>Annual electrocardiograms (EKGs) or other cardiac screening for low-risk patients without symptoms</td>
<td>2,268,194</td>
<td>6%</td>
<td>147,423</td>
<td>$60,499,385</td>
</tr>
<tr>
<td>Routine annual cervical cytology screening (Pap tests) in women 21–65 years of age</td>
<td>199,865</td>
<td>81%</td>
<td>161,539</td>
<td>$37,558,706</td>
</tr>
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<td>PSA-based screening for prostate cancer in all men regardless of age.</td>
<td>313,011</td>
<td>42%</td>
<td>132,793</td>
<td>$31,501,675</td>
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*Certain measure had a waste index of 100%*
Many “supply side” initiatives are restructuring provider incentives to move from volume to value:

- Medical Homes
- Accountable Care
- Bundled Payments
- Reference Pricing
- Global Budgets
- High Performing Networks
- Health Information Technology
Unfortunately, some “demand-side” initiatives – including consumer cost sharing and a lack of incentives to stay within an ACO - discourage consumers from pursuing the “Triple Aim”
Impact of Aligning Physicians and Patients: Financial Incentives to Lower Cholesterol

The alignment of clinically nuanced, provider-facing and consumer engagement initiatives is a necessary and critical step to improve quality of care, enhance patient experience, and contain cost growth.
Discussion

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