Changing the Health Care Cost Discussion from "How Much" to "How Well"

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• 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
Role of Consumer Cost-Sharing in Clinical Decisions

• For today’s discussion, our focus is on costs paid by the consumer, not the employer or third party administrator.

• Ideally consumer cost-sharing levels would be set to encourage the clinically appropriate use of health care services.

• Instead, archaic “one-size-fits-all” cost-sharing fails to acknowledge the differences in clinical value among medical interventions.

• Consumer cost-sharing is rising rapidly.

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

- Small firms
- All firms
- Large firms

Source: Kaiser Family Foundation and Health Research and Educational Trust
“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)
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.

**One in Four** adults with non-group coverage report going without needed care due to cost.

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Innovative Solutions Needed

• Consumers do not have the necessary information to make informed health care decisions

• While important, clinician incentives and providing accurate price and quality data does not ensure appropriate care delivery

• Consumer engagement solutions are necessary to better allocate health expenditures on the clinical benefit – not only the price or profitability – of services
Potential Solution to Cost-Related Non-Adherence

Clinically Nuanced Cost-Sharing

What is clinical nuance?

Services differ in clinical benefit produced:
- [Icon: Pill]
- [Icon: Human]
- [Icon: Nurse]

Clinical benefits from a specific service depend on:
- Who receives it
- Who provides it
- Where it's provided
Implementing Clinical Nuance: Value-Based Insurance Design

- Sets consumer cost-sharing level on clinical benefit – not acquisition price – of the service
  - Reduce or eliminate financial barriers to high-value clinical services and providers

- Successfully implemented by hundreds of public and private payers
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
- Partnership for Sustainable Health Care
- Families USA
- AHIP
- 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
- AARP

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

• Patient Protection and Affordable Care Act
• Medicare
• State Health Reform
• HSA-qualified HDHPs
• Cadillac Tax
• High Cost Drugs
• Alternative Payment Models
• 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
Putting Innovation into Action: Translating Research into Policy

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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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- **State Health Reform**
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Value-Based Insurance Design
Growing Role in State Health Reform

- State Exchanges
- CO-OPs
- Medicaid
- State Innovation Models
- State Employee Benefit Plans
CMS Rules Enable V-BID in Medicaid

Plans may vary cost-sharing for
- drugs, outpatient, inpatient, and emergency visits
- specific groups of individuals based on clinical factors
- an outpatient service according to where and by whom the service is provided

V-BID was prominently featured in Healthy Michigan Plan
• Patient Protection and Affordable Care Act
• Medicare
• State Health Reform
• High Deductible Health Plans
• Cadillac Tax
• High Cost Drugs
• Alternative Payment Models
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


M | V-BID
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.
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.
High Value Health Plan
V-BID HDHP Hybrid with “Smarter Deductibles”:

- Lower premiums than PPOs and HMOs; slight premium increase over existing HDHPs
- >40 million likely enrollees
- Substantially lower aggregate healthcare expenditures on a population level
- Bipartisan legislation to be introduced in this session
- Vehicle to avoid the “Cadillac tax”
Putting Innovation into Action: Translating Research into Policy

- Patient Protection and Affordable Care Act
- Medicare
- State Health Reform
- High Deductible Health Plans
- **Cadillac Tax**
- High Cost Drugs
- Alternative Payment Models
What is the "Cadillac Tax"?

Section 4980I of Patient Protection and Affordable Care Act mandates that if a health plan's benefits exceed...

$10,200 for Individual Coverage

$27,500 for Spouse/Family Coverage

the coverage provider must pay a 40% excise tax on each dollar above the cap in 2018.

Common Features of "Cadillac Plans"

- Many Covered Services
- Low Cost-Sharing
- Broad Provider Networks
Trade-In a "Cadillac Plan" for Value-Based Insurance Design

Turn in a "Cadillac Plan" loaded with unnecessary features...

- Covers low-value services
- Subject to 40% excise tax in 2018

Dodge a non-nuanced High Deductible Health Plan...

- Higher out-of-pocket costs
- Increased rates of non-adherence

Choose a clinically nuanced V-BID plan that...

- Covers evidence-based services
- Enhances adherance
- Avoids the Cadillac tax
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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.
"Reward the GOOD SOLDIER"

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
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• Alternative Payment Models
Many “supply side” initiatives are restructuring provider incentives:

- Payment reform
  - Global budgets
  - Pay-for-performance
  - Bundled payments
  - Accountable care
- Medical homes
- Narrow networks
- Health information technology
Unfortunately, “supply-side” initiatives have pay little attention to consumer decision-making or the “demand-side” of care-seeking behavior:

- Benefit design
- Literacy
- Shared decision-making
Precision Medicine Requires Precision Benefit Design

- Using clinical nuance to align payment reform and consumer engagement initiatives can help improve quality of care, enhance patient experience, and contain cost growth
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