Meeting Notes

The third meeting of the Social Justice & Health Disparities Working Group was held on February 25, 2021 from 3:00-4:30pm.

Dr. Dora Hughes opened the meeting with a brief overview of the working group plan and a discussion of suggested priorities for consideration. The first three priorities raised during previous working group discussion that have been identified for deep dives include:

1) Promoting equity through insurance design
2) Racial and ethnic data collection
3) Carrier and employer strategies, including clinical initiatives, contracting mechanisms and other tools

Other possible priorities for further discussion may include:

1) Bias in artificial intelligence
2) Race correction in diagnostic tools
3) Telehealth, including minimizing cost sharing and reciprocity for MD and VA providers.

Dr. Hughes emphasized that this is "phase one," and priorities could be raised in future working group efforts.

This week's guest speaker was Mark Fendrick, MD, Professor and Director of the Value-Based Insurance Design Center at the University of Michigan. He presentation on value-based insurance design and health equity was titled "V-BID X: Expanding Coverage of Essential Clinical Care Without Increasing Premiums or Deductibles."

Dr. Mark Fendrick on Value-Based Insurance Design and Health Equity

The COVID-19 pandemic has highlighted the fact that many Americans—particularly low-income populations—do not have the money to cover unexpected expenses and may skip or postpone care depending on the associated out-of-pocket costs. Dr. Fendrick began his presentation with an overview of how many health insurance plans do not provide affordable coverage for high-value services to treat many chronic conditions and COVID-19 related illnesses that disproportionately affect communities of color, as cost-sharing associated with (steadily increasing) health plan deductibles result in consumers having to pay full price for both low- *and* high-value care prior to meeting the deductible.

He stated that "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."

Dr. Fendrick urged health insurers to redesign their benefit packages to cover essential medical services more generously and implement payment and benefit reforms that prevent a post-pandemic resurgence of medical care that does not provide clinical benefit. He proposed a value-based insurance design (V-BID X) as an alternative to "blunt" consumer cost sharing. This design sets consumer cost-sharing on clinical benefit, not price, which results in little or no out-of-pocket cost for high value care. He argued that enhanced coverage of essential services prior to meeting the plan deductible is fiscally feasible without increasing premiums or deductibles by reducing spending on low-value or wasteful clinical services.

In short:

- Expand pre-deductible coverage/reduce cost sharing on high value clinical services
- Identity, measure, and reduce low value care to pay for more generous coverage of high value care
- Implement clinically driven payment models and plan designs that increase use of high value services and deter the use of low value ones.

Key takeaways from the presentation were:

- Cost neutral V-BID designs are feasible. Coverage can be enhanced for targeted high-value services, without raising premiums and deductibles.
- There are a large number of plausible combinations of services or cost sharing changes that could fit different needs and goals, depending on the carrier and market.

Discussion

Dr. Hughes asked Dr. Fendrick if plans that have adopted this type of model have seen outcomes related to health outcomes and cost savings. Dr. Fendrick replied that VBID plans have shown they can increase utilization of high value drugs without increasing total expenditures. This is one of the reasons why the Medicare Senior Savings Model focused first on insulin. Dr. Fendrick also discussed the Medicare Advantage V-BID demo, which will cover both medical and socioeconomic determinants. He noted that in terms of overall spending, with interventions related to chronic diseases like heart failure, diabetes, and chronic obstructive pulmonary disease, cost neutrality is achieved fairly quickly. Alternatively, it can be difficult to achieve cost neutrality for interventions related to other conditions like mental health disorders and HIV, because the benefit of the interventions is people live a long time. This is the first year V-BID X has been incorporated into individual and group market plans.

Mila Kofman reminded the group that about half of the Exchange's twenty-five products on the individual side are standard plans with pre-deductible coverage. In addition, CareFirst now offers insulin and diabetes supplies at no cost, and Kaiser is adding that feature. She asked Dr. Fendrick to speak further on how services are identified as low value, as a service that does not work well for one population might work very well for another.

Dr. Fendrick answered that they started by looking at the U.S. Preventive Services Task Force's (USPSTF) D Rated Services. These are services the USPSTF recommends against, as there is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefit. That said, in some cases a service that receives a D rating for a majority of the population may receive a different rating for a small population based on specific clinical parameters.

Dr. Fendrick then emphasized that any intervention that improves access and affordability has a tremendous benefit for the underserved. He gave the example of a VBID randomized trial where patients who had experienced a heart attack had their medication cost sharing removed for important medications, and a substantial portion of the increased utilization and reduction in cardiovascular events occurred in people with low income.

Colette Chichester asked if the selection in low and high value targets adequately addresses the populations that most need help, specifically black and brown communities.

Dr. Fendrick replied that since this past summer he has been focused on COVID-19 vaccine hesitancy and understanding the lack of trust and other issues that arise in relation to underuse of high value services. VBID is just one small portion of a greater initiative to make sure the necessary policies are in place to ensure people have access to education to make their own decisions regarding what services they should and should not get. He stated that he does believe the underserved actually receive a lower amount of low value services, but low value care issues are still particularly problematic.

Cara James stated that she has seen some analysis on VBID and disparities reduction across a number of different populations, and while cost reductions can help benefit those who are low income and people of color, in thinking about next steps for VBID X what may be done to further reduce disparities that still remain?

Dr. Fendrick replied that the Medicare Advantage VBID plan provides supplemental benefits related to nutrition, transportation, pest control, utilities, and so on.

Mila Kofman reminded the group that the Exchange has the entire individual market, and 90% are full pay and don't qualify for APTC. However, one issue we see in DC is that regardless of income, women of color still experience racial disparities in maternal health outcomes. She asked how the VBID model could help tackle this issue.

Dr. Fendrick responded that the average out-of-pocket cost for well insured person to have a baby is $3000. He suggested that every plan should offer at least one high-quality location where a person can deliver at zero cost sharing. He hopes that this may encourage other hospitals to become better providers and lower their cost sharing. He stated that we particularly need to apply VBID principles to 1) not just prenatal care but also deliveries and postnatal care, and 2) trauma.

Dr. Hughes asked the working group for their general reactions to VBID, and there were questions about how VBID principles aligns with the suite of other proposed interventions, and if VBID will be effective in relation to reducing health disparities.

Dr. Hughes then asked the plans to review ways in which they are already applying VBID principles.

Colette Chichester described CareFirst's VBID-type approach to care delivery in relation to their diabetes initiative. They chose diabetes because it was a top issue across their jurisdictions. The project launched in January 2021, so they do not have any data yet related to whether or not the initiative has reduced health disparities.

Daniel Wilson stated that United Healthcare is having these conversations related to COVID-19, as the pandemic has made them reconsider their delivery system to better meet the needs of the people they serve.

Allison Mangiaracino stated that Kaiser has not looked at applying VBID principles yet beyond their own insulin policies. She said that although there is some evidence it could be beneficial in adherence, whether it closes disparities is uncharted territory and urged the group to really think about the empirical basis for using VBID to close disparities. She reviewed some of the ways Kaiser has addressed disparities in what she considers an evidence-based way, including Kaiser's Institute for Culturally Competent Care and their program to address implicit bias in the care setting.

Cara James reiterated that while there is no one solution to address health disparities, at its core VBID is about reducing cost and improving access to care, including social needs, and she urged the group to think of VBID as part of a greater package of wraparound pieces that will help reduce health disparities for communities of color. She also noted that she was not comfortable with the idea of plans only covering patients receiving certain types of care at specific locations, because it may impede patient access and overburden specific hospitals.

Dr. Hughes closed the meeting with a reminder about the next meeting.

Attendee List

Diane Lewis
Mila Kofman
Dora Hughes
Helen Mittmann
Purvee Kempf
Mark Fendrick – Guest Speaker
Pamela Riley
Philip Barlow
Tamara Watkins
Yolondra Barlow
Sherry Dai
Allison Mangiaracino
Cara James
Colette Chichester
Karima Woods
Anneta Arno
Paul Spiedell
Daniel Wilson
Margarita Dilone