Promoting Access to High-Value Care

Background

Health care affordability for patients is determined not just by the cost of insurance coverage (e.g., the premium), but also by the amount of cost-sharing required (e.g., deductibles, co-payments, and coinsurance). While increasing access to health insurance is significantly beneficial to patients, health care can remain unaffordable, even for those with coverage. A popular and successful provision of the Affordable Care Act (ACA) reduces concerns about the cost of preventive care. This provision requires private, non-grandfathered health insurance plans to cover, without patient cost-sharing (zero-dollar), the preventive services recommended by four designated expert organizations. At the same time, more should be done to facilitate and incentivize high-value care, including care that prevents and manages chronic conditions.

Barriers to Affordable Access

As the health care system has worked to implement the ACA's zero-dollar preventive services requirement, physicians and patients continue to experience significant barriers to care.

Underinsurance and Cost-Related Non-Adherence (CRN)

Rates of underinsurance (out-of-pocket costs that are high relative to income) continue to rise, with 13 percent of adults underinsured in 2005 and 28 percent of adults underinsured in 2016. Even when a service is covered by a health plan, patients may incur significant costs in the form of cost-sharing and/or large medical bills that they must pay before meeting their deductible. Such costs have been shown to cause people, especially those in low-income and vulnerable populations, to forgo not only unnecessary but also necessary care.

Similarly, CRN occurs when financial barriers prevent patients from pursuing recommended medical care. CRN has been identified across the continuum of care – physician visits, preventive screenings, prescription drugs, etc. – and is especially problematic for vulnerable populations.

Translating Clinical Goals into Benefit Designs

To meet the ACA's zero-dollar preventive services requirement, health plans have been challenged to translate the clinical goals of the designated expert organizations into insurance benefit design. This has added complexity to billing and payment practices, sometimes resulting in unexpected patient cost-sharing.

Additionally, health plan financial incentives for patients do not always support high-value care which proactively manages medical risk and prevents serious morbidity. For example, findings from a zero-dollar preventive screening can lead to expensive, but necessary, medical care. Also, some preventive interventions may result in significant patient cost-sharing. Illustrations of these misaligned incentives include the person with prediabetes who cannot afford the cost-sharing associated with a diabetes prevention program, and the person newly diagnosed with breast cancer who cannot afford the cost of care she will incur prior to meeting her deductible.

Expanding Access

While zero-dollar screenings are a significant advance, health insurance must also provide access to affordable ongoing care for patients at higher risk for serious disease and/or advancement of existing disease.

Provider-facing initiatives (such as payment reform) can align financial incentives between payers and providers around quality metrics. Patient-facing initiatives (including benefit design) can create financial incentives between patients and third-party payers, impacting patients' clinical incentives to pursue care. While both payment reform and benefit design may theoretically be working toward the same goal of quality care,

unless both efforts intentionally align their incentives, patients, providers, and payers will have difficulty achieving their shared quality goals.

Alignment – Value-Based Insurance Design

One approach to better alignment of clinical and financial incentives is a benefit design method called, "Value-Based Insurance Design" (VBID). The AMA has long supported VBID, and VBID has been embraced by the federal government. VBID plans are designed with "clinical nuance," recognizing that medical services may differ in the amount of health produced and that the clinical benefit derived from a specific service depends on the person receiving it, as well as when, where, and by whom the service is provided. VBID plans vary patients' out-of-pocket costs based on the value of specific services to patients.

VBID has been gaining momentum, with hundreds of private self-insured employers, public organizations, nonprofits, and insurance plans having designed and tested VBID programs. Health plans can be encouraged to experiment with innovative plan designs that implement discrete elements of VBID. For example, to help patients with diabetes keep their glucose well-controlled and minimize risk for morbidity, plans could choose to reduce the patient cost-sharing for critical diabetes items or services, such as insulin or vision exams.

Legislative and Regulatory Improvements

Obstacles preventing customization of VBID plans may be alleviated through legislative and regulatory changes. For example, high deductible health plans paired with health savings accounts (HSA-HDHPs) have been among the fastest-growing plan types in the U.S. While current Internal Revenue Service (IRS) regulations permit a "safe harbor" that allows coverage of specified preventive services prior to satisfaction of the plan deductible, that safe harbor is significantly limited. IRS regulations state that services to treat "an existing illness, injury, or condition" cannot be included in pre-deductible coverage in HSA-HDHPs. Thus, if a health plan wanted to develop an HSA-HDHP according to VBID principles, many essential chronic disease prevention and management services could not be covered before the deductible is met, often making those services unaffordable. Returning to the diabetes example, an HSA-HDHP would not be allowed to reduce cost-sharing for diabetes items or services until after patients meet their deductible, defeating the purpose for some patients.

Moving Forward

In striving for better alignment between clinical and financial incentives for high-value care, the AMA supports:

- VBID plans designed with clinical nuance;
- Initiatives that align provider-facing financial incentives created through payment reform and patient-facing financial incentives created through benefit design reform, to ensure that patient, provider, and payer incentives all promote the same quality care; and
- Legislative and regulatory flexibility to accommodate VBID that preserves coverage without patient cost-sharing for evidence-based preventive services and allows innovations that expand access to affordable care, including changes needed to allow HSA-HDHPs to provide pre-deductible coverage for preventive and chronic care management services.

Additionally, the AMA is developing:

- Coding guidance tools to help providers appropriately bill for zero-dollar preventive services and promote common understanding; and
- Physician educational tools on physician-patient conversations about the scope of preventive services provided without cost-sharing.

To support these efforts, national medical specialty societies are encouraged to identify high-value services and collaborate with payers to experiment with plan designs to align patient financial incentives with high-value services.

To learn more, view the AMA's Joint Report of the Council on Medical Service and the Council on Science and Public Health, Aligning Clinical and Financial Incentives for High-Value Care.

Additional Resources:

- Value-Based Insurance Design
- Value of Preventive Services